Sierra – Sacramento Valley Emergency Medical Services Agency

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ADMINISTRATIVE BULLETIN

Date: April 24,2024

To: EMS System Participants

From: John Poland, Regional Executive Director
Troy M. Falck MD, FACEP, FAAEM, Medical Director

Subject: S-SV EMS Agency Prehospital Policy/Protocol Manual Update #74

Enclosed is the S-SV EMS Agency Prehospital Care Policy/Protocol Manual Update #74, effective June 1, 2024. Please note the following regarding this matter:

- EMS system participants are responsible for distribution of applicable new/revised S-SV EMS Agency policies and protocols to their personnel.
- Prehospital service providers are responsible for providing necessary orientation/training to their field personnel regarding new/revised S-SV EMS Agency policies and protocols.
- Base/Modified Base Hospital Medical Directors and Coordinators are responsible for providing orientation/training to their emergency department physicians and MICNs regarding new/revised S-SV EMS Agency policies and protocols.
- All new/revised S-SV EMS Agency policies and protocols will be posted on the S-SV EMS Agency website (www.ssvems.com) and updated on the S-SV EMS Agency mobile application prior to June 1, 2024.

Please contact the S-SV EMS Agency with any questions you may have regarding this matter.

REFERENCE	TITLE	ACTION	UPDATE COMMENTS
TOC	Table Of Contents	Replace	Revised to reflect changes to policies, i.e. - new, removed, title changes.
305	Base/Modified Base Hospital Program	Replace	Due for routine review. No substantive changes.
307	Ambulance Patient Offload Time (APOT)	Replace	Updated with NEMSIS V3.5 data elements.
377	BLS Optional Skills Base/Modified Base Hospital Medical Control Requirements	Replace	Removal of King Airway device.
460 & 460 (A)	Tactical Emergency Medical Services (TEMS)	Replace	Due for routine review. No substantive changes.
477	BLS Optional Skills Provider Approval/ Requirements	Replace	Removal of King Airway device.
505	Patient Destination	Replace	Due for routine review. No substantive changes.
505-A	S-SV EMS Regional Hospital Capabilities	Replace	Addition of Tahoe Forest Hospital as a Primary Stroke Center.
605	EMS Documentation	Replace	Updated language regarding PCR completion and EMS data submission processes/timelines.
701	ALS Provider Agency Inventory Requirements	Replace	Added spit hood, pediatric sidestream ETCO2 circuit, & PO acetaminophen. Updated analgesic inventory requirements.
702	ALS Specialty Program Provider Inventory Requirements	Replace	Updated analgesic inventory requirements.
703	LALS Provider Agency Inventory Requirements	Replace	Added spit hood, pediatric sidestream ETCO2 circuit, & PO acetaminophen.
704	BLS Provider Agency Inventory Requirements	Replace	Added spit hood.
705 & 705-A	Prehospital Provider Agency Unit Inspections	Replace	Updated language regarding annual unit inspection process.
706	Equipment & Supply Shortages	Replace	Due for routine review. No substantive changes.
715	Biomedical Equipment Maintenance	Replace	Due for routine review. No substantive changes.

REFERENCE	TITLE	ACTION	UPDATE COMMENTS
800	Index 800	Replace	Revised to reflect changes to policies, i.e. - new, removed, title changes.
801	Emergency Medical Technician (EMT) Scope Of Practice	Replace	Removal of King Airway device.
802	AEMT Scope Of Practice	Replace	Addition of fentanyl to AEMT II scope of practice.
803	Paramedic Scope Of Practice	Replace	Formatting changes only. No substantive changes.
844	Paramedic Utilization Of Non-Invasive High Flow Nasal Cannual During IFTs	Replace	Updated ETCO2 monitoring language.
852	Patient Restraint Mechanisms	Replace	Additional language regarding management of actively spitting patients.
C-1 & C-1 (LALS)	Non-Traumatic Pulseless Arrest	Replace	Updated mechanical CPR device indication/contraindication language. Updated language for consistency with ACLS.
C-2 & C-2 (LALS)	Return Of Spontaneous Circulation (ROSC)	Replace	Due for routine review. No substantive changes.
C-3 & C-3 (LALS)	Bradycardia With Pulses	Replace	Removal of morphine for TCP sedation/pain control.
C-4 & C-4 (LALS)	Tachycardia With Pulses	Replace	Removal of morphine for pre-cardioversion sedation/pain control.
C-6 & C-6 (LALS)	Chest Discomfort/Suspected Acute Coronary Syndrome (ACS)	Replace	Removal of morphine.
R-3 & R-3 (LALS)	Acute Respiratory Distress	Replace	Due for routine review. No substantive changes.
M-1 & M-1 (LALS)	Allergic Reaction/Anaphylaxis	Replace	Due for routine review. No substantive changes.
M-4	BLS Naloxone Administration For Suspected Opioid Overdose	Replace	Additional language regarding airway & ventilatory support.
M-6 & M-6 (LALS)	General Medical Treatment	Replace	Incorporation of nausea/vomiting treatment, expanded sepsis assessment/treatment language.
M-7	Nausea/Vomiting	**Remove**	Protocol contents merged into General Medical Treatment Protocol M-6.

REFERENCE	TITLE	ACTION	UPDATE COMMENTS
M-8 & M-8 (LALS)	Pain Management	Replace	Removal of morphine. Revised language regarding non-traumatic related/chronic pain & acute injury treatment modalities.
M-10	Finger Stick Blood Glucose Testing By EMT Personnel	**Remove**	Protocol contents merged into General Medical Treatment Protocol M-6.
E-2 & E-2 (LALS)	Hypothermia & Avalanche/Snow Immersion Suffocation Resuscitation	Replace	Title change & additional clarification language regarding snow immersion suffocation resuscitation.
E-3 & E-3 (LALS)	Frostbite	Replace	Updated reference to new pediatric pain management protocol numbering (M-8P).
E-4 & E-4 (LALS)	Bites/Envenomations	Replace	Updated reference to new pediatric pain management protocol numbering (M-8P).
T-1 & T-1 (LALS)	General Trauma Management	Replace	Updated reference to new pediatric pain management protocol numbering (M-8P).
T-3 & T-3 (LALS)	Suspected Moderate/Severe Traumatic Brain Injury (TBI)	Replace	Updated language regarding PPV, advanced airway use and target $EtCO_2$. Updated SBP & fluid bolus language.
T-4 & T-4 (LALS)	Hemorrhage	Replace	Updated list of approved Hemostatic Agents. Additional TXA information in the ALS/BLS protocol.
T-5 & T-5 (LALS)	Burns	Replace	Updated reference to new pediatric pain management protocol numbering (M-8P).
T-6 & T-6 (LALS)	Traumatic Pulseless Arrest	**Add**	New traumatic cardiac arrest protocol.
C-1N & C-1N (LALS)	Neonatal Resuscitation	**Add**	Renumbered from P-2. Due for routine review. No other substantive changes.
C-1P & C-1P (LALS)	Pediatric Pulseless Arrest	**Add**	Renumbered from P-4. Added EtCO2. Revised epinephrine dosing. Added narcotic OD language.
C-3P & C-3P (LALS)	Pediatric Bradycardia With Pulses	**Add**	Renumbered from P-6. Updated O2 administration language. Added EtCO2.
C-4P & C-4P (LALS)	Pediatric Tachycardia With Pulses	**Add**	Renumbered from P-8. Updated O2 administration language. Added EtCO2.
R-1P & R-1P (LALS)	Pediatric Foreign Body Airway Obstruction	**Add**	Renumbered from P-10. Updated O2 administration language.
R-2P & R-2P (LALS)	Pediatric Respiratory Arrest	**Add**	Renumbered from P-12. Updated O2 administration language. Added EtCO2.

REFERENCE	TITLE	ACTION	UPDATE COMMENTS
M-1P & M-1P (LALS)	Pediatric Allergic Reaction/Anaphylaxis	**Add**	Renumbered from P-18. Updated O2 administration language. Updated BLS epinephrine administration language. Updated high risk and in extremis criteria on page 2.
M-5P & M-5P (LALS)	Pediatric Ingestions & Overdose	**Add**	Renumbered from P-22. Updated O2 administration language. Added EtCO2. Added Poison Control contact information.
M-8P & M-8P (LALS)	Pediatric Pain Management	**Add**	Renumbered from P-34. Updated O2 administration language. Added EtCO2. Added Poison Control contact information. Removal of morphine. Revised language regarding non-traumatic related/ chronic pain & acute injury treatment modalities.
M-11P & M-11P (LALS)	Pediatric Behavioral Emergencies	**Add**	New pediatric behavioral emergencies protocol.
N-1P & N-1P (LALS)	Pediatric Altered Level Of Consciousness	**Add**	Renumbered from P-24. Updated O2 administration language. Added EtO2.
N-2P & N-2P (LALS)	Pediatric Seizure	**Add**	Renumbered from P-26. Updated O2 administration language. Added EtCO2. Added PO acetaminophen for febrile pts ≤ 5 yo.
T-3P & T-3P (LALS)	Pediatric Suspected Moderate/Severe Traumatic Brain Injury (TBI)	Replace	Renumbered from P-28. Due for routine review. No other substantive changes.
P-2 & P-2 (LALS)	Neonatal Resuscitation	**Remove**	Replaced with C-1N.
P-4 & P-4 (LALS)	Pediatric Pulseless Arrest	**Remove**	Replaced with C-1P.
P-6 & P-6 (LALS)	Pediatric Bradycardia - With Pulses	**Remove**	Replaced with C-3P.
P-8 & P-8 (LALS)	Pediatric Tachycardia - With Pulses	**Remove**	Replaced with C-4P.
P-10 & P-10 (LALS)	Pediatric Foreign Body Airway Obstruction	**Remove**	Replaced with R-1P
P-12 & P-12 (LALS)	Pediatric Respiratory Failure/Arrest	**Remove**	Replaced with R-2P.
P-18 & P-18 (LALS)	Pediatric Allergic Reaction/Anaphylaxis	**Remove**	Replaced with M-1P.

REFERENCE	TITLE	ACTION	UPDATE COMMENTS
P-22 & P-22 (LALS)	Pediatric Overdose/Poisoning	**Remove**	Replaced with M-5P.
P-24 & P-24 (LALS)	Pediatric Altered Level Of Consciousness	**Remove**	Replaced with N-1P.
P-26 & P-26 (LALS)	Pediatric Seizure	**Remove**	Replaced with N-2P.
P-28 & P-28 (LALS)	Pediatric Suspected Moderate/Severe Traumatic Brain Injury (TBI)	**Remove**	Replaced with T-3P.
P-34 & P-34 (LALS)	Pediatric Pain Management	**Remove**	Replaced with M-8P.
1100	Index 1100	Replace	Revised to reflect changes to policies, i.e. - new, removed, title changes.
1101	Vascular Access	Replace	Due for routine review. No substantive changes.
1110 & 1110 A-L	ALS/LALS Annual Infrequently Used Skills Verification & Regional Training Module	Replace	Renumbered Infrequently Used Skills Verification Sheets. Removal of King Airway. Removal of Morphine.

Sierra – Sacramento Valley EMS Agency Policy/Protocol Manual
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Cardiovascular

ADULT PATIENT TREATMENT PROTOCOLS (LALS - AEMT)

Cardiovascular

Respiratory

Medical

Neurological

Sierra – Sacramento Valley EMS Agency Program Policy			
Base/Modified Base Hospital Program			
	Effective: 06/01/2024	Next Review: 04/2027	**305**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish requirements for base and modified base hospitals in the S-SV EMS region.

AUTHORITY:

A. HSC, Division 2.5, § 1797.16, 1797.107, 1797.171, 1797.204, 1797.206, 1797.214, 1797.218, 1797.220, 1798.102, and 1798.104.

B. CCR, Title 22, Division 9, Chapters 3 & 4.

DEFINITIONS:

A. **Base Hospital –** A hospital that meets the requirements contained in this policy, and utilizes S-SV EMS authorized Mobile Intensive Care Nurses (MICNs) and/or emergency department physicians to provide medical direction/supervision to prehospital EMS personnel in the S-SV EMS region. Base hospitals shall have a current base hospital agreement in place with S-SV EMS in order to operate as such.

B. **Modified Base Hospital –** A hospital that meets the requirements contained in this policy, and utilizes only emergency department physicians to provide medical direction/supervision to prehospital EMS personnel in the S-SV EMS region. Modified base hospitals shall have a current modified base hospital agreement in place with S-SV EMS in order to operate as such.

C. **Emergency Medical Services Quality Improvement Program (EMSQIP) –** Methods of evaluation that are composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct process, and recognize excellence in performance and delivery of care, pursuant to the provisions of California Code of Regulations, Title 22, Chapter 12 and S-SV EMS policies.

POLICY:

S-SV EMS shall designate base and modified hospitals to receive ambulance patients and provide medical direction/supervision to prehospital EMS personnel in the S-SV EMS region.

PROCEDURE:

A. An S-SV EMS designated base or modified base hospital shall:

1. Be licensed by the California Department of Public Health as a general acute care hospital.

2. Be accredited by a Centers for Medicare and Medicaid Services approved deeming authority.

3. Have a special permit for basic or comprehensive emergency medical service pursuant to the provisions of California Code of Regulations, Title 22, Division 5, or have been granted approval by the California EMS Authority for utilization as a base hospital pursuant to the provisions of Section 1798.101 of the California Health and Safety Code.

4. Have and agree to utilize/maintain two-way telecommunications capable of direct two-way voice communication with prehospital EMS personnel.

5. Maintain a record of all online medical direction between prehospital EMS and base/modified base hospital personnel as specified in S-SV EMS polices.

6. Have a written agreement with S-SV EMS, which is reviewed every three (3) years, indicating the concurrence of hospital administration, medical staff and emergency department staff to meet the requirements for program participation as specified in this policy.

7. Designate a base/modified base hospital medical director who shall be a physician on the hospital staff, licensed in the State of California who is certified or prepared for certification by the American Board of Emergency Medicine. The requirement of board certification or prepared for certification may be waived by the S-SV EMS Medical Director. The base/modified base hospital medical director shall be regularly assigned to the emergency department, have experience in and knowledge of base/modified base hospital radio operations and S-SV EMS policies, procedures and protocols, and shall be responsible for functions of the base/modified base hospital including the EMSQIP.

8. Identify a base/modified base hospital coordinator who is a California licensed Registered Nurse with experience in and knowledge of base/modified base hospital operations and S-SV EMS policies, procedures and protocols to act as a prehospital liaison to the local EMS system.

9. Assure that nurses giving medical direction to prehospital personnel are trained and authorized as MICNs by S-SV EMS.

10. Have a physician licensed in the State of California, experienced in emergency medical care, assigned to the emergency department; available at all times to provide immediate medical direction to MICN and/or prehospital EMS personnel. This physician shall have experience in and knowledge of base/modified base hospital radio operations and S-SV EMS policies, procedures and protocols.

11. Ensure that a mechanism exists for prehospital EMS providers to contract for the provision of medications, medical supplies and equipment used for patient care according S-SV EMS policies and procedures.

12. Provide for continuing education in accordance with S-SV EMS policies.

13. Agree to participate in the S-SV EMS EMSQIP, which may include making available all relevant records for program monitoring and evaluation.

B. S-SV EMS may deny, suspend, or revoke base/modified base hospital approval for failure to comply with any applicable policies, procedures, statutes or regulations.

GENERAL PROVISIONS:

A. Education:

An S-SV EMS designated base/modified base hospital shall:

1. Act as an education resource for prehospital EMS provider agencies.

2. Maintain approval as an EMS continuing education provider.

3. Provide formal education programs for prehospital EMS personnel.

4. Assist in providing special and mandatory training programs deemed necessary by S-SV EMS.

5. Provide supervised clinical experience for prehospital EMS students/trainees in accordance with CCR, Title 22 and S-SV EMS policies and procedures.

6. Provide clinical skills remediation training for prehospital EMS personnel as needed.

B. EMS System Involvement:

An S-SV EMS designated base/modified base hospital shall participate in S-SV EMS regional committee meetings and other EMS activities that affect the region.

C. Patient Care Records:

An S-SV EMS designated base/modified base hospital shall participate in a collaborative manner with S-SV EMS data collection programs.

D. Multi Casualty Incidents/Disaster Planning and Response:

1. An S-SV EMS designated base/modified base hospitals shall reasonably participate in local and regional disaster drills; including utilization of EMResource.

2. An S-SV EMS designated base/modified base hospital shall actively participate in local and regional disaster related planning efforts.

3. During a Multi Casualty Incident (MCI) or disaster, the procedures indicated in applicable MCI plans and S-SV EMS policies/protocols shall be followed.

Sierra – Sacramento Valley EMS Agency Program Policy			
Ambulance Patient Offload Time (APOT)			
	Effective: 06/01/2024	Next Review: 01/2027	**307**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

A. To establish standards for the timely transfer of patient care responsibilities from EMS prehospital personnel to hospital emergency department (ED) medical personnel.

B. To establish standardized methodologies for collecting, calculating, and reporting Ambulance Patient Offload Time (APOT).

AUTHORITY:

A. HSC, Division 2.5, Chapter 4, Article 1, § 1797.120.5, § 1797.120.6, § 1797.129.7, § 1787.225, § 1797.227 & § 1797.228.

B. CCR, Title 22, Division 9, Chapter 3, § 100127 & Chapter 4, § 100169.

C. S-SV EMS Base/Modified Base Hospital Agreements.

DEFINITIONS:

A. **Ambulance Patient Offload Time (APOT) –** The time interval between the arrival of a 911 ambulance patient at a hospital ED ambulance bay and the time the patient is transferred from the ambulance cot to the ED gurney, bed, chair or other acceptable location, and ED medical personnel assume complete responsibility for care of the patient.

B. **APOT 1.1** – An APOT time interval measure. This metric is a continuous variable measured in minutes, aggregated, and reported as a median.

C. **APOT 1.2** – An APOT interval measure. This metric is a continuous variable measured in minutes, aggregated, and reported as a 90th percentile.

D. **APOT 2** – An APOT time interval process measure. This metric demonstrates the incidence of ambulance patient offload times expressed as a percentage of total EMS patient transports within a twenty (20) minute target, and exceeding that time in reference to 60-, 120- and 180-minute intervals.

POLICY:

A. APOT Documentation and Standards:

1. EMS prehospital personnel shall adequately document APOT on all incidents.

   - All incident times, including 'Patient Arrived at Destination Date/Time' and 'Destination Patient Transfer of Care Date/Time' shall be accurately documented in the electronic patient care report.
   - Any misrepresentation of APOT documentation in the electronic patient care report is a serious infraction, which may result in disciplinary action.

2. The expectation is that all ambulance patients are transferred from the ambulance cot/equipment to the ED gurney, bed, chair or other acceptable location, and ED medical personnel assume complete responsibility for care of the patient as soon as possible after ED arrival. The standard APOT for the S-SV EMS region is 20 minutes, and 911 ambulance patients shall have an APOT time of 20 minutes or less, 90% of the time. The following time measurements exceed/significantly exceed S-SV EMS APOT standards:

   - Exceeds APOT Standard:
     - APOT 1.1: 21 – 30 minutes
     - APOT 1.2: 21 – 30 minutes
     - APOT 2: 21 – 60 minutes

   - Significantly Exceeds APOT Standard:
     - APOT 1.1: Greater than 30 minutes
     - APOT 1.2: Greater than 30 minutes
     - APOT 2: Greater than 60 minutes

B. APOT Calculations/Reporting:

1. APOT calculations will be completed by S-SV EMS staff on a monthly basis, utilizing electronic patient care report data from the S-SV EMS data system.

   - Incidents with obvious data errors, that cannot be subsequently resolved/ verified, will be excluded from APOT calculations and reporting.

2. S-SV EMS will produce/publish a system-wide APOT report on a monthly basis. This APOT report will be available to all EMS system participants as well as the general public.

3. S-SV EMS will provide APOT data to the California EMS Authority, as required by current statutes and regulations.

4. S-SV EMS will utilize the following National Emergency Medical Services Information System (NEMSIS) Version 3.5 (V3.5) data codes, descriptions, and criteria to calculate, evaluate and report APOT measures:

NEMSIS V3.5 Data Code	NEMSIS V3.5 Data Description	Criteria/ Calculation
dAgency.03	EMS Agency Name	All S-SV EMS Authorized Emergency Transport Providers
eResponse.05	Type of Service Requested	Emergency Response (Primary Response Area)
eDisposition.30	Transport Disposition	Transport by This EMS Unit (This Crew Only); or Transport by This EMS Unit, with a Member of Another Crew
eDisposition.21	Type of Destination	Hospital-Emergency Department
eDisposition.01	Destination/Transferred To, Name	Hospitals receiving emergency pts transported by ambulance
eTimes.11 eTimes.12	Patient Arrived at Destination Date/Time Destination Patient Transfer of Care Date/Time	Calculation = Difference (in minutes) between eTimes.11 & eTimes.12

Sierra – Sacramento Valley EMS Agency Program Policy			
BLS Optional Skills Base/Modified Base Hospital Medical Control			
	Effective: 06/01/2024	Next Review: 01/2027	**377**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish the requirements for base/modified base hospital medical control of Public Safety First Aid (PSFA), Emergency Medical Responder (EMR) and Emergency Medical Technician (EMT) personnel authorized to utilize any or all BLS optional skills.

AUTHORITY:

A. HSC, Division 2.5, § 1797.200, 1798, 1798.2, 1798.104.

B. CCR, Title 22, Chapters 1.5 and 2.

POLICY:

A. An EMS prehospital service provider desiring to utilize any of the BLS optional skills listed in this policy must be approved by S-SV EMS, and continually meet all requirements set forth by state law/regulations and S-SV EMS policies related to the utilization of such skills.

B. PSFA, EMR or EMT personnel must be functioning under the oversight of an S-SV EMS approved BLS optional skills provider in order to utilize any of the BLS optional skills listed in this policy.

C. The following BLS optional skills may be authorized by S-SV EMS for use by Public Safety First Aid (PSFA) personnel in accordance with applicable S-SV EMS policies and treatment protocols:

1. Administration of atropine and pralidoxime chloride by auto–injector.

2. Administration of epinephrine by auto-injector.

3. Administration of intranasal (IN) naloxone.

4. Administration of supplemental oxygen.

5. Utilization of oropharyngeal airways (OPAs) and nasopharyngeal airways (NPAs).

A. The following BLS optional skills may be authorized by S-SV EMS for use by Emergency Medical Responder (EMR) personnel in accordance with applicable S-SV EMS policies and treatment protocols:

1. Administration of atropine and pralidoxime chloride by auto–injector.

2. Administration of epinephrine by auto-injector.

3. Administration of intranasal (IN) naloxone.

B. The following BLS optional skills may be authorized by S-SV EMS for use by Emergency Medical Technician (EMT) personnel in accordance with applicable S-SV EMS policies and treatment protocols:

1. Administration of atropine and pralidoxime chloride by auto-injector.

2. Administration of epinephrine by auto-injector or intramuscular (IM) injection.

3. Administration of intranasal (IN) naloxone.

4. Utilization of a size 3, 4, or 5 i-gel advanced airway device.

PROCEDURE:

The base/modified base hospital shall provide medical control for PSFA, EMR and/or EMT BLS optional skills authorized personnel which includes the following:

A. Appointment of a physician medical director for monitoring the utilization of BLS optional skills. A registered nurse, paramedic and/or AEMT may assist the medical director with responsibilities of monitoring the BLS optional skills.

B. Assist with periodic training, skills proficiency demonstrations, organized field care audits, structured clinical experience and continuous quality improvement in compliance with S-SV EMS policies as necessary.

Sierra – Sacramento Valley EMS Agency Program Policy			
Tactical Emergency Medical Services (TEMS)			
	Effective: 06/01/2024	Next Review: 04/2027	**460**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

A. To define the different types of tactical emergency medical services (TEMS) utilized in the S-SV EMS region.

B. To establish the training, program approval, utilization and equipment requirements for TEMS programs and personnel.

DEFINITIONS:

A. **Tactical Casualty Care (TCC) –** The delivery of specialized TEMS to casualties of active shooter/mass violence incidents by EMS personnel. TCC trained EMS personnel respond as medical support to law enforcement incidents and provide field tactical medical care to casualties usually in an area where there is minimal to no direct or immediate safety threat.

B. **Tactical Medicine for Special Operations –** The delivery of specialized TEMS to casualties of any active law enforcement incident by law enforcement personnel assigned to a Special Weapons and Tactics (SWAT) operations team. Tactical Medicine for Special Operations personnel respond as an integral part of a SWAT operation team and may provide field tactical medical care to casualties in an area where there is a direct and immediate safety threat.

AUTHORITY:

A. HSC, Division 2.5, § 1797.218, 1797.220 & 1798.

B. CCR, Title 22, Division 9, § 100145 & 100169.

C. California POST/EMSA Tactical Medicine Operational Programs and Standardized Training Recommendations – July 2009.

D. California Tactical Casualty Care Training Guidelines (EMSA #370) – June 2017.

POLICY:

A. The tactical incident response environment presents unique challenges to law enforcement personnel and EMS personnel providing emergency medical services in that environment. TEMS personnel must have a clear understanding of law enforcement response and tactics, and the mission-specific objectives of a tactical operation when planning for and providing EMS support.

B. TEMS trained personnel should be utilized when available to provide emergency medical services during an active shooter/mass violence incident and/or to support law enforcement special operations as appropriate. If necessary, EMS personnel without specific TEMS training may be utilized to provide emergency medical care during these type of incidents as requested/directed by Incident/Unified Command.

PROCEDURE:

A. Tactical Casualty Care (TCC)

1. Tactical First Aid/TEMS First Responder Operations (FRO) Training Requirement:

- Tactical First Aid/TEMS FRO training provides EMS personnel basic TCC techniques and a broad overview of law enforcement tactical operations and rescue operations methodologies. Upon course completion, participants will possess basic knowledge and skills to administer TCC to casualties during an active law enforcement incident.
- A minimum of four (4) hours training is required, although eight (8) hours of training is recommended, and shall include the following topics:
  - An overview of the California tactical casualty care initiative and its emergency medical and fire agency personnel response to active law enforcement incidents within state EMS systems.
  - Common tactical and rescue terminology and operations.
  - Description and demonstration of basic tactical casualty care techniques.
  - Casualty movement and evacuation techniques.
  - Medical planning and threat assessment considerations.
  - Comprehensive, competency-based student demonstration and, when applicable, student skills testing.

2. Tactical Lifesaver/TEMS Technician Training Requirement:

- Tactical Lifesaver/TEMS Technician training provides EMS personnel more advanced life support tactical medicine techniques and comprehensive instruction on the role of EMS in tactical response planning, response, and inter-department operations when providing medical support to law enforcement personnel during active shooter/mass violence incidents.

- A minimum of 40 hours training is required, and shall include the following topics:

    - Introduction and course administration and safety.
    - An overview of the California tactical casualty care initiative.
    - The role of California EMS personnel as it relates to medical planning, EMS medical support response, and inter-department operations.
    - Common tactical and rescue terminology and operations.
    - Casualty movement and evacuation techniques.
    - Threat assessment considerations.
    - Hemostasis: hemorrhage control management skills.
    - Airway and respiration management skills.
    - Circulation management skills.
    - Environmental injuries management.
    - Medication administration and pain management.
    - Medical aspects of tactical operations.
    - Team health management.
    - Comprehensive, competency-based student demonstration and skills testing.

3. Tactical First Aid/TEMS FRO and/or Tactical Lifesaver/TEMS Technician TCC Training Program Approval:

    - S-SV EMS is responsible for approving/monitoring TCC training programs conducted within the S-SV EMS region.
    - Programs shall meet the applicable requirements contained in the California Tactical Casualty Care Training Guidelines (EMSA #370) to receive S-SV EMS TCC training program approval.
    - Interested entities may contact S-SV EMS to request a TCC training program application.

4. TCC Providers/Personnel:

    - BLS/ALS prehospital service providers located within the S-SV EMS region may provide TCC services, in coordination with law enforcement, without the need for special TCC service provider approval.
    - Medical direction/oversight of TCC trained personnel is provided by the S-SV EMS Medical Director (through established S-SV EMS policies/protocols), in coordination with local law enforcement.
    - Equipment and supplies carried/utilized by TCC trained personnel shall be consistent with items listed in the S-SV EMS Prehospital Provider Agency Inventory Requirements Policy (701).

B. Tactical Medicine for Special Operations Programs

1. The California Commission on Peace Officer Standards and Training (POST) is responsible for approving/monitoring Tactical Medicine for Special Operations training programs.

2. Tactical Medicine for Special Operations TEMS personnel shall successfully complete all initial and ongoing recommended training provided by a POST approved Tactical Medicine for Special Operations training program.

3. Medical direction/oversight of Tactical Medicine for Special Operations personnel is provided by a licensed physician associated with the approved program, in coordination with the S-SV EMS Medical Director. Prehospital EMS personnel shall only provide medical care that is within their approved scope of practice.

4. Tactical Medicine for Special Operations service provider programs require S-SV EMS approval.

5. Equipment and supplies carried/utilized by Tactical Medicine for Special Operations TEMS personnel shall be consistent with the items listed in the 'California POST/EMSA Tactical Medicine Operational Programs and Standardized Training Recommendations' document. Equipment and supplies shall be based on the appropriate level and approved scope of practice of personnel utilized for the particular tactical medicine program.

Sierra – Sacramento Valley EMS Agency
Tactical Casualty Care (TCC) Training Program Application
Reference No. 460-A

☐ Initial	☐ Renewal	☐ Program Update

Level of TCC Program

☐ Tactical First Aid/Tactical Medicine FRO
(Minimum 4 hour course, 8 hours recommended)

☐ Tactical Life Saver/Tactical EMS Technician
(Minimum 40 hour course)

TCC Program Name:		
CE Provider # (if applicable):		
Street Address:		
City:	State:	Zip Code:
Telephone:	Fax:	Email:
Program Director Name:		
Program Director Certification/License Number and Expiration:		

I certify that I have read and understand the S-SV EMS 'Tactical Emergency Medical Services (TEMS)' Policy (460) as well as the California Tactical Casualty Care Training Guidelines (EMSA #370), and that I/this agency will comply with all guidelines, policies, and procedures described therein. I agree to comply with all audit & review provisions required/conducted by the S-SV EMS Agency. Furthermore, I certify that all information on this application is true and correct to the best of my knowledge.

_____ _____
Program Director Signature Date

Required Supporting Documentation

☐ Instructor Resume
☐ Course Curriculum/Training Material
☐ Course Outline with Hourly Description
☐ Course Safety Policy
☐ List of Psychomotor Skills
☐ List of Tactical Medical Scenarios
☐ Written/Skills Examinations
☐ Proposed CE Certificate/Course Completion
☐ Fee $100

S-SV EMS Agency Use Only

Application Received	Reviewed By	Approval Date	Renewal Date	CE Provider #	Method of Payment

Sierra – Sacramento Valley EMS Agency Program Policy			
BLS Optional Skills Provider Approval/Requirements			
	Effective: 06/01/2024	Next Review: 01/2027	**477**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish the BLS optional skills provider approval process and ongoing requirements of an S-SV EMS approved BLS optional skills provider.

AUTHORITY:

A. HSC, Division 2.5.

B. CCR, Title 22, Division 9, Chapters 1.5 and 2.

POLICY:

A. An EMS prehospital service provider desiring to utilize any of the BLS optional skills listed in this policy must be approved by S-SV EMS, and continually meet all requirements set forth by state law/regulations and S-SV EMS policies related to the utilization of such skills. BLS optional skills provider approval may be revoked or suspended for failure to comply with the requirements of this policy.

B. PSFA, EMR or EMT personnel must be functioning under the oversight of an S-SV EMS approved BLS optional skills provider in order to utilize any of the BLS optional skills listed in this policy.

C. The following BLS optional skills may be authorized by S-SV EMS for use by Public Safety First Aid (PSFA) personnel in accordance with applicable S-SV EMS policies and treatment protocols:

1. Administration of atropine and pralidoxime chloride by auto–injector.

2. Administration of epinephrine by auto-injector.

3. Administration of intranasal (IN) naloxone.

4. Administration of supplemental oxygen.

5. Utilization of oropharyngeal airways (OPAs) and nasopharyngeal airways (NPAs).

A. The following BLS optional skills may be authorized by S-SV EMS for use by Emergency Medical Responder (EMR) personnel in accordance with applicable S-SV EMS policies and treatment protocols:

1. Administration of atropine and pralidoxime chloride by auto–injector.

2. Administration of epinephrine by auto-injector.

3. Administration of intranasal (IN) naloxone.

B. The following BLS optional skills may be authorized by S-SV EMS for use by Emergency Medical Technician (EMT) personnel in accordance with applicable S-SV EMS policies and treatment protocols:

1. Administration of atropine and pralidoxime chloride by auto-injector.

2. Administration of epinephrine by auto-injector or intramuscular (IM) injection.

3. Administration of intranasal (IN) naloxone.

4. Utilization of a size 3, 4, or 5 i-gel advanced airway device.

D. BLS Optional Skills Provider Approval Process:

1. An EMS prehospital service provider desiring to utilize any of the BLS optional skills listed in this policy shall submit a written request to S-SV EMS for approval to utilize such skills. The written request shall include the following:

- A letter of intent to utilize the BLS optional skills, expressing willingness to abide by all S-SV EMS policies, procedures, and requirements.
- A listing of BLS optional skills requesting authorization to utilize and level of personnel (PSFA, EMR and/or EMT) that will be utilizing the optional skills.
- A description of the geographic area within which the BLS optional skills will be utilized (size, population, population distribution and any other unique characteristics associated with the area that may impact the program).
- A description of the need for use of the BLS optional skills.
- Name and credentials of the organization’s proposed BLS optional skills principal instructor. The principal instructor shall be a physician, registered nurse, physician assistant, paramedic, or Advanced EMT licensed/certified in California, or a physician licensed in another state immediately adjacent to the S-SV EMS region.
- A description of the organization’s procedures for collection and retention of BLS optional skills utilization medical records.
- A description of the organization’s quality improvement (QI) monitoring and oversight processes related to BLS optional skills utilization.

2. Program approval or disapproval shall be made by S-SV EMS within thirty (30) calendar days after receipt of all required documentation listed in this section.

E. Approved BLS Optional Skills Provider Requirements:

An S-SV EMS approved BLS optional skills provider shall continually comply with the following:

1. Initial and Ongoing Training Requirements:

- Provide initial BLS optional skills training/testing utilizing S-SV EMS approved or provided curriculum.
- Provide all necessary training equipment for initial and ongoing training.
- Utilize only S-SV EMS approved principal instructors to teach the required curriculum.
  - An EMT trained and authorized to utilize the BLS optional skills may assist in the training and demonstration of skills competency.
- Ensure that each authorized PSFA, EMR, or EMT individual demonstrates competency in the utilization of all approved optional skills, a minimum of once every twelve (12) months.
  - Personnel authorized to verify skills competency shall be a physician, registered nurse, physician assistant, paramedic, Advanced EMT, or appropriately trained EMT licensed/certified in California, or a physician licensed in another state immediately adjacent S-SV EMS Region.
- Maintain adequate documentation of initial and ongoing BLS optional skills training, including records of the required annual skills competency verification. Training records shall be maintained for a minimum of four (4) years and are subject to inspection by S-SV EMS representatives upon request.

2. Records/Data Collection Requirements:

- Ensure that a written (605-A, 605-B, or equivalent) or electronic patient care report is completed for each patient on whom a BLS optional skill is utilized.
- Provide a copy of the completed patient care report referenced above to S-SV EMS within seven (7) calendar days after utilization of any of the following BLS optional skills:
  - Administration of atropine and pralidoxime chloride by auto-injector.
  - Administration of epinephrine by auto-injector or IM injection.
  - Administration of IN naloxone.
  - Utilization of an i-gel advanced airway device.

3. Continuous Quality Improvement (CQI) Requirements:

    - Designate sufficient/qualified staff to ensure timely/competent review of all calls where a BLS optional skill is utilized. At a minimum, the review of these calls shall focus on the following:
        - Documentation accuracy.
        - Compliance with S-SV EMS policies and treatment protocols.
        - Identification of potential provider or system issues related to the utilization of BLS optional skills.
    - Submit S-SV EMS required BLS optional skills utilization data as part of the EMS prehospital service provider's Emergency Medical Services Quality Improvement Program (EMSQIP) annual report.

4. Other Program Requirements:

    - Notify S-SV EMS of any changes related to the provider's BLS optional skills program within 30 calendar days.
    - Notify S-SV EMS, by the next business day, of any incident involving a potential policy/protocol violation or resulting in potential patient harm from the use of a BLS optional skill.

Sierra – Sacramento Valley EMS Agency Program Policy			
Patient Destination			
	Effective: 06/01/2024	Next Review: 04/2027	**505**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish procedures for determining the appropriate destination of patients transported by ambulance in the S-SV EMS region.

AUTHORITY:

A. HSC, Division 2.5, § 1797.67, 1797.88, 1798.165 & 1798.170.

B. CCR, Title 13, § 1105(c).

C. CCR, Title 22, Division 9, Chapters 2, 3, 4 & 7.

POLICY:

A. In the absence of decisive factors to the contrary, EMS personnel shall transport emergency patients to the most accessible medical facility equipped, staffed, and prepared to receive emergency cases and administer emergency care appropriate to the needs of the patients. In determining the most accessible facility, EMS personnel shall take into consideration traffic obstructions, weather conditions, or similar factors which clearly affect transport time.

B. Hospitals unable to accept patients due to incapacitating internal disaster shall be considered not prepared to receive emergency cases.

C. All hospitals shall maintain their current facility status on EMResource, and shall update their facility status no less than once every 24 hours. All hospitals shall respond to EMResource hospital polls initiated by S-SV EMS or the applicable Medical Health Operational Area Coordinator within 30 minutes of notification.

PROCEDURE:

A. The most accessible medical facility shall ordinarily be the nearest licensed healthcare facility which maintains and operates a basic emergency department, except for the following circumstances:

1. The base/modified base hospital may direct a patient be transported to a further acute care hospital equipped, staffed, and prepared to receive emergency cases, which in the judgment of the base/modified base hospital physician or MICN, is more appropriate to the medical needs of the patient. Such direction shall take into consideration the prehospital provider's time and/or travel limitations.

2. S-SV EMS policies/protocols governing transport of special category patients to designated special care facilities shall be followed.

3. The Control Facility (CF) is responsible for the dispersal of all patients during multiple casualty incidents (MCIs).

4. In the event of an unprecedented demand for medical/health services beyond the capacity of current providers and resources available through local, regional, state, and/or federal mutual aid, Crisis Standard of Care Procedures may be implemented to include alternate patient transportation/destination orders.

B. A member of a health care service plan should be transported to a hospital that contracts with the plan when prehospital EMS personnel and/or the base/modified base hospital determines that the condition of the member permits such transport. However, when prehospital personnel determine that such transport would unreasonably remove the transport unit from the area, the member may be transported to the nearest hospital capable of providing appropriate treatment.

C. When a patient, or their legally authorized representative, requests transportation to a hospital other than the most accessible, the request should be honored when prehospital EMS personnel and/or the base/modified base hospital determines that the condition of the patient permits such transport; except when prehospital EMS personnel determine that such transport would unreasonably remove the transport unit from the area. In such cases:

1. Arrangements should be made for alternative transport if possible.

2. If such transport cannot be obtained without unacceptable delay, the patient may be transported to the nearest hospital capable of providing appropriate treatment.

D. When a private physician requests emergency transportation to a hospital other than the most accessible, the request should be honored unless:

1. The base/modified base hospital determines that the condition of the patient does not permit such transport. In such cases, base/modified base hospital directions shall be followed. If communication with the requesting physician is feasible, the base/modified base hospital should contact the physician and explain the situation.

2. Prehospital EMS personnel determine that such transportation would unreasonably remove the unit from the area. In such cases:

    - Arrangements should be made for alternate transportation if possible.
    - If alternate transportation cannot be arranged without unacceptable delay, and the private physician is immediately accessible, the patient may be transported to a mutually agreed-upon alternate destination.
    - If alternate transportation cannot be arranged without unacceptable delay, and the private physician is not immediately accessible, the patient may be transported to the nearest hospital capable of providing appropriate treatment.

Sierra - Sacramento Valley EMS Regional Hospital Capabilities (505-A)

Hospital Type Abbreviations/Definitions

BASE (Base Hospital): EMS medical direction provided by MICNs and ED physicians.
MOD (Modified Base Hospital): EMS medical direction provided by ED physicians only (no MICNs).
REC (Receiving Hospital): Unable to provide EMS medical direction, but able to receive ambulance patients.

Stroke Center Abbreviations

PSC - Primary Stroke Center **TSC -** Thrombectomy Capable Stroke Center **CSC -** Comprehensive Stroke Center

Hospitals Located Within The S-SV EMS Region

Hospital Name	County	Hospital Type	Helispot/ Helipad	Trauma Center	Stroke Center	STEMI Center	L&D	Other
Enloe Medical Center	Butte	BASE	X	Level II	PSC	X	X	
Orchard Hospital	Butte	REC	X					
Oroville Hospital	Butte	BASE	X		PSC		X	
Colusa Medical Center	Colusa	MOD	X					
Glenn Medical Center	Glenn	REC	X					
Sierra Nevada Memorial Hospital	Nevada	MOD	X		PSC		X	
Tahoe Forest Hospital	Nevada	BASE	X	Level III	PSC		X	
Kaiser Roseville Medical Center	Placer	MOD			PSC	X	X	
Sutter Auburn Faith Hospital	Placer	MOD			PSC			
Sutter Roseville Medical Center	Placer	BASE	X	Level II	TSC	X	X	
Mayers Memorial Hospital	Shasta	BASE	X					
Mercy Medical Center Redding	Shasta	BASE	X	Level II	TSC	X	X	
Shasta Regional Medical Center	Shasta	BASE	X		PSC	X		
Fairchild Medical Center	Siskiyou	BASE	X	Level IV	PSC		X	
Mercy Medical Center Mt. Shasta	Siskiyou	BASE	X	Level III	PSC		X	
St. Elizabeth Community Hospital	Tehama	BASE	X	Level III	PSC		X	
Adventist Health +Rideout	Yuba	BASE	X	Level III	PSC	X	X	

S-SV EMS Designated MCI Control Facilities (CFs)

Control Facility (CF)	Coverage Area
Enloe Medical Center	Butte, Colusa & Glenn Counties
Adventist Health +Rideout	Sutter & Yuba Counties
Sutter Roseville Medical Center	Western Slope of Nevada & Placer Counties
Tahoe Forest Hospital (Back-Up: REMSA)	Tahoe Basin & Eastern Slope of Nevada & Placer Counties
Mercy Medical Center Redding	Shasta, Siskiyou & Tehama Counties

Sierra - Sacramento Valley EMS Regional Hospital Capabilities (505-A)

Sacramento County Hospitals								
Hospital Name	**County**	**Hospital Type**	**Helispot/ Helipad**	**Trauma Center**	**Stroke Center**	**STEMI Center**	**L&D**	**Other**
Kaiser Sacramento Medical Center	Sac.	REC			PSC			
Kaiser South Sacramento Medical Center	Sac.	REC	X	Level II	CSC	X	X	
Mercy General Hospital	Sac.	REC			PSC	X	X	VAD
Mercy Hospital of Folsom	Sac.	REC	X		PSC		X	
Mercy San Juan Medical Center	Sac.	REC	X	Level II	CSC	X	X	
Methodist Hospital	Sac.	REC			PSC		X	
Sacramento VA Medical Center	Sac.	REC						
Sutter Sacramento Medical Center	Sac.	REC	X		PSC	X	X	VAD
UC Davis Medical Center	Sac.	BASE	X	Level I & Pediatric	CSC	X	X	VAD & Burn
Nevada Hospitals								
Hospital Name	**County**	**Hospital Type**	**Helispot/ Helipad**	**Trauma Center**	**Stroke Center**	**STEMI Center**	**L&D**	**Other**
Northern Nevada Medical Center	Washoe	REC	X		PSC	X		
Northern Nevada Sierra Medical Center	Washoe	REC			PSC	X	X	
Renown Regional Medical Center	Washoe	REC	X	Level II	CSC	X	X	
Renown South Meadows Medical Center	Washoe	REC						
St. Mary's Regional Medical Center	Washoe	REC	X		PSC	X		
Oregon Hospitals								
Hospital Name	**County**	**Hospital Type**	**Helispot/ Helipad**	**Trauma Center**	**Stroke Center**	**STEMI Center**	**L&D**	**Other**
Providence Medical Center	Jackson	REC	X	Level III	X	X	X	
Rogue Regional Medical Center	Jackson	REC	X	Level II	X	X	X	
Sky Lakes Medical Center	Klamath	REC	X	Level III			X	

Sierra – Sacramento Valley EMS Agency Program Policy			
EMS Documentation			
	Effective: 06/01/2024	Next Review: 04/2027	**605**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To specify EMS patient care report (PCR) documentation and data requirements.

AUTHORITY:

A. HSC, Division 2.5, § 1797.202, 1797.204, 1797.220, 1797.227, and 1798.

B. CCR, Title 22, Division 9, Chapters 3 and 4.

POLICY:

A. BLS non-transport providers shall complete a PCR for any EMS incident that results in a patient refusal of EMS care without ALS/LALS involvement.

B. BLS non-transport providers shall complete a S-SV EMS BLS Skills Utilization PCR (605-A), or electronic PCR (ePCR) compliant with current California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) date standards (if available), to document the utilization of any of the following prior to ALS/LALS arrival:

   1. Defibrillation (AED shock delivered).

   2. BLS optional skills included in S-SV EMS Policy No. 477.

C. ALS/LALS non-transport providers and all transport providers shall utilize an ePCR software system, compliant with current CEMSIS/NEMSIS standards, for EMS documentation as follows:

   1. ALS/LALS non-transport personnel shall complete an ePCR for any EMS incident that results in their arrival at scene prior to a transport provider, unless patient contact was limited to BLS assessment and/or oxygen administration only, and patient care was assumed by a transport provider.

   2. Transport personnel shall complete an ePCR for any EMS incident that results in their arrival on scene. If the non-transport and transport personnel are from the same agency, a single ePCR by the appropriate unit is adequate.

3. For multiple patient incidents, an ePCR shall be completed for each individual patient (including patients who are determined to be deceased on scene).

4. For multiple casualty incidents (MCIs), the Medical Group Supervisor (or designee) shall complete a separate ePCR documenting pertinent incident information (MCI type, incident details, patient count/triage categories, etc.).

D. A PCR is a legal medical record. EMS personnel shall provide clear, legible, concise, complete, and accurate patient care documentation. Any form of misrepresentation is a serious infraction, which may result in disciplinary action.

E. EMS providers who fail to comply with EMS documentation laws, regulations, and/or policies may be suspended from providing service until they comply.

PROCEDURE:

A. All applicable/required PCR data fields shall be accurately completed.

1. EMS procedures and/or medication administrations, including specific dose, route, and response to treatment as applicable, shall be adequately documented in the Treatment/Procedures section. ALS/LALS personnel shall also document all pertinent procedures/medications utilized by bystanders or BLS personnel (including prior to their arrival on scene) in the Treatment/Procedures section.

2. The total volume of IV/IO fluid infused shall be adequately documented in the Treatment/Procedures and/or Narrative section.

3. All pertinent vital signs, including applicable cardiac rhythm interpretations, shall be adequately documented in the Vital Signs section. Vital signs shall be obtained/documented as close as possible to initial patient contact, a minimum of every 15 minutes during patient care (or more frequently if clinically indicated), and as close as possible to transfer of patient care at the receiving hospital.

4. The Narrative section shall be completed utilizing one of the following formats:

- SOAP (Subjective, Objective, Assessment, and Plan).
- CHART (Complaint, History, Assessment, Rx/pt. medications, and Treatment).
- Chronological order.

5. Response, patient care, and/or transport delays shall be adequately documented in the appropriate section(s) of the PCR.

6. A written or electronic legal signature of the individual completing the PCR is required.

B. The following information, when available, shall be documented on an interim PCR (605-B or equivalent), and left at the receiving facility at time of patient delivery:

   1. Basic incident and patient demographic information.

   2. Chief complaint, time of symptom onset, pertinent medical history, medications, and medication allergies.

   3. Pertinent vital signs.

   4. EMS treatment rendered (time, type, dose, route, response, etc.).

   5. Relevant patient care related documents (DNR/POLST forms, 12 Lead EKGs, cardiac monitor rhythm strips, etc.).

   6. Name, title, and ID of EMS personnel completing the documentation.

C. PCRs shall be completed within twenty-four (24) hours after completion of the patient encounter (NEMSIS V3.5 data element eTimes.13 – 'Unit Back in Service Date/Time'), and shall be distributed as follows:

   1. If a BLS optional skill was utilized, a copy of the completed PCR shall be provided/ available to S-SV EMS within seven (7) calendar days of the incident.

   2. PCRs shall be provided/available to the applicable receiving, base, and/or modified base hospital upon completion, but no later than twenty-four (24) hours after completion of the patient encounter.

D. Any EMS provider required to complete/submit ePCR data pursuant to this policy, and who chooses not to utilize the S-SV EMS ImageTrend ePCR software system, shall submit EMS data to S-SV EMS in the following manner:

   1. EMS data shall be continually compliant with current CEMSIS/NEMSIS standards and the current S-SV EMS data schematron.

   2. EMS data for all incidents required by this policy shall be submitted to the EMS data system utilized by S-SV EMS within twenty-four (24) hours after completion of the patient encounter. Any ePCR record that fails to import shall be identified, corrected, and successfully submitted to the EMS data system utilized by S-SV EMS within seventy-two (72) hours after completion of the patient encounter.

E. PCRs for adult and emancipated minor patients shall be preserved for at least seven (7) years. PCRs for unemancipated minor patients shall be preserved for at least one (1) year after such minor has reached the age of 18 years old and, in any case, not less than seven (7) years.

Sierra – Sacramento Valley EMS Agency Program Policy			
ALS Provider Agency Inventory Requirements			
	Effective: 06/01/2024	Next Review: 04/2027	**701**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish a standardized inventory for ALS response vehicles in the S-SV EMS region.

AUTHORITY:

California Health and Safety Code, Division 2.5, § 1797.204 and 1797.220.

California Code of Regulations, Title 22, Division 9.

California Code of Regulations, Title 13.

California Vehicle Code, Section 2418.5.

Emergency Medical Services Authority Guidelines and Recommendations, Highway Patrol Handbook 82.4.

POLICY:

All S-SV EMS approved ALS response vehicles shall carry the minimum equipment and supply inventory listed in this policy. Reasonable variations may occur; however, any exceptions or additions shall have prior S-SV EMS approval.

Radio Equipment & Miscellaneous Equipment/Supplies	ALS Transport	ALS Non-Transport
Mobile UHF Med-Net Radio	1	Optional
Portable UHF Med-Net Radio **OR** Mobile Telephone	1	1
Maps (paper or electronic covering normal service area)	1	1
DOT Emergency Response Guidebook (ERG)	1	1
FIRESCOPE Field Operations Guide (FOG)	1	1
NEMSIS Version 3.4 Compliant Electronic PCR System	1	1
Refusal of EMS Care Forms	10	5
Triage Ribbon System	Optional	Optional
DMS All Risk Triage Tags	10	10
Triage Kit (MCI vests for 'Triage Unit Leader' and 'Medical Group Supervisor', pens, trauma shears, clipboard, patient tracking sheets, START Triage reference sheet, barrier tape, glow sticks)	1	Optional
Non-Sterile Gloves (various sizes)	10 pr. each	10 pr. each
Infection Control Kit with Particulate Filter Respirator (N95, etc.)	1 per crew	1 per crew
Antiseptic Hand Wipes **OR** Waterless Hand Sanitizer	10 **OR** 1	10 **OR** 1
Covered Waste Container (red biohazard bags acceptable)	1	1
Adult, Pediatric & Thigh BP Cuff	1 each	1 each
Stethoscope	1	1
Flashlight **OR** Penlight	1	1
Bedpan **OR** Fracture Pan	1	0
Urinal	1	0
Sharps Container	1	1
Padded Soft Wrist & Ankle Restraints	1 set	Optional
Lightweight, Sheer, Protective Mesh Hood (Spit Hood)	Optional	Optional
Pillows, Sheets, Pillowcases & Towels	2 each	0
Blankets	2	1
Emesis Basin/Disposable Emesis Bags	2	1
Length Based Pediatric Resuscitation Tape	1	1
Ambulance Cot & Vehicle Securing Equipment	1	0
Collapsible Stretcher/Breakaway Flat	1	Optional
Soft Stretcher/Portable Patient Transport Unit (MegaMover, etc.)	Optional	Optional
Stair Chair	Optional	Optional

Biomedical Equipment/Supplies	ALS Transport	ALS Non-Transport
Mechanical Chest Compression Device (S-SV EMS approved)	Optional	Optional
Thermometer	1	1
Pulse Oximeter	1	1
Portable Monitor/Defibrillator (capable of synchronized cardioversion, transcutaneous pacing, 12 Lead ECG with printout and waveform capnography)	1	1
Spare Monitor/Defibrillator Battery	1	1
Adult Defibrillator Electrodes **OR** Paddles with Pads/Gel	2 sets	2 sets
Pediatric Defibrillator Electrodes **OR** Paddles with Pads/Gel	1 set	1 set
Monitor/Defibrillator Electrode Leads/Wires	2 sets	1 set
Monitor/Defibrillator ECG Paper	1 roll	1 roll
Adult/Pediatric ECG Electrodes	48	24
CO-Oximeter	Optional	Optional
Glucometer	1	1
Glucometer Test Strips	10	5
Lancets	10	5
Airway & Oxygen Equipment/Supplies	**ALS Transport**	**ALS Non-Transport**
Ambulance Mounted ‘H’ or ‘M’ Oxygen Tank	1	0
Ambulance Wall Mounted Oxygen Regulator with Liter Flow	1	0
Portable ‘D’ or ‘E’ Oxygen Cylinder	2	1
Portable Oxygen Regulator with Liter Flow	1	1
Nasal Cannula	4	2
Adult Non-Rebreather Oxygen Mask	4	2
Pediatric Oxygen Mask	2	1
Handheld Nebulizer & Aerosol/Nebulizer Mask	2 each	1 each
Disposable CPAP Circuit with Mask	2	1
Adult Bag Valve Mask (BVM) With S, M & L Adult Masks	1	1
Pediatric Bag Valve Mask (BVM) With Neonate & Child Masks	1	1
BVM PEEP Valve	Optional	Optional
Inspiratory Impedance Threshold Device (ITD)	Optional	Optional
Oropharyngeal Airways: Sizes 40 mm – 110 mm or Equivalent	2 each	1 each

Airway & Oxygen Equipment/Supplies (continued)	ALS Transport	ALS Non-Transport
Nasopharyngeal Airways: Sizes 20 Fr – 34 Fr or Equivalent	2 each	1 each
Water Soluble Lubricant	2	1
Ambulance Mounted Suction Unit	1	0
Portable Mechanical Suction Unit	1	1
Spare Suction Canisters/Bags with Lids	2	Optional
Tonsillar Tip Suction Handle	2	1
Suction Catheters: Sizes 6 Fr – 14 Fr	1 each	1 each
Video Laryngoscope Device with Adult & Pediatric Blades	Optional	Optional
Laryngoscope Handle	1	1
Straight (Miller) Laryngoscope Blades: Sizes 0 – 4	1 each	1 each
Curved (Macintosh) Laryngoscope Blades: Sizes 3, 4	1 each	1 each
Spare Laryngoscope Handle Batteries	1 set	1 set
Spare Laryngoscope Blade Bulb (if not using disposable blades)	1	1
Magill Forceps: Adult & Pediatric	1 each	1 each
Cuffed Endotracheal Tubes: Sizes 6.0, 6.5, 7.0, 7.5, 8.0, 8.5	2 each	1 each
Adult Endotracheal Tube Stylet	2	1
Flex Guide ETT Introducer	2	1
i-gel Airway Devices: Sizes 1.0, 1.5, 2.0, 2.5	1 each	1 each
i-gel Airway Devices: Sizes 3, 4, 5	1 each	1 each
Advanced Airway Tube/Device Holder	2	1
Mainstream $EtCO_2$ Disposable Capnography Circuit	2	1
Sidestream $EtCO_2$ Disposable Capnography Circuit, Adult	2	1
Sidestream $EtCO_2$ Disposable Capnography Circuit, Pediatric	2	1
Cricothyrotomy Equipment (one of the following sets) • Jet ventilation device with adult & pediatric transtracheal catheters or a minimum 12 ga x 3” airway catheter; **OR** • Adult (4.0 mm) & pediatric (2.0 mm) Rusch QuickTrach Needle Cricothyrotomy Device; **OR** • ENK Flow Modulator Kit	1 set	1 set
Minimum 14 ga x 3.25” Needle Thoracostomy Catheter	2	2
Needle Thoracostomy Catheter One-Way Valve	Optional	Optional

Immobilization Equipment/Supplies	ALS Transport	ALS Non-Transport
Kendrick Extrication Device (KED) or Equivalent	1	Optional
Adult Long Spine Board with Straps	2	1
Pediatric Spine Board	1	1
Head Immobilization Set	2	1
Rigid C-Collars: Sizes Pediatric & S, M, L Adult **OR** Adjustable	2 each	2 each
XCollar Plus	Optional	Optional
Approved Commercial Pelvic Binder	Optional	Optional
Arm & Leg Splints (SAM, cardboard, vacuum, etc.)	2 each	2 each
Traction Splint	1	1
Obstetrical Equipment/Supplies	**ALS Transport**	**ALS Non-Transport**
OB Kit (gloves, cord clamps, dressings, bulb syringe, cap, etc.)	2	1
Bandaging Equipment/Supplies	**ALS Transport**	**ALS Non-Transport**
Band-Aids	10	10
Bandage Shears	1	1
1” & 2” Adhesive Tape Rolls	2 each	1 each
Non-Sterile 4x4 Compresses	50	10
Sterile 4x4 Compresses	10	5
2”, 3” or 4” Kling/Kerlix Rolls	5	2
Triangular Bandages	4	2
Surgipads	Optional	Optional
Trauma Dressing	2	1
Petroleum Gauze	2	2
Chest Seal (Asherman, Bolin, Halo, HyFin, SAM or equivalent)	Optional	Optional
Approved Hemostatic Agent	Optional	Optional
Approved Commercial Tourniquet Device	2	2
Hydrogen Peroxide	Optional	Optional
1000 mL Sterile Irrigation Solution	2	1
Potable Water	2 liters	2 liters
Cold Packs & Heat Packs	4 each	2 each

IV/IO Access & Medication Administration Equipment/Supplies	ALS Transport	ALS Non-Transport
Alcohol Swabs	20	10
Chlorhexidine Swabs/Skin Prep	5	5
IV Start Pack or Equivalent (with tourniquet)	4	2
IV Catheter: Sizes 14 ga, 16 ga, 18 ga, 20 ga	6 each	2 each
IV Catheter: Sizes 22 ga, 24 ga	4 each	2 each
Micro-Drip & Macro-Drip IV Set **OR** Selectable Drip IV Set	4 each	2 each
Blood Administration Set	Optional	Optional
Buretrol Set	Optional	Optional
IV Flow Regulator Set (Dial-A-Flo)	Optional	Optional
IV Extension Set	4	2
Saline Locks	Optional	Optional
3-Way Stopcock	2	1
10 mL NS Vials or Pre-Filled Syringes	Optional	Optional
IV Fluid Pressure Infusion Bag	1	1
IV Fluid Warmer	Optional	Optional
Syringes: Sizes: 1 mL, 3 – 5 mL, 10 mL	3 each	2 each
50 – 60 mL Syringe	1	1
22 ga, 25 ga Safety Injection Needles	2 each	2 each
Filter Needle (only if utilizing medications in ampules)	2	2
Vial Access Cannulas	2	2
Mucosal Atomizer Device (MAD)	2	2
Arm Boards: Sizes Short & Long	2 each	1 each
Vacutainer Holder, Needle & Blood Collection Tubes	Optional	Optional

IO Equipment (one of the following sets)

- Pediatric Bone Injection Gun or New Intraosseous Device (2 Transport, 1 Non-Transport)
- Adult New Intraosseous Device (2 Transport, 1 Non-Transport)

OR

- EZ-IO, SAM IO, or BD IO Driver (1 Transport, 1 Non-Transport)
- 15 mm Needle Set (Optional)
- 25 mm Needle Set
  - If carrying 15 mm Needle Set (1 Transport, 1 Non-Transport)
  - If not carrying 15 mm Needle Set (2 Transport, 1 Non-Transport)
- 45 mm Needle Set (1 Transport, 1 Non-Transport)

IV Solutions	ALS Transport	ALS Non-Transport
Lactated Ringers 1000 mL Bag	Optional	Optional
Normal Saline and/or 5% Dextrose 100 mL Bag	Optional	Optional
Normal Saline 250 mL Bag	2	1
Normal Saline 1000 mL Bag	6	2
Medications	**ALS Transport**	**ALS Non-Transport**
Acetaminophen – IV (1000 mg/100 mL)	2	2
Acetaminophen – PO (32 mg/mL)	960 mg	960 mg
Activated Charcoal	50 gm	Optional
Adenosine (6 mg/2 mL)	3	3
Albuterol (2.5 mg/3 mL)	6	4
Amiodarone (150 mg/3 mL)	6	3
Aspirin (chewable tablets)	8	8
Atropine (1 mg/10 mL)	2	2
Calcium Chloride (1 gm/10 mL)	4	2
Dextrose 10% (250 mL bag)	3	2
Diphenhydramine (50 mg/1 mL)	2	2
Diphenhydramine elixir (100 mg)	1	1
Epinephrine 1:1,000 (1 mg/1 mL – 1 mL vial or ampule)	5	5
Epinephrine 1:10,000 (1 mg/10 mL)	8	4
Glucagon (1 mg)	1	1
Glucose Oral Product (minimum 15 gm)	2	1
Ipratropium (500 mcg/2.5 mL)	2	2
Ketorolac (30 mg/1 mL)	2	2
Lidocaine 2% (100 mg/5 mL)	2	2
Mark-1/DuoDote Kit	Optional	Optional
Naloxone (2 mg/2 mL)	4	2
Nitroglycerin 0.4 mg (tablet bottle or aerosol spray)	2	1
Ondansetron (4 mg/2 mL)	6	2
Ondansetron Oral Disintegrating Tablets (4 mg)	4	2
Racemic Epinephrine	Optional	Optional
Sodium Bicarbonate (50 mEq/50 mL)	2	1

Medications (continued)	ALS Transport	ALS Non-Transport
Tranexamic Acid (1 gm/10 mL)	Optional	Optional
Controlled Substances	**ALS Transport**	**ALS Non-Transport**
Controlled Substances Locking Storage Container	1	1
Controlled Substances Tracking Sheet	1	1
Carpuject Holder (only if utilizing capuject supplied medications)	1	1
Fentanyl (50 mcg/1 mL concentration)	400 mcg minimum 1000 mcg maximum	400 mcg minimum 1000 mcg maximum
Ketamine (50 mg/1 mL concentration)	200 mg minimum 1000 mg maximum	200 mg minimum 1000 mg maximum
Midazolam (5 mg/1 mL concentration)	20 mg minimum 60 mg maximum	20 mg minimum 60 mg maximum

Sierra – Sacramento Valley EMS Agency Program Policy			
ALS Specialty Program Provider Inventory Requirements			
	Effective: 06/01/2024	Next Review: 04/2027	**702**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish a standardized inventory for S-SV EMS approved ALS specialty program providers (Bike Team, Fireline and Ski Patrol).

AUTHORITY:

A. California Health and Safety Code, Division 2.5, § 1797.204 and 1797.220.

B. California Code of Regulations, Title 22, Division 9.

C. FIRESCOPE California Incident Command System Position Manual Fireline Emergency Medical Technician/Fireline Paramedic (EMTF/EMPF) ICS 702 (12/2016)

POLICY:

A. ALS specialty program provider personnel shall carry the minimum equipment and supply inventory listed in this policy. Reasonable variations may occur; however, any exceptions or additions shall have prior S-SV EMS approval.

B. Any S-SV EMS approved ALS service provider may utilize appropriately trained personnel to provide ALS bike team services during special events.

C. S-SV EMS approval is required to provide ALS Fireline and ALS Ski Patrol services.

D. The Fireline Paramedic shall report to the incident with the full complement of EMS equipment/supplies. The Incident Medical Unit will re-supply the Fireline Paramedic to the best of their ability.

E. Fireline Paramedic providers should stock sufficient quantities of medical supplies and medications (especially controlled substances) to avoid the need for mid-incident restock. Incident Medical Units may not be capable of re-supplying controlled substances.

F. Controlled substances shall be secured in accordance with S-SV EMS Management of Controlled Substances policy (710) and the providers' policies and procedures.

Equipment/Supplies	Bike Team	Fireline	Ski Patrol
Portable Radio or Mobile Telephone	1	1	1
NEMSIS V3.5 Compliant Electronic PCR System	1	1	1
Pen, Pencil, Writing Pad	1 each	1 each	1 each
Refusal of EMS Care Forms	3	3	3
DMS All Risk Triage Tags	5	5	5
Non-Sterile Gloves	10/crew	10/crew	10/crew
Infection Control Kit/Mask	1/crew	1/crew	1/crew
Antiseptic Hand Wipes or Hand Sanitizer	5 or 1	5 or 1	5 or 1
Red Biohazard Bag	1	1	1
Adult BP Cuff	1	1	1
Pediatric BP Cuff	1	0	1
Stethoscope	1	1	1
Flashlight or Penlight	1	1	1
Sharps Container	1	1	1
Spit Hood	Optional	Optional	Optional
Emergency/Heated Blanket	1	2	1
Disposable Emesis Bags	2	Optional	2
Length Based Pediatric Resuscitation Tape	1	0	1
Thermometer (with covers as needed) Hypothermic Capable Required for Ski Patrol	Optional	1	1
Pulse Oximeter	1	1	1
Compact Semi-Automatic Defibrillator with screen, battery, monitoring and defibrillation electrodes, electrode wires and EKG paper as necessary	1	1	1
Glucometer	1	1	1
Glucometer Test Strips	4	4	4
Lancets	4	4	4
Portable Oxygen Cylinder	1	0	1
Portable Oxygen Regulator with Liter Flow	1	0	1
Adult Nasal Cannula	1	0	1
Adult Non-Rebreather Oxygen Mask	1	0	1
Pediatric Oxygen Mask	1	0	1
Handheld Nebulizer	1	0	1

Equipment/Supplies	Bike Team	Fireline	Ski Patrol
Adult BVM (with appropriate size BVM masks)	1 each	1 each	1 each
OPAs	1 kit	1 kit	1 kit
NPAs	1 kit	1 kit	1 kit
Water Soluble Lubricant	1	1	1
Handheld Manual Suction Device	1	1	1
Laryngoscope Handle & Appropriate Size Blades	1 set	1 set	1 set
Magill Forceps: Adult & Pediatric	1 each	1 adult	1 each
Cuffed Endotracheal Tubes: Sizes 6.5 & 7.5	1 each	1 each	1 each
Endotracheal Tubes: Sizes 6.0, 7.0, 8.0 & 8.5	Optional	Optional	Optional
Adult Endotracheal Tube Stylet	1	1	1
Flex Guide ETT Introducer	1	1	1
i-gel Airway Device: Sizes 1.0, 1.5, 2.0, 2.5	Optional	0	Optional
i-gel Airway Device: Size 3	Optional	Optional	Optional
i-gel Airway Device: Sizes 4 & 5	1 each	1 each	1 each
Advanced Airway Tube/Device Holder	1	1	1
Colorimetric CO2 Detector	1	1	1
Cricothyrotomy Equipment (one of the following) • Adult (4.0 mm) & pediatric (2.0 mm) Rusch QuickTrach Needle Cricothyrotomy Device; or • ENK Flow Modulator Kit	Optional	Optional	1 set
14 ga x 3.25” Needle Thoracostomy Catheter	2	2	2
Rigid C-Collars: Adjustable Adult & Pediatric	1 each	1 adult	1 each
Backboard	0	0	1
Pelvic Binder	0	0	1
Moldable Splint or Extremity Splints	1 each	1 each	1 each
Bandage Shears	1	1	1
Band-Aids	10	10	10
1” Tape	1	1	1
Non-Sterile 4x4 Compresses	10	10	10
Sterile 4x4 Compresses	5	5	5
Kling/Kerlix Rolls	2	2	2
Coban Wraps	0	2	0
Ace Bandage	1	2	1

Equipment/Supplies	Bike Team	Fireline	Ski Patrol
Triangular Bandages	2	2	2
Trauma Dressing	2	4	2
Petroleum Gauze	2	2	2
Burn sheet	Optional	1	Optional
Chest Seal	Optional	Optional	Optional
Approved Hemostatic Agent	Optional	Optional	Optional
Approved Commercial Tourniquet Device	2	2	2
Cold Packs	2	2	0
Hot Packs	0	0	2
Eye Wash	0	1	0
Splinter Kit	0	1	0
Alcohol Preps	5	5	5
Chlorhexidine Swabs/Skin Prep	2	2	2
IV Start Pack	2	2	2
IV Catheter: Sizes 14 ga, 16 ga, 18 ga, 20 ga	2 each	2 each	2 each
IV Catheter: Size 22 ga	2 each	0	2 each
IV Administration Set (Macro-Drip or Selectable)	2	2	2
IV Extension Set or Saline Lock	2	2	2
3-Way Stopcock	1	1	1
10 mL NS Vials or Pre-Filled Syringes	Optional	Optional	Optional
Syringes (1 mL and 10 mL)	2 each	2 each	2 each
22 ga/25 ga Safety Injection Needles	2	2	2
Vial Access Cannulas	2	2	2
Mucosal Atomizer Device (MAD)	2	2	2
Adult IO Equipment (EZ-IO, SAM IO, BD IO or NIO)	1 set	Optional	1 set
Pediatric IO Equipment (EZ-IO, BIG or NIO)	1 set	0	1 set
IV Fluid Pressure Infusion Bag	1	Optional	1
Normal Saline 1000 mL (2 – 500 mL bags OK)	2	1	1
Acetaminophen – IV (1000 mg/100 mL)	1	1	1
Adenosine (6 mg/2 mL)	3	3	3
Albuterol (2.5 mg/3 mL or MDI)	2	1	2
Amiodarone (150 mg/3 mL)	3	3	3

Equipment/Supplies	Bike Team	Fireline	Ski Patrol
Aspirin (chewable tablets)	8	20	8
Atropine (1 mg/10 mL)	2	2	2
Dextrose 10% (250 mL bag)	1	1	1
Diphenhydramine (50 mg/1 mL)	2	2	2
Diphenhydramine elixir (100 mg)	Optional	1	Optional
Epinephrine 1:1,000 (1 mg/1 mL vial/ampule)	2	4	2
Epinephrine 1:10,000 (1 mg/10 mL)	4	2	4
Glucagon (1 mg)	1	1	1
Glucose Oral Product (minimum 15 gm)	1	1	1
Ipratropium (500 mcg/2.5 mL)	1	0	1
Ketorolac (30 mg/1 mL)	1	1	1
Lidocaine 2% (100 mg/5 mL)	1	Optional	1
Naloxone (2 mg/2 mL)	2	2	2
Nitroglycerin 0.4 mg (tablet bottle or aerosol spray)	1	1	1
Ondansetron (4 mg/2 mL)	1	1	1
Ondansetron Oral Disintegrating Tablets (4 mg)	2	2	2
Racemic Epinephrine	Optional	Optional	Optional
Tranexamic Acid (1 gm/10 mL)	Optional	Optional	Optional
Controlled Substances Storage Container	1	1	1
Carpuject Holder (if necessary)	1	1	1
Fentanyl (50 mcg/1 mL concentration)	200 mcg minimum 400 mcg maximum	500 mcg	200 mcg minimum 400 mcg maximum
Ketamine (50 mg/1 mL concentration)	200 mg minimum 1000 mg maximum	200 mg minimum 1000 mg maximum	200 mg minimum 1000 mg maximum
Midazolam (5 mg/1 mL concentration)	10 mg minimum 20 mg maximum	20 mg	10 mg minimum 20 mg maximum

Sierra – Sacramento Valley EMS Agency Program Policy			
LALS Provider Agency Inventory Requirements			
	Effective: 06/01/2024	Next Review: 04/2027	**703**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish a standardized inventory for LALS response vehicles in the S-SV EMS region.

AUTHORITY:

California Health and Safety Code, Division 2.5, § 1797.204 and 1797.220.

California Code of Regulations, Title 22, Division 9.

California Code of Regulations, Title 13.

California Vehicle Code, Section 2418.5.

Emergency Medical Services Authority Guidelines and Recommendations, Highway Patrol Handbook 82.4.

POLICY:

All S-SV EMS approved LALS response vehicles shall carry the minimum equipment and supply inventory listed in this policy. Reasonable variations may occur; however, any exceptions or additions shall have prior S-SV EMS approval.

Radio Equipment & Miscellaneous Equipment/Supplies	LALS Transport	LALS Non Transport
Mobile UHF Med-Net Radio	1	Optional
Portable UHF Med-Net Radio **OR** Mobile Telephone	1	1
Maps (paper or electronic covering normal service area)	1	1
DOT Emergency Response Guidebook (ERG)	1	1
FIRESCOPE Field Operations Guide (FOG)	1	1
NEMSIS Version 3.5 Compliant Electronic PCR System	1	1
Refusal of EMS Care Forms	10	5
Triage Ribbon System	Optional	Optional
DMS All Risk Triage Tags	10	10
Triage Kit (MCI vests for 'Triage Unit Leader' and 'Medical Group Supervisor', pens, trauma shears, clipboard, patient tracking sheets, START Triage reference sheet, barrier tape, glow sticks)	1	Optional
Non-Sterile Gloves (various sizes)	10 pr. each	10 pr. each
Infection Control Kit With Particulate Filter Respirator (N95, etc.)	1 per crew	1 per crew
Antiseptic Hand Wipes **OR** Waterless Hand Sanitizer	10 **OR** 1	10 **OR** 1
Covered Waste Container (red biohazard bags acceptable)	1	1
Adult, Pediatric & Thigh BP Cuff	1 each	1 each
Stethoscope	1	1
Flashlight **OR** Penlight	1	1
Bedpan **OR** Fracture Pan	1	0
Urinal	1	0
Sharps Container	1	1
Padded Soft Wrist & Ankle Restraints	1 set	Optional
Lightweight, Sheer, Protective Mesh Hood (Spit Hood)	Optional	Optional
Pillows, Sheets, Pillowcases & Towels	2 each	0
Blankets	2	1
Emesis Basin/Disposable Emesis Bags	2	1
Length Based Pediatric Resuscitation Tape	1	1
Ambulance Cot & Vehicle Securing Equipment	1	0
Collapsible Stretcher/Breakaway Flat	1	Optional
Soft Stretcher/Portable Patient Transport Unit (MegaMover, etc.)	Optional	Optional
Stair Chair	Optional	Optional

Biomedical Equipment/Supplies	LALS Transport	LALS Non Transport
Mechanical Chest Compression Device (S-SV EMS approved)	Optional	Optional
Thermometer	1	1
Pulse Oximeter	1	1
Portable Monitor/Defibrillator **OR** AED • AEMT Providers: AED • **(AEMT II Providers Only)**: Portable monitor/defibrillator capable of synchronized cardioversion, 12 Lead ECG with printout and waveform capnography	1	1
Spare Monitor/Defibrillator Battery **(AEMT II Providers Only)**	1	1
Adult Defibrillator Electrodes **OR** Paddles With Pads/Gel	2 sets	2 sets
Pediatric Defibrillator Electrodes **OR** Paddles With Pads/Gel	1 set	1 set
Monitor/Defibrillator **OR** AED Electrode Leads/Wires	1 set	1 set
Monitor/Defibrillator ECG Paper **(AEMT II Providers Only)**	1 roll	1 roll
Adult/Pediatric ECG Electrodes **(AEMT II Providers Only)**	48	24
Glucometer	1	1
Glucometer Test Strips	10	5
Lancets	10	5
Airway & Oxygen Equipment/Supplies	**LALS Transport**	**LALS Non Transport**
Ambulance Mounted ‘H’ or ‘M’ Oxygen Tank	1	0
Ambulance Wall Mounted Oxygen Regulator With Liter Flow	1	0
Portable ‘D’ or ‘E’ Oxygen Cylinder	2	1
Portable Oxygen Regulator With Liter Flow	1	1
Nasal Cannula	4	2
Adult Non-Rebreather Oxygen Mask	4	2
Pediatric Oxygen Mask	2	1
Handheld Nebulizer & Aerosol/Nebulizer Mask	2 each	1 each
Disposable CPAP Circuit With Mask	2	1
Adult Bag Valve Mask (BVM) With S, M & L Adult Masks	1	1
Pediatric Bag Valve Mask (BVM) With Neonate & Child Masks	1	1
BVM PEEP Valve	Optional	Optional
Inspiratory Impedance Threshold Device (ITD)	Optional	Optional

Airway & Oxygen Equipment/Supplies (continued)	LALS Transport	LALS Non Transport
Water Soluble Lubricant	2	1
Oropharyngeal Airways: Sizes 40 mm – 110 mm or Equivalent	2 each	1 each
Nasopharyngeal Airways: Sizes 20 Fr – 34 Fr or Equivalent	2 each	1 each
Ambulance Mounted Suction Unit	1	0
Portable Mechanical Suction Unit	1	1
Spare Suction Canisters/Bags With Lids	2	Optional
Tonsillar Tip Suction Handle	2	1
Suction Catheters: Sizes 6 Fr – 14 Fr	1 each	1 each
i-gel Airway Devices: Sizes 1.0, 1.5, 2.0, 2.5	Optional	Optional
i-gel Airway Devices: Sizes 3, 4, 5	1 each	1 each
Advanced Airway Tube/Device Holder	2	1
Mainstream $EtCO_2$ Disposable Capnography Circuit **OR** Colorimetric Device	2	1
Sidestream $EtCO_2$ Disposable Capnography Circuit, Adult **(AEMT Providers Only)**	2	1
Sidestream $EtCO_2$ Disposable Capnography Circuit, Pediatric **(AEMT Providers Only)**	2	1
Immobilization Equipment/Supplies	**LALS Transport**	**LALS Non Transport**
Kendrick Extrication Device (KED) or Equivalent	1	Optional
Adult Long Spine Board With Straps	2	1
Pediatric Spine Board	1	1
Head Immobilization Set	2	1
Rigid C-Collars: Sizes Pediatric & S, M, L Adult **OR** Adjustable	2 each	2 each
XCollar Plus	Optional	Optional
Approved Commercial Pelvic Binder	Optional	Optional
Arm & Leg Splints (SAM, cardboard, vacuum, etc.)	2 each	2 each
Traction Splint	1	1
Obstetrical Equipment/Supplies	**LALS Transport**	**LALS Non Transport**
OB Kit (gloves, cord clamps, dressings, bulb syringe, cap, etc.)	2	1

Bandaging Equipment/Supplies	LALS Transport	LALS Non Transport
Band-Aids	10	10
Bandage Shears	1	1
1” & 2” Adhesive Tape Rolls	2 each	1 each
Non-Sterile 4x4 Compresses	50	10
Sterile 4x4 Compresses	10	5
2”, 3” or 4” Kling/Kerlix Rolls	5	2
Triangular Bandages	4	2
Surgipads	Optional	Optional
Trauma Dressing	2	1
Petroleum Gauze	2	2
Chest Seal (Asherman, Bolin, Halo, HyFin, SAM or equivalent)	Optional	Optional
Approved Hemostatic Agent	Optional	Optional
Approved Commercial Tourniquet Device	2	2
Hydrogen Peroxide	Optional	Optional
1000 mL Sterile Irrigation Solution	2	1
Potable Water	2 liters	2 liters
Cold Packs & Heat Packs	4 each	2 each
IV/IO Access & Medication Administration Equipment/Supplies	**LALS Transport**	**LALS Non Transport**
Alcohol Swabs	20	10
Chlorhexidine Swabs/Skin Prep	5	5
IV Start Pack or Equivalent (with tourniquet)	4	2
IV Catheter: Sizes 14 ga, 16 ga, 18 ga, 20 ga	6 each	2 each
IV Catheter: Sizes 22 ga, 24 ga	2 each	2 each
Micro-Drip & Macro-Drip IV Set **OR** Selectable Drip IV Set	4 each	2 each
Blood Administration Set	Optional	Optional
Buretrol Set	Optional	Optional
IV Extension Set	4	2
Saline Locks	Optional	Optional
3-Way Stopcock	1	1
10 mL NS Vials or Pre-Filled Syringes	Optional	Optional

IV/IO Access & Medication Administration Equipment/Supplies (continued)	LALS Transport	LALS Non Transport
IV Fluid Pressure Infusion Bag	1	1
IV Fluid Warmer	Optional	Optional
Syringes: Sizes: 1 mL, 3 – 5 mL, 10 mL	3 each	2 each
50 – 60 mL Syringe	1	1
22 ga, 25 ga Safety Injection Needles	2 each	2 each
Filter Needle (only if utilizing medications in ampules)	2	2
Vial Access Cannulas	2	2
Mucosal Atomizer Device (MAD)	2	2
Arm Boards: Sizes Short & Long	2 each	1 each
Vacutainer Holder, Needle & Blood Collection Tubes	Optional	Optional
EZ-IO, SAM IO or BD IO Driver (only if using mechanical IO)	1	1
Pediatric Bone Injection Gun or New Intraosseous Device **OR** EZ-IO, SAM IO or BD IO 15 mm or 25 mm Needle Set	2	1
IV Solutions	**LALS Transport**	**LALS Non Transport**
Lactated Ringers 1000 mL Bag	Optional	Optional
Normal Saline 250 mL Bag	2	1
Normal Saline 1000 mL Bag	6	2
Medications	**LALS Transport**	**LALS Non Transport**
Acetaminophen – PO (32 mg/ml)	960 mg	960 mg
Activated Charcoal	50gm	Optional
Albuterol (2.5 mg/3 mL)	6	4
Aspirin (chewable tablets)	8	8
Atropine (1 mg/10 mL) **(AEMT II Providers Only)**	2	2
Dextrose 10% (250 mL bag)	3	2
Epinephrine 1:1,000 (1 mg/1 mL – 1mL vial or ampule)	5	5
Epinephrine 1:10,000 (1 mg/10 mL) **(AEMT II Providers Only)**	8	4
Glucagon (1 mg)	1	1
Glucose Oral Product (minimum 15 gm)	2	1
Lidocaine 2% (100 mg/5 mL) **(AEMT II Providers Only)**	6	3
Mark-1/DuoDote Kit	Optional	Optional

Medications (continued)	LALS Transport	LALS Non Transport
Naloxone (2 mg/2 mL)	4	2
Nitroglycerin 0.4 mg (tablet bottle or aerosol spray)	2	1
Sodium Bicarbonate (50 mEq/50 mL) **(AEMT II Providers Only)**	2	1
Controlled Substances (AEMT II Providers Only)	**LALS Transport**	**LALS Non Transport**
Controlled Substances Locking Storage Container	1	1
Controlled Substances Tracking Sheet	1	1
Carpuject Holder (only if utilizing capuject supplied medications)	1	1
Midazolam (5mg/mL concentration)	20 mg minimum 60 mg maximum	20 mg minimum 60 mg maximum
Fentanyl (50 mg/mL concentration)	400 mcg minimum 1000 mcg maximum	400 mcg minimum 1000 mcg maximum

Sierra – Sacramento Valley EMS Agency Program Policy			
BLS Provider Agency Inventory Requirements			
	Effective: 06/01/2024	Next Review: 04/2027	**704**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish a standardized inventory for BLS response vehicles in the S-SV EMS region.

AUTHORITY:

California Health and Safety Code, Division 2.5, § 1797.204 and 1797.220.

California Code of Regulations, Title 22, Division 9.

California Code of Regulations, Title 13.

California Vehicle Code, Section 2418.5.

Emergency Medical Services Authority Guidelines and Recommendations, Highway Patrol Handbook 82.4.

POLICY:

All S-SV EMS approved BLS response vehicles shall carry the minimum equipment and supply inventory listed in this policy. Reasonable variations may occur; however, any exceptions or additions shall have prior S-SV EMS approval.

Radio Equipment & Miscellaneous Equipment/Supplies	BLS Transport	BLS Non Transport
Mobile UHF Med-Net Radio	1	0
Portable UHF Med-Net Radio or Mobile Telephone	1	0
Maps (paper or electronic covering normal service area)	1	1
DOT Emergency Response Guidebook (ERG)	1	1
FIRESCOPE Field Operations Guide (FOG)	1	1
NEMSIS Version 3.5 Compliant Electronic PCR System	1	Optional
Refusal of EMS Care Forms	5	5
Triage Ribbon System	Optional	Optional
DMS All Risk Triage Tags	10	10
Triage Kit (MCI vests for 'Triage Unit Leader' and 'Medical Group Supervisor', pens, trauma shears, clipboard, patient tracking sheets, START Triage reference sheet, barrier tape, glow sticks)	1	Optional
Non-Sterile Gloves (various sizes)	10 pr. each	10 pr. each
Infection Control Kit With Particulate Filter Respirator (N95, etc.)	1 per crew	1 per crew
Antiseptic Hand Wipes or Waterless Hand Sanitizer	10 **OR** 1	10 **OR** 1
Covered Waste Container (red biohazard bags acceptable)	1	1
Adult, Pediatric & Thigh BP Cuff	1 each	1 each
Stethoscope	1	1
Flashlight or Penlight	1	1
Bedpan or Fracture Pan	1	0
Urinal	1	0
Sharps Container	Optional	Optional
Padded Soft Wrist & Ankle Restraints	1 set	0
Lightweight, Sheer, Protective Mesh Hood (Spit Hood)	Optional	Optional
Pillows, Sheets, Pillowcases & Towels	2 each	0
Blankets	2	1
Emesis Basin/Disposable Emesis Bags	2	1
Ambulance Cot & Vehicle Securing Equipment	1	0
Collapsible Stretcher/Breakaway Flat	1	Optional
Soft Stretcher/Portable Patient Transport Unit (MegaMover, etc.)	Optional	Optional
Stair Chair	Optional	Optional

Biomedical Equipment/Supplies	BLS Transport	BLS Non Transport
Mechanical Chest Compression Device (S-SV EMS approved)	Optional	Optional
Thermometer	Optional	Optional
Pulse Oximeter	1	1
AED With Adult & Pediatric Defibrillator Electrodes	Optional	Optional
Glucometer, Test Strips & Lancets **(EMT Expanded Scope)**	Optional	Optional
Airway & Oxygen Equipment/Supplies	**BLS Transport**	**BLS Non Transport**
Ambulance Mounted ‘H’ or ‘M’ Oxygen Tank	1	0
Ambulance Wall Mounted Oxygen Regulator With Liter Flow	1	0
Portable ‘D’ or ‘E’ Oxygen Cylinder	2	1
Portable Oxygen Regulator With Liter Flow	1	1
Nasal Cannula	4	2
Adult Non-Rebreather Oxygen Mask	4	2
Pediatric Oxygen Mask	2	1
Disposable CPAP Circuit With Mask	Optional	Optional
Adult Bag Valve Mask (BVM) With S, M & L Adult Masks	1	1
Pediatric Bag Valve Mask (BVM) With Neonate & Child Masks	1	1
BVM PEEP Valve	Optional	Optional
Inspiratory Impedance Threshold Device (ITD)	Optional	Optional
Water Soluble Lubricant	2	1
Oropharyngeal Airways: Sizes 40 mm – 110 mm or Equivalent	2 each	1 each
Nasopharyngeal Airways: Sizes 20 Fr – 34 Fr or Equivalent	2 each	1 each
Ambulance Mounted Suction Unit	1	0
Portable Mechanical Suction Unit (hand held manual suction unit acceptable for BLS non transport)	1	1
Spare Suction Canisters/Bags With Lids	2	Optional
Tonsillar Tip Suction Handle (if not using hand held suction unit)	2	1
i-gel Airway Devices: Sizes 3, 4, 5 **(EMT Optional Skills)**	1 each	1 each
i-gel Airway Device Holder **(EMT Optional Skills)**	2	1
ETCO2 Colorimetric Device **(EMT Optional Skills)**	2	1

Immobilization Equipment/Supplies	BLS Transport	BLS Non Transport
Kendrick Extrication Device (KED) or Equivalent	1	Optional
Adult Long Spine Board With Straps	2	1
Pediatric Spine Board	1	Optional
Head Immobilization Set	2	1
Rigid C-Collars: Sizes Pediatric & S, M, L Adult or Adjustable	2 each	2 each
XCollar Plus	Optional	Optional
Arm & Leg Splints (SAM, cardboard, vacuum, etc.)	2 each	2 each
Traction Splint	1	1
Obstetrical Equipment/Supplies	**BLS Transport**	**BLS Non Transport**
OB Kit (gloves, cord clamps, dressings, bulb syringe, cap, etc.)	2	1
Bandaging Equipment/Supplies	**BLS Transport**	**BLS Non Transport**
Band-Aids	10	10
Bandage Shears	1	1
1” & 2” Adhesive Tape Rolls	2 each	1 each
Non-Sterile 4x4 Compresses	50	10
Sterile 4x4 Compresses	10	5
2”, 3” or 4” Kling/Kerlix Rolls	5	2
Triangular Bandages	4	2
Surgipads	Optional	Optional
Trauma Dressing	2	1
Petroleum Gauze	2	2
Chest Seal (Asherman, Bolin, Halo, HyFin, SAM or equivalent)	Optional	Optional
Approved Hemostatic Agent	Optional	Optional
Approved Commercial Tourniquet Device	Optional	Optional
Hydrogen Peroxide	Optional	Optional
1000 mL Sterile Irrigation Solution	2	1
Potable Water	2 liters	2 liters
Cold Packs & Heat Packs	4 each	2 each

Medication & Medication Administration Equipment/Supplies	BLS Transport	BLS Non Transport
Alcohol Swabs	20	10
Chlorhexidine Swabs/Skin Prep	Optional	Optional
Mucosal Atomizer Device **(EMT Optional Skills)**	Optional	Optional
Aspirin, Chewable Tablets **(EMT Expanded Scope)**	Optional	Optional
Epinephrine Optional Skills Provider Supplies: Epinephrine 1:1000 Auto Injectors • Adult 0.3 mg • Pediatric 0.15 mg **Or** Epinephrine 1:1000 IM Injection Kit containing all of the following: • Epinephrine/Adrenalin, 1:1000, 1 mg/ml, 1 mg vial (1) • EpiRite Syringe (3) • 22 – 25 ga X 1.5" safety injection needle (3) • Alcohol prep pads (6) • Portable sharps container (1)	Optional	Optional
Glucose Oral Product, Minimum 15gm	2	1
Mark-1/DuoDote Kit **(EMT Optional Skills)**	Optional	Optional
Naloxone, 2mg/2mL or 4 mg IN prep. **(EMT Optional Skills)**	4	2

Sierra – Sacramento Valley EMS Agency Program Policy			
Prehospital Provider Agency Unit Inspections			
	Effective: 06/01/2024	Next Review: 04/2027	**705**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish procedures for conducting annual and unannounced unit inspections that ensure prehospital EMS provider compliance with S-SV EMS inventory requirements.

AUTHORITY:

A. HSC, Division 2.5, § 1797.204 & 1797.220.

B. CCR, Title 22, Division 9.

C. CVC, § 2418.5.

D. CHP Ambulance Driver's Handbook 82.4, Title 13.

POLICY:

S-SV EMS representatives will conduct inspections of all BLS/LALS/ALS transport and LALS/ALS non-transport EMS provider vehicles within the S-SV EMS region. The inspections will occur once a year as scheduled or any time without prior notice.

PROCEDURE:

A. Annual Unit Inspections:

1. An S-SV EMS representative will contact the prehospital EMS provider to schedule annual inspections.

2. Prehospital EMS providers shall complete a S-SV EMS Agency Vehicle Inspection Form (705-A) prior to inspection.

3. The annual inspection will consist of an examination of S-SV EMS required inventory, including visual inspection of expiration dates on medications and supplies and an operational demonstration of all required equipment.

4. The S-SV EMS representative may also examine the unit's controlled substance medications/records, as applicable, for compliance with S-SV EMS Management of Controlled Substances Policy.

B. Unannounced Unit Inspections:

1. When conducting an unannounced inspection, the S-SV EMS representative will notify a crew member on the unit to be inspected of the intent to conduct an inspection.

2. The unit will not be removed from service; however, dispatch will be notified of the inspection.

3. In the event an emergency call comes in and it is necessary for the unit to respond, the inspection will be discontinued.

4. When conducting the inspection, the S-SV EMS representative will inspect the unit's required equipment and supplies to ensure compliance with S-SV EMS policies.

C. General Information:

1. In the event the S-SV EMS representative determines there is a deficiency with equipment or supplies, the representative may advise the supervisor of the unit that there is a deficiency and give them the opportunity to immediately correct the deficiency. If the supervisor cannot correct the deficiency, and the S-SV EMS representative feels the deficiency may compromise patient care, the unit may be removed from service until corrections are made.

2. The S-SV EMS representative will complete an inspection report for every unit inspected.

    - The inspection report will indicate the type of inspection, and any deficiencies or issues identified.
    - Completed inspection reports will be maintained by S-SV EMS, with a copy provided to the EMS prehospital provider upon request.

	S-SV EMS Agency Vehicle Inspection Form	705-A

EMS PROVIDER & INSPECTION TYPE/DETAILS	
EMS Provider Name:	
☐ Initial/New Vehicle Inspection ☐ Annual Vehicle Inspection ☐ Unannounced Vehicle Inspection	
Inspection Date:	Inspection Location:

UNIT DETAILS & INSPECTION RESULTS

Unit ID	Year	Make	Model	Mileage	Type/Level: (ALS, BLS, Ambulance, Non-Transport, etc.)	Inspection Results
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient

UNIT DETAILS & INSPECTION RESULTS (continued)						
Unit ID	**Year**	**Make**	**Model**	**Mileage**	**Type/Level: (ALS, BLS, Ambulance, Non-Transport, etc.)**	**Inspection Results**
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient
						☐ Passed ☐ Deficient

VEHICLE INSPECTION COMMENTS (INCLUDING DETAILS OF ANY DEFICIENCIES)
Name/Title of S-SV EMS Staff Conducting Inspection:

Sierra – Sacramento Valley EMS Agency Program Policy			
Equipment & Supply Shortages			
	Effective: 06/01/2024	Next Review: 04/2027	**706**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To provide direction to EMS prehospital provider agencies regarding notifications and procedures for current or anticipated equipment/supply shortages.

AUTHORITY:

A. HSC, Division 2.5.

B. CCR, Title 22, Division 9.

POLICY:

A. This policy applies to instances when an equipment/supply shortage is the result of a manufacturers recall, manufacturers back order, or is otherwise confirmed to be unavailable from routine equipment/supply vendors.

B. EMS prehospital provider agencies are encouraged to maintain relationships with multiple vendor sources, when possible, in order to prevent or minimize disruption to the delivery of EMS prehospital patient care.

C. EMS prehospital provider agencies shall attempt to procure equipment/supplies from any reasonably available vendor source prior to notifying S-SV EMS and requesting assistance/direction. S-SV EMS notification shall be made timely enough to allow for appropriate assistance/direction prior to impacting EMS prehospital patient care.

PROCEDURE:

A. If an EMS prehospital provider agency becomes aware of a current or anticipated equipment/supply shortage beyond their control, they shall first attempt to mitigate the situation utilizing the following means:

1. Attempt to procure the identified equipment/supplies from reasonably available alternate vendor sources.

2. Complete a full inventory of the identified equipment/supplies (including restock supplies, back up vehicles and any other storage location), and rotate available stock to in-service vehicles.

B. In the event of an acute equipment/supply shortage (i.e., manufacturer recall), the EMS prehospital provider agency shall immediately notify S-SV EMS.

C. Once S-SV EMS is notified of a current or anticipated equipment/supply shortage, any of the following actions may be implemented:

1. Assist the EMS prehospital provider agency in identifying other sources to procure the identified equipment/supplies.

2. Approve a temporary policy variance allowing the EMS prehospital provider agency to utilize the identified equipment/supplies in an alternate method, preparation, or concentration.

3. Approve a temporary policy variance allowing the EMS prehospital provider agency to stock less than the minimum required inventory of the identified equipment/supplies.

4. Approve a temporary policy variance allowing the EMS prehospital provider agency to utilize appropriate substitute equipment/supplies.

5. Other direction as determined appropriate by the S-SV EMS Medical Director.

D. Any S-SV EMS variance will be approved on a temporary basis, and will only apply to the applicable equipment/supply shortage identified. EMS prehospital provider agencies shall continually attempt to procure the identified equipment/supplies. EMS prehospital provider agencies shall update S-SV EMS on the status of their procurement on a regular basis and when the temporary variance is no longer needed.

E. When notified of an acute or potential equipment/supply shortage that has the potential to affect multiple EMS prehospital provider agencies, S-SV EMS will notify appropriate providers as soon as possible and will provide any necessary direction.

Sierra – Sacramento Valley EMS Agency Program Policy			
Biomedical Equipment Maintenance			
	Effective: 06/01/2024	Next Review: 04/2027	**715**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To ensure EMS prehospital providers establish/maintain an adequate biomedical equipment maintenance program, and that pertinent equipment malfunctions are reported to S-SV EMS in a timely manner.

AUTHORITY:

A. HSC, Division 2.5, § 1797.204, 1797.220.

B. CCR, Title 22, Division 9, Chapters 2, 3 and 4.

POLICY:

A. EMS prehospital providers in the S-SV EMS region shall have a maintenance program for biomedical equipment utilized for patient care in the prehospital setting.

B. Preventative maintenance on biomedical equipment shall meet or exceed the criteria recommended by the manufacturer.

C. Individuals performing scheduled maintenance or repair shall possess the necessary credentials recommended by the manufacturer.

D. EMS prehospital providers shall immediately remove from service any biomedical equipment suspected of malfunctioning. Any malfunctioning biomedical equipment shall not be placed back into service until properly serviced or repaired by the manufacturer or manufacturer's authorized service program.

E. Prehospital providers/personnel are required to report any observed or suspected instances of biomedical equipment failure as follows:

1. Immediately to an on-duty supervisor.

2. Immediately to the RN or physician staff at the receiving facility if the malfunctioning equipment failure impacted or has a potential to impact patient health and well-being.

3. To S-SV EMS by the end of the next business day. This report shall include the EMS prehospital provider's name, date of incident, type/model of device, patient's name, run number, description of incident, impact or potential impact on patient care, and any applicable remediation/corrective actions taken.

F. Records documenting compliance with this policy shall be subject to review and inspection by S-SV EMS representatives.

837-D	MCI Details/Feedback Form
838	Crisis Standard Of Care Procedures
838-A	Crisis Standard Of Care Altered 911/EMD Triage Algorithm
838-B	Crisis Standard Of Care EMS System Orders
838-C	Crisis Standard Of Care Prehospital Treatment Orders
838-D	Medical & Health Disaster Responsibilities By Primary Entity
839	Physician On Scene
840	Medical Control For Transfers Between Acute Care Facilities
841	Paramedic Monitoring Of Magnesium Sulfate, Nitroglycerin, Heparin, &/Or Amiodarone Infusions During IFTs
842	Paramedic Monitoring Of Blood Transfusions During IFTs
843	Paramedic Utilization Of Automatic Transport Ventilators During IFTs
844	Paramedic Utilization Of Non-Invasive High Flow Nasal Cannula During IFTs
848	Reduction/Cancellation Of ALS Response
849	Transfer Of Patient Care
850	Refusal Of EMS Care
850-A	Refusal Of EMS Care Form
851	EMS Care Of Minor Patients
852	Patient Restraint Mechanisms
853	Tasered Patient Care & Transport
862	HEMS Aircraft Requesting & Utilization
883	Prohibition On Carrying Of Weapons By EMS Personnel
890	Communication Failure

ADULT PATIENT TREATMENT PROTOCOLS (BLS/ALS)

Cardiovascular

C-1 Non-Traumatic Pulseless Arrest

C-2 Return Of Spontaneous Circulation (ROSC)

C-3 Bradycardia With Pulses

C-4 Tachycardia With Pulses

C-5 Ventricular Assist Device (VAD)

C-6 Chest Discomfort/Suspected Acute Coronary Syndrome (ACS)

Respiratory

R-1 Airway Obstruction

R-2 Respiratory Arrest

R-3 Acute Respiratory Distress

Medical

M-1 Allergic Reaction/Anaphylaxis

M-3 Phenothiazine/Dystonic Reaction

M-4 BLS Naloxone Administration For Suspected Opioid Overdose

M-5 Ingestions & Overdoses

M-6 General Medical Treatment

M-8 Pain Management

M-9 CO Exposure/Poisoning

M-11 Behavioral Emergencies

Neurological

N-1 Altered Level Of Consciousness

N-2 Seizure

N-3 Suspected Stroke

Obstetrics/Gynecology

OB/G-1	Childbirth

Environmental

E-1	Hyperthermia
E-2	Hypothermia & Avalanche/Snow Immersion Suffocation Resuscitation
E-3	Frostbite
E-4	Bites/Envenomations
E-7	Hazardous Material Exposure
E-8	Nerve Agent Treatment

Trauma

T-1	General Trauma Management
T-2	Tension Pneumothorax
T-3	Suspected Moderate/Severe Traumatic Brain Injury (TBI)
T-4	Hemorrhage
T-5	Burns
T-6	Traumatic Pulseless Arrest

Pediatric Patient Treatment Protocols (BLS/ALS)

P-1	General Pediatric Protocol
C-1N	Neonatal Resuscitation
P-3	Brief Resolved Unexplained Event (BRUE)
C-1P	Pediatric Pulseless Arrest
C-3P	Pediatric Bradycardia With Pulses
C-4P	Pediatric Tachycardia With Pulses
R-1P	Pediatric Foreign Body Airway Obstruction
R-2P	Pediatric Respiratory Arrest
P-14	Pediatric Respiratory Distress – Wheezing

P-16 Pediatric Respiratory Distress – Stridor

M-1P Pediatric Allergic Reaction/Anaphylaxis

P-20 Pediatric Shock

M-5P Pediatric Ingestions & Overdoses

M-8P Pediatric Pain Management

M-11P Pediatric Behavioral Emergencies

N-1P Pediatric Altered Level Of Consciousness

N-2P Pediatric Seizure

T-3P Pediatric Suspected Moderate/Severe Traumatic Brain Injury (TBI)

ADULT PATIENT TREATMENT PROTOCOLS (LALS - AEMT)

Cardiovascular (LALS)

C-1 (LALS) Non-Traumatic Pulseless Arrest

C-2 (LALS) Return Of Spontaneous Circulation (ROSC)

C-3 (LALS) Bradycardia With Pulses

C-4 (LALS) Tachycardia With Pulses

C-5 (LALS) Ventricular Assist Device (VAD)

C-6 (LALS) Chest Discomfort/Suspected Acute Coronary Syndrome (ACS)

Respiratory (LALS)

R-1 (LALS) Airway Obstruction

R-2 (LALS) Respiratory Arrest

R-3 (LALS) Acute Respiratory Distress

Medical (LALS)

M-1 (LALS) Allergic Reaction/Anaphylaxis

M-5 (LALS) Ingestions & Overdoses

M-6 (LALS) General Medical Treatment

M-8 (LALS) Pain Management

M-9 (LALS CO Exposure/Poisoning

M-11 (LALS) Behavioral Emergencies

Neurological (LALS)

N-1 (LALS) Altered Level Of Consciousness

N-2 (LALS) Seizure

N-3 (LALS) Suspected Stroke

Obstetrics/Gynecology (LALS)

OB/G-1 (LALS) Childbirth

Environmental (LALS)

E-1 (LALS) Hyperthermia

E-2 (LALS) Hypothermia & Avalanche/Snow Immersion Suffocation Resuscitation

E-3 (LALS) Frostbite

E-4 (LALS) Bites/Envenomations

E-7 (LALS) Hazardous Material Exposure

E-8 (LALS) Nerve Agent Treatment

Trauma (LALS)

T-1 (LALS) General Trauma Management

T-3 (LALS) Suspected Moderate/Severe Traumatic Brain Injury (TBI)

T-4 (LALS) Hemorrhage

T-5 (LALS) Burns

Pediatric Patient Treatment Protocols (LALS)

P-1 General Pediatric Protocol

C-1N Neonatal Resuscitation

P-3 Brief Resolved Unexplained Event (BRUE)

C-1P	Pediatric Pulseless Arrest
C-3P	Pediatric Bradycardia With Pulses
C-4P	Pediatric Tachycardia With Pulses
R-1P	Pediatric Foreign Body Airway Obstruction
R-2P	Pediatric Respiratory Arrest
P-14	Pediatric Respiratory Distress – Wheezing
P-16	Pediatric Respiratory Distress – Stridor
M-1P	Pediatric Allergic Reaction/Anaphylaxis
P-20	Pediatric Shock
M-5P	Pediatric Ingestions & Overdoses
M-8P	Pediatric Pain Management
M-11P	Pediatric Behavioral Emergencies
N-1P	Pediatric Altered Level Of Consciousness
N-2P	Pediatric Seizure
T-3P	Pediatric Suspected Moderate/Severe Traumatic Brain Injury (TBI)

Sierra – Sacramento Valley EMS Agency Program Policy			
Emergency Medical Technician (EMT) Scope Of Practice			
	Effective: 06/01/2024	Next Review: 04/2027	**801**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish the Emergency Medical Technician (EMT) scope of practice in the S-SV EMS region.

AUTHORITY:

A. California Health and Safety Code, Division 2.5.

B. California Code of Regulations, Title 22, Division 9, Chapter 2, § 100063 and 100064.

POLICY:

A. The scope of practice of an EMT in the S-SV EMS region shall not exceed those activities specified in this policy.

B. During a mutual aid response into another jurisdiction, an EMT may utilize the scope of practice for which s/he is trained and authorized according to the policies, procedures and protocols established by S-SV EMS where the EMT is employed as part of an organized EMS system.

C. Basic Scope of Practice:

During training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfer (IFT), a certified EMT or supervised EMT student is authorized to do any of the following:

1. Evaluate the ill and injured.

2. Render basic life support, rescue and emergency medical care to patients.

3. Obtain diagnostic signs to include, but not be limited to, temperature, blood pressure, pulse and respiration rates, pulse oximetry, level of consciousness and pupil status.

4. Perform cardiopulmonary resuscitation (CPR), including the use of mechanical adjuncts to basic cardiopulmonary resuscitation (as approved by S-SV EMS).

5. Administer oxygen.

6. Use the following adjunctive airway and breathing aids:

    - Oropharyngeal airway;
    - Nasopharyngeal airway;
    - Suction devices;
    - Basic oxygen delivery devices for supplemental oxygen therapy including, but not limited to, humidifiers, partial rebreathers, and venturi masks; and
    - Manual and mechanical ventilating devices designed for prehospital use including continuous positive airway pressure.

7. Use various stretchers and spinal motion restriction/immobilization devices.

8. Provide initial prehospital emergency care to patients, including, but not limited to:

    - Bleeding control through the application of S-SV EMS approved commercial tourniquet devices;
    - Use of S-SV EMS approved hemostatic dressings;
    - Spinal motion restriction or immobilization;
    - Seated spinal motion restriction or immobilization;
    - Extremity splinting; and
    - Traction splinting.

9. Administer oral glucose or sugar solutions.

10. Extricate entrapped persons.

11. Perform field triage.

12. Transport patients.

13. Apply mechanical patient restraint.

14. Set up for ALS procedures, under the direction of an AEMT or Paramedic.

15. Perform automated external defibrillation.

16. Assist patients with the administration of physician-prescribed devices including, but not limited to, patient-operated medication pumps, sublingual nitroglycerin, and self-administered emergency medications, including epinephrine devices.

D. Expanded Scope of Practice:

1. In addition to the basic scope of practice activities authorized above, a certified EMT may use any or all of the expanded scope of practice items listed in this section of the policy, under the following conditions:

   - The individual is part of the organized EMS system, functioning under the oversight of an S-SV EMS approved prehospital service provider.
   - The individual has been authorized by the S-SV EMS approved prehospital service provider to utilize the expanded scope of practice.
   - The individual has received adequate training on the expanded scope of practice items they have been authorized to use.
   - The expanded scope of practice items are not mandatory. S-SV EMS approved prehospital service providers may determine which, if any, expanded scope of practice items to use based on organizational or community needs.

2. Authorized expanded scope of practice items include the following:

   - Administration of aspirin in accordance with S-SV EMS policies/protocols.
   - Performance of finger stick blood glucose testing in accordance with the S-SV EMS policies/protocols.
   - Monitoring of intravenous lines delivering glucose solutions or isotonic balanced salt solutions including Ringer's lactate for volume replacement under the following conditions:
     - If in the prehospital setting, no other ALS procedures have been initiated.
     - If during an IFT, the patient is non-critical and deemed stable by the transferring physician, the physician approves transport by an EMT, and nothing has been added to the intravenous fluids.
     - The EMT may monitor, maintain, and adjust, if necessary, in order to maintain a preset rate of flow and turn off the flow of intravenous fluid.
   - Transferring a patient, who is deemed appropriate for transfer by the transferring physician, and who has nasogastric (NG) tubes, gastrostomy tubes, heparin locks, foley catheters, tracheostomy tubes and/or indwelling vascular access lines, excluding arterial lines under the following conditions:
     - Nasogastric Tubes:
       - Nasogastric tubes shall be clamped. No form of suction shall be allowed during transport.
       - A nasogastric tube shall be appropriately secured to the nose and shall also be secured to the patients clothing to prevent accidental dislodgement or patient discomfort.
       - Any tubing shall be clamped, and no feedings shall be infused during transport to prevent the possibility of aspiration.
       - Unless contraindicated by medical condition, any patient fed within the last two (2) hours shall be placed on the gurney in semi-fowlers position to help prevent the possibility of aspiration.

- Abdominal Tubes (gastrostomy tubes, ureterostomy tubes, etc.):
  - EMTs shall check that abdominal tubes are secured in place in an appropriate fashion, the integrity of the drainage system is intact and drainage bags are emptied prior to transfer, with the time noted. Drainage amount and characteristics shall be noted.
  - Drainage bags shall be secured to the patient in an appropriate fashion to prevent dislodgement, disconnection, or backflow.
  - Any dressing drainage shall be noted.
  - Dislodged tubes shall not be reinserted. A clean, dry dressing shall be applied to the site. Time and circumstances of dislodgement shall be noted.
- Foley Catheters:
  - Catheters shall be checked prior to transfer to assure that the catheter is appropriately secured to the patient, the system is intact, and the drainage bag is secured to prevent dislodgement, disconnection and backflow.
  - Amount and characteristics of urine shall be noted.
  - If the drainage system becomes disconnected or dislodged during transport, the EMT will clamp the Foley if disconnected, but in no circumstances shall the catheter be reinserted if dislodged.
- Tracheostomy Tubes:
  - Tracheostomy tubes shall be checked to assure they are secured to the patient in an appropriate fashion.
  - EMTs may suction at the opening only to remove secretions the patient is unable to clear. Amount and characteristic of secretions shall be noted.
  - If the inner cannula becomes dislodged or is expelled, the EMT shall rinse it in sterile sodium chloride and gently reinsert it or allow the patient to reinsert it if capable.

E. Optional Skills:

1. In addition to the basic and expanded scope of practice activities authorized above, a certified EMT may use any or all of the optional skills listed in this section of the policy, under the following conditions:

   - The individual is part of the organized EMS system, functioning under the oversight of an S-SV EMS approved BLS optional skills provider.
   - The individual has been authorized by the S-SV EMS approved BLS optional skills provider to use the optional skills.
   - The individual has received adequate training on the optional skills that they have been authorized to use.

2. Authorized optional skills items include the following:

    - Administration of intranasal (IN) naloxone in accordance with S-SV EMS policies/protocols.
    - Administration of epinephrine by auto-injector or intramuscular (IM) injection in accordance with S-SV EMS policies/protocols.
    - Use of a size 3, 4, or 5 i-gel airway devices in accordance with S-SV EMS policies/protocols.
    - Administration of atropine and pralidoxime chloride by auto-injector in accordance with S-SV EMS policies/protocols.

Sierra – Sacramento Valley EMS Agency Program Policy			
Advanced EMT (AEMT) Scope Of Practice			
	Effective: 06/01/2024	Next Review: 04/2027	**802**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish the Advanced Emergency Medical Technician (AEMT) scope of practice in the S-SV EMS region.

AUTHORITY:

A. HSC, Division 2.5, § 1797.107, 1797.171, 1797.160, 1797.214.

B. CCR, Title 22, Division 9, Chapter 3, § 100106, 100106.1, 100106.2.

POLICY:

A. An AEMT may perform any activity identified in the scope of practice of an EMT as specified in S-SV EMS EMT Scope of Practice Policy (801).

B. A certified AEMT or an AEMT trainee, as part of an organized EMS system, while caring for patients in a hospital as part of their training or continuing education, under the direct supervision of a Physician or Registered Nurse, or while at the scene of a medical emergency or during transport, or during interfacility transfer is authorized to perform all of the following procedures:

1. Perform pulmonary ventilation by use of an i-gel LMA device.

2. Perform trachea-bronchial suctioning of an intubated patient.

3. Institute intravenous (IV) catheters, saline locks, needles or other cannula (IV lines), in peripheral veins.

4. Administer the following intravenously:

- Glucose solutions.
- Isotonic balanced salt solutions (including Ringer's lactate solution).
- Naloxone.
- Intravenous administration of 50% dextrose, and 10% dextrose.

5. Establish and maintain intraosseous (IO) access in a pediatric patient.

6. Obtain venous and/or capillary blood samples for laboratory analysis.

7. Use a blood glucose measuring device.

8. Use a waveform capnography ($PETCO_2$) measuring device.

9. Administer the following medications in a route other than intravenous:

    - Sublingual nitroglycerine preparations.
    - Aspirin.
    - Glucagon.
    - Inhaled beta-2 agonist (bronchodilators).
    - Activated charcoal.
    - Naloxone.
    - Epinephrine 1:1,000.

C. In addition to the activities authorized above, an AEMT previously certified as an EMT-II is authorized to perform the following optional skills (identified by the term 'AEMT II Only' in S-SV EMS policies and treatment protocols):

1. Administer the following medications:

    - Lidocaine hydrochloride.
    - Atropine sulfate.
    - Sodium bicarbonate.
    - Epinephrine 1:10,000.
    - Fentanyl.
    - Morphine sulfate.
    - Benzodiazepines (midazolam).

2. Perform synchronized cardioversion and defibrillation.

3. Utilize electrocardiographic devices and monitor electrocardiograms.

AEMTs who were not certified as EMT-IIs prior to July 1, 2010 are not allowed to utilize the scope of practice items listed in this section.

Sierra – Sacramento Valley EMS Agency Program Policy			
Paramedic Scope Of Practice			
	Effective: 06/01/2024	Next Review: 04/2027	**803**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish the paramedic scope of practice in the S-SV EMS region.

AUTHORITY:

A. HSC, Division 2.5, § 1797.84, 1797.172, 1797.220.

B. CCR, Title 22, Division 9, Chapter 4, § 10046 & 100147.

POLICY:

A. A paramedic may perform any activity identified in the scope of practice of an EMT (S-SV EMS Policy 801), or any activity identified in the scope of practice of an Advanced EMT (S-SV EMS Policy 802), without requiring a separate certification.

B. Activities listed in the 'Paramedic Basic Scope of Practice' section of this policy may be performed by paramedic students or paramedics under the following conditions:

1. Paramedic students currently enrolled in an approved paramedic training program, who are under the direct supervision of an approved paramedic field preceptor in the prehospital setting, or who are under the direct supervision of a physician, registered nurse, or physician assistant in the hospital setting.

2. California licensed and S-SV EMS accredited paramedics who are part of the organized EMS system, functioning under the oversight of an S-SV EMS approved paramedic prehospital service provider agency as follows:

- Under the direct supervision of a physician, registered nurse, or physician assistant in the hospital setting for the purposes of CE or while working in a rural hospital pursuant to § 1797.195 of the California Health and Safety Code.
- Standing order patient care specified in S-SV EMS approved policies/protocols.
- Base/modified base hospital physician or MICN on-line medical direction.
- Physician direction as specified in S-SV EMS Physician On Scene Policy (839).
- Physician interfacility transport written orders as specified in S-SV EMS Medical Control For Transfers Between Acute Care Facilities Policy (840).

C. Activities listed in the ‘Paramedic Optional Scope of Practice’ section of this policy, as applicable to the specific provider agency, may be performed by paramedic students under the conditions indicated above, or by California licensed and S-SV EMS accredited paramedics who are part of the organized EMS system and are functioning under the oversight of an S-SV EMS approved paramedic optional skills provider.

D. Paramedic Basic Scope of Practice:

1. Utilize electrocardiographic devices and monitor electrocardiograms, including 12-lead electrocardiograms.

2. Perform defibrillation, synchronized cardioversion, and external cardiac pacing.

3. Visualize the airway by use of a laryngoscope and remove foreign bodies with Magill forceps.

4. Perform pulmonary ventilation by use of an i-gel LMA device, stomal intubation, or adult oral endotracheal intubation.

5. Utilize ventilation devices for continuous positive airway pressure.

6. Institute IV catheters, saline locks, needles, or other cannula, in peripheral veins and monitor/administer medications through pre-existing vascular access.

7. Institute intraosseous access.

8. Administer IV or IO glucose solutions or isotonic balanced salt solutions, including Ringer's Lactate solution.

9. Obtain venous blood samples.

10. Use laboratory devices, including point of care testing, for prehospital screening use to measure lab values including, but not limited to glucose, capnometry, capnography, and carbon monoxide.

11. Utilize Valsalva maneuver.

12. Perform percutaneous needle cricothyroidotomy.

13. Perform needle thoracostomy.

14. Monitor thoracostomy tubes.

15. Monitor and adjust IV solutions containing potassium ≤ 40 mEq/L.

16. Administer approved medications by the following routes: IV, IO, intramuscular, subcutaneous, inhalation, transcutaneous, rectal, sublingual, endotracheal, intranasal, oral, or topical.

17. Administer the following medications:

- 10% dextrose.
- 50% dextrose.
- Activated charcoal.
- Adenosine.
- Albuterol.
- Amiodarone.
- Aspirin.
- Atropine sulfate.
- Calcium chloride.
- Diphenhydramine hydrochloride.
- Dopamine hydrochloride.
- Epinephrine.
- Fentanyl.
- Glucagon.
- Ipratropium bromide.
- IV acetaminophen.
- Lidocaine hydrochloride.
- Ketamine.
- Ketorolac.
- Midazolam.
- Morphine sulfate.
- Naloxone hydrochloride.
- Nitroglycerin preparations (except intravenous).
- Ondansetron.
- Pralidoxime chloride.
- Sodium bicarbonate.
- TXA.

E. Paramedic Optional Scope of Practice:

1. Perform the following during interfacility patient transports:

- Monitoring of magnesium sulfate, nitroglycerin, heparin, &/or amiodarone infusions.
- Monitoring of blood transfusions.
- Utilization of an automatic transport ventilator (ATV).
- Utilization of non-invasive High Flow Nasal Cannula (HFNC).

Sierra – Sacramento Valley EMS Agency Program Policy			
Paramedic Utilization Of Non-Invasive High Flow Nasal Cannula During IFTs			
	Effective: 06/01/2024	Next Review: 03/2026	**844**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To provide parameters for paramedic utilization of non-invasive High Flow Nasal Cannula (HFNC) during interfacility transports (IFTs).

AUTHORITY:

A. HSC, Division 2.5, § 1797.220.

B. CCR, Title 22, Chapter 4, Article 1, § 100145.

POLICY:

A. Only appropriately trained paramedics who are on duty with an S-SV EMS authorized paramedic IFT optional skills provider may utilize non-invasive HFNC during IFTs.

B. Patients will be on non-invasive HFNC prior to transport. Paramedics will not initiate non-invasive HFNC.

C. Provider agencies utilizing non-invasive HFNC equipment shall follow the manufacturer instructions for use, maintenance, cleaning, and regular testing. At a minimum, non-invasive HFNC equipment shall undergo annual preventative testing/ maintenance by qualified manufacturer's representative personnel.

D. Paramedics must be thoroughly trained and regularly retrained on the use of the non-invasive HFNC equipment. Such training shall occur no less than annually and shall be documented.

PROCEDURE:

A. Written transfer orders from the transferring physician shall be obtained prior to transport. These orders must provide for maintaining and titrating flow (LPM), FiO2 and SpO2 goals for non-invasive HFNC during transport and shall include a telephone number where the transferring and/or base/modified base hospital physician can be reached during the patient transport. These written orders shall be attached to the completed PCR.

B. Non-invasive HFNC support must be administered utilizing non-invasive HFNC equipment familiar to the paramedic.

C. If a non-invasive HFNC equipment failure occurs and the paramedic is unable to maintain oxygen administration utilizing non-invasive HFNC, the paramedic shall discontinue use of non-invasive HFNC, provide appropriate oxygenation/ventilation support, and notify the transferring physician and/or base/modified base hospital as soon as possible. S-SV EMS shall also be notified of any non-invasive HFNC failure by the end of the next business day.

D. Paramedics shall continually observe the patient and document patient response to treatment and any changes while the non-invasive HFNC is operational.

E. Initial non-invasive HFNC settings and any subsequent changes shall be documented on the PCR.

F. The paramedic is responsible for airway management and must frequently reassess respiratory effort for effectiveness of non-invasive HFNC oxygen delivery.

G. Non-invasive BP monitoring equipment shall be utilized. Vital signs shall be monitored and documented every 15 minutes and any time there is any change in patient condition or adjustment of the non-invasive HFNC settings.

H. Continuous pulse oximetry and cardiac monitoring shall be maintained throughout transport, and values/rhythms shall be documented every 15 minutes and any time there is a change in patient condition.

Sierra – Sacramento Valley EMS Agency Program Policy			
Patient Restraint Mechanisms			
	Effective: 06/01/2024	Next Review: 04/2027	**852**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To provide guidelines on the use of restraint mechanisms by EMS personnel for patients who are violent, potentially violent, or who may harm themselves or others.

AUTHORITY:

A. HSC, Division 2.5, § 1797.202, 1797.220, and 1798.

B. CCR, Title 22.

C. WIC, 5150.

PRINCIPLES:

A. Restraint mechanisms are to be used only when necessary, in situations where the patient is potentially violent or is exhibiting behavior that is dangerous to self or others.

B. Prehospital personnel must consider that aggressive or violent behavior may be a symptom of medical conditions such as head trauma, hypoxia, alcohol or drug related problems, hypoglycemia or other metabolic disorders, stress, or psychiatric disorders.

C. The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway or compromise vascular or neurological status.

D. Restraints applied by law enforcement require the officer to remain available at the scene and/or during transport to remove or adjust the restraints for patient safety.

POLICY:

A. General Principals

1. Restrained patients shall not be transported in a prone position. EMS personnel must ensure that the patient's position does not compromise their respiratory/ circulatory systems and does not preclude any necessary medical intervention to protect or manage the airway should vomiting occur.

2. Monitor vital signs and be prepared to provide airway/ventilation management.

3. The base and/or receiving hospital shall be informed as soon as possible that the patient has been restrained, the type of restraint used and the reason for restraint.

B. Forms of Restraint

1. Physical Restraint:

- Restraint devices applied by EMS personnel must be padded soft restraints that will allow for quick release.
- Restrained extremities should be evaluated for pulse quality, capillary refill, color, temperature, nerve, and motor function immediately following application and every 10 minutes thereafter. It is recognized that the evaluation of vascular and neurological status requires patient cooperation, and thus may be difficult or impossible to monitor.
- Restraints shall be applied in such a manner that they do not cause vascular, neurological, or respiratory compromise. Any abnormal findings require the restraints to be removed and reapplied, or supporting documentation as to why restraints could not be removed and reapplied.
- Restraints shall not be attached to movable side rails of a gurney.
- It the patient is actively spitting; a surgical mask or oxygen mask (at appropriate flow rate) may be placed over the patient's mouth to protect EMS personnel and others. If this method fails, a light weight, sheer, protective mesh hood may be used. When the mesh hood is placed over the patient's head, their mouth and/or nose shall never be obstructed, and the patient's airway/respiratory status shall be continuously monitored. The mesh hood shall never be tightened in any manner to secure it around the patient's neck.
- The following forms of restraint shall not be applied by EMS personnel:
  - Hard plastic ties or any restraint device requiring a key to remove.
  - Restraining a patient's hands and feet behind the patient.
  - "Sandwich" restraints, using backboard, scoop-stretcher, or flats.

2. Chemical Restraint:

- If a patient is combative, such that harm to self or others is likely, consider chemical restraint as follows:
  - Pediatric patients: Contact base/modified base hospital for consultation.
  - Adult patients: Midazolam* 5 mg IV/IO **OR** 10 mg IM/IN.

  *Continuous cardiac & EtCO2 monitoring required following administration of Midazolam

C. Law Enforcement Applied Restraints

1. The general principles of this policy shall pertain to patients with restraints applied by law enforcement who are treated/transported by EMS personnel.

2. Restraint devices applied by law enforcement must provide sufficient slack to allow the patient to straighten their abdomen/chest and to take full tidal volume breaths.

3. Restraint devices applied by law enforcement require the officer's continued presence to ensure patient and scene safety. The officer should accompany the patient in the ambulance or follow the ambulance during transport. Patients in custody/arrest remain the responsibility of law enforcement.

4. At the discretion of law enforcement, applied restraint devices may be replaced by EMS restraints if doing so does not threaten the safety of the patient and/or EMS personnel.

D. Interfacility Transport of Psychiatric Patients

Two-point, locking, padded cuff and belt restraints and/or two-point locking, padded ankle restraints may only be used during interfacility transport of psychiatric patients on a 5150 hold, under the following circumstances:

1. Transport personnel must be provided with a written restraint order from the transferring physician/designee as part of the transfer record.

2. Transport personnel shall always have immediate access to the restraint key during transport.

3. Restrained extremities should be evaluated for pulse quality, capillary refill, color, temperature, nerve, and motor function immediately following application and every 10 minutes thereafter. Any abnormal findings require the restraints to be adjusted or removed and reapplied, or supporting documentation as to why restraints could not be adjusted or removed and reapplied.

E. Documentation

The following information shall be documented on the patient care report:

1. Reason for restraint.

2. Type of restraint utilized and identity of personnel applying restraint.

3. Assessment of the vascular/neurological status of the restrained extremities and cardiac/respiratory status of the restrained patient.

1101	Vascular Access
1102	Airway & Ventilation Management
1103	Needle Cricothyrotomy
1106	Mechanical Chest Compression Devices
1107	12-Lead EKG Procedure
1108	Prehospital Blood Draws
1110	ALS/LALS Annual Infrequently Used Skills Verification & Regional Training Module
1110-A	AEMT Infrequently Used Skills Annual Verification Tracking Sheet
1110-B	Paramedic Infrequently Used Skills Annual Verification Tracking Sheet
1110-C	Adult Endotracheal Intubation Skills Verification Checklist
1110-D	Adult i-gel Airway Device Skills Verification Checklist
1110-E	Pediatric i-gel Airway Device Skills Verification Checklist
1110-F	Needle Cricothyrotomy Skills Verification Checklist
1110-G	Needle Thoracostomy Skills Verification Checklist
1110-H	Adult Cardioversion/Defibrillation Skills Verification Checklist
1110-I	Pediatric Cardioversion/Defibrillation Skills Verification Checklist
1110-J	Transcutaneous Cardiac Pacing Skills Verification Checklist
1110-K	Intraosseous Infusion Skills Verification Checklist
1110-L	Multiple Casualty Incidents (MCI) Response Procedures Checklist

Sierra – Sacramento Valley EMS Agency Program Policy			
Vascular Access			
	Effective: 06/01/2024	Next Review: 01/2027	**1101**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

To establish vascular access and fluid administration guidelines for prehospital personnel.

AUTHORITY:

A. HSC, Division 2.5, § 1797.220 and 1798.

B. CCR, Title 22, Division 9, Chapters 3 & 4.

POLICY:

A. Vascular Access Guidelines

1. Over-the-needle catheters may be inserted into peripheral veins and external jugular veins for administration of intravenous medications/fluid boluses, or the anticipated need to administer intravenous medications/fluid boluses.

2. Avoid more than three (3) vascular access attempts per patient, unless necessary for emergent treatment.

3. Do not establish vascular access in an extremity that has a functioning dialysis shunt, unless the patient is in extremis and no other vascular access is available or appropriate.

4. Do not connect the primary IV tubing directly to the IV catheter. IV extension/saline lock tubing shall be utilized between the primary IV tubing and the IV catheter.

5. Saline locks are encouraged when fluid boluses or numerous medication administrations are not expected to be necessary.

6. When large volumes of fluid may be required, large bore catheters (14-18 gauge) should be used, and placed in proximal veins when available. This includes, but is not limited to, patients requiring adenosine, STEMI patients, stroke patients, trauma patients, and patients in cardiac arrest.

7. Consider establishing two (2) IV's in patients who have, or are at risk for decompensation (e.g. hypovolemic shock). Do not delay patient transport to establish additional vascular access.

8. To keep open (TKO) shall be the default rate unless otherwise specified in the applicable treatment protocol. TKO indicates a rate of 25-30 mL per hour (25-30 micro drops per minute, or 5 macro drops per minute).

9. A 'fluid bolus' in an adult patient consists of up to 1000 mL (unless otherwise specified in the applicable treatment protocol) of crystalloid solution delivered as rapidly as possible, with reassessment of hemodynamic parameters, respiratory status and lung sounds before and after administration.

10. A 'fluid bolus' in a pediatric patient consists of 20 mL/kg of crystalloid solution delivered as rapidly as possible, with reassessment of hemodynamic parameters, respiratory status and lung sounds before and after administration.

B. External Jugular (EJ) Vein Cannulation

1. EJ vein cannulation may be utilized in any situation where an IO would be acceptable.

2. Contraindications (Relative):

- Suspected coagulopathy (e.g. advanced liver disease or taking coumadin).
- Suspected cervical spine injury.
- Inability to tolerate supine position.
- Stable patient.

3. Procedure:

- Place patient in Trendelenburg or supine position and elevate shoulders.
- Turn head 45 to 60 degrees to side opposite of intended venipuncture site.
- Palpate to assure no pulsatile quality to vessel.
- Prep site with a recognized antiseptic agent, wipe dry with a sterile gauze pad.
- "Tourniquet" vein by placing finger just above clavicle near midclavicular line.
- Stabilize skin over vein with thumb.
- Point needle toward shoulder in direction of vein, and puncture vein midway between jaw and clavicle over belly of sternocleidomastoid muscle.
- Maintain compression of vein at clavicle area until needle is withdrawn and IV tubing has been connected in order to prevent air from entering vein.
- Secure IV site.

4. Possible Complications:

    - Air embolism.
    - Hematoma requiring compression of neck.
    - Extravasation of fluid or medication, infection, thrombosis.

C. Intraosseous Infusion

1. Indications:

    - Emergency situations, when lifesaving fluids or drugs should be administered and attempts at placing a peripheral IV would likely be unsuccessful or too time consuming.
    - Adult (paramedics) and pediatric (paramedic or AEMT) patients, weighing ≥ 3 kg, who present with one (1) or more of the following clinical conditions:
        - Cardiac arrest.
        - Hemodynamic instability (B/P < 90 mmHg & clinical signs of shock).
        - Imminent respiratory failure.
        - Status epilepticus with prolonged seizure activity greater than 10 minutes, and refractory to IN/IM anticonvulsants.
        - Toxic conditions requiring immediate IV access for antidote.

2. Contraindications:

    - Fracture or suspected vascular compromise in targeted bone.
    - Excessive tissue or absence of adequate anatomical landmarks.
    - Infection at area of insertion site.
    - Previous significant orthopedic procedure at site (e.g. prosthetic limb/joint).
    - IO access in targeted bone within past 48 hours.

3. Site Selection:

    - Site selection depends on patient age/size/anatomy, presenting condition, ability to locate anatomical landmarks, provider training/experience, and clinical judgment. Site selection is also dependent on the absence of contraindications, accessibility of the site and the ability to monitor and secure the site. Humeral site may be preferred for high volume fluid administration and/or lower extremity trauma (see 'IO Insertion Site Instructions' at the end of this policy).
    - No more than one (1) attempt allowed in each bone.

4. Insertion Procedure:

    - Prep site with a recognized antiseptic agent, wipe dry with a sterile gauze pad.
    - Insert the device according to manufacturer specific directions.

- Attach primed extension set to needle and secure needle per manufacturer instructions.
- For patients unresponsive to pain:
  - Rapid flush with 10 mL of normal saline.
- For patients responsive to pain:
  - Prime extension set with 2% lidocaine.
  - Slowly administer 2% lidocaine over 120 seconds.
    - Adult – 40 mg.
    - Pediatric – 0.5 mg/kg (maximum 40 mg).
  - Allow lidocaine to dwell in IO space 60 seconds.
  - Rapid flush with 10 mL of normal saline.
  - Slowly administer a subsequent ½ dose of 2% lidocaine over 60 seconds.
    - Adult – 20 mg.
    - Pediatric – ½ the initial dose (maximum 20 mg).
- Connect fluids to extension set using IV tubing – infusion may need to be pressurized to achieve desired rate.
- Dress site and secure tubing.

5. Possible Complications:

   - Infiltration of fluids/drugs into the subcutaneous tissue due to improper placement.
   - Cessation of the infusion due to clotting in the needle, or the bevel of the needle being lodged against the posterior cortex.
   - Osteomyelitis or sepsis.
   - Fluid overload.
   - Fat or bone emboli.
   - Fracture.

6. S-SV EMS Approved IO Devices:

   - Manual IO device – bone marrow type needles, 15 and 18 gauge size.
   - BD Intraosseous Vascular Access System.
   - EZ-IO.
   - NIO.
   - SAM IO.

D. Preexisting Vascular Access Device (PVAD)

1. Paramedic personnel may access the following types of PVADs on any patient who is in extremis and when no other vascular access is available or appropriate:

   - Indwelling catheter/device, exiting externally, inserted into the superior vena cava or right atrium (Broviac, Hickman, PICC and others).

    - Note: subcutaneous access, requiring special equipment and entry through the skin, is not approved for use by prehospital personnel.
- Hemodialysis shunt (fistulas/grafts).

2. Indications:

   In the absence of any other observable vascular access, when the patient has one or more of the following:

   - Cardiopulmonary arrest.
   - Extremis due to circulatory shock.
   - Critical need for pharmacological intervention.

3. Complications:

   - Infection: Due to the location of the catheter, strict adherence to aseptic technique is crucial when handling a PVAD.
     - Use of sterile gloves is recommended.
     - Prep injectable port and surrounding skin with chlorhexidine prior to attaching I.V. tubing.
     - Use new supplies if equipment becomes contaminated.
     - Re-cover port with sterile dressing and securely tape.
   - Air Embolism: The PVAD provides a direct line into the central circulation; introduction of air into these devices can be hazardous.

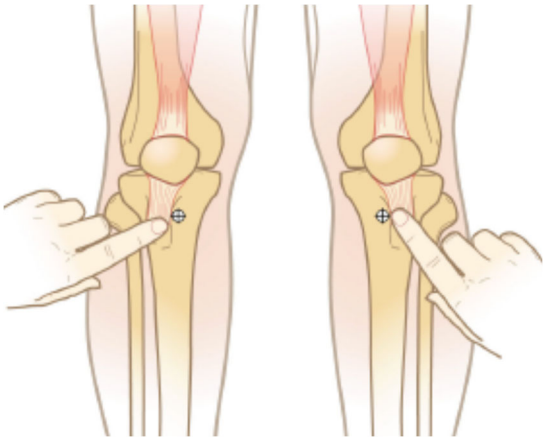
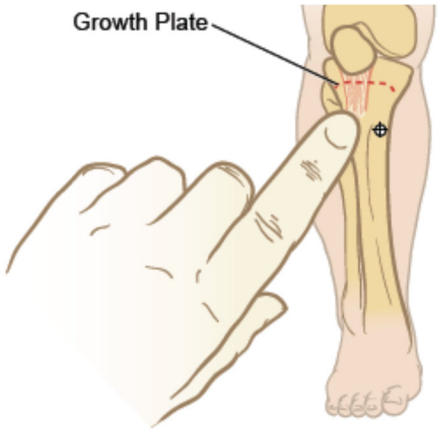
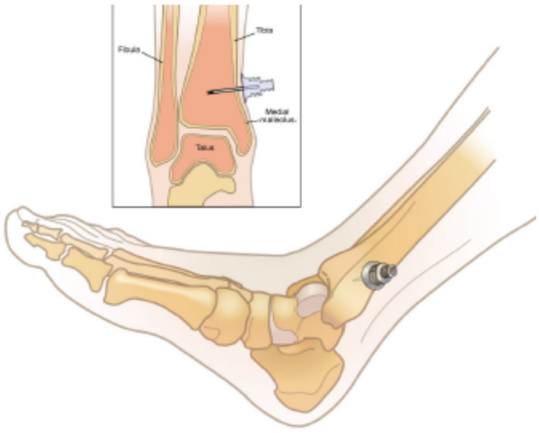
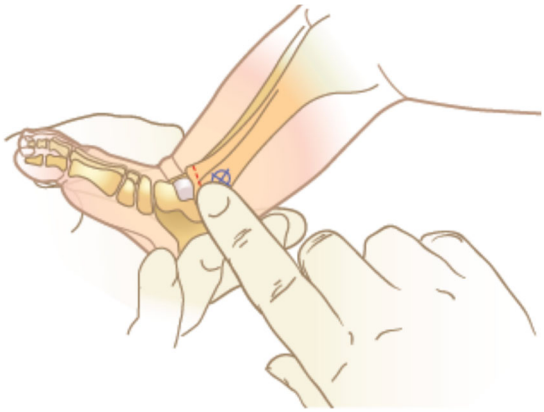
4. Approved Infusions:

   - Intravenous solutions.
   - All medications except diazepam (Valium), as it interacts with silicone causing crystallization of the medications and deterioration of the silicone.

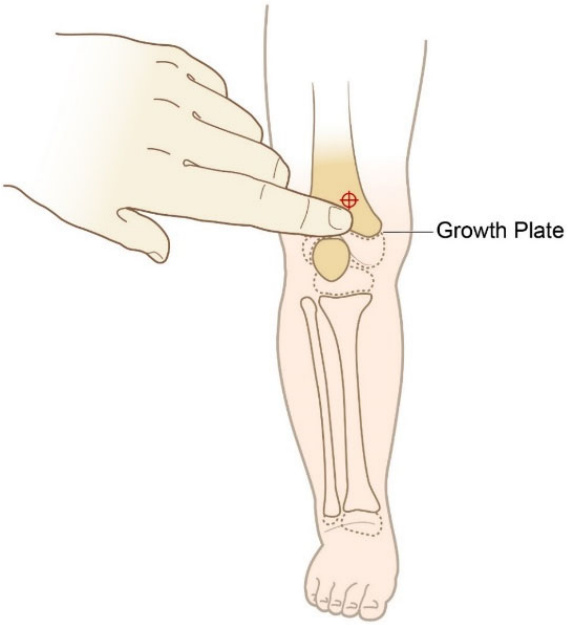
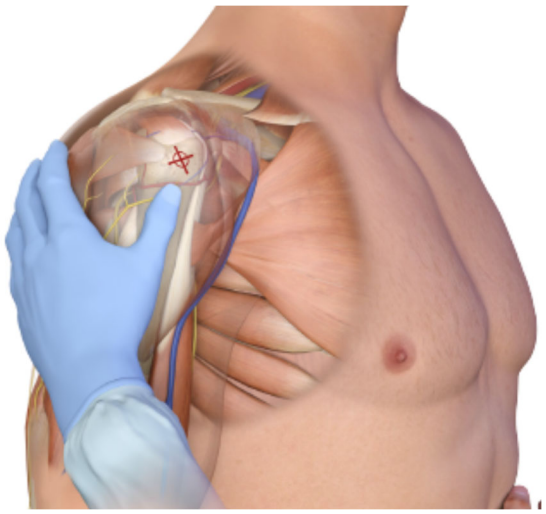
5. Procedure:

   - Do not remove injection cap from catheter.
   - Do not use a syringe smaller than 10 ml to prevent catheter damage from excess infusion pressure.
   - Always expel air from syringe prior to administration.
   - Follow all medications with 5 ml of saline to avoid clots.
   - Do not inject medications or fluids if resistance is met when establishing patency.
   - Do not allow I.V. fluids to run dry.
   - Do not manipulate or remove an indwelling catheter under any circumstances.
   - Should damage occur to the external catheter, clamp immediately between the skin exit site and the damaged area to prevent air embolism or blood loss.

IO Insertion Site Instructions

Proximal Tibia – Adults	Proximal Tibia – Infants & Small Children
Extend the leg - insertion site is approx. 3 cm (2 finger widths) below the patella and approx. 2 cm (1 finger width) medial, along the flat aspect of the tibia. 	Extend the leg - insertion site is just below the patella, approx. 1 cm (1 finger width) and slightly medial, approx. 1 cm (1 finger width) along the flat aspect of the tibia. Pinch the tibia between your fingers to identify the center of the medial and lateral borders. 
Distal Tibia – Adults	**Distal Tibia – Infants & Small Children**
Approx. 3 cm (2 finger widths) proximal to the most prominent aspect of the medial malleolus. Palpate the anterior and posterior borders of the tibia to assure that your insertion site is on the flat center aspect of the bone. 	Approx. 1-2 cm (1 finger width) proximal to the most prominent aspect of the medial malleolus. Palpate the anterior and posterior borders of the tibia to assure that your insertion site is on the flat center aspect of the bone. 

Distal Femur – Infants & Small Children	Humerus – Adult Only

Secure the leg out-stretched to ensure the knee does not bend. Identify the patella by palpation. The insertion site is just proximal to the patella (maximum 1 cm) and approximately 1-2 cm medial to midline.
 
 	
	• Place pts hand over the abdomen (elbow adducted and humerus internally rotated).
	• Place your palm on the pts shoulder anteriorly.
	  ○ The area that feels like a “ball” under your palm is the general target area.
	  ○ You should be able to feel this ball, even on obese pts, by pushing deeply.
	• Place the ulnar aspect of one hand vertically over the axilla.
	• Place the ulnar aspect of the opposite hand along the midline of the upper arm laterally.
	• Place your thumbs together over the arm - this identifies the vertical line of insertion on the proximal humerus
	• Palpate deeply as you climb up the humerus to the surgical neck.
	  ○ It will feel like a golf ball on a tee – the spot where the “ball” meets the “tee” is the surgical neck.
	  ○ The insertion site is on the most prominent aspect of the greater tubercle, 1 to 2 cm above the surgical neck.
	 

Sierra – Sacramento Valley EMS Agency Program Policy			
ALS/LALS Annual Infrequently Used Skills Verification & Regional Training Module			
	Effective: 06/01/2024	Next Review: 01/2027	**1110**
	Approval: Troy M. Falck, MD – Medical Director		SIGNATURE ON FILE
	Approval: John Poland – Executive Director		SIGNATURE ON FILE

PURPOSE:

A. To identify medical procedures (skills) utilized infrequently by ALS/LALS personnel in the prehospital setting, and provide a standardized method for annual evaluation of all S-SV EMS certified AEMT's and accredited paramedic's ability to safely, efficiently and adequately perform them.

B. To establish a standardized method of ensuring that appropriate education and training is provided to all ALS/LALS prehospital personnel in the S-SV EMS region on a regularly scheduled basis.

AUTHORITY:

A. HSC, Division 2.5, § 1797.214.

B. CCR, Title 22, Division 9, § 100107, 100128, 100147, 100165, 100169, & Chapter 12

DEFINITIONS

A. **Infrequently Used Skills –** Medical procedures that are performed rarely by ALS/LALS personnel in the prehospital setting and/or that may result in serious complications when performed incorrectly.

B. **Regional Training Module –** A standardized training module developed by S-SV EMS in conjunction with the S-SV EMS Regional Quality Improvement Committee.

POLICY:

A. Prehospital service provider agencies shall verify that every S-SV EMS certified AEMT and accredited paramedic affiliated with their organization has successfully performed all of the skills listed in the applicable Infrequently Used Skills Annual Verification Tracking Sheet (1110-A or 1110-B) a minimum of once during every 12-month period. Under special circumstances, an extension to the 12-month requirement may be approved by S-SV EMS upon request.

B. All infrequently used skills shall be verified by successful performance in a structured training environment, utilizing the S-SV EMS approved infrequently used skills verification checklists (1110-C through 1110-L). A copy of the completed applicable Infrequently Used Skills Annual Verification Tracking Sheet (1110-A or 1110-B) shall be maintained in the employee's file for a period of not less than four (4) years, and shall be made available for review by S-SV EMS representatives upon request.

C. Skills competency verification shall be conducted by one of the following:

   1. Service provider's CQI coordinator or their designee.

   2. Service provider's medical director.

   3. Base/modified base hospital prehospital coordinator or their designee.

D. Regional training modules will be developed and distributed by S-SV EMS on an annual basis. All ALS/LALS service provider agencies are required to deliver these training modules and ensure that their affiliated AEMT and paramedic personnel complete this training no later than the end of the current calendar year. BLS personnel are encouraged to complete this training as appropriate, but it is not a mandatory requirement.

E. Any AEMT or paramedic who is determined to not have current skills verification and/or regional training module completion documentation on file shall not be allowed to function as an AEMT or paramedic in the S-SV EMS region until they complete the required skills verification and/or regional training module.

	AEMT Infrequently Used Skills Annual Verification Tracking Sheet	1110-A

AEMT Name:	Calendar Year:
AEMT Certification #:	Service Provider:

Instructions: LALS prehospital service providers shall verify that each S-SV EMS certified AEMT affiliated with their organization has successfully performed all of the applicable skills listed on this sheet, a minimum of once every 12 months (note: verification is not required for skills not currently being utilized by the prehospital service provider). Under special circumstances, an extension to this requirement may be approved by S-SV EMS upon request.

All infrequently used skills shall be verified by successful performance in a structured training environment, utilizing the S-SV EMS approved infrequently used skills verification checklists (as indicated below). A copy of this completed tracking sheet shall be maintained in the employee's file for a period of not less than four (4) years, and be made available for review by S-SV EMS representatives upon request. The individual infrequently used skills verification checklists are not required to be maintained.
Skills competency verification shall be conducted by one of the following:

- Service provider's CQI coordinator or their designee.
- Service provider's medical director.
- Base/modified base hospital prehospital coordinator or their designee.

Skills Verification Checklist Description	Verification Date	Evaluator Initials
1. Adult i-gel Airway Device (1110-D)		
2. Pediatric i-gel Airway Device (1110-E)		
3. Adult Cardioversion/Defibrillation (1110-H) – **AEMT II ONLY**		
4. Pediatric Cardioversion/Defibrillation (1110-I) – **AEMT II ONLY**		
5. Intraosseous Infusion (1110-K)		
6. Multiple Casualty Incident (MCI) (1110-L)		
7. Regional Training Module		

	Paramedic Infrequently Used Skills Annual Verification Tracking Sheet	**1110-B**

Paramedic Name:	Calendar Year:
Paramedic License #:	Service Provider:

Instructions: ALS prehospital service providers shall verify that each S-SV EMS accredited paramedic affiliated with their organization has successfully performed all of the applicable skills listed on this sheet, a minimum of once every 12 months (note: verification is not required for skills not currently being utilized by the prehospital service provider). Under special circumstances, an extension to this requirement may be approved by S-SV EMS upon request.

All infrequently used skills shall be verified by successful performance in a structured training environment, utilizing the S-SV EMS approved infrequently used skills verification checklists (as indicated below). A copy of this completed tracking sheet shall be maintained in the employee's file for a period of not less than four (4) years, and be made available for review by S-SV EMS representatives upon request. The individual infrequently used skills verification checklists are not required to be maintained.
Skills competency verification shall be conducted by one of the following:

- Service provider's CQI coordinator or their designee.
- Service provider's medical director.
- Base/modified base hospital prehospital coordinator or their designee.

Skills Verification Checklist Description	Verification Date	Evaluator Initials
1. Adult Oral Endotracheal Intubation (1110-C)		
2. Adult i-gel Airway Device (1110-D)		
3. Pediatric i-gel Airway Device (1110-E)		
4. Needle Cricothyrotomy (1110-F)		
5. Needle Chest Decompression (1110-G)		
6. Adult Cardioversion/Defibrillation (1110-H)		
7. Pediatric Cardioversion/Defibrillation (1110-I)		
8. Transcutaneous Cardiac Pacing (1110-J)		
9. Intraosseous Infusion (1110-K)		
10. Multiple Casualty Incident (MCI) (1110-L)		
11. Regional Training Module		

	Infrequently Used Skills Verification Checklist **Adult Oral Intubation**	**1110-C**

Name:	Date:
Provider Agency:	Evaluator:

Objective: Describe the indications for adult oral intubation and demonstrate the ability to proficiently perform the procedure.

Equipment: Appropriate PPE, adult intubation manikin, laryngoscope handle, adult laryngoscope blades, adult endotracheal tubes, malleable stylet, flex guide ETT introducer, 10 mL syringe, tape or tube holder, stethoscope, oropharyngeal airway (OPA), bag-valve mask (BVM), nasal cannula (NC), non-rebreather mask (NRM), suction device, ETCO2 monitoring equipment, 2% lidocaine.

Performance Criteria: The paramedic will be required to adequately describe the indications for adult oral intubation and proficiently perform the procedure on a manikin.

Step	Description	Does	Does Not
1	Verbalizes/demonstrates use of appropriate PPE		
2	Verbalizes indications for adult oral intubation • Cardiac arrest • Respiratory arrest or severe compromise • Sustained altered mental status with GCS ≤8 (relative indication) • Impending airway edema in the setting of respiratory tract burn or anaphylaxis (relative indication)		
3	Verbalizes the following procedures that should be utilized based on patient condition and circumstances: • If possible, pre-oxygenate with high flow O_2 via NRM or BVM as appropriate for three (3) minutes • Apply high flow NC (10 – 15 L/min) in addition to NRM or BVM to augment pre-oxygenation • Position patient in a semi-recumbent or reverse trendelenburg position if possible • Continue utilizing passive oxygenation via NC during intubation attempts • Perform jaw thrust to maintain pharyngeal patency and apply airway		
4	Prepares equipment for procedure • Ensures suction device is available and working • Ensures flex guide ETT introducer is available • Selects proper size ET tube and checks cuff for patency • Inserts stylet so end is not protruding past end of endotracheal tube • Selects appropriate laryngoscope blade, attaches to handle and checks light		
5	Places patient's head in sniffing position		
6	Instructs other rescuer to stop ventilations and removes OPA (if in place)		
7	May consider cricoid pressure or external laryngeal manipulation (ELM)		

	Infrequently Used Skills Verification Checklist Adult Oral Intubation	1110-C

Step	Description	Does	Does Not
8	Inserts blade into mouth with a right to left sweeping motion while displacing tongue		
9	Applies upward lifting action with laryngoscope without using teeth as a fulcrum		
10	Visualizes glottic opening		
11	Inserts ET tube from right pharynx, passing tube through the glottic opening (intubation attempt should take no longer than 30 seconds)		
12	Removes laryngoscope		
13	Inflates cuff with sufficient volume of air and disconnects syringe		
14	Attaches BVM to ET tube and ventilates at appropriate rate and volume		
15	Confirms airway patency with physical assessment (chest rise, auscultation over the epigastrium and bilaterally over each lung), and waveform capnography ETCO2 monitoring equipment		
16	Properly secures ET tube using tape or commercial tube holder		
17	Reevaluates tube placement after each patient movement		
18	Demonstrates proper use of the flex guide ETT introducer for difficult intubations		

	Infrequently Used Skills Verification Checklist **Adult i-gel Airway Device**	**1110-D**

Name:	Date:
Provider Agency:	Evaluator:

Objective: Describe the indications/contraindications for utilization of an adult i-gel airway device and demonstrate the ability to proficiently perform the procedure.

Equipment: Appropriate PPE, adult airway manikin, oropharyngeal airway (OPA), appropriate sized i-gel device, water soluble lubricant, tape or i-gel airway support strap, stethoscope, bag valve mask (BVM), nasal cannula (NC), non-rebreather mask (NRM), suction device, waveform capnography ETCO2 monitoring equipment.

Performance Criteria: The individual is required to describe the indications/contraindications for placement of an adult i-gel device and proficiently perform the procedure on an adult airway manikin.

Step	Description	Does	Does Not
1	Verbalizes/demonstrates use of appropriate PPE		
2	Verbalizes selection of appropriate i-gel device based on patient size: • Size 3 – i-gel small adult device (30-60kg) • Size 4 – i-gel medium adult device (50-90kg) • Size 5 – i-gel large adult device (90+kg)		
3	Verbalizes i-gel device indications: • Patients in need of advanced airway protection and/or unable to be adequately ventilated with a BVM when orotracheal intubation is unavailable or unsuccessful • Patients in need of rapid advanced airway control when orotracheal intubation is anticipated to be difficult or likely to interrupt continuous chest compressions		
4	Verbalizes i-gel device contraindications: • Intact gag reflex • Caustic ingestion • Unresolved complete airway obstruction • Trismus or limited ability to open the mouth and insert the device (relative) • Oral trauma (relative) • Distorted anatomy that prohibits proper device placement (relative)		
5	Verbalizes the procedures that should be utilized prior to placement of an i-gel device as patient condition and circumstances permit: • If possible, pre-oxygenate with high flow O_2 via NRM or BVM as appropriate for three (3) minutes • Apply high flow NC (10 – 15 L/min) in addition to NRM or BVM to augment pre-oxygenation • Position patient in a semi-recumbent or reverse trendelenburg position if possible • Continue utilizing passive oxygenation via NC during i-gel device placement		

Step	Description	Does	Does Not
6	Opens the package and removes the protective cradle containing the i-gel device		
7	Removes i-gel device from the protective cradle and transfers it to the palm of the same hand, supporting the device between the thumb and index finger		
8	Places a small amount of a water-based lubricant onto the middle of the smooth surface of the protective cradle		
9	Grasps i-gel device with the opposite (free) hand along the integral bite block and lubricates the back, sides and front of the cuff with a thin layer of lubricant		
10	Inspects i-gel device to confirm there are no foreign bodies of lubricant obstructing the distal opening		
11	Places i-gel device back into the protective cradle in preparation for insertion		
12	Removes i-gel device from the protective cradle and grasps the lubricated device firmly along the integrated bite block		
13	Positions i-gel device so that the cuff outlet is facing towards the chin of the patient		
14	Instructs other rescuer to stop ventilations and removes OPA		
15	Places patient's head in the 'sniffing' position and gently presses down on the chin		
16	Introduces the leading soft tip of the i-gel device into the patient's mouth in a direction towards the hard palate		
17	Glides the i-gel device downwards and backwards along the hard palate with a continuous but gentle push until a definitive resistance is felt: • The teeth should be resting on the integral bite block • Sometimes the 'give-way' is felt before the end point resistance is met – It is important to continue to insert the device until a definitive resistance is felt • Once definitive resistance is met and the teeth are located on the integral bite block, do not repeatedly push the device down or apply excessive force during insertion		
18	Attaches a BVM to the i-gel device and ventilates at appropriate rate and volume		
19	Confirms i-gel device patency with physical assessment (chest rise, auscultation over the epigastrium and bilaterally over each lung), and appropriate ETCO2 monitoring methods based on available equipment		
20	Properly secures i-gel device using tape or airway support strap		
21	Re-evaluates i-gel device placement after each patient movement or upon transfer of care to other prehospital or hospital personnel		

	Infrequently Used Skills Verification Checklist **Pediatric i-gel Airway Device**	**1110-E**

Name:	Date:
Provider Agency:	Evaluator:

Objective: Describe the indications/contraindications for utilization of a pediatric i-gel airway device and demonstrate the ability to proficiently perform the procedure.

Equipment: Appropriate PPE, pediatric airway manikin, oropharyngeal airway (OPA), appropriate sized i-gel device, water soluble lubricant, tape or i-gel airway support strap, stethoscope, bag valve mask (BVM), nasal cannula (NC), non-rebreather mask (NRM), suction device, waveform capnography ETCO2 monitoring equipment.

Performance Criteria: The individual is required to describe the indications/contraindications for placement of a pediatric i-gel device and proficiently perform the procedure on a pediatric airway manikin.

Step	Description	Does	Does Not
1	Verbalizes/demonstrates use of appropriate PPE		
2	Verbalizes selection of appropriate i-gel device based on patient size: • Size 1.0 – i-gel neonate device (2-5kg) • Size 1.5 – i-gel infant device (5-12kg) • Size 2.0 – i-gel small pediatric device (10-25+kg) • Size 2.5 – i-gel large pediatric device (25-35 kg)		
3	Verbalizes i-gel device indications: • Pediatric patients in need of advanced airway protection or unable to be adequately ventilated with a BVM.		
4	Verbalizes i-gel device contraindications: • Intact gag reflex • Caustic ingestion • Unresolved complete airway obstruction • Trismus or limited ability to open the mouth and insert the device (relative) • Oral trauma (relative) • Distorted anatomy that prohibits proper device placement (relative)		
5	Verbalizes the procedures that should be utilized prior to placement of an i-gel device as patient condition and circumstances permit: • If possible, pre-oxygenate with high flow O_2 via NRM or BVM as appropriate for three (3) minutes • Apply high flow NC (10 – 15 L/min) in addition to NRM or BVM to augment pre-oxygenation • Position patient in a semi-recumbent or reverse trendelenburg position if possible • Continue utilizing passive oxygenation via NC during i-gel device placement		
6	Opens the package and removes the cage pack containing the i-gel device		

Step	Description	Does	Does Not
7	Opens the cage pack and transfers i-gel device into the lid of the cage		
8	Places a small amount of a water-based lubricant onto the middle of the smooth surface of the cage pack		
9	Grasps i-gel device along the integral bite block and lubricates the back, sides and front of the cuff with a thin layer of lubricant		
10	Inspects i-gel device to confirm there are no foreign bodies of lubricant obstructing the distal opening		
11	Places i-gel device back into the cage pack in preparation for insertion		
12	Removes i-gel device from the cage pack and grasps the lubricated device firmly along the integrated bite block		
13	Positions i-gel device so that the cuff outlet is facing towards the chin of the patient		
14	Instructs other rescuer to stop ventilations and removes OPA		
15	Places patient's head in the 'sniffing' position and gently presses down on the chin		
16	Introduces the leading soft tip of the i-gel device into the patient's mouth in a direction towards the hard palate		
17	Glides the i-gel device downwards and backwards along the hard palate with a continuous but gentle push until a definitive resistance is felt: • The teeth should be resting on the integral bite block • Sometimes the 'give-way' is felt before the end point resistance is met – It is important to continue to insert the device until a definitive resistance is felt • Once definitive resistance is met and the teeth are located on the integral bite block, do not repeatedly push the device down or apply excessive force during insertion		
18	Attaches a BVM to the i-gel device and ventilates at appropriate rate and volume		
19	Confirms i-gel device patency with physical assessment (chest rise, auscultation over the epigastrium and bilaterally over each lung), and appropriate ETCO2 monitoring methods based on available equipment		
20	Properly secures i-gel device using tape or airway support strap		
21	Re-evaluates i-gel device placement after each patient movement or upon transfer of care to other prehospital or hospital personnel		

	Infrequently Used Skills Verification Checklist **Needle Cricothyrotomy**	**1110-F**

Name:	Date:
Provider Agency:	Evaluator:

Objective: Describe the indications/contraindications for needle cricothyrotomy and demonstrate the ability to proficiently perform the procedure.

Equipment: Appropriate PPE, cricothyrotomy manikin, antiseptic agent, tape, 10 ml syringe, 12ga or 14ga over-the-needle catheter and jet insufflation device or ENK Oxygen Flow Modulator, or Rusch QuickTrach® Emergency Needle Cricothyrotomy Kit and BVM.

Performance Criteria: The individual will be required to describe the indications/contraindications for needle cricothyrotomy and proficiently perform the procedure on a cricothyrotomy manikin.

Step	Description	Does	Does Not
1	Verbalizes/demonstrates use of appropriate PPE		

2	Verbalizes indications for needle cricothyrotomy:
	• Inability to maintain the airway with standard airway procedures. Typically involves patients with one or more of the following:
	  ○ Airway obstruction by uncontrolled bleeding into the oral cavity and/or vomiting
	  ○ Severe maxillofacial trauma – blunt, penetrating, or associated with mandibular fracture
	  ○ Laryngeal foreign body that cannot be removed expeditiously
	  ○ Swelling of upper airway structures
	  ○ Infection (e.g., epiglottitis, Ludwig's angina)
	  ○ Allergic reaction or hereditary angioedema
	  ○ Chemical or thermal burns to the epiglottis and upper airway		

3	Verbalizes contraindications for needle cricothyrotomy: • Age < 3 years or estimated weight <15 kg • Ability to maintain airway utilizing less invasive procedures • Conscious patient • Moving ambulance • Midline neck hematoma or massive subcutaneous emphysema		
4	Selects appropriate size catheter/device for patient size		

5	Assembles and checks the equipment:
	• If using jet inflation device/ENK Oxygen Flow Modulator:
	  ○ Attaches 10 ml syringe to 12/14ga catheter
	  ○ Connects jet insufflation device/ENK Oxygen Flow Modulator to high flow oxygen source
	• If using the QuickTrach Cricothyrotomy Kit, device comes pre-assembled with syringe attached		

6	Stabilizes larynx with thumb and forefinger and locates cricoid membrane		

	Infrequently Used Skills Verification Checklist Needle Cricothyrotomy	1110-F

Step	Description	Does	Does Not
7	Inserts catheter/device: • If using a 12/14 gauge catheter with jet insufflation device/ENK Oxygen Flow Modulator, inserts needle downward through the midline of the cricoid membrane at a 45^0 – 60^0 angle toward the carina while applying negative pressure to the syringe • If using the QuickTrach Cricothyrotomy Kit, punctures cricoid membrane at a 90^0 angle		
8	Verifies needle has entered the trachea by aspirating air into syringe		
9	Advances catheter/cannula: • If using a 12/14 gauge catheter with jet insufflation device/ENK Oxygen Flow Modulator, advances catheter over the needle towards the carina • If using the QuickTrach Cricothyrotomy Kit: o Changes angle of insertion to 45^0 and advances to the level of the stopper o Removes stopper (does not advance device with needle still attached) o Slides plastic cannula into the trachea until flange rests on the neck		
10	Removes and properly disposes needle and syringe		
11	Secures catheter/cannula		
12	Provides Ventilation: • If using Jet insufflation device/ENK Oxygen Flow Modulator, attaches oxygen supply tubing to catheter and provides ventilation using appropriate inspiratory to expiratory ratio (seconds): o Jet insufflation device ratio – 1:4 o ENK Oxygen Flow Modulator ratio – 4:6 • If using the QuickTrach Cricothyrotomy Kit, attaches BVM to connecting tube and provides ventilation at appropriate rate		
13	Verifies proper placement by the observance of chest rise and fall (jet insufflation device and QuickTrach Cricothyrotomy Kit only), auscultation of lung sounds and the absence of subcutaneous emphysema		

	Infrequently Used Skills Verification Checklist Needle Thoracostomy	**1110-G**

Name:	Date:
Provider Agency:	Evaluator:
Objective: Describe the indications/contraindications for needle thoracostomy and demonstrate the ability to proficiently perform the procedure.	
Equipment: Appropriate PPE, thoracostomy manikin or simulated chest, Minimum 14ga x 3.25” catheter designed for needle decompression, stethoscope, stopcock or one way valve, tape, antiseptic agent, tape.	
Performance Criteria: The individual will be required to describe the indications/contraindications for needle thoracostomy and proficiently perform the procedure on a manikin or simulated chest.	

Step	Description	Does	Does Not
1	Verbalizes/demonstrates use of appropriate PPE		

2	Verbalizes indications for needle thoracostomy (either of the following):
	• Suspected tension pneumothorax with absent or diminished breath sounds and at least one of the following:
	  ○ Combined hypotension (SBP <90) and SpO2 <94%
	  ○ Penetrating injury to the thorax
	• Traumatic cardiac arrest with suspected tension pneumothorax		

3	Verbalizes minimum catheter size required for procedure (14 ga x 3.25”)		
4	Verbalizes that only two (2) attempts are allowed on affected side(s) without base/ modified base hospital contact		
5	Verbalizes/identifies approved needle thoracostomy sites (any of the following): • Mid-clavicular line in the 2nd intercostal space • Mid-axillary line in the 4th or 5th intercostal space (above anatomic nipple line) • Anterior axillary line in the 5th intercostal space (above anatomic nipple line)		
6	Prepares site using aseptic technique		
7	Removes end cap from catheter and attaches empty 10 mL syringe		
8	Inserts needle with syringe attached into skin at a 90º angle just over the superior border of the rib		
9	Advances catheter until air is freely aspirated		
10	If using a 3.25” length catheter, advances catheter over the needle until catheter hub rests against the skin		
11	Removes syringe and needle and leaves catheter in place		
12	Attaches stopcock or one-way valve and secures catheter/tubing		
13	Rechecks breath sounds and closely monitors patient status		

	Infrequently Used Skills Verification Checklist **Adult Cardioversion/Defibrillation**	**1110-H**

Name:	Date:
Provider Agency:	Evaluator:
Objective: Describe/recognize the indications for synchronized cardioversion and defibrillation on an adult patient and proficiently perform both procedures.	
Equipment: Appropriate PPE, adult defibrillation manikin, cardiac rhythm simulator, monitor/defibrillator, adult defibrillation paddles with conductive medium or adult defibrillation electrodes.	
Performance Criteria: The AEMT II or paramedic will be required to adequately describe/recognize the indications for synchronized cardioversion and defibrillation on an adult patient and proficiently perform both procedures on a manikin.	

Step	Description	Does	Does Not
1	Verbalizes/demonstrates use of appropriate PPE		

2	Verbalizes indications for synchronized cardioversion
	• Persistent tachycardia causing any of the following:
	  ○ Hypotension
	  ○ Acutely altered mental status
	  ○ Signs of shock
	  ○ Ischemic chest discomfort
	  ○ Acute Heart Failure		

3	Recognizes rhythm on the monitor requiring cardioversion		
4	Verbalizes consideration of pre-cardioversion sedation (one of the following): • Midazolam: 5mg IV/IO • Fentanyl: 25 – 50 mcg IV/IO		
5	Correctly applies hands free defibrillation electrodes or conductive medium		
6	Ensures that ‘SYNC’ button on the monitor is selected and that the synchronization indicators are active on the QRS complex		
7	Selects appropriate initial cardioversion dose: • Narrow regular: 50 – 100 J • Narrow irregular: 120 – 200 J • Wide regular: 100 J		
8	Charges defibrillator		
9	If using paddles, places them on appropriate landmarks with firm pressure		
10	Verbally states “CLEAR” and visually checks that other rescuers are clear		
11	Delivers cardioversion by holding down the ‘SHOCK’ button until the defibrillator discharges		
12	Reassesses and properly identifies cardiac rhythm on the monitor		

Step	Description	Does	Does Not
13	Repeats cardioversion steps at least one time, increasing dose in a stepwise fashion for subsequent attempts		
*****AEMT II or paramedic is advised that patient has become pulseless and apneic*****			
14	Recognizes rhythm on the monitor requiring defibrillation		
15	Reassess patient to confirm absence of pulses		
16	Turns off 'SYNC' button and selects appropriate defibrillation dose based on manufacturer recommendation (200 j if unknown)		
17	Charges defibrillator		
18	If using paddles, places them on appropriate landmarks with firm pressure		
19	Verbally states "CLEAR" and visually checks that other rescuers are clear		
20	Delivers defibrillation		
21	Initiates CPR x 2 minutes		
22	Reassesses patient and cardiac rhythm confirming patient remains pulseless and in a rhythm requiring defibrillation		
23	Repeats defibrillation steps at least one time utilizing the appropriate subsequent dose based on manufacturer recommendation		

	Infrequently Used Skills Verification Checklist **Pediatric Cardioversion/Defibrillation**	**1110-I**

Name:	Date:
Provider Agency:	Evaluator:

Objective: Describe/recognize the indications for synchronized cardioversion and defibrillation on a pediatric patient and proficiently perform both procedures.

Equipment: Appropriate PPE, pediatric defibrillation manikin, length based pediatric resuscitation tape, cardiac rhythm simulator, monitor/defibrillator, pediatric defibrillation paddles with conductive medium or pediatric defibrillation electrodes.

Performance Criteria: The AEMT II or paramedic will be required to adequately describe/recognize the indications for synchronized cardioversion and defibrillation on a pediatric patient and proficiently perform both procedures on a manikin.

Step	Description	Does	Does Not
1	Verbalizes/demonstrates use of appropriate PPE		

2	Verbalizes indications for synchronized cardioversion
	• Probable SVT or VT with cardiopulmonary compromise including:
	  ○ Hypotension
	  ○ Acutely altered mental status
	  ○ Signs of shock		

3	Verbalizes that pediatric cardioversion is a base/modified base hospital order		
4	Recognizes rhythm on the monitor requiring cardioversion		
5	Correctly applies hands free defibrillation electrodes or conductive medium		
6	Ensures that ‘SYNC’ button on the monitor is selected and that the synchronization indicators are active on the QRS complex		
7	Selects appropriate initial cardioversion dose: • 0.5 – 1 J/kg (calculated using length based pediatric resuscitation tape)		
8	Charges defibrillator		
9	If using paddles, places them on appropriate landmarks with firm pressure		
10	Verbally states “CLEAR” and visually checks that other rescuers are clear		
11	Delivers cardioversion by holding down the ‘SHOCK’ button until the defibrillator discharges		
12	Re-assesses and properly identifies cardiac rhythm on the monitor		
13	Repeats cardioversion steps at least one time, increasing dose • 2 J/kg (calculated using length based pediatric resuscitation tape)		

	Infrequently Used Skills Verification Checklist Pediatric Cardioversion/Defibrillation	1110-I

Step	Description	Does	Does Not
AEMT II or paramedic is advised that patient has become pulseless and apneic			
14	Recognizes rhythm on the monitor requiring defibrillation		
15	Reassess patient to confirm absence of pulses		
16	Turns off 'SYNC' button and selects appropriate initial defibrillation dose • 2 J/kg (calculated using length based pediatric resuscitation tape)		
17	Charges defibrillator		
18	If using paddles, places them on appropriate landmarks with firm pressure		
19	Verbally states "CLEAR" and visually checks that other rescuers are clear		
20	Delivers defibrillation		
21	Initiates CPR x 2 minutes		
22	Reassesses patient and cardiac rhythm confirming patient remains pulseless and in a rhythm requiring defibrillation		
23	Repeats defibrillation steps at least one time utilizing the appropriate subsequent dose • 4 J/kg (calculated using length based pediatric resuscitation tape)		

	Infrequently Used Skills Verification Checklist **Transcutaneous Cardiac Pacing**	**1110-J**

Name:	Date:
Provider Agency:	Evaluator:

Objective: Describe the indications for transcutaneous cardiac pacing and demonstrate the ability to proficiently perform the procedure.

Equipment: Appropriate PPE, adult manikin, cardiac monitor with pacing capabilities, cardiac rhythm simulator, EKG and pacing electrodes, appropriate skin prep items (razor, 4x4's, etc.).

Performance Criteria: The paramedic will be required to adequately describe the indications for transcutaneous cardiac pacing and proficiently perform the procedure on a manikin.

Step	Description	Does	Does Not
1	States/demonstrates use of appropriate PPE		

2	States indications for transcutaneous cardiac pacing
	• Persistent bradycardia causing any of the following:
	  ○ Hypotension
	  ○ Acutely altered mental status
	  ○ Signs of shock
	  ○ Ischemic chest discomfort
	  ○ Acute Heart Failure
	• Atropine ineffective or not indicated
	• Verbalizes that pediatric transcutaneous pacing is a base/modified base hospital order		

3	Recognizes rhythm on the monitor requiring transcutaneous cardiac pacing		
4	Explains procedure to patient/family and informs that discomfort may occur as a result of nerve stimulation or muscle contraction		
5	Verbalizes consideration of sedation (one of the following): • Midazolam: 2 – 5 mg IV/IO • Fentanyl: 25 – 50 mcg IV/IO		
6	Properly places EKG electrodes on patient's chest, far enough away from pacing electrodes to ensure a clear signal – ensures EKG electrodes remain attached during pacing therapy		
7	Properly places pacing electrodes on patient's chest		
8	Selects pacing mode on the cardiac monitor		
9	Selects initial pacing rate of 60/min		
10	Sets initial current at 10 mA and increases by 10 mA increments while assessing for mechanical capture		

Step	Description	Does	Does Not
11	Describes confirmation of pacing capture • Recognizes electrical capture on the EKG • Recognizes mechanical capture by evaluation of patient cardiac output, pulses, increased BP and improved circulatory status		
12	Once pacing is initiated (mechanical capture), properly adjusts rate based on patient's clinical response (60 – 70/min)		
13	Monitor's/re-evaluates patient as needed and increases current as necessary to maintain mechanical capture		

	Infrequently Used Skills Verification Checklist Intraosseous (IO) Infusion	**1110-K**

Name:	Date:
Provider Agency:	Evaluator:

Objective: Describe the indications/contraindications for powered IO device utilization and demonstrate the ability to proficiently perform the procedure.

Equipment: Appropriate PPE, IO manikin, S-SV EMS approved powered IO device/needle, needle securing supplies, antiseptic agent, 10 mL syringe, flush solution or prefilled syringe, IV extension set, IV administration set, IV solution, blood pressure cuff or pressure bag, 2% lidocaine.

Performance Criteria: The AEMT (pediatric only) or paramedic (pediatric and adult patients) will be required to adequately describe the indications/contraindications for powered IO device utilization and proficiently perform the procedure on an IO manikin.

Step	Description	Does	Does Not
1	Verbalizes/demonstrates use of appropriate PPE		

2	Verbalizes indications for IO infusion
	• Weight ≥3 kg and unable to achieve IV access rapidly (within 60 – 90 seconds) in a patient with one or more of the following:
	  ○ Cardiac arrest
	  ○ Hemodynamic instability (SBP <90 and signs of shock)
	  ○ Imminent respiratory failure
	  ○ Status epilepticus with prolonged seizure activity <10 minutes
	  ○ Toxic conditions requiring immediate IV access for antidote		

3	Verbalizes contraindications for IO infusion (any of the following) • Fracture or suspected vascular compromise in targeted bone • Excessive tissue or absence of adequate anatomic landmarks • Infection at area of insertion site • Previous significant orthopedic procedure at site (e.g., prosthetic limb) • IO access in targeted bone within past 48 hours		
4	Verbalizes/selects appropriate adult IO site (paramedic only) • Proximal Tibia: Approximately 3 cm (2 finger widths) below the patella and approximately 2 cm (1 finger width) medial, along the flat aspect of the tibia • Distal Tibia: Approximately 3 cm (2 finger widths) proximal to the most prominent aspect of the medial malleolus • Humerus: On the most prominent aspect of the greater tubercle, 1 – 2 cm above the surgical neck		
5	Verbalizes/selects appropriate pediatric IO site (AEMT & paramedic) • Proximal Tibia: Just below patella, approximately 1 cm (1 finger width) and slightly medial, approximately 1 cm along the flat aspect of the tibia • Distal Tibia: approximately 1-2 cm (1 finger width) proximal to the most prominent aspect of the medial malleolus • Distal Femur: Just proximal to the patella (maximum 1 cm) and approximately 1 – 2 cm medial to midline		

	Infrequently Used Skills Verification Checklist Intraosseous (IO) Infusion	1110-K

Step	Description	Does	Does Not
6	Prepares equipment for procedure • Primes extension set with normal saline (if patient unresponsive to pain) or 2% lidocaine (if patient responsive to pain) • Assembles IV bag, IV tubing and pressure infuser • Fills 10 mL syringe with normal saline flush solution (or uses prefilled syringe) • Assembles 2% lidocaine if necessary (patients responsive to pain) • Selects appropriate size needle or device (based on manufacturer) • Attaches needle to driver (based on manufacturer)		
7	Preps IO site using aseptic technique		
8	Inserts IO needle according to manufacturer specific instructions		
9	Stabilizes needle, removes stylet from catheter and places in sharps container		
10	If using manufacturer supplied stabilizer device, place prior to attaching extension set (or at appropriate time per manufacturer instructions)		
11	Attaches primed extension set to IO catheter		
12	Secure IO needle per manufacturer instructions		

13	For patients unresponsive to pain
	• Administers rapid flush of 10 mL of normal saline
	For patients responsive to pain:
	• Slowly administers 2% lidocaine over 120 seconds
	  ○ Adult – 40 mg
	  ○ Pediatric – 0.5 mg/kg (maximum 40 mg)
	• Allows lidocaine to dwell in IO space 60 seconds
	• Administers rapid flush of 10 mL of normal saline
	• Slowly administers a subsequent ½ dose of 2% lidocaine over 60 seconds
	  ○ Adult – 20 mg
	  ○ Pediatric – ½ the initial dose (maximum 20 mg)		

14	Connects fluids to extension set using IV tubing and administers fluid by applying pressure to the fluid bag if necessary to achieve desired rate		
15	Dresses site and secures tubing		
16	Checks administration rate and IO site for infiltration		

	Multiple Casualty Incident (MCI) Response Procedures Checklist	1110-L

Name:	Date:
Provider Agency:	Evaluator:

Objective: Describe/demonstrate the procedures for managing EMS aspects of an MCI.

Equipment: MCI identification vests, S-SV EMS approved triage tags, S-SV EMS MCI Checklist and Medical Branch Organizational Chart (837-A), S-SV EMS Prehospital Patient Tracking Worksheet (837-B).

Performance Criteria: Prehospital personnel will be required to adequately describe/demonstrate the criteria for declaring an MCI, the procedures for managing an MCI and the appropriate utilization of triage tags. Performance criteria may be assessed through instructor-led training, or by participation in a tabletop or full-scale MCI exercise.

Step	Description	Does	Does Not

1	Verbalizes MCI definition/criteria:
	• An incident which requires more emergency medical resources to adequately deal with victims than those available during routine responses, including an incident that meets any of the following criteria:
	  ○ Five (5) or more IMMEDIATE and/or DELAYED patients, or
	  ○ Ten (10) or more MINOR patients, irrespective of the number of IMMEDIATE and/or DELAYED patients, or
	  ○ At the discretion of prehospital or hospital providers		

2	Describes the roles/functions of the Control Facility (CF), the requirement/ importance of early CF notification/utilization (including a pre-alert when possible), and identifies the appropriate CF to notify/utilize based on the incident location: • Enloe Medical Center – Butte, Colusa & Glenn counties • Rideout Regional Medical Center – Sutter & Yuba counties • Sutter Roseville Medical Center – Western slope of Nevada & Placer counties • Tahoe Forest Hospital – Tahoe & eastern slope of Nevada & Placer counties • Mercy Medical Center Redding – Shasta, Siskiyou & Tehama counties		
3	Verbalizes/demonstrates the most appropriate method of CF communication during an MCI (telephone, radio – including channel, etc.) based on local procedures		
4	Verbalizes/demonstrates requirement to check in with or establish Incident Command (IC) and/or Medical Command upon arrival at scene		
5	Verbalizes/demonstrates required roles/functions during an MCI (Triage, Treatment & Transportation), and describes a basic understanding of these roles/functions		
6	Describes/demonstrates MCI identification vest utilization		
7	Describes/demonstrates the ordering process for additional transport/medical resources (all additional resources must be ordered through the IC)		
8	Demonstrates appropriate utilization of triage tags and verbalizes/demonstrates the use of triage tags on all patients prior to transport		

Step	Description	Does	Does Not
9	Describes/demonstrates triage procedures/considerations: • Initial triage should take no longer than 30 – 60 seconds per patient • Treatment prior to triage of all patients shall be restricted to airway establishment and hemorrhage control, to include the use of tourniquets and/or hemostatic dressings • CPR generally should not be initiated unless an overabundance of ALS personnel, equipment, transport units, and immediate receiving facilities exist • Any patient who has a tourniquet or hemostatic dressing applied to control hemorrhage shall be deemed an 'IMMEDIATE' regardless of the START triage algorithm • Patients placed in spinal motion restriction and/or unaccompanied pediatric patients must be categorized as 'DELAYED' at a minimum, as these patients require an ED room/bed upon arrival at the receiving hospital		
10	**(OPTIONAL)** – Describes/demonstrates appropriate utilization of a colored ribbon patient triage system if utilized by the EMS provider		
11	Describes/demonstrates appropriate CF communication requirements/procedures: • The Patient Transportation Unit Leader/Medical Communications Coordinator will contact the CF and provide patient information and total number of transport resources available • Patient information provided to the CF will be limited to age, gender, triage category, triage tag number, primary injury type and any special considerations (pregnancy, burns, etc.) • The Patient Transportation Unit Leader/Medical Communications Coordinator will work collaboratively with the CF to ensure appropriate patient distribution based on patient conditions and available transportation resources		
12	Describes/demonstrates appropriate utilization of the S-SV EMS Prehospital Patient Tracking Worksheet (837-B)		
13	Describes/demonstrates notification of the CF when all patients have been transported and the incident has ended		