Sierra – Sacramento Valley EMS Agency
Regional Emergency Medical Advisory Committee
(REMAC)

MEETING AGENDA

Meeting Date & Time

- **Tuesday, July 16, 2024, 9:00 am – 12:00 pm**

Meeting Locations & Virtual Attendance Information

- **Primary Meeting Location:** 535 Menlo Drive, Suite A, Rocklin, CA 95675
- **Alternate Meeting Location:** 1255 East Street, 2nd Floor, Redding, CA 96001
- **Zoom:** https://us02web.zoom.us/j/83922294138?pwd=Won3j7S9E4PFwfYPriSasydMTMS6on.1
- **Telephone:** (669) 900-9128, **Meeting ID:** 839 2229 4138, **Passcode:** 035487

Note: All Zoom & telephone attendees are muted on entry. Please remain on mute unless actively speaking/interacting. If joining by telephone, dial *6 on your keypad to unmute/mute your line.

Meeting Agenda

Item	Title	Leader
A	**Call to Order & Introductions**	**Chairperson**
B	**Approval of Previous Meeting Minutes** (September 19, 2023)	**Chairperson**
C	**Approval of Meeting Agenda**	**Chairperson**
D	**Public Comment**	**Attendees**
E	**S-SV EMS Policy Actions**	**S-SV EMS Staff**
(E-1)	**830 (830A):** Suspected Child Abuse/Neglect Reporting	Trenton Quirk
(E-2)	**832 (832A):** Suspected Elder/Dependent Adult Abuse Reporting	Trenton Quirk
(E-3)	**852:** Patient Restraint Mechanisms	Trenton Quirk
(E-4)	**904:** EMR Initial & Renewal Certification	Trenton Quirk
(E-5)	**913:** Paramedic Accreditation	Trenton Quirk
(E-6)	**915:** MICN Authorization/Reauthorization	Trenton Quirk

Item	Title	Leader
(E-7)	**927 (927A):** EMS Incident Reporting & Investigation	Brittany Pohley
(E-8)	**G-2:** Determination of Death (formerly Policy 820)	Brittany Pohley
(E-9)	**G-3:** DNR, POLST & End of Life Option Act (formerly Policy 823)	Brittany Pohley
(E-10)	**M-6P:** General Pediatric Protocol	Brittany Pohley
(E-11)	**M-8P:** Pediatric Pain Management	Brittany Pohley
(E-12)	**N-2P:** Pediatric Seizure	Michelle Moss
(E-13)	**PR-1:** 12-Lead EKG (formerly Policy 1107)	Michelle Moss
(E-14)	**PR-3:** Needle Cricothyrotomy (formerly Policy 1103)	Michelle Moss
(E-15)	**PR-4:** Pleural Decompression (formerly Protocol T-2) (added requirement to utilize a confirmation device)	Michelle Moss
(E-16)	**PR-5:** Prehospital Blood Draws (formerly Policy 1108)	Michelle Moss
(E-17)	**PR-6:** Vascular Access	Michelle Moss
(E-18)	**R-3P:** Pediatric Acute Respiratory Distress	Brittany Pohley
F	**EMS Aircraft Provider Reports**	**Attendees**
G	**EMS Ground Provider Reports**	**Attendees**
H	**Hospital Provider Reports**	**Attendees**
(H-1)	KHR APOT Report	Chris Britton
(H-2)	MMCR/St. Elizabeth VAN Score Report	Kevin Baird
I	**S-SV EMS Agency Reports**	**S-SV EMS Staff**
(I-1)	EMS Data System	Jeff McManus
(I-2)	EMS Quality Management	Michelle Moss
(I-3)	Regional Specialty Committees	Michelle Moss
(I-4)	Operations	Patrick Comstock

Sierra – Sacramento EMS Agency – REMAC Meeting Agenda

Item	Title	Leader
(I-5)	Regional Executive Director's Report	John Poland
J	Medical Director's Report	Troy M. Falck, MD
K	**Next REMAC Meeting (October 15, 2024, 9:00 am) & Adjournment**	**Chairperson**

Sierra – Sacramento Valley EMS Agency
Regional Emergency Medical Advisory Committee
(REMAC)

MEETING MINUTES

Meeting Date
• **Tuesday, April 16, 2024**

A. Call to Order/Introductions

- Dr. Royer called the meeting to order at 9:00 am, all attendees introduced themselves.

B. Approval of Previous Minutes: January 16, 2024

- The minutes were unanimously approved by the committee with no changes.

C. Approval of Agenda

- The committee approved the agenda as written with no change.

D. Public Comment

- There will be a free, all-day, CE event in Nevada County on May 11. There is a flyer with the information on the S-SV EMS website.

E. GEMS Provider Member Appointments: 7/1/2024 – 6/30/2026 Term

- S-SV EMS asked for nominations before the meeting for every category. The Committee can also nominate members at the meeting.

- **S-SV EMS North Counties – Public (1 – Primary, 1 – Alternate)**
  - Nominations: Richard Harrison (McCloud FD)
  - Terri Arrwood said she would like to be considered for the alternate position.
  - Jeremy Veldstra motioned to approve the North Counties Public, Gerald Gross seconded. Primary, Richard Harrison and Alternate, Terri Arrwood approved unanimously.

- **S-SV EMS North Counties – Private (1 – Primary, 1 – Alternate)**
  - Nominations: Jason Swann, Rich Lemon (Dignity EMS)
  - It was suggested that Rich Lemon serve as the primary, and Jason Swann serve as the alternate.
  - Jeremy Veldstra motioned to approve the North Counties Private, Joe Morris seconded. Primary, Rich Lemon and Alternate, Jason Swann approved unanimously.

- **S-SV EMS South Counties – Public (1 – Primary, 1 – Alternate)**
  - Nominations: Clayton Thomas (Penn Valley FPD)
  - Alex Burk was also nominated.
  - Clayton Thomas indicated he would like to remain the primary. Alex Burk will become the alternate member.

- Jeremy Veldstra motioned to approve the South Counties Public; Joe Morris seconded. Primary, Clayton Thomas and Alternate, Alex Burk approved unanimously.

- **S-SV EMS South Counties – Private (1 – Primary, 1 – Alternate)**
  - Nominations: Fred Gregory (AMR Placer)
  - Matt Smith was also nominated.
  - Fred Gregory will be the primary and Matt Smith will be the alternate.
  - Jeremy Veldstra motioned to approve the South Counties Private, Debbie Madding seconded. Primary, Fred Gregory and Alternate, Matt Smith approved unanimously.

F. HEMS Provider Member Appointments: 7/1/2024 – 6/30/2026 Term
All S-SV EMS Counties (1 – Primary, 1 – Alternate)

- Nominations: Jimmy Garcia was nominated.
- Angela Hurlburt indicated she would be interested.
- Jimmy Garcia will be the primary and Angela Hurlburt will serve as the alternate.
- Jeremy Veldstra motioned to approve the HEMS All Counties members; Debbie Madding seconded. Primary, Jimmy Garcia and Alternate, Angela Hurlburt approved unanimously.

G. Officer Elections: 7/1/2024 – 6/30/2026 Term

The Chair and Vice-Chairperson positions are nominated/elected every 2 years.

- **Chairperson –** Dr. Royer was nominated for the Chair. There were no other nominations.
- Clayton Thomas motioned to approve Dr. Royer as the Chairperson. Debbie Madding seconded. Motion passed unanimously.
- **Vice-Chairperson –** Clayton Thomas was nominated as the Vice-Chairperson. There were no other nominations.
- Dr. Royer motioned to approve Clayton Thomas as the Vice-Chairperson. Debbie Madding seconded. Motion passed unanimously.

H. S-SV EMS Policy Actions

Policy Actions for Final Review & Approval:

Policy	Name	Motion	Second	Committee Vote
305	**Base/Modified Base Hospital Program** • There were no recommended changes to this policy.	Jeremy Veldstra	Debbie Madding	Passed Unanimously
460	**Tactical Emergency Medical Services (TEMS)** • There were no recommended changes to this policy.	Clayton Thomas	Jeremy Veldstra	Passed Unanimously

505	**Patient Destination** • There were no recommended changes to this policy. • Tahoe Forest Hospital has recently applied to become a Stroke Receiving Center. This will be updated when appropriate.	Clayton Thomas	Dr. Morris	Passed Unanimously
605	**EMS Documentation** • CEMSIS/NEMSIS moved from version 3.4 to 3.5. • In the process of finalizing the S-SV EMS schematron for ground providers only. • Information was recently sent out, by email, regarding the ePCR completion timeline. The State EMS Authority has gotten more aggressive with this lately. • Jeff will be making sure everyone is compliant. • There were some minor language changes in Item E, page 3, as well as at the top of page 4. This language is to stay compliant with the State's requirements. • It was suggested to remove Item 5, at the bottom of page 2.	Clayton Thomas	Jeremy Veldstra	Passed Unanimously
701	**ALS Provider Agency Inventory Requirements** • Spit hood was added to page 2. • On page 4, added 'Sidestream $EtCO_2$ Disposable Capnography Circuit Pediatric". • On page 7, added Acetaminophen – PO (960 mg/30 mL) under 'Medications'. • It was recommended to make the minimum 200 for Ketamine. • It was recommended to change the wording on the Acetaminophen to reflect the pediatric dosing.	Clayton Thomas	Dr. Morris	Passed Unanimously

705	**Prehospital Provider Agency Unit Inspections** • Under 'Procedure', added "Providers shall complete a S-SV EMS 705-A form prior to inspection". • Page 3, line 31, added 'an' and removed 'complete'. • Page 2, Item 4, line 1, removed 'will' and added 'may'. • Policies 705 (705-A), 706, and 715 were passed together.	Jeremy Veldstra	Clayton Thomas	Passed Unanimously
706	**Equipment & Supply Shortages** • On page 2, Item D, added lines 29-32. • Policies 705 (705-A), 706, and 715 were passed together.	Jeremy Veldstra	Clayton Thomas	Passed Unanimously
715	**Biomedical Equipment Maintenance** • On page 1, Item B, removed "Periodic" and added "Preventative", item E removed the first sentence and added lines 30-32. • On page 2, item 3, removed 'Reported' and added "To", line 7, added "or potential impact", line 8, added "remediation/corrective", and removed the end of that sentence. • Policies 705 (705-A), 706, and 715 were passed together.	Jeremy Veldstra	Clayton Thomas	Passed Unanimously
852	**Patient Restraint Mechanisms** • On page 2, under "Physical Restraint", added lines 22-28 – which is 'spit hood' guidance.	Clayton Thomas	Debbie Madding	Passed Unanimously
C-1P	**Pediatric Pulseless Arrest** • On page 2, in the yellow box, under Epinephrine 'repeat every 3-5 minutes'. • UC Davis requested that "If Opioid overdose suspected: Naloxone – 0.1 mg/kg IV/IO (max: 2 mg)" be added to the yellow box. • Policies C-1P, C-3P, and C-4P were discussed and passed together.	Clayton Thomas	Debbie Madding	Passed Unanimously

C-3P	**Pediatric Bradycardia – With Pulses** • UC Davis requested that in the yellow BLS box, remove "High flow $O^{2"}$and change it to "O^2 at appropriate rate if hypoxemic (SpO2) <94%) or short of breath". This will change in other policies as well. • Policies C-1P, C-3P, and C-4P were discussed and passed together.	Clayton Thomas	Debbie Madding	Passed Unanimously
C-4P	**Pediatric Tachycardia – With Pulses** • UC Davis requested that in the yellow BLS box, remove "High flow $O^{2"}$and change it to "O^2 at appropriate rate if hypoxemic (SpO2) <94%) or short of breath". This will change in other policies as well. • Under ALS, added "and $EtCo_2$" – this should be added to the Bradycardia policy as well. • Policies C-1P, C-3P, and C-4P were discussed and passed together.	Clayton Thomas	Debbie Madding	Passed Unanimously
M-1P	**Pediatric Allergic Reaction/Anaphylaxis** • All changes in the top, yellow box, were UC Davis recommendations. • On page 2, UC Davis suggested that Epinephrine be removed totally. S-SV believes it should remain in the policy. • It was suggested, on page 2, to remove "High risk" from the box, and insert "history of anaphylaxis, or significant exposure with worsening symptoms." • It was suggested, on page 2 in the hypotension box, to change 'Hypotension' to 'Hypoperfusion'. • It was suggested to add weights to the BLS box on page 1.	Dr. Morris	Clayton Thomas	Passed Unanimously
M-5P	**Pediatric Ingestions & Overdoses** • UC Davis requested that in the yellow BLS box, remove "High flow $O^{2"}$and change it to "O^2 at appropriate rate if hypoxemic (SpO2) <94%) or short of breath". • Added to the BLS box, last bullet point, "Contact Poison Control" with their phone number. • Under ALS, added 'and $EtCo_2$".	Clayton Thomas	Debbie Madding	Passed Unanimously

M-6P	**General Pediatric Protocol** • This protocol was revamped and now includes BRUE, sepsis, shock, nausea and vomiting. • In the top box, the last bullet point was added. It was suggested to add "and weight of patient" after 'sizes of equipment' and remove the rest of the last bullet point. • In the hypotension chart, in the hypotension column, the SBP <70 should be 70 + (2 x age). • Page 3 is Shock/Sepsis and a few things were removed from the top green box that weren't pertinent to pediatric care. • On page 3, under the ALS box, removed the third bullet point, and removed 'if DNA suspected' from the fourth bullet point. Acetaminophen was added to the bottom box on page 3. • Page 4 is Nausea/Vomiting, which is the same as the adult protocol. • On page 4, under the Zofran box, it was suggested to add a dose of 0.15mg/kg. • Due to concerns, this protocol will be brought back to the next meeting. It was suggested to send the protocol to OB's for review/feedback as well as Pharmacists.			No vote – this policy will be brought back to the July meeting.
M-8P	**Pediatric Pain Management** • Weights are weight based. • Under 'Acute Injury' – Midazolam requires a base consultation. • The updated hypotension chart was added to the bottom of page 2. • On page 2, in the bottom blue box, the last bullet point is new. • This will be updated to match the other UC Davis recommendations.	Clayton Thomas	Debbie Madding	Passed Unanimously

M-11P	**Pediatric Behavioral Emergencies** • This is a new protocol. • This was sent to UC Davis for review and there were no recommended changes. • EtCO2 needs to be added under the ALS box.	Clayton Thomas	Debbie Madding	Passed Unanimously
N-1P	**Pediatric Altered Level of Consciousness** • This has the same changes as the others - oxygen and EtCO2. • No other recommended changes.	Clayton Thomas	Debbie Madding	Passed Unanimously
N-2P	**Pediatric Seizure** • Under the ALS box, added 'and EtCO2', and 'Obtain temperature. If temperature >100.4 consider 15 mg/kg acetaminophen PO (max: 1000mg) – single dose only'. • Under Midazolam, removed 'repeat same administer 2nd dose'. • It was suggested to add 'route appropriate' under the Midazolam box, after the second bullet point. • It was suggested to add "for active seizures when appropriate' after 'High flow O_2'.	Clayton Thomas	Debbie Madding	Passed Unanimously
R-1P	**Pediatric Foreign Body Airway Obstruction** • The only change, which is a UC Davis suggestion, is in red in the top green box. • No other recommended changes.	Clayton Thomas	Debbie Madding	Passed Unanimously
R-2P	**Pediatric Respiratory Arrest** • The only change is the addition of EtCo2. • No other recommended changes.	Clayton Thomas	Debbie Madding	Passed Unanimously

R-3P	**Pediatric Acute Respiratory Distress** • The UC Davis suggested changes are under the Contraindications: suspected croup/epiglottitis, and 'unable to protect airway'. • In the top yellow box, under Epinephrine Administration, it was suggested to remove the word 'only'. • On page 2, under Croup/Epiglottitis, UC Davis suggested adding: Minimize pt stimulation, and Do Not Attempt I-Gel. • Under Base/Modified Base, UC Davis recommended adding "preferred 1st line treatment" after Racemic epinephrine. The Committee suggested removing the addition. • There was a lot of discussion and concern. • It was suggested to make 2 new boxes, one for cricothyrotomy - with the weight/age restriction, and one for modification route. • On page 1, in the Epinephrine box, it needs to read "EMT personnel only" after Epinephrine 1:1,000 IM. In the same box, it was suggested to change the 15kg weight to 7.5 kg. • This policy will be brought back to the July meeting.			Not voted on. This will be brought back to the July meeting.
T-4	**Hemorrhage** • This is an adult protocol. • It was suggested to add some language regarding topical application for wounds/nosebleeds.	Clayton Thomas	Dr. Morris	Passed Unanimously

I. EMS Aircraft Provider Updates

- No updates were given.

J. Ground EMS Provider Updates

- AMR- They have a new Clinical Education Specialist named Chris Newsom.
- Penn Valley – they now have LUCAS devices on all of their ALS vehicles.

K. Hospital Provider Updates

- UC Davis Medical Center –
  - The new EMS entrance will officially open on either 5/13 or 5/14.
  - They should have 24 beds back online by the end of July.
- Kaiser Roseville Medical Center –
  - They have a new paramedic/nurse liaison Chris Britton. He's been with Kaiser Roseville for nearly 20 years.
  - No new construction updates.
  - Next month begins a new APOT project.
  - Kaiser Roseville has had a big policy change as far as security is concerned. Any patients that come on their campus will be screened, wanded, and their belongings will also be wanded.
  - They have increased armed security as well.
- Sutter Roseville Medical Center –
  - Just got a metal detector in the ED
  - Contracted with Imagetrend to be able to have real-time data
  - Had their first meeting with Growth Factory to use AI to improve business flow.

L. S-SV EMS Agency Reports

L-1. EMS Data System

- Modifying month-end reports on an interactive dashboard.
- PCR completion compliance – if you're with Imagetrend Jeff is happy to help you build a report to ensure you are compliant.
- Reach out to Jeff McManus with any questions/concerns concerning data.

L-2. EMS Quality Management

- Specialty centers: there is a STEMI dashboard that gets updated quarterly with the tracked STEMI metrics. These are available to EMS if they're interested. Eventually HEMS and Stroke will also be available.
- The Regional Training Module is done but will take a little bit to get on the website. It should be up early to mid-May.
- Pain management and airway management are a big audit focus this year.
- Brittany sent out a request for audit to ALS ground providers only – asking for their LMA and ET success rates. There will be more asked of the providers.
- There are a surprising number of LMAs being placed and then removed – per the data. Brittany did a 6-month audit of all LMAs and ETs. The majority didn't have a good reason to remove the LMAs. There are a lot of concerns regarding this.

L-3. Regional Committees

- The PAC Committee is working on some education modules.
- There was a STEMI meeting.
- The Trauma meeting is next month.
- Implementing new registries for all of the specialty centers.

L-4. Operations

- S-SV hired a new Certification Specialist – Whitney Sullivan.
- S-SV is going to get a new software program for all certifications.
- Provider transport permits are being sent out soon. They will not be approved until S-SV EMS has the full application and payment.

L-5. Regional Executive Director's Report

- Working on revising the MCI Protocol and Policy.
- S-SV's RDMHS, Patti Carter, will be retiring at the end of May. S-SV will be looking to refill the position and will send out notice.
- There are several bills that have been introduced that have to do with EMS matters. The EMS Authority has convened a E-Pack (a group of several EMS System stakeholders) to talk about a new chapter of regulations which will focus on EMS System design matters.

.

L-6. Medical Director's Report

- Gun/Weapon safety – there was recently a case in the S-SV system where an elderly patient was transported to the ED with a weapon and then committed suicide at the receiving facility. Please be careful when dealing with all patients.

M. Next Meeting Date & Adjournment

- July 16, 2024, at 9:00 am.
- The meeting was adjourned at 11:41 am.

Sierra – Sacramento Valley EMS Agency Program Policy			
Suspected Child Abuse/Neglect Reporting			
	Effective: DRAFT	Next Review: DRAFT	**830**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish requirements/procedures for EMS personnel to report suspected child abuse and/or neglect.

AUTHORITY:

PC, Ch. 916 (Part 4, Title 1, Chapter 2, Article 2.5) § 11164 - 11174.3.

DEFINITIONS:

A. **Agencies authorized to accept mandated reports –** Police Department, Sheriff's Department, and Child Protective Services (CPS).

B. **Child –** Any person under the age of eighteen (18).

C. **Mandated reporter –** Includes paid firefighters, EMRs, EMTs, AEMTs, paramedics, teachers, peace officers, any healthcare practitioner, clergy member, child care custodian, or an employee of a child protective agency.

D. **Neglect –** The negligent failure of a parent or caretaker to provide adequate food, clothing, shelter, medical/dental care, or supervision.

E. **Physical abuse –** A physical injury, including death, to a child that appears to have been inflicted by other than accidental means.

F. **Sexual abuse –** Sexual assault on, or the exploitation of a minor. Sexual assault includes: rape, rape in concert (aiding or abetting or acting in concert with another person in the commission of a rape), incest, sodomy, oral copulation, penetration of genital or anal opening by a foreign object, and child molestation. It also includes lewd or lascivious conduct with a child under the age of fourteen years, which may apply to any lewd touching if done with the intent of arousing or gratifying the sexual desires of either the person involved or the child. Sexual exploitation refers to conduct or activities related to pornography depicting minors, and promoting prostitution by minors.

PRINCIPLES:

A. The purpose of reporting suspected child abuse/neglect is to protect the child, prevent further abuse/neglect of the child and other children in the home, and begin treatment of the entire family. The infliction of injury/neglect, rather than the degree of that injury/neglect, is the determinant for intervention by law enforcement and/or CPS.

B. California PC, § 11166 and 11168, requires that mandated reporters promptly report all suspected non-accidental injuries, sexual abuse, or neglect of children to local law enforcement and/or CPS.

C. It is the job of law enforcement, CPS and the courts to determine whether child abuse/neglect has, in fact, occurred. It is not necessary for the mandated reporter to determine child abuse/neglect, but only to suspect that it may have occurred. Children under the age of five, especially less than six months, are at highest risk.

D. All healthcare professionals are mandated to report suspected child abuse/neglect that they have knowledge of or observe in their professional capacity. Any person who fails to report as required may be punished by six months in jail and/or a $1,000 fine.

E. When a mandated reporter has knowledge of or has observed child abuse/neglect, that individual is required to report to law enforcement and/or CPS immediately or as soon as practically possible by telephone, and shall complete/submit the suspected child abuse/neglect report form within 36 hours.

F. When two or more mandated reporters are present at scene and jointly have knowledge of a known or suspected instance of child abuse/neglect, the telephone report can be made by a selected member and a single written report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the designated reporter failed to uphold their agreement, shall thereafter make the report.

G. When a mandated reporter is not performing their job duties, they become discretionary reporters and are not required by law to report.

H. Those persons legally required to report suspected child abuse/neglect have immunity from criminal or civil liability for reporting as required.

POLICY:

A. If EMS personnel suspect child abuse/neglect, a prompt verbal report shall be made to law enforcement and/or CPS. If the child is in imminent danger, law enforcement shall be immediately notified/requested. To make a verbal report to CPS, call the applicable county CPS office using the appropriate 24-hour contact telephone number listed in this policy.

B. The suspected child abuse/neglect report shall be completed according to the instructions on the back of the form. The report shall be filled out as completely and clearly as possible. The completed form shall be submitted to law enforcement and/or CPS within 36 hours. A copy of the report should also be retained by the reporting party. An electronic version of the form/instructions can be obtained at the following link: https://oag.ca.gov/sites/all/files/agweb/pdfs/childabuse/ss_8572.pdf

C. The following information shall also be included in the PCR:

1. The name, department and badge # of the law enforcement officer and/or the name of the CPS social worker the report was made to.

2. The time of notification.

3. The disposition of the child, if not transported.

Suspected Child Abuse/Neglect Reporting Contact Information	
Butte County	**Colusa County**
Chico Area (North County) Child Protective Services: ~~(888) 268-8822~~ ~~2445 Carmichael Dr., Chico, CA 95928~~ *(800) 400-0902* *765 East Ave. Suite 120 Chico, CA 95926* Oroville Area (South County) Child Protective Services: (800) 400-0902 78 Table Mountain Blvd., Oroville, CA 95965	Child Protective Services: (530) 458-0280 251 East Webster St., Colusa, CA 95932
Glenn County	**Nevada County**
Child Welfare Services: (530) 934-1429 420 E. Laurel St., Willows, CA 95988	Child Protective Services: (530) 273-4291 988 McCourtney Rd., Grass Valley, CA 95949
Placer County	**Shasta County**
Family & Children Services: (916) 872-6549 1000 Sunset Blvd., Rocklin, CA 95765	Child Protective Services: (530) 225-5144 1313 Yuba St., Redding, CA 96001
Siskiyou County	**Sutter County**
Child Protective Services: (530) 841-4200 ~~1215 South Main St., Yreka, CA 96097~~ *2060 Campus Dr., Yreka, CA 96097*	Child Protective Services: (530) 822-7227 ~~1635 Live Oak Blvd., Yuba City, CA 95991~~ *1965 Live Oak Blvd., Suite A, Yuba City, CA 95991*
Tehama County	**Yuba County**

Child Protective Services: (530) 527-1911 310 South Main St., Red Bluff, CA 96080	Child Protective Services: (530) 749-6288 5730 Packard Ave., Marysville, CA 95901

1

Sierra – Sacramento Valley EMS Agency Program Policy			
Suspected Elder/Dependent Adult Abuse Reporting			
	Effective: DRAFT	Next Review: DRAFT	**832**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish requirements/procedures for EMS personnel to report suspected elder/ dependent adult abuse.

AUTHORITY:

A. WIC § 15630 et seq.

B. CCR, Title 22, § 100160 and § 100075.

DEFINITIONS:

A. **Dependent adult –** Any person between the ages of 18 and 64 years who meets one or both of the following criteria:

1. Has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age.

2. Is admitted as an inpatient to a 24-hour health facility, as defined in HSC § 1250, 1250.2, or 1250.3.

B. **Developmentally disabled person –** A person with a developmental disability specified by or as described as follows:

"Developmental disability" means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature.

C. **Elder/dependent adult abuse –** Either of the following:

1. Physical abuse, neglect, financial abuse, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering.

2. The deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

D. **Elder –** Any person 65 years of age or older.

E. **Reasonable suspicion –** An objectively reasonable suspicion that a person would entertain, based upon facts that could cause a reasonable person in a like position, drawing when appropriate upon his or her training and experience, to suspect abuse.

PRINCIPLES:

A. Paid firefighters, EMRs, EMTs, AEMTs, paramedics, and MICNs are mandated reporters, and have a legal obligation to report known or suspected elder or dependent adult abuse under the following circumstances:

1. When the reporter who in their professional capacity, or within the scope of their employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse, or neglect; or

2. When the reporter has observed a physical injury where the nature of the injury, its location on the body, or the repetition of the injury, clearly indicates that physical abuse has occurred; or

3. When the reporter is told by an elder or dependent adult that they have experienced behavior, including an act or omission, constituting physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, or the reporter reasonably suspects that abuse has occurred.

B. Any mandated reporter who has knowledge, or reasonably suspects, that types of elder or dependent adult abuse for which reports are not mandated have been inflicted upon an elder or dependent adult, or that his or her emotional well-being is endangered in any other way, may report the known or suspected instance of abuse.

C. Reports made under the law are confidential. The identity of all persons making reports of elder or dependent abuse is also confidential. This information will be shared only between the investigating and licensing agencies, with the district attorney in a criminal prosecution resulting from the report, by court order, or when the reporter waives the right to remain anonymous.

D. When two or more persons who are required to report are present and jointly have knowledge of a known or suspected instance of abuse of an elder or dependent adult, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall hereafter make the report.

E. Mandated reporters who report suspected cases of elder or dependent adult abuse, in good faith, have absolute immunity, both civilly and criminally, for making a report of abuse of an elder or dependent adult. This includes taking of photographs of the victim and surroundings to submit with the report.

F. All healthcare professionals are mandated to report suspected elder/dependent adult abuse that they have knowledge of or observe in their professional capacity. Failure to report physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, is a misdemeanor, punishable by not more than six months in the county jail, by a fine of not more than one thousand dollars ($1,000); or both fine and imprisonment. Any mandated reporter who willfully fails to report physical abuse, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, where that abuse results in death or great bodily injury, shall be punished by not more than one year in a county jail, by a fine of not more than five thousand dollars ($5,000), or by both fine and imprisonment.

POLICY:

A. Verbal reports of physical abuse are to be made immediately, or as soon as possible, by telephone.

B. When reporting abuse that allegedly occurred in a long-term care facility or adult day health care center, contact either the local law enforcement agency or the local Ombudsman program. When the abuse is alleged to have occurred anywhere else, contact either the local law enforcement agency or the local County Adult Protective Services.

C. A written Report of Suspected Dependent Adult/Elder Abuse must be completed and submitted to the agency initially contacted within two (2) working days of the verbal report. Electronic versions of the reporting forms and instructions can be obtained at the following links:

1. Report of Suspected Dependent Adult/Elder Abuse (SOC 341): https://cdss.ca.gov/portals/9/fmuforms/q-t/soc341.pdf?ver=2018-11-15-132736-097

2. Report of Suspected Dependent Adult/Elder Financial Abuse (SOC 342): https://www.cdss.ca.gov/cdssweb/entres/forms/English/soc342.pdf

https://www.cdss.ca.gov/Portals/9/fmuforms/q-t/SOC342.pdf

D. The following information shall also be included in the PCR:

1. The name, department and badge # of the law enforcement officer and/or the name of the APS social worker or Local Ombudsman the report was made to.

2. The time of notification.

3. The disposition of the elder or dependent adult if not transported.

Suspected Elder/Dependent Adult Abuse Reporting Contact Information	
Butte County	**Colusa County**
Ombudsman: (530) 898-5923 Adult Protective Services: (800) 664-9774 78 Table Mountain Blvd., Oroville, CA 95965	Ombudsman: (530) 898-5923 Adult Protective Services: (530) 458-0280 251 East Webster St., Colusa, CA 95932
Glenn County	**Nevada County**
Ombudsman: (530) 898-5923 Adult Protective Services: ~~(530) 934-1429~~ *(530) 865-1178* P.O. Box 611, Willows, CA 95988	Ombudsman: (916) 376-8910 Adult Protective Services: ~~(530) 265-1340~~ ~~500 Crown Point, Grass Valley, CA 95945~~ *(530) 265-1639* *950 Maidu Ave. Nevada City, CA 95959*
Placer County	**Shasta County**
Ombudsman: (916) 376-8910 Adult Protective Services: (916) 787-8860 101 Cirby Hills Dr., Roseville, CA 95678	Ombudsman: (530) 229-1435 Adult Protective Services: ~~(530) 225-8798~~ *(530) 225-5798* PO Box 496005, Redding, CA 96049
Siskiyou County	**Sutter County**
Ombudsman: (530) 229-1435 Adult Protective Services: (530) 842-7009 2060 Campus Dr., Yreka, CA 96097	Ombudsman: (916) 376-8910 Adult Protective Services: ~~(530) 822-7151~~ ~~1965 Live Oak Blvd., Yuba City, CA 95991~~ *(530) 822-7227* *1445 Veterans Memorial Cir Yuba City, CA 95993*
Tehama County	**Yuba County**
Ombudsman: (530) 898-5923 Adult Protective Services: (530) 527-1911 PO Box 1515, Red Bluff, CA 96080	Ombudsman: (916) 376-8910 Adult Protective Services: (530) 749-6471 5730 Packard Ave., Marysville, CA 95901

Sierra – Sacramento Valley EMS Agency Program Policy			
Patient Restraint Mechanisms			
	Effective: DRAFT	Next Review: DRAFT	**852**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

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:

- *For patients who are combative, such that harm to self or others is likely, consult treatments outlined in protocols M-11 and M-11P respectively.*
- ~~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.

Sierra – Sacramento Valley EMS Agency Program Policy			
EMR Initial & Renewal Certification			
	Effective: DRAFT	Next Review: DRAFT	**904**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To specify the process for obtaining a S-SV EMS Emergency Medical Responder (EMR) certification.

AUTHORITY:

A. HSC, Division 2.5, § 1797.204, 1797.210 & 1797.212.

B. CCR, Title 22, Division 9, Chapter 1.5.

POLICY:

A. S-SV EMS certification is required to function as an EMR in the S-SV EMS region.

B. This policy does not apply to personnel who are certified by another EMR certifying entity (CAL FIRE, CHP, etc.).

C. No individual shall hold themselves out to be an EMR unless that individual is currently certified as such by S-SV EMS or another appropriate EMR certifying entity.

D. A S-SV EMS certified EMR is responsible for notifying S-SV EMS of their current mailing address and shall notify S-SV EMS in writing within thirty (30) calendar days of any and all changes of the mailing address.

PROCEDURE:

A. S-SV EMS Initial EMR Certification:

1. To be eligible for a S-SV EMS initial EMR certification, an individual shall meet/ complete the following:

- Be 18 years of age or older.
- Meet one of the following training/eligibility requirements:
  - Possess a course completion record, dated within the past twelve (12) months, from an S-SV EMS approved EMR training program.

- Possess a course completion record or other documented proof of successful completion, dated within the past twelve (12) months of any initial training program that meets or exceeds the U.S. Department of Transportation Emergency Medical Responder National Emergency Medical Services Educational Standards and Instructional Guidelines.
- Possess a current EMR certification card issued by another certifying entity. Acceptance of an EMR certification card issued by another certifying entity shall be at the sole discretion of the S-SV EMS Agency.

- Complete a state criminal history background check within 60 days from the date of application.
- Complete the S-SV EMS Agency EMR Initial Certification Application, and provide copies of the following:
  - Proof of compliance with one of the training/eligibility requirements listed above.
  - A current and valid U.S. state-issued Driver's License or photo identification.
  - A completed S-SV EMS Live Scan form.
- Pay the non-refundable/non-transferable initial certification fee.

2. S-SV EMS shall issue a*n* ~~wallet-sized~~ EMR certificate ~~card~~ to eligible individuals who apply for an initial S-SV EMS EMR certificate and meet all of the requirements listed in this section of the policy.

   - The *certificate* effective date ~~of certification~~ shall be the day the certificate is issued.
   - The ~~certification~~ *certificate* expiration date shall be the last day of the month two (2) years from the effective date.

B. S-SV EMS Renewal EMR Certification:

1. To be eligible for a S-SV EMS renewal EMR certification, an individual shall meet/ complete the following:

   - Possess a current S-SV EMS issued EMR certification.
   - Meet one of the following continuing education (CE) requirements:
     - Successfully complete a 12-hour refresher course from an approved EMR training program within 24 months prior to applying for renewal, or
     - Obtain at least 12 hours CE, within 24 months prior to applying for renewal, from an approved CE provider in accordance with the provisions contained in California Code of Regulations (Title 22, Division 9, Chapter 11).
   - Complete the S-SV EMS EMR Renewal Certification Application and provide copies of the following:
     - Proof of compliance with one of the continuing education requirements listed above.
     - A current and valid S-SV EMS Issued EMR certification card.
     - A current and valid U.S. state-issued Driver's License or photo identification.

- A completed skills competency verification form (904-A).
  - Verification of skills competency shall be valid for a maximum of two (2) years for the purpose of applying for EMR certification renewal.
- Pay the non-refundable/non-transferable renewal certification fee.

2. A S-SV EMS certified EMR who is a member of the Armed Forces of the United States and whose certification expires while deployed on active duty, or whose certification expires less than six (6) months from the date they return from active duty deployment with the Armed Forces of the United States shall have six (6) months from the date they return from active duty deployment to complete the EMR certification renewal requirements. In order to qualify for this exception, the individual shall:

   - Submit proof of membership in the Armed Forces of the United States.
   - Submit documentation of his or her deployment starting and ending dates.

   CE credit may be given for documented training that meets the requirements contained in California Code of Regulations (Title 22, Division 9, Chapter 11) while the individual was deployed on active duty. CE documentation shall include verification from the individual's Commanding Officer attesting to the training.

3. S-SV EMS shall issue a ~~wallet-sized~~ EMR certificate ~~card~~ to eligible individuals who apply for a S-SV EMS renewal EMR certificate and meet all of the requirements listed in this section of the policy.

   - If the EMR renewal requirements are met within six (6) months prior to the current ~~certification~~ *certificate* expiration date, the effective date of the renewal *certificate* shall be the date immediately following the expiration date of the current certificate. The ~~certification~~ *certificate* will expire the last day of the month two (2) years from the day prior to the effective date.
   - If the EMR renewal requirements are met more than six (6) months prior to the expiration date, the effective date of the renewal *certificate* shall be the day the certificate is issued. The ~~certification~~ *certificate* expiration date will be the last day of the month two (2) years from the effective date.

C. Reinstatement of an Expired S-SV EMS EMR Certification:

1. To be eligible for a S-SV EMS renewal EMR certification following expiration of a previously issued S-SV EMS EMR certification, an individual shall meet/complete the following:

   - Possess an expired S-SV EMS issued EMR certification.
     - If S-SV EMS has submitted a 'No Longer Interested' (NLI) request to the DOJ due to the time lapse following expiration of the previously issued EMR

certification, the individual shall complete a state criminal history background check within 60 days from the date of application.

- Complete the EMR Renewal Certification Application and provide copies of the following:
  - Proof of compliance with one of the continuing education requirements listed below (based on the period of lapse).
  - An expired S-SV EMS issued EMR certification.
  - A completed S-SV EMS Live Scan form (if required).
  - A current and valid U.S. state-issued Driver's License or photo identification.
  - A completed skills competency verification form (904-A).
    - Verification of skills competency shall be valid for a maximum of two (2) years for the purpose of applying for EMT certification renewal.
- Pay the non-refundable/non-transferable renewal certification fee.
- Meet the following CE requirements:
  - Lapse of less than six (6) months:
    - Successfully complete a 12-hour refresher course from an approved EMR training program within 24 months prior to applying for renewal, or
    - Obtain at least 12 hours of CE, within 24 months prior to applying for renewal, from an approved CE provider in accordance with the provisions contained in California Code of Regulations (Title 22, Division 9, Chapter 11).
  - Lapse of six (6) months or more, but less than 12 months:
    - Successfully complete a 12-hour refresher course from an approved EMR training program, and an additional 12 hours of CE, within 24 months prior to applying for reinstatement, or
    - Obtain at least 24 hours of CE, within 24 months prior to applying for reinstatement, from an approved CE provider in accordance with the provisions contained in California Code of Regulations (Title 22, Division 9, Chapter 11).

2. S-SV EMS shall issue a ~~wallet-sized~~ EMR certificate ~~card~~ to eligible individuals who apply for reinstatement of a S-SV EMS EMR certificate and meet all of the requirements listed in this section of the policy.

   - The effective date of ~~certification~~ the *certificate* shall be the day the certificate is issued.
   - The ~~certification~~ *certificate* expiration date shall be the last day of the month two (2) years from the effective date.

D. Denial, Suspension, or Revocation of an S-SV EMS Issued EMR Certification:

A S-SV EMS issued EMR certification may be denied, suspended, or revoked for any act that is substantially related to the qualifications, functions, and duties of an EMR and is evidence of a threat to the public health and safety (pursuant to California Health and Safety Code, Division 2.5 § 1798.200).

E. Application Processing:

1. A completed EMR application and all required supporting documentation must be submitted to S-SV EMS prior to processing.

   - ~~Incomplete applications will be maintained by S-SV EMS for 60 days awaiting required supporting documentation. All applications not completed within 60 days will be destroyed.~~

2. S-SV EMS will normally process completed applications within 10 business days.

   - S-SV EMS is required to receive and review an EMR applicant's criminal background results before issuing an EMR certification.
   - Application processing may be delayed, and additional information/ investigation may be required prior to processing for applicants with a criminal background.

Sierra – Sacramento Valley EMS Agency Program Policy			
Paramedic Accreditation			
	Effective: DRAFT	Next Review: DRAFT	**913**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish the requirements for obtaining and maintaining accreditation to practice as a paramedic in the S-SV EMS region.

AUTHORITY:

A. HSC, Division 2.5, § 1797.84, 1797.185, 1797.194, and 1797.214

B. CCR, Title 22, Division 9, Chapter 4, § 100166.

POLICY:

A. Initial Paramedic Accreditation:

1. To obtain initial S-SV EMS paramedic accreditation, an individual shall:

- Submit a completed paramedic accreditation application.
- Provide a copy of their current California paramedic license.
- Provide a copy of their current U.S. state-issued driver's license or photo identification card.
- Effective on or after July 1, 2024, provide a copy of their current PALS, PEPP, APLS or Handtevy Prehospital Pediatric Provider Course (for entities using the Handtevy system) recognition.
- Effective on or after July 1, 2024, provide a copy of their current ACLS Course recognition.
- Successfully complete an S-SV EMS paramedic accreditation class and pass a policy/protocol examination with a minimum score of 80%.
  - If the examination is failed twice, the individual will be required to repeat the paramedic accreditation class prior to re-testing.
- Provide verification of one of the following:
  - Current paramedic accreditation from another California LEMSA.
  - Successful completion of a paramedic training program field internship conducted in the S-SV EMS region within the previous six (6) months.

- Successful completion of a supervised field evaluation consisting of a minimum of five (5), but no more than ten (10), ALS contacts conducted in the S-SV EMS region within the previous 60 days.
- Pay the accreditation fee.

2. An individual with a current California paramedic license may practice in the paramedic basic scope of practice, under the affiliation of an S-SV EMS approved ALS prehospital service provider agency and direct supervision of an S-SV EMS accredited paramedic, until they have completed the initial accreditation process. This temporary authorization shall be valid for a maximum of 60 days, after which time all initial accreditation requirements must be met for the individual to continue to practice as a paramedic in the S-SV EMS region.

3. If initial accreditation requirements are not met within 60 days of completion of the S-SV EMS paramedic accreditation class, the individual must repeat all initial accreditation requirements to obtain S-SV EMS paramedic accreditation.

4. S-SV EMS will issue a ~~wallet-sized~~ paramedic accreditation ~~card~~ *certificate* to eligible individuals, within 10 working days of submission/verification of all requirements listed in this section of the policy.

   - The accreditation *certificate* effective date will be the day the ~~card~~ *certificate* was issued.
   - The accreditation *certificate* expiration date will be the expiration date listed on the individual's current California paramedic license.

B. Renewal/Maintenance of Paramedic Accreditation:

1. To renew/maintain accreditation, an S-SV EMS accredited paramedic shall complete the following each time they renew their California paramedic license:

   - Submit a completed S-SV EMS paramedic reaccreditation application.
   - Provide a copy of their renewed California paramedic license.
   - Provide a copy of their current PALS, PEPP, APLS or Handtevy Prehospital Pediatric Provider Course (for entities using the Handtevy system) recognition.
   - Effective on or after July 1, 2024, provide a copy of their current ACLS Course recognition.
   - Complete S-SV EMS mandated education.

2. Failure to comply with the renewal/maintenance of paramedic accreditation requirements listed in this policy will result in a lapse of paramedic accreditation, and the individual will not be allowed to practice as a paramedic in the S-SV EMS region until they comply with the renewal/maintenance of paramedic accreditation requirements.

- For a lapse greater than 6 months, the individual shall also successfully complete an S-SV EMS paramedic accreditation class and pass a policy/protocol examination with a minimum score of 80% to be eligible for paramedic accreditation renewal.

3. S-SV EMS will issue a ~~wallet-sized~~ paramedic accreditation ~~card~~ *certificate* to eligible individuals, within 10 working days of submission/verification of all requirements listed in this section of the policy.

   - The accreditation *certificate* effective date will be the effective date listed on the individual's renewed California paramedic license.
   - The accreditation *certificate* expiration date will be the expiration date listed on the individual's renewed California paramedic license.

C. ALS Prehospital Service Provider Agency Responsibilities:

1. ALS prehospital service provider agencies are responsible for the following:

   - Verifying their paramedic personnel have a current and valid S-SV EMS accreditation prior to allowing them to practice independently as a paramedic in the S-SV EMS region.
   - Verifying the accreditation renewal/maintenance status of their paramedic personnel on an ongoing basis.
   - Ensuring that their paramedic personnel are kept current on S-SV EMS policies/protocols.
   - Ensuring that their paramedic personnel complete all S-SV EMS required training/education.

2. If there is a change in the employment status of an S-SV EMS accredited paramedic employee, the ALS prehospital service provider agency shall submit a completed S-SV EMS Paramedic Employee Status Report (913-A or online form) to S-SV EMS within 30 calendar days of such change.

Sierra – Sacramento Valley EMS Agency Program Policy			
MICN Authorization/Reauthorization			
	Effective: DRAFT	Next Review: DRAFT	**915**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish a mechanism for obtaining authorization or reauthorization as a Mobile Intensive Care Nurse (MICN) within the S-SV EMS region. MICN means a registered nurse (RN) authorized by the S-SV EMS Medical Director to provide instructions to prehospital EMS personnel according to approved S-SV EMS policies/protocols.

AUTHORITY:

A. HSC, Division 2.5, § 1797.56, 1797.200, 1797.220, 1798.100, and 1798.105.

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

C. BPC, § 2725.

POLICY:

A. An individual shall comply with the initial authorization requirements and obtain S-SV EMS MICN authorization prior to functioning as a MICN in the S-SV EMS region.

B. A MICN shall comply with the reauthorization requirements, prior to the expiration date of their current authorization, in order to maintain S-SV EMS MICN authorization. Failure to comply with the reauthorization requirements means that the MICN has failed to maintain authorization, and shall not function as a MICN in the S-SV EMS region until all reauthorization requirements are met.

C. A MICN shall only provide medical direction to prehospital personnel when they are on-duty in a S-SV EMS base hospital emergency department.

PROCEDURE:

MICN Initial Authorization Requirements:

A. To be eligible for initial MICN authorization, an individual shall comply with the following requirements:

1. Be currently licensed as a RN in California.

2. Be currently employed in a S-SV EMS base hospital emergency department, and be recommended for MICN authorization by the base hospital.

3. Have a minimum of six months (1040 hours) of clinical experience within the last 24 months in an acute care hospital emergency department.

4. Meet one of the following training program criteria:

   - Successful completion of a S-SV EMS approved MICN training program (including the four-hour ground ambulance ride-along and base hospital orientation components) within the previous 12 months.
   - Successful completion of a S-SV EMS approved MICN training program within the previous 12 – 24 months, successful completion of a MICN training program from another California LEMSA within the previous 24 months, or possess a current/valid MICN authorization from another California LEMSA, and complete the following additional requirements within the previous 90 days:
     - A minimum four-hour ride-along with a S-SV EMS approved ALS 911 ground ambulance provider, which includes two ALS contacts or two ALS patient scenarios conducted by the paramedic.
     - A base hospital orientation with the S-SV EMS designated base hospital.

5. Attend a S-SV EMS Paramedic Accreditation course within the last 90 days (note: this training may also be conducted by S-SV EMS representatives during the initial MICN training program).

6. Submit a completed MICN initial authorization application.

7. Provide documentation/evidence of the items listed above, in addition to copies of the following current/valid items:

   - U.S. state-issued driver's license or photo identification card.
   - Healthcare Provider CPR recognition.
   - ACLS recognition.
   - PALS or APLS recognition.

8. Pay the S-SV EMS MICN initial authorization fee.

B. S-SV EMS will issue a ~~wallet-sized~~ MICN authorization ~~card~~ *certificate* within ten business days to eligible individuals who apply for initial MICN authorization and comply with the initial authorization requirements listed in this policy. The effective date of the MICN authorization *certificate* will be the day the ~~card~~ *certificate* is issued, and the expiration date will be the last day of the month two years from the effective date of the initial authorization.

MICN Reauthorization:

A. A MICN shall comply with the following requirements, prior to the expiration date of their current authorization, in order to be eligible for S-SV EMS MICN reauthorization:

1. Submit a completed MICN reauthorization application.

2. Maintain and provide copies of the following current/valid items:

   - California RN license.
   - U.S. state-issued driver's license or photo identification card.
   - Healthcare Provider CPR recognition.
   - ACLS recognition.
   - PALS or APLS recognition.

3. Complete 12 hours of EMS continuing education during the current authorization cycle as follows:

   - A minimum of four hours of prehospital care focused education of recorded or written patient care records.
   - A minimum four-hour ride-along with a S-SV EMS approved ALS 911 ground ambulance provider, which includes two ALS contacts or two ALS patient scenarios conducted by the paramedic.
   - The remaining four hours may be from either of the categories above, or the MICN may complete an additional four-hour ride-along with a S-SV EMS approved ALS non-transport provider, which includes two ALS contacts or two ALS patient scenarios conducted by the paramedic.

4. Maintain employment in a S-SV EMS base hospital emergency department and provide documentation of base hospital reauthorization recommendation.

5. Pay the S-SV EMS MICN reauthorization fee.

B. S-SV EMS will issue a ~~wallet-sized~~ MICN authorization ~~card~~ *certificate* within ten business days, to eligible individuals who apply for MICN reauthorization and comply with the MICN reauthorization requirements listed in this policy.

If the reauthorization requirements are met within six months prior to the current authorization expiration date, the effective date of reauthorization *certificate* will be the date immediately following the expiration date of the current authorization *certificate* and will expire two years from the day prior to the effective date. If the reauthorization requirements are met greater than six months prior to the current authorization *certificate* expiration date, the effective date of reauthorization *certificate* will be the date the individual applied for reauthorization, and the authorization *certificate* expiration date will be the last day of the month two years from the effective date.

MICN Reauthorization After Lapse:

A. In addition to the reauthorization requirements specified in this policy, an individual with a lapsed MICN authorization shall also meet the following requirements in order to be eligible for reauthorization:

1. If the authorization has been lapsed for less than 12 months, the MICN shall attend an S-SV EMS Paramedic Accreditation course within the previous 90 days.

2. If the authorization has been lapsed between 12 – 24 months, the MICN shall:

   - Attend a S-SV EMS Paramedic Accreditation course within the previous 90 days.
   - Complete a base hospital MICN re-orientation with the S-SV EMS base hospital within the previous 90 days.
   - Complete an additional four-hour ride-along with a S-SV EMS approved ALS 911 ground ambulance provider, which includes two additional ALS contacts or two additional ALS patient scenarios conducted by the paramedic (total of eight hours of ambulance ride-along). At least four hours of ambulance ride along shall be completed within the previous 90 days.

3. If the authorization has been lapsed for greater than 24 months, all of the initial authorization requirements must be met.

B. S-SV EMS will issue a ~~wallet-sized~~ MICN authorization ~~card~~ *certificate* within ten business days, to eligible individuals who apply for MICN reauthorization and successfully complete the requirements listed in this policy. The effective date of the MICN reauthorization *certificate* will be the day the ~~card~~ *certificate* is issued, and the *certificate* expiration date will be the last day of the month two years from the effective date of the reauthorization *certificate*.

APPLICATION PROCESSING:

A completed *MICN authorization/reauthorization* application and all required supporting documentation must be submitted to S-SV EMS prior to processing. ~~Incomplete applications will not be processed, but will be maintained by S-SV EMS for 60 days awaiting required supporting documentation. All applications not completed within 60 days will be destroyed.~~

Sierra – Sacramento Valley EMS Agency Program Policy			
EMS Incident Reporting & Investigation			
	Effective: DRAFT	Next Review: DRAFT	**927**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish incident reporting and investigation requirements for EMS personnel, EMS provider agencies and base/modified base hospitals.

AUTHORITY:

A. HSC, Division 2.5, § 1797.200 and 1798.

B. CCR, Title 22, Division 9, Chapters 2, 3, 4, 6 & 12.

REPORTABLE INCIDENTS:

A. Sentinel Events – An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.

B. Breach of the standard of care (i.e. failure to assess/act, patient abandonment).

C. Medication errors.

D. Treatment errors, or errors in assessment/application of treatment guidelines.

E. Care beyond the appropriate scope of practice.

F. Failure to follow S-SV EMS policy or protocol.

G. Any alleged or known injury to a patient as a result of actions by EMS personnel.

H. Suspected violations of HSC, Division 2.5, § 1798.200, including:

1. Fraud in the procurement of any certificate or license.

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

5. The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel.

6. Conviction of any crime which is substantially related to the qualifications, functions, and duties of prehospital personnel. The record of conviction or a certified copy of the record shall be conclusive evidence of the conviction.

7. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel.

8. Violating or attempting to violate any federal or state statute or regulation that regulates narcotics, dangerous drugs, or controlled substances.

9. Addiction to, the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

10. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license/ certification.

11. Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired.

12. Unprofessional conduct exhibited by any of the following

    - The mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance. Nothing in this section shall be deemed to prohibit an EMT, AEMT, or paramedic from assisting a peace officer, or a peace officer who is acting in the dual capacity of peace officer and EMT, AEMT, or paramedic, from using that force that is reasonably necessary to effect a lawful arrest or detention.
    - The failure to maintain confidentiality of patient medical information, except as disclosure is otherwise permitted or required by law.
    - The commission of any sexually related offense specified under PC, § 290.

I. Critical vehicle and non-biomedical equipment failures shall be reported utilizing the S-SV EMS Critical Vehicle Failure/Equipment Failure Report Form.

J. *Biomedical equipment failures shall be reported in accordance with S-SV EMS Policy 715.*

POLICY:

A. EMS Personnel Responsibilities:

1. Immediately notify the receiving facility RN or physician if a reportable incident impacts or has a potential to impact a patient's health and well-being.

2. Notify the on-duty supervisor of any reportable incident as soon as possible, and subsequently submit a written incident report describing the details of the reportable incident ~~within 24 hours of occurrence/identification~~. *by the end of the shift in which the event occurred.*

3. Reasonably cooperate with the investigation of any reportable incident.

B. EMS Provider Agency and/or Hospital Staff Responsibilities:

1. If the EMS provider agency or hospital is the reporting entity:

- Provide a written report of the incident and any other pertinent incident related materials to the investigating entity within three (3) working days of becoming aware of a reportable incident.
- Provide reasonable/appropriate information to the investigating entity to assist them in completing their investigation.

2. If EMS provider agency or hospital staff receive notification of a reportable incident from another reporting entity:

- Acknowledge receipt of the incident to the reporting entity within three (3) working days.
- Conduct an adequate investigation of the incident, which at a minimum shall include:
  - A review of all pertinent incident related documentation, including PCRs, incident reports and any other documentation relevant to the investigation.
  - A review of other materials relevant to the investigation (medical records, voice recordings, etc.).
  - Interviews with complainants, witnesses, prehospital personnel and/or hospital personnel deemed relevant to the investigation.
- Determine the appropriate action/resolution, which may include one or more of the following:
  - No action necessary.
  - Remedial education.

- Provider disciplinary action.
- Referral of prehospital personnel to S-SV EMS and/or EMSA for further review and/or potential certification/license action.
- Referral of the incident to S-SV EMS for possible case review and/or policy/protocol revision.

C. Investigations should be completed in a timely manner, and should be routinely resolved within 21 calendar days of notification. The reporting entity shall be advised if the investigation is expected to last longer than 21 calendar days, and appropriate updates shall be provided until a resolution is reached.

D. EMS provider agencies shall utilize the S-SV EMS Prehospital Provider Incident Tracking Form (927-A), or similar provider agency documentation, to record the notification, investigation, findings and resolution of reportable incidents. This documentation shall be provided to S-SV EMS upon request, or for any incident that requires referral to S-SV EMS for additional review/action.

E. Appropriate notification of investigation completion/findings/resolution, in compliance with current employment and confidentiality laws, shall be provided to the reporting entity at the conclusion of the investigation.

F. EMS provider agencies and/or hospitals shall report any of the following to S-SV EMS within three (3) working days of occurrence confirmation:

1. Sentinel Events.

2. Any alleged or known injury to a patient as a result of actions or omissions by EMS personnel.

3. Any alleged or known violation of HSC, Division 2.5, § 1798.200.

4. Any incident believed to require S-SV EMS notification, including if the reporting party is not satisfied with the investigating entity's incident findings/resolution.

G. EMS provider agencies shall notify S-SV EMS within three (3) working days of the occurrence of any of following:

1. An EMT, AEMT or paramedic is terminated or suspended for disciplinary cause.

2. An EMT, AEMT or paramedic resigns/retires following notice of an investigation based upon evidence indicating disciplinary cause.

3. An EMT, AEMT or paramedic is removed from EMT/AEMT/paramedic related duties for disciplinary cause after the completion of the employer's investigation.

	S-SV EMS Prehospital Provider Incident Tracking Form	927-A

CONFIDENTIAL

(In accordance with California Civil Code Section 56, et seq, California Evidence Code Section 1040 and section 1157. Et seq, and California Code of Regulations, Title 22, Division 9)

Reporting Entity Information:

Name of Reporting Entity:	
Phone Number:	Email Address:
Date Received:	Receipt Acknowledgement Date:

Incident Logistics:

☐ Butte ☐ Colusa ☐ Glenn ☐ Nevada ☐ Placer ☐ Shasta ☐ Siskiyou ☐ Sutter ☐ Tehama ☐ Yuba		
Date Investigation Opened:	Date Investigation Closed:	
Incident Date:	Incident Time:	Run #:
Incident Location:		
Prehospital Agencies Involved:		
Hospitals Involved:		
Personnel Involved:		

Type of Reportable Incident(s):

☐ Sentinel Event	☐ Breach of the Standard of Care
☐ Medication Error	☐ Treatment Error
☐ Key Equipment Failure Related to Patient Care	☐ Care Beyond the Appropriate Scope of Practice
☐ Failure to Follow S-SV EMS Policy/Protocol	☐ Suspected Violation of HSC, Div. 2.5, § 1798.200
☐ Alleged or Known Injury to a Patient as a Result of Actions by EMS Personnel	
☐ Other	

Specific Issue(s):

☐ Airway	☐ Inappropriate Behavior	☐ MICN Issues
☐ AMA/RAS	☐ Interpersonal	☐ Patient Assessment
☐ Base/Modified Base Contact	☐ Manpower/Resource Utilization	☐ Patient Transfer
☐ Destination	☐ MCI	☐ Patient Turnover
☐ Dispatch	☐ Medical Control	☐ Physician Issues
☐ Documentation	☐ Medication Broken/Missing	☐ Policy Clarification
☐ Equipment Failure	☐ Medication Error	☐ Scope of Practice
☐ Equipment Utilization	☐ Other:	

CONFIDENTIAL

(In accordance with California Civil Code Section 56, et seq, California Evidence Code Section 1040 and section 1157. Et seq, and California Code of Regulations, Title 22, Division 9)

Description of Incident (attach additional documentation if necessary):

Incident Investigation Checklist (items used/reviewed during the incident investigation):

☐ Base Hosp. Audio Files	☐ Dispatch Audio Files	☐ PCR
☐ Base Hosp. Documentation	☐ Dispatch Logs	☐ RAS/AMA Forms
☐ Cardiac Monitor/AED Reports	☐ Incident Reports	☐ S-SV EMS Policy/Protocol
☐ Prehospital Personnel Interview(s):		
☐ Interviews/Discussions With Other Personnel:		
☐ Other:		

	S-SV EMS Prehospital Provider Incident Tracking Form	927-A

CONFIDENTIAL

(In accordance with California Civil Code Section 56, et seq, California Evidence Code Section 1040 and section 1157. Et seq, and California Code of Regulations, Title 22, Division 9)

Comments (attach additional documentation if necessary):

Resolution(s):

☐ No Action Required	☐ Remedial Education	☐ Disciplinary Action
☐ Referral to S-SV EMS and/or the California EMS Authority for Potential Certification/Licensure Action		
☐ Referral to S-SV EMS for Possible Case Review or Policy/Protocol Revision		
☐ Other:		
S-SV EMS Agency Referral Date:		
Date Notification of Resolution Provided to Reporting Party:		

Investigator Information

Name/Title of Person Completing Investigation:

Sierra – Sacramento Valley EMS Agency Treatment Protocol	G-2
Determination Of Death	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

General Procedures/Considerations:

- CPR need not be initiated and may be discontinued for pts who meet Obvious Death or Probable Death criteria as contained in this protocol, at the time of initial assessment.
- A valid Do Not Resuscitate (DNR) should be honored for any pt with absent respirations, pulses and neurological response, regardless of the cause of death (e.g. terminal illness, trauma).
- Hypothermia, drug and/or alcohol overdose can mask neurological reflexes. If any doubt exists about contributing environmental factors (e.g. cold water submersion) and no valid DNR exists, initiate resuscitation and treat according to applicable S-SV EMS protocol.
- In the event of a declared MCI, death may be determined in accordance with START/JUMP START criteria.
- For all pts treated under this protocol, the following must be assessed/confirmed (as possible):

  - Absent respirations: look, listen (auscultate), and feel for respirations for a minimum of 30 secs.
  - Absent pulses: palpate both the carotid and apical pulses for a minimum of 30 secs.
  - Absent neurological response: check pupil response with a light and check for response to painful stimuli.

- If the base/modified base hospital physician directs EMS personnel to stop resuscitation efforts once transport has begun, the ambulance shall reduce transport code and continue transport to the original destination hospital.
- If determination of death is made at rendezvous location with HEMS aircraft, the body shall not be moved from the ambulance and an immediate request for law enforcement shall be made.
- If there is any objection/disagreement by family members or EMS personnel to terminating or withholding resuscitation for pts who have a valid DNR or meet probable death criteria, BLS measures (including defibrillation) shall continue or begin immediately and EMS personnel shall contact the base/modified base hospital for further direction.

Instructions for EMS Personnel Upon Determination of Death:

- If not already on scene, request law enforcement
- Minimize contact with the body and scene to protect potential crime scene evidence
- Appropriate EMS personnel shall remain on scene until released by law enforcement
- Provide law enforcement with the following minimum information:

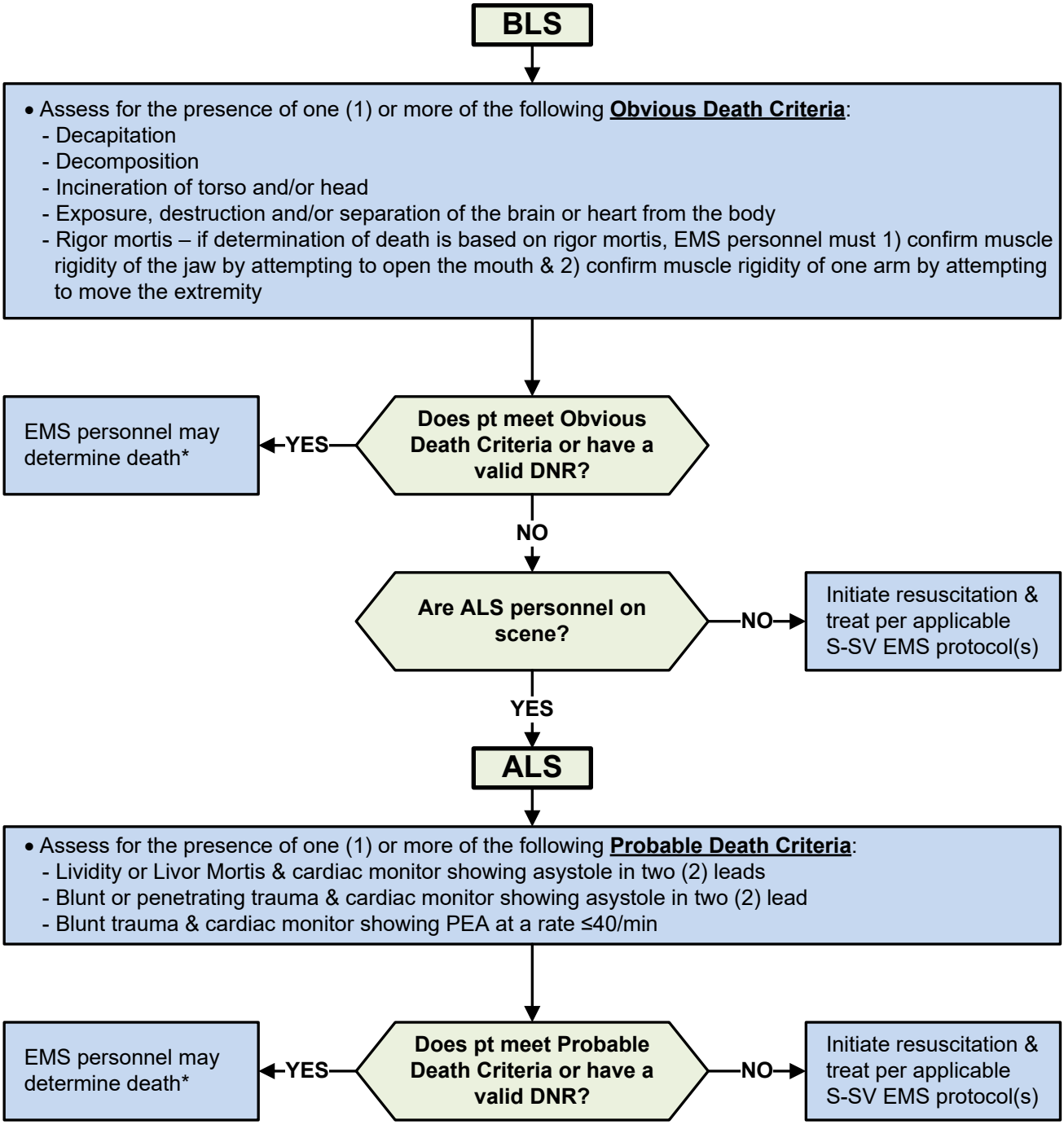
  - Unit ID
  - Name and certification/license # of EMS provider determining death
  - Patient demographics and known, pertinent medical history
  - Determination of death date and time

- At a minimum, the PCR must include the following:

  - Time of determination of death
  - Six-second cardiac monitor strip of each lead for pts meeting probable death criteria

See page 2 for Determination of Death Assessment Criteria

Determination of Death Assessment Criteria
(all pts must have absent respirations, pulses & neurological response)



***Once EMS personnel have determined death, they shall follow the 'Instructions for EMS Personnel Upon Determination of Death' contained on page 1 of this protocol**

Sierra – Sacramento Valley EMS Agency Treatment Protocol	G-3
DNR, POLST & End of Life Option Act	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

DEFINITIONS

Advance Health Care Directive (AHCD) – A document that allows an individual to provide healthcare instructions &/or appoint an agent to make healthcare decisions when they are unable or prefer to have someone speak for them.

Agent or Attorney-In-Fact – An individual designated in a power of attorney for health care to make a health care decision for the pt, regardless of whether the person is known as an agent or attorney-in-fact, or by some other term.

Aid-in-Dying Drug – A drug prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about their death.

Do Not Resuscitate (DNR) – A request to withhold interventions to restore cardiac activity & respirations (no chest compressions, defibrillation, assisted ventilation, advanced airways, or cardiotonic medications).

DNR Wrist or Neck Medallion – A MedicAlert® or other approved wrist or neck medallion, engraved with the words "Do Not Resuscitate", and a patient ID number.

Durable Power of Attorney for Health Care (DPAHC) – A document that allows an individual to appoint an agent/attorney-in-fact to make health care decisions if they become incapacitated. The DPAHC must be immediately available and the agent/attorney-in-fact must be physically present. Decisions made by the agent/attorney-in-fact must be within the limits set by the DPAHC, if any.

EMSA/CMA Prehospital DNR Form – A form developed by the California Emergency Medical Services Authority (EMSA) and California Medical Association (CMA) for the purpose of instructing EMS personnel to forgo resuscitation attempts in the event of a pt's cardiopulmonary arrest in the out of hospital setting. The form must be signed and dated by a physician and pt/representative to be valid.

End of Life Option Act – A law authorizing an adult, 18 years or older, who meets certain qualifications and who has been determined by their attending physician to be suffering from a terminal disease, to request an aid-in-dying drug prescribed for the purpose of ending their life in a humane and dignified manner.

Physician's Orders for Life Sustaining Treatment (POLST) – A physician order form that addresses a patient's wishes about a specific set of medical issues related to end-of-life care. The form must be signed and dated by a physician and pt/representative to be valid.

VALID DNR ORDERS/FORMS

- EMSA/CMA Prehospital DNR form
- POLST form
- DNR wrist or neck medallion
- DNR order in the medical record of a licensed healthcare facility signed by a physician (or an RN verifying a valid verbal physician order on a physician order sheet), or an electronic physician's order
- Verbal DNR order given by the patient's physician
- An AHCD or DPAHC with the agent/attorney-in-fact physically present and stating the pt refuses resuscitative measures

DNR orders do not expire and photocopies/electronic physician's orders are considered valid

DNR, POLST & End Of Life Option Act

- **All pts shall receive an immediate assessment/evaluation by EMS personnel.**
- A copy of applicable DNR orders/forms shall be attached to the EMS patient care report (PCR) when available.
  - If DNR orders/forms are not available, document the method of DNR verification in the PCR.
  - If DNR bracelet or neck medallion present, document the medallion number in the PCR.
  - If applicable, document the name/contact information of any agent, attorney-in-fact or other pt representative.
- If pt is transported by EMS, DNR orders/forms shall be taken with the pt to the receiving facility.
- Pts with a POLST form indicating "Comfort-Focused Treatment", are typically only transported to a hospital if their comfort needs cannot be met in their current location/setting. These pts who have no signs of pain or respiratory distress, & who have sufficient family/caretaker support present, may be released at scene by EMS personnel & not transported to the hospital, unless transportation is requested by the patient/legal representative.
- EMS personnel shall contact the base/modified base hospital for consultation for any questions or concerns regarding EMS treatment/transport of a patient with a POLST form.
- Provide supportive care to family members/caregivers as appropriate.

DNR Pt

- Verify pt identity & confirm validity of DNR orders/form
- Provide palliative treatment for pain, dyspnea or other medical conditions
- If pt is in cardiac arrest, initiate BLS resuscitative measures pending confirmation of a valid DNR

Non-Cardiac Arrest

- If conscious, determine if pt wishes to have resuscitative measures/treatment other than as documented on the DNR orders/form
  - If yes, ignore the DNR orders & provide treatment per applicable S-SV EMS protocol(s)
  - If no, follow DNR orders
- If unconscious, follow DNR orders

Cardiac Arrest

- If pt has a valid DNR, discontinue CPR if already initiated
- If unable to validate DNR, or there is objection by family members/caretakers regarding withholding resuscitation, continue BLS resuscitative measures & consult with the base/modified base hospital

End of Life Option Act Pt

If a terminally ill individual appears to have ingested an Aid-in-Dying drug:

- Provide comfort care (e.g. oxygen, non-invasive airway positioning, suctioning) as indicated
- Determine whether there are DNR orders available, and follow such orders as applicable
- If family objects, consult with base/modified base hospital for consultation
- Do not start resuscitation measures if pt is in cardiac arrest

Sierra – Sacramento Valley EMS Agency Treatment Protocol	M-6P
Pediatric General Medical Treatment	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

- The purpose of this protocol is to provide standing order assessment/treatment modalities for pediatric pt complaints not addressed by other S-SV EMS treatment protocols – including nausea/vomiting, BRUE & suspected shock.
- Neonatal Resuscitation Protocol (C-1N) shall be utilized for pts during the first 28 days of life.
- Pediatric protocols shall be utilized for pts >28 days old up to and including 14 years of age.
- Utilize applicable adult protocols when there is not a pediatric protocol applicable to the pt's complaint/condition.
- A parent/reliable family member reported weight, length-based pediatric resuscitation tape or Handtevy shall be utilized for determining **sizes of equipment and defibrillation/cardioversion joule settings. Once weight has been determined, medication dosing should be based on S-SV EMS pediatric protocols.**

Normal Vital Signs & Hypotension Definition for Neonate & Pediatric Patients

Age	Normal Pulse Rate	Normal Resp. Rate	Normal SBP	Hypotension
<28 days	100 - 205	30 - 50	60 - 80	SBP <60
1-12 months	90 - 180	30 - 50	70 - 100	SBP <70
1-2 years	80 - 140	24 - 40	80 - 110	SBP <70 + age x2
3-5 years	65 - 120	20 - 30	90 - 110	SBP <70 + age x2
6-9 years	60 - 120	20 - 30	100 - 120	SBP <70 + age x2
10-14 years	50 - 100	12 - 20	100 - 120	SBP <90

BLS

- Assess V/S, including SpO_2 & temperature (if able)
- O_2 at appropriate rate if pt hypoxemic (SpO_2 <94%), short of breath, cyanotic, or has signs of shock
- Assess and obtain medical history

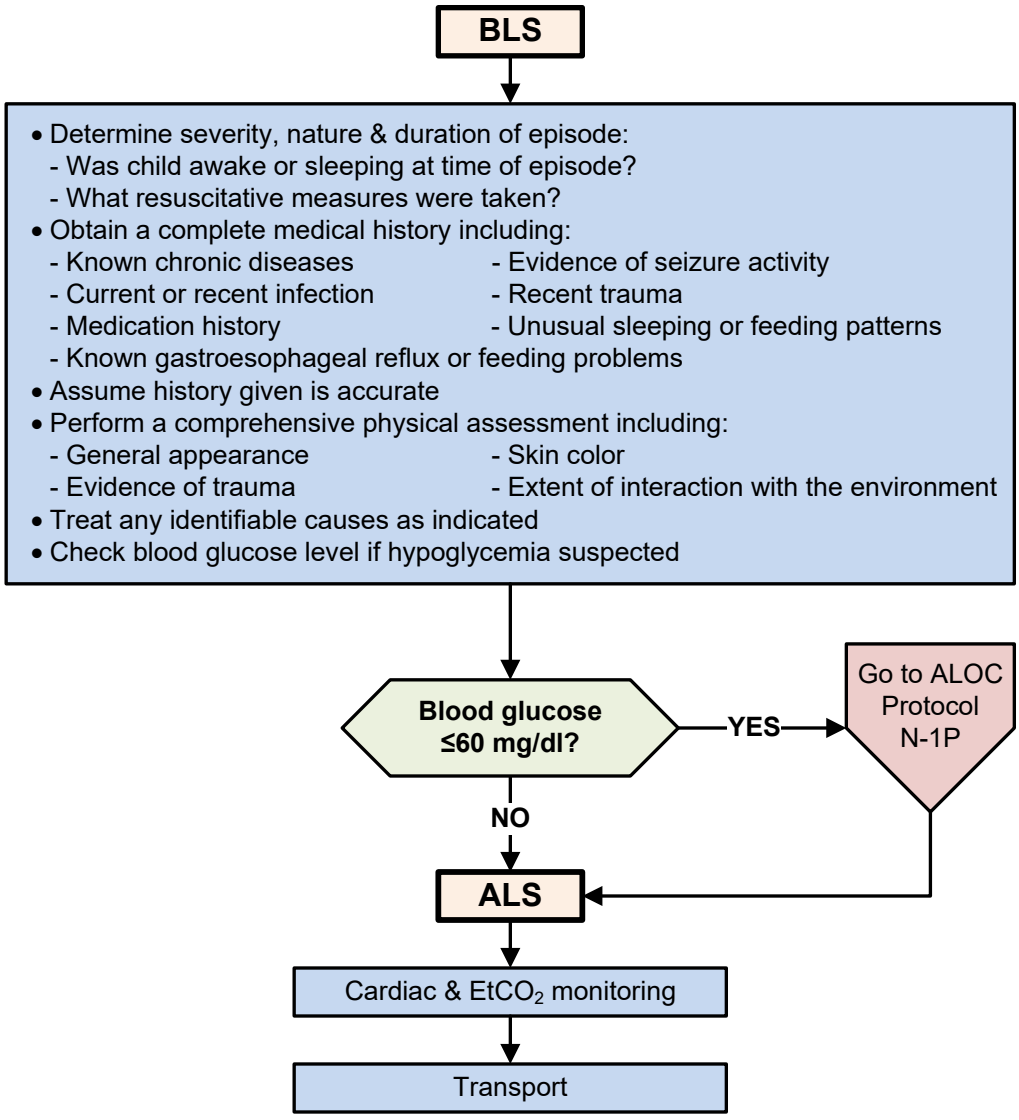
- Refer to other pages/sections of this protocol as applicable/appropriate:
  - BRUE - Page 2
  - Suspected Sepsis - Page 3
  - Nausea/Vomiting - Page 4

ALS

- Consider the following additional assessment/treatment modalities, as appropriate based on pt's condition & clinical presentation
  - Cardiac monitor/12-lead EKG
  - $EtCO_2$ monitoring
  - IV/IO NS 20 mL/kg, to max 1000 mL

Brief Resolved Unexplained Event (BRUE)

- Brief resolved unexplained event (BRUE) is an event occurring in an infant younger than one (1) year of age when the observer reports a sudden, brief (lasting <1 min, but typically <20-30 secs), and now resolved episode of any of the following:
  - Cyanosis or pallor
  - Marked change in tone (hyper- or hypotonia)
  - Absent, decreased, or irregular breathing
  - Altered level of responsiveness
- BRUE should be suspected when there is no explanation for a qualifying event after conducting an appropriate history & physical examination.
- All infants ≤1 year of age with possible BRUE should be transported by EMS for further medical evaluation. If the parent/guardian refuses EMS transport, base/modified base hospital consultation is required prior to release.
- EMS personnel shall make every effort to obtain the contact information of the person who witnessed the event, & provide this information to the receiving hospital upon pt delivery.



Suspected Shock/Sepsis

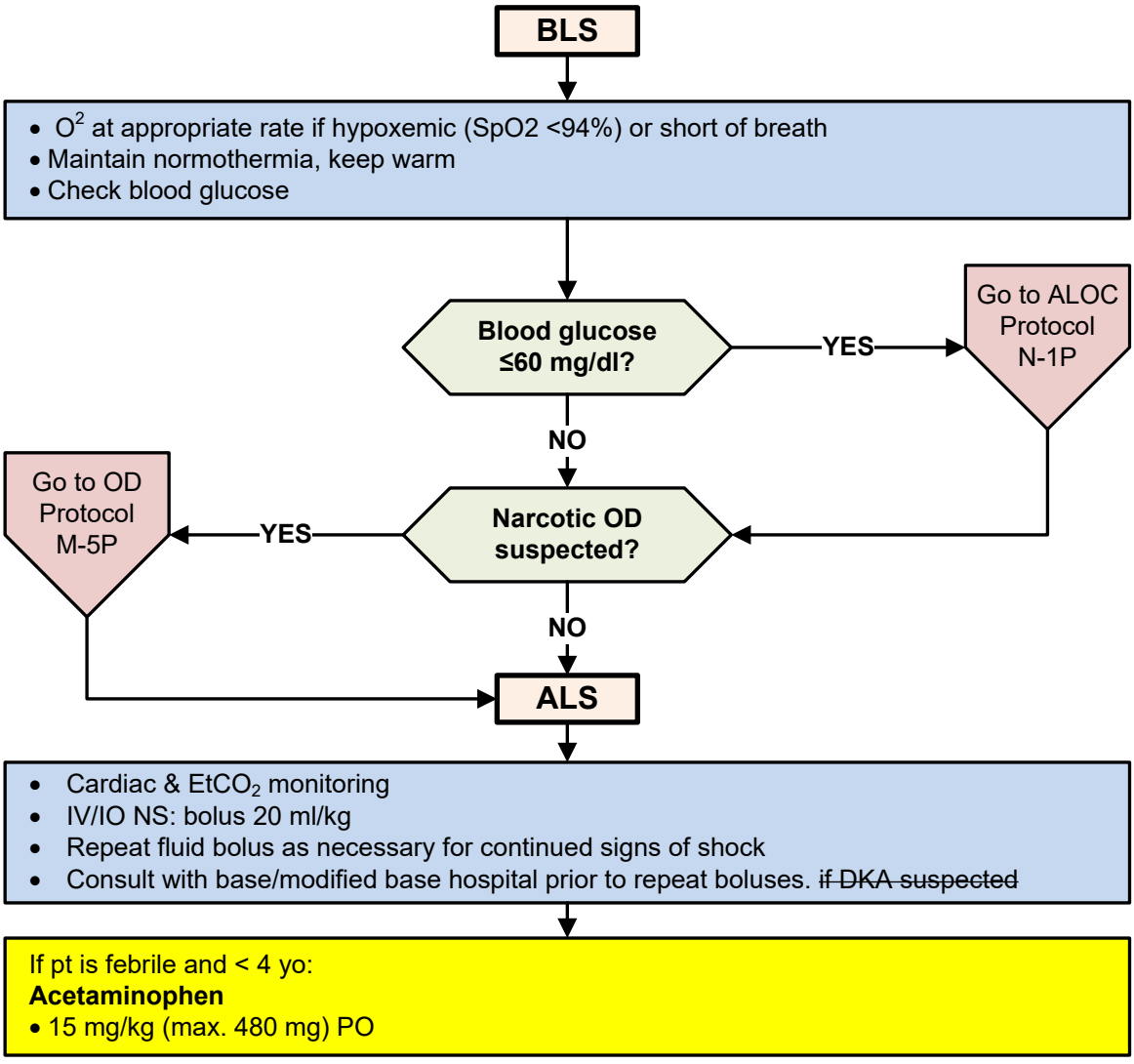
- Shock/Sepsis may be subtle and difficult to recognize.
- Early recognition of sepsis is critical to expedite hospital care and antibiotic administration.
- Septic pts are susceptible to traumatic lung injury. If BVM ventilation is necessary, avoid excessive tidal volumes.
- Obtain history including:
  - Onset and duration of symptoms
  - Fluid loss (vomiting/diarrhea)
  - Fever/Infection/Trauma/Ingestion
  - History of allergic reaction/cardiac disease or rhythm disturbance

Compensated Shock Signs/Symptoms:

- Tachycardia
- Cool extremities
- Weak peripheral pulses compared to central pulses
- Normal blood pressure

Decompensated Shock Signs/Symptoms:

- Hypotension &/or bradycardia (late findings)
- Altered mental status
- Decreased urine output
- Tachypnea
- Non-detectable distal pulses with weak central pulses



Nausea/Vomiting

- Nausea/vomiting can be symptoms of a multitude of different causes. If possible, the specific underlying cause should be determined and treated. The use of an antiemetic may relieve symptoms while leaving the cause untreated, and possibly, more difficult to detect. EMS personnel should weigh the benefits of antiemetic use against the possible risk of making an accurate diagnosis more difficult, and the possible side effects of the antiemetic agent.
- Treatment of nausea/vomiting is indicated for pts where it may contribute to a worsening of their medical condition, or where the pt's airway may be endangered.
- EMS personnel may consider administering Zofran (Ondansetron) prophylactically, prior to or immediately after opioid administration, for a pt with a history of nausea/vomiting secondary to opioid administration. Zofran (Ondansetron) may also be administered prior to transport to a pt with a history of motion sickness.

BLS

Assess/treat underlying cause of nausea/vomiting as appropriate

ALS

Zofran (Ondansetron)

Pediatric Pts (<4 yo)
- **0.15 mg/kg (max. 4 mg) IM, or slow IV/IO (over 60 seconds)**

BASE/MODIFIED BASE HOSPITAL ORDER ONLY

Pediatric Pts (4 - 14 yo)
- **4 mg oral disintegrating tablet, OR 4 mg IM, or slow IV/IO (over 30 seconds)**
- **Additional doses require base/modified base hospital consultation**

Zofran (Ondansetron) is contraindicated during the first 8 weeks of pregnancy

Sierra – Sacramento Valley EMS Agency Treatment Protocol	M-8P
Pediatric Pain Management	
Approval: Troy M. Falck, MD – Medical Director	Effective: 06/01/2024
Approval: John Poland – Executive Director	Next Review: 04/2027

- All pts with a report of pain shall be appropriately assessed and treatment decisions/interventions shall be adequately documented on the PCR.
- A variety of pharmacological and non-pharmacological interventions may be utilized to treat pain. Consider the pt's hemodynamic status, age, and previous medical history/medications when choosing analgesic interventions.
- Treatment goals should be directed at reducing pain to a tolerable level; pts may not experience complete pain relief.

BLS

- Assess V/S including pain scale & SpO_2, every 15 mins or as indicated by pt's clinical condition
- Assess/document pain score using standard 1-10 pain scale before and after each pain management intervention and at a minimum of every 15 mins
- O_2 at appropriate rate if hypoxemic (SpO_2 <94%) or short of breath
- Utilize non-pharmacological pain management techniques as appropriate, including:
  - Place in position of comfort and provide distraction/verbal reassurance to minimize anxiety
  - Apply ice packs &/or splints for pain secondary to trauma

Pain not effectively managed with non-pharmaceutical pain management techniques

Review/consider 'Medication Contraindications & Administration Notes' below & proceed to page 2

Medication Contraindications & Administration Notes

ⓘ **For pts < 4 yo, consult with base/modified base hospital prior to *medication administration***
ⓘ **All slow IVP medications contained in this protocol shall be administered over 60 seconds**

Acetaminophen
ⓘ Do not administer to pts with any of the following:
- Severe hepatic impairment
- Active liver disease

ⓘ Discontinue infusion if patient becomes hypotensive (see table on page 2)

Ketamine
ⓘ Do not administer to pts with any of the following:
- Pregnancy
- Multi-system trauma
- Suspected internal bleeding
- Active external bleeding

Ketorolac
ⓘ Do not administer to pts with any of the following:
- Pregnancy
- NSAID allergy
- Active bleeding
- Multi-system trauma
- ALOC or suspected moderate/severe TBI
- Current use of anticoagulants or steroids
- Hx of asthma, GI bleeding, ulcers
- Hx of renal disease/insufficiency/transplant

Fentanyl/Midazolam
ⓘ Do not administer to pts with any of the following:
- Hypotension (Pediatric Hypotension Table – page 2)
- SpO2 <94% or RR <12
- ALOC or suspected moderate/severe TBI

ⓘ There is an increased risk of deeper level of sedation & airway/respiratory compromise when administering midazolam to pts receiving fentanyl

ALS

- Continuous cardiac monitoring
- IV/IO NS TKO – if indicated by pt's clinical condition or necessary for medication administration
  - May bolus up to 20 mL/kg if indicated by pt's clinical condition
- Administer analgesic intervention as indicated below when appropriate

Non-Trauma Related/Chronic Pain

Acetaminophen: 15 mg/kg IV/IO infusion over 15 mins (max: 1000 mg) – single dose only; **OR**
Ketorolac: 0.5 mg/kg IV/IO or IM (max: 15 mg) – single dose only

If pain not effectively managed:

- Contact base/modified base hospital for additional pain management consultation

Pain Related to Acute Injury/Burns/Frostbite

Moderate Pain

Acetaminophen: 15 mg/kg IV/IO infusion over 15 mins (max: 1000 mg) – single dose
OR
Ketorolac: 0.5 mg/kg IV/IO or IM (max: 15 mg) – single dose

If pain not effectively managed:

- Continuous $EtCO_2$ monitoring

Fentanyl: 1 mcg/kg slow IV/IO or IM/IN (max single dose: 50 mcg) – may repeat every 5 mins to max 4 doses

Pediatric Normal SBP & Hypotension Table

Age	Normal SBP	Hypotension
1-12 mos	70-100	SBP <70
1-2 yrs	80-110	SBP <70 + age (yrs) x 2
3-5 yrs	90-110	
6-9 yrs	100-120	
10-14 yrs	100-120	SBP <90

Severe Pain

- Continuous $EtCO_2$ monitoring

Fentanyl: 1 mcg/kg slow IV/IO or IM/IN (max single dose: 50 mcg)
OR
Ketamine: 0.3 mg/kg slow IV/IO (max single dose: 30 mg)

Acetaminophen: 15 mg/kg IV/IO infusion over 15 mins (max: 1000 mg) – single dose

If pain not effectively managed:

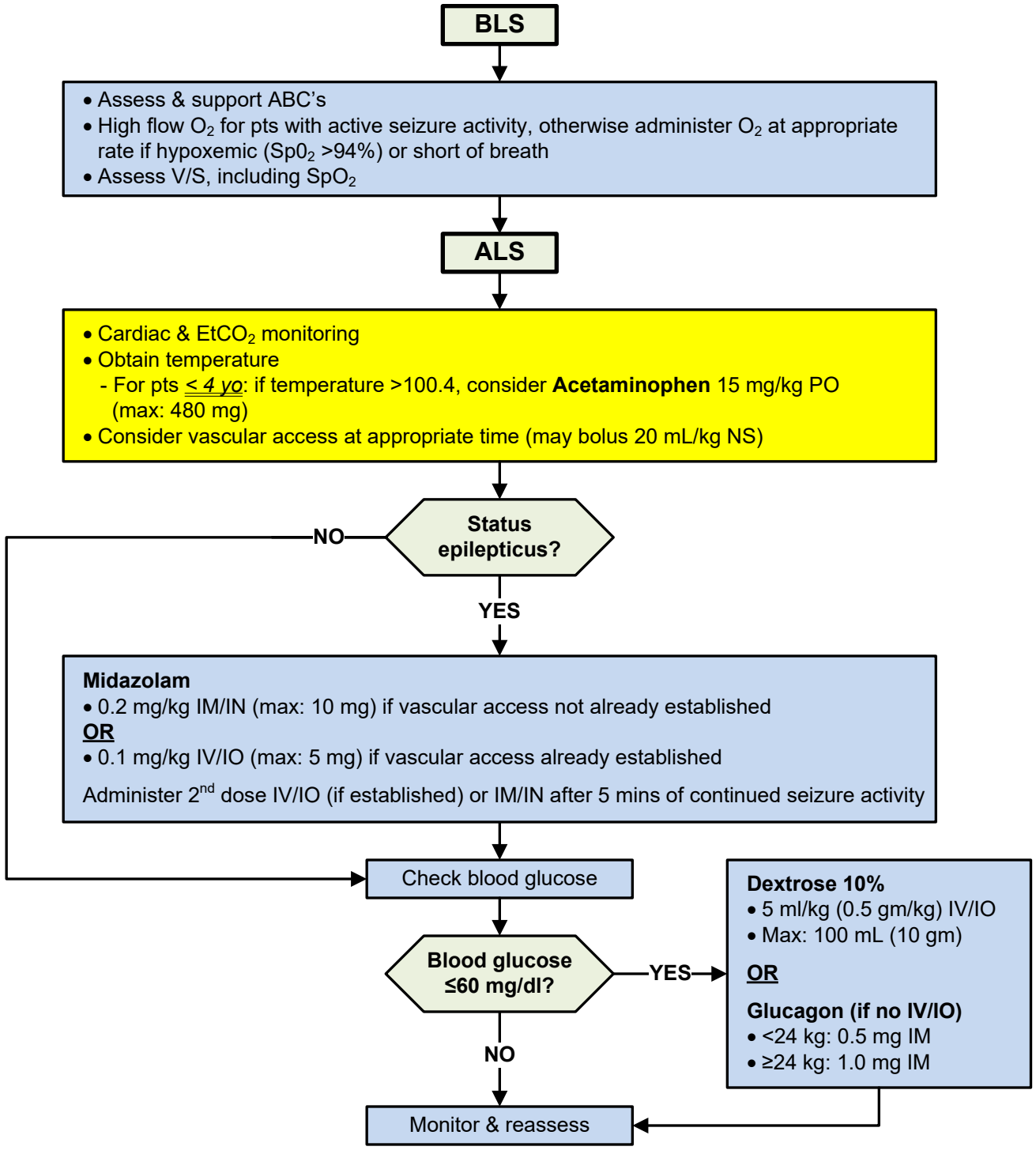
- If fentanyl previously administered, may repeat fentanyl every 5 mins to max 4 doses
- If ketamine previously administered, may repeat once after 10 - 15 mins to max 2 doses

&/OR
Midazolam: 0.05 mg/kg slow IV/IO (max single dose: 1 mg)

- May repeat once after 5 mins to max 2 doses
- Wait 5 mins after fentanyl/ketamine administration before administering midazolam

Sierra – Sacramento Valley EMS Agency Treatment Protocol	N-2P
Pediatric Seizure	
Approval: Troy M. Falck, MD – Medical Director	Effective: 06/01/2024
Approval: John Poland – Executive Director	Next Review: 04/2027

- **Febrile:** Cooling measures: loosen clothing and/or remove outer clothing/blankets.
- **Status Epilepticus:** 2 or more seizures without periods of consciousness, or a single seizure lasting >5 mins.
- Only continuous or repetitive seizure activity requires ALS intervention.



Sierra – Sacramento Valley EMS Agency Treatment Protocol	PR-1
12-Lead EKG	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

INDICATIONS

12-lead EKG procedures shall be performed on pts who present with one or more of the following:

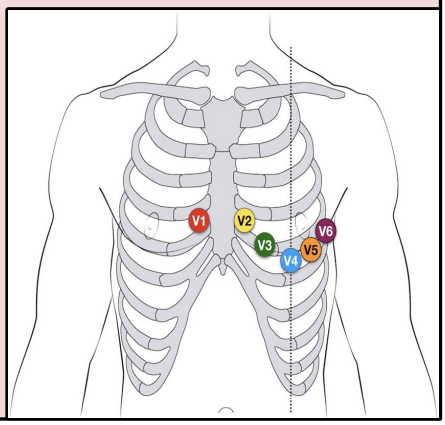
- Sign/symptoms suggestive of acute coronary syndrome (ACS) such as:
  - Non-traumatic chest or upper abdominal discomfort
  - Syncope/near-syncope
  - Acute generalized weakness
  - Dyspnea
- Cardiac dysrhythmias on 4-lead EKG
- ROSC following cardiac arrest

PRE-PROCEDURE

- Assess vital signs including SpO_2
- Administer O_2 as indicated by clinical condition

PROCEDURE

- Prepare EKG monitor and connect 12-lead cables
- Utilize packaged electrodes designed for single pt use (not bulk)
- Prep skin as necessary (e.g. wiping with 4x4 gauze, shaving)
- Enter, at a minimum, pt's age, gender, and last name/first initial into the cardiac monitor
- Apply chest leads using the landmarks indicated on the diagram
- While acquiring the 12-lead EKG:
  - Position pt away from 60hz RF noise (light switches, smartphones, LED lights, etc.)
  - Position pt supine, or semi-fowler with their arms at their side and legs uncrossed
  - Instruct pt to breath normally and remain still
  - Don't converse with or touch pt during acquisition
- Interpret the EKG findings
- If isoelectric line has significant artifact or machine reads "poor data quality" (or equivalent), attempt to reacquire a clean 12-lead EKG if pt condition allows



POST-PROCEDURE

- 12-lead EKG's meeting STEMI criteria shall be transmitted to the appropriate facility (closest hospital or STEMI Receiving Center depending on incident specific circumstances) as soon as possible if transmission capabilities are available
- For pts with suspected ACS, serial 12-lead EKGs should be obtained if the pt's clinical status changes or if EKG changes are noted on the cardiac monitor, and every 15 minutes if transport times are long
- Copies of 12-lead EKGs shall be provided to the receiving hospital physician upon EMS arrival, left at the receiving hospital at time of pt delivery, and attached to the EMS pt care report (PCR)

Sierra – Sacramento Valley EMS Agency Treatment Protocol	PR-3
Needle Cricothyrotomy	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

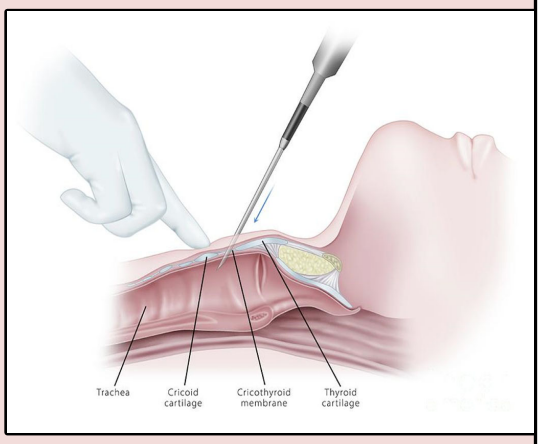
INDICATIONS

- Needle cricothyrotomy may be performed by paramedic personnel for unconscious pts ≥3 yo, when there is an inability to maintain the airway utilizing less invasive airway procedures due to one or more of the following:
  - Airway obstruction
  - Angioedema
  - Infection (e.g., epiglottitis)
  - Severe maxillofacial trauma
  - Laryngeal foreign body that cannot be removed expeditiously
  - Severe swelling of upper airway structures
  - Chemical or thermal burns to the epiglottis or upper airway
- Do not perform needle cricothyrotomy in a moving ambulance or if the pt has a midline neck hematoma or massive subcutaneous emphysema

PRE-PROCEDURE

- Attempt less invasive airway procedures, when indicated & appropriate

PROCEDURE



- Prepare equipment:
  - Oxygen source
  - Bag-valve-mask
  - Approved needle cricothyrotomy equipment
- Position pt supine with access to the base of the neck (hyperextend head/neck)
- Identify placement landmarks:
  - Thyroid cartilage
  - Cricoid cartilage
  - Cricothyroid membrane (between the thyroid and cricoid cartilage)
- Cleanse the site with an antiseptic solution
- Using the non-dominant hand, stabilize the area by placing the thumb and middle finger on both sides of the thyroid cartilage
- With syringe attached, insert needle/catheter through the cricothyroid membrane at midline, directing at a 45° angle caudally
- Aspirate to confirm proper placement in trachea
- Advance catheter while stabilizing needle
- Ventilate (1 second inflation, 2 second exhalation), observe chest rise & auscultate lungs
- Adequately secure catheter

POST-PROCEDURE

- Reassess for complications
- Administer high flow O_2 and monitor SpO_2
- Continuous cardiac and $EtCO_2$ monitoring

Sierra – Sacramento Valley EMS Agency Treatment Protocol	PR-4
PLEURAL DECOMPRESSION	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

INDICATIONS

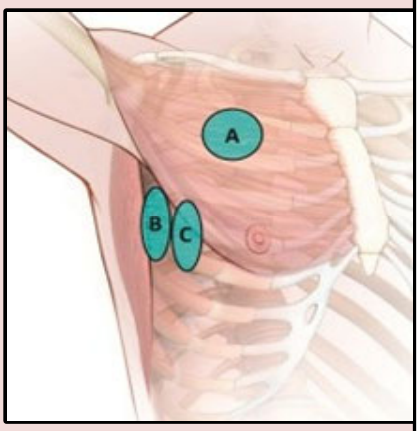
- Suspected tension pneumothorax with absent or diminished breath sounds & one or both of the following:
  - Combined hypotension (SBP <90) and SpO_2 <94%
  - Penetrating injury to the thorax
- Traumatic cardiac arrest if chest or multi-system trauma is suspected

PRE-PROCEDURE

- Assess respiratory status, manage airway & assist ventilations as appropriate
- Administer high flow O_2 & monitor SpO_2
- Assess & continually monitor vital signs

PROCEDURE

- Identify & prep the site - approved sites in preferred order:
  - **A** - Mid-clavicular line in the 2nd intercostal space
  - **B** - Mid-axillary line in the 4th or 5th intercostal space above the nipple line
  - **C** - Anterior axillary line in the 5th intercostal space above the nipple line



- Capnospot® Pneumothorax Decompression Indicator Procedure:
  - Use a minimum 14g x 3.25" catheter specifically designed for needle decompression
  - Attach Capnospot® Decompression Indicator to the catheter prior to insertion
  - Insert needle with syringe attached at a 90^0 angle, just over the superior border of the rib, & advance until air is freely aspirated or a “pop” is felt, then advance only the catheter until the hub rests against the skin
  - Observe for color change from blue to yellow within 10 secs to confirm catheter placement
- Simplified Pneumothorax Emergency Air Release (SPEAR®) Procedure:
  - Insert in accordance with manufacturer’s directions for use
- Adequately secure catheter
- If an initial attempt at 1 approved site is unsuccessful, consider utilizing an alternate approved site
- 2 attempts allowed on affected side(s) without base/modified base hospital contact

POST-PROCEDURE

- Reassess breath sounds
- Administer high flow O_2 & monitor SpO_2
- Continuous cardiac & $EtCO_2$ monitoring
- Assess & document vital signs every 3-5 mins (if possible)
- Monitor Capnospot® (if used) & breath sounds for signs of development of tension pneumothorax

Sierra – Sacramento Valley EMS Agency Treatment Protocol	PR-5
Venous Blood Draws	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

INDICATIONS

- Paramedics or AEMTs may perform blood draws on pts with a medical complaint, when there is an agreement to do so in place between the EMS provider agency & the receiving hospital
- Paramedics may perform chemical testing blood draws at the direction of law enforcement (LE) under the following parameters:
  - Fire department/district employees are not allowed to perform chemical testing blood draws
  - Personnel must be authorized to perform chemical testing blood draws by their employer
  - Medical treatment & emergency calls take precedence over chemical testing blood draw requests

PRE-PROCEDURE

- Assess for & provide medical treatment as indicated/appropriate

MEDICAL BLOOD DRAW PROCEDURE

- Select appropriate equipment & site:
  - If drawing blood from an IV catheter, attach blood draw adapter to the IV catheter hub & draw blood sample prior to IV fluid administration
  - If no IV has been established, or if IV fluids have been administered, prep site with an appropriate disinfectant agent, place tourniquet 3 - 4 inches above collections site & perform venipuncture
- Insert the blood tubes in the following order (releasing tourniquet when blood starts to flow):
  - Blue, Red, Green, Purple
- Apply slight pressure to the site with a gauze pad & secure with tape
- Gently invert each tube a few times (do not shake or mix vigorously)
- Label samples as follows:
  - Patient name & date of birth
  - Date & time of blood draw
  - EMS unit number
- Place labeled tubes in a specimen collection bag & turn over to appropriate hospital staff
- Adequately document medical blood draws on the PCR

CHEMICAL TESTING BLOOD DRAW PROCEDURE

- Suspects shall be in LE custody and shall consent to the blood draw - if the suspect refuses or is unable to consent, the paramedic shall stop the procedure immediately
- Paramedics shall not draw blood on a struggling or restrained suspect
- Blood draw kits shall be supplied by the requesting LE agency
- Alcohol or other volatile organic disinfectant shall not be used to clean the skin at the draw site - a suitable aqueous disinfectant (normally included in the LE supplied blood draw kit) shall be utilized
- The arresting officer must be present when the blood draw is performed & the blood sample is the property of the arresting officer
- In addition to routine incident information, the paramedic shall document the following on the PCR:
  - Blood draw kit number
  - Requesting officer's name & badge number
  - Suspect/Pt's consent for the procedure
  - Skin prep used and site of blood draw(s)

Sierra – Sacramento Valley EMS Agency Treatment Protocol	PR-6
Vascular Access	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

INDICATIONS

- Vascular access may be established by authorized EMS personnel when there is a current or anticipated need to administer intravenous medications/fluids.

ADDITIONAL DIRECTIONS/CONSIDERATIONS

- Do not delay transport to establish vascular access unless clinically necessary.
- Avoid establishing vascular access in an extremity with a functioning dialysis shunt unless no other vascular access is available/appropriate.
- Intraosseous (IO) access or external jugular (EJ) vein cannulation shall only be attempted if unable to establish peripheral vascular access & immediate medication/fluid administration is necessary.
- IO site selection is dependent on pt age/size/anatomy, presenting condition, ability to locate anatomical landmarks, provider training/experience, and clinical judgment.
- Preexisting Vascular Access Devices (PVADs) may be utilized for pts in extremis when no other vascular access is available/appropriate.
- Limit vascular access attempts to three (3) unless necessary for emergent treatment.
- 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.

INTRAOSSEOUS (IO) ACCESS

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.

Procedure:

- Prep site with a recognized antiseptic agent & wipe dry with a sterile gauze pad.
- Insert device per manufacturer specific instructions.
- Attach primed extension set to needle & secure needle per manufacturer instructions.
- For pts 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 pts - 40 mg.
    - Pediatric pts - 0.5 mg/kg (max: 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.
- Connect fluids to extension set – infusion may need to be pressurized to achieve desired rate.
- Dress site and secure tubing.

EXTERNAL JUGULAR (EJ) VEIN CANNULATION

Contraindications:

- Suspected coagulopathy (e.g. advanced liver disease, anti-coagulant medications)
- Suspected cervical spine injury
- Inability to tolerate supine position

Procedure:

- Place pt in Trendelenburg or supine position and elevate shoulders.
- Turn head 45° - 60° to side opposite of intended venipuncture site.
- Palpate to assure no pulsatile quality to vessel.
- Prep site with 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 & puncture vein midway between jaw & clavicle, over belly of sternocleidomastoid muscle.
- Maintain compression of vein at clavicle area until needle is withdrawn & IV tubing has been connected in order to prevent air from entering vein.
- Secure IV site.

PREEXISTING VASCULAR ACCESS DEVICE (PVAD) UTILIZATION

Contraindications:

- Subcutaneous access requiring special equipment & entry through the skin is not approved for use by EMS personnel

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 IV 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 & the damaged area to prevent air embolism or blood loss.

Sierra – Sacramento Valley EMS Agency Treatment Protocol	R-3P
Pediatric Respiratory Distress	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

- Consider respiratory failure for pts with a history of increased work of breathing & presenting with ALOC & a slow or normal respiratory rate without retractions.
- The hallmark of upper airway obstruction (croup, epiglottitis, foreign body aiway obstruction) is inspiratory stridor.
- Do not attempt to visualize the throat or insert anything into the mouth if epiglottitis suspected.

Continuous Positive Airway Pressure (CPAP) Utilization Information

- **Indications:**
  - CHF with pulmonary edema
  - Moderate to severe respiratory distress
  - Near drowning
- **Contraindications:**
  - <8 years of age
  - Agonal respirations
  - SBP <90
  - Respiratory or cardiac arrest
  - Inability to maintain airway
  - Major trauma/head injury/chest trauma
  - Suspected croup/epiglottitis
  - Suspected pneumothorax
  - Severe decreased LOC (unable to protect airway)
- **Complications:**
  - Hypotension
  - Pneumothorax
  - Corneal drying

Epinephrine Administration

- Epinephrine is indicated for pts with suspected asthma who are in severe distress.
- Administer Auto-Injector/IM epinephrine into the lateral thigh, midway between waist & knee.

BLS

- Assess & support ABCs
- High flow O_2
- Assess V/S, including SpO_2
- Assess history and physical, determine degree of illness
- Minimize stimulation – keep pt calm & consider allowing parent to hold the child &/or O2 delivery device if their presence calms the child
- Consider CPAP, when appropriate/indicated, for moderate to severe distress (pts ≥8 yo only)

Suspected asthma & in severe distress

YES

Epinephrine 1:1,000 IM (authorized & trained EMT personnel only)

- Patients 7.5 – 30 kg
  - 0.15 mg pediatric auto-injector

  OR
  - 0.15 mg (0.15 mL) via approved syringe
- Patients > 30 kg
  - 0.3 mg adult auto-injector

  OR
  - 0.3 mg (0.3 mL) via approved syringe

SEE PAGE 2 FOR ALS TREATMENT OF WHEEZING OR SUSPECTED CROUP/EPIGLOTTITIS

Wheezing

ALS

Mild Distress
- Mild wheezing
- Mild shortness of breath
- Cough

- Cardiac & $EtCO_2$ monitoring

Albuterol 5 mg & Ipratropium 500 mcg
- Nebulizer
- May repeat **(albuterol 2.5-5 mg only)** for continued respiratory distress

Moderate – Severe Distress
- Cyanosis
- Accessory muscle use
- Inability to speak >3 words
- Severe wheezing/shortness of breath
- Decreased or absent air movement

- Cardiac & $EtCO_2$ monitoring
- IV/IO NS (may bolus 20 mL/kg)

Albuterol 5 mg & Ipratropium 500 mcg
- Nebulizer, CPAP, or BVM
- May repeat **(albuterol 2.5-5 mg only)** for continued respiratory distress

Epinephrine 1:1,000 (for severe distress only)
- 0.01 mg/kg IM (max: 0.3 mg)

Suspected Croup/Epiglottitis

ALS

- Cardiac *& $EtCO_2$* monitoring
- Consider nebulized saline
- ***Minimize pt stimulation***
- If full upper airway occlusion suspected – ensure proper airway positioning & BVM seal, attempt to ventilate & reassess – ***DO NOT ATTEMPT I-GEL***

Unable to ventilate/maintain airway utilizing less invasive procedures?

YES → Perform needle cricothyrotomy as airway of last resort

NO

Base/Modified Base Hospital Order Only

Racemic epinephrine
- One (1) - 0.5 ml vial of 2.25% inhalation solution (mix with NS to = 5 ml of volume)

OR

Nebulized epinephrine
- 1:1000 - 0.5 mL/kg (max: 5 mL) nebulizer or BVM (if <5 mL, mix with NS to = 5 mL of volume)