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

MEETING AGENDA

Meeting Date & Time
• **Tuesday, October 15, 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/82284088099?pwd=cE01U0RxUjBQQlBidnQxdUI0QVY5QT09 • **Telephone:** (669) 900-9128, **Meeting ID:** 822 8408 8099, **Passcode:** 1702 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** (July 16, 2024)	**Chairperson**
C	**Approval of Meeting Agenda**	**Chairperson**
D	**Public Comment**	**Attendees**
E	**S-SV EMS Policy Actions**	**S-SV EMS Staff**
(E-1)	**410:** EMS Service Provider Permit	Trenton Quirk
(E-2)	**701:** ALS Provider Agency Inventory Requirements	Trenton Quirk
(E-3)	**508 & 508-A:** Ambulance Patient Diversion	Trenton Quirk
(E-4)	**807:** COVID-19 Testing Sample Collection By EMS Personnel	Trenton Quirk
(E-5)	**808 & 808-A:** EMS Personnel Administration Of Intramuscular Influenza &/Or COVID -19 Vaccine	Trenton Quirk
(E-6)	**1007:** EMS Student Field Training	Trenton Quirk

Sierra – Sacramento EMS Agency – REMAC Meeting Agenda

Item	Title	Leader
(E-7)	**1110-H:** Infrequently Used Skills Verification Checklist Adult Cardioversion/Defibrillation	Brittany Pohley
(E-8)	**C-1:** Non-Traumatic Pulseless Arrest	Brittany Pohley
(E-9)	**C-4:** Tachycardia With Pulses	Brittany Pohley
(E-10)	**M-3:** Phenothiazine/Dystonic Reaction	Brittany Pohley
(E-11)	**M-11P:** Pediatric Behavioral Emergencies	Brittany Pohley
(E-12)	**N-3:** Suspected Stroke	Brittany Pohley
(E-13)	**OB-G1:** Childbirth	Brittany Pohley
(E-14)	**OB-G2:** Obstetric Emergencies	Brittany Pohley
(E-15)	**T-4:** Hemorrhage	Brittany Pohley
(E-16)	**G-1:** Multiple Patient Incidents/S-SV EMS Regional MCI Plan	Brittany Pohley
F	**EMS Aircraft Provider Reports**	**Attendees**
G	**EMS Ground Provider Reports**	**Attendees**
H	**Hospital Provider Reports**	**Attendees**
I	**S-SV EMS Agency Reports**	**S-SV EMS Staff**
(I-1)	**EMS Data System**	Jeff McManus
(I-2)	**EMS Quality Management/QI Initiatives**	Michelle Moss
(I-3)	**Regional Specialty Committees**	Michelle Moss
(I-4)	**Operations**	Patrick Comstock
(I-5)	**Regional Executive Director's Report**	John Poland
(I-6)	**Medical Director's Report**	Troy M. Falck, MD
J	**2025 REMAC Meeting Schedule & Adjournment:** • January 21, 2025 • April 15, 2025 • July 15, 2025 • October 21, 2025	**Chairperson**

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

MEETING MINUTES

Meeting Date
Tuesday, July 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: April 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 run review at Sutter Roseville in September, the date is TBD.

E. S-SV EMS Policy Actions

Policy Actions for Final Review & Approval:

Policy	Name	Motion	Second	Committee Vote
830 (830)A	**Suspected Child Abuse/Neglect Reporting** • There were no recommended changes to this policy. • The contact information was updated.	Dr. Iwai	Dr. Morris	Passed Unanimously
832 (832)A	**Suspected Elder/Dependent Adult Abuse Reporting** • There were no recommended changes to this policy. • The contact information and the link were updated.	Dr. Iwai	Dr. Morris	Passed Unanimously

852	**Patient Restraint Mechanisms** • Removed protocol language under Chemical Restraint. • Added a reference to M-11 and M-11P to reduce the language. • On page 2, line 22, “It” should be changed to “If”.	Debbie Madding	Dr. Iwai	Passed Unanimously
904	**EMR Initial & Renewal Certification** • S-SV EMS is going to an online certification process, the language in this policy was updated to reflect the new process.	Debbie Madding	Dr. Goldsmith	Passed Unanimously
913	**Paramedic Accreditation** • S-SV EMS is going to an online certification process, the language in this policy was updated to reflect the new process.	Debbie Madding	Dr. Goldsmith	Passed Unanimously
915	**MICN Authorization/Reauthorization** • S-SV EMS is going to an online certification process, the language in this policy was updated to reflect the new process.	Debbie Madding	Dr. Goldsmith	Passed Unanimously
927	**EMS Incident Reporting & Investigation** • On page 2, added lines 42-43. • On page 3, added Item J at the top. • On page 3, under Policy, item 2.	Dr. Iwai	Josh Sher	Passed Unanimously
G2	**Determination Of Death (formerly Policy 820)** • This was previously a policy that has been converted to a protocol. • The information is now in an algorithm format to make it easier. • On the bottom of page 1, the very last sentence, it was recommended to change ‘each lead’ to ‘2 leads’ to match the language on page 2.	Rich Lemon	Dr. Iwai	Passed Unanimously

G3	**DNR, POLST & End of Life Option Act (formerly Policy 823)** • This was previously a policy that has been converted to a protocol. • The information is now in an algorithm format to make it easier.	Dr. Iwai	Debbie Madding	Passed Unanimously
M-6P	**General Pediatric Protocol** • This protocol was introduced at the April meeting, but not voted on due to changes that needed to be made. • On page 1, in the top box, last bullet point, the verbiage in red is the new addition. • On page 1, the systolic blood pressures were corrected. • On page 3, at the very bottom, Acetaminophen was added for febrile patients with a dosing. • On page 4, in the Zofran box, added "BASE/MODIFIED BASE HOSPITAL ORDER ONLY".	Dr. Iwai	Rich Lemon	Passed Unanimously
M-8P	**Pediatric Pain Management** • On page 1, under "Medication Contraindications & Administration Notes", added the highlighted box.	Dr. Iwai	Rich Lemon	Passed Unanimously
N-2P	**Pediatric Seizure** • Under the ALS box, in the highlighted box, added '≤4 yo'.	Dr. Iwai	Rich Lemon	Passed Unanimously
PR-1	**12-Lead EKG** • This was converted to a protocol from a policy. • No changes have been made.	Dr. Iwai	Dr. Morris	Passed Unanimously
PR-3	**Needle Cricothyrotomy** • This was converted to a protocol from a policy. • No changes have been made.	Dr. Iwai	Dr. Morris	Passed Unanimously
PR-4	**Pleural Decompression (formerly Protocol T-2)** • Michelle presented 2 new devices that will help to confirm Medics are in the correct space, one or the other will be mandatory to stock. • The cost is about $35 - $40 per device.	Dr. Iwai	Dr. Morris	Passed Unanimously

PR-5	**Prehospital Blood Draws (formerly Policy 1108)** • There were no changes.	Dr. Iwai	Dr. Morris	Passed Unanimously
PR-6	**Vascular Access** • This was reorganized to put IO in front of EJ. • The pictures were removed. • No other changes were made. • It was suggested to add the approved sites under the IO box.	Dr. Iwai	Dr. Morris	Passed Unanimously
R-3P	**Pediatric Acute Respiratory Distress** • This was brought back from the April meeting due to some changes. • On page 1, in the bottom box, added "authorized & trained EMT personnel only" under Epinephrine. • Changed the weight for patients from 15 to 7.5kg • On page 2, Racemic Epinephrine was separated into the bottom box. Added "Unable to ventilate/maintain airway utilizing less invasive procedures?" above the Racemic Epinephrine box. • It was recommended to add the age cut-off. • It was recommended to add a reference page for pediatric ages w/calculations, in the M6-P as well as in the app.	Dr. Iwai	Dr. Morris	Passed Unanimously

F. EMS Aircraft Provider Updates

- REACH – Q3 adding finger thoracostomy for RNs only. They had a slight reorganization; Jimmy Garcia moved back into the Sacramento area, and Micah Redmond will be Redding. They've been doing some various fire drills and LZ training.

G. Ground EMS Provider Updates

- Dignity Ambulance:
  - Hiring and onboarding new hires now.
  - Operations will be moving from their current location in Anderson to a new location in Redding.
  - DMSU is now being provided by Dignity Health.
  - IN the process of airway training, and recently spent $10K on new training aids.
  - St. Es purchased 4 new Zoll monitors.
  - Staffing has transitioned to a dual medic component, on their 911trucks.
- AMR Shasta:
  - Recently hired 15 staff members and as of 8/1 they'll be fully staffed.
  - Another BLS rig 7 days/week was added and should be up and running by mid-August.

- Bi-County Ambulance:
  - Continually hiring staff.
  - Researching video-laryngoscope.
  - Dara Dunn has been training staff on airways with a homemade dummy.
  - Been training a lot on pain meds.
- AMR:
  - Hired 33 in June.
  - Training on difficult airways with the help of pig lungs.

H. Hospital Provider Updates

- Sutter Roseville:
  - They've hired a lot of nurses, currently have over 100 MICNs.
  - Debbie Madding does a large audit of radio calls for the MICNs.
- UC Davis Medical Center:
  - Yesterday 24 additional beds were opened.
  - A new ambulance bay has been opened.
  - Conducting MICN education on increasing the number of immediate patients they can take from MCI, currently process is to take 5 immediate adults and always the first 6 pediatric patients.
- Kaiser Roseville Medical Center:
  - Construction continues. The only entrance for ambulance traffic is Lead Hill and will remain so for a while. Construction is supposed to continue through 2027.
  - Construction should add another 36 beds to their current 140.
  - They've been working on a big APOT project and have been concentrating heavily on EMS since January.
  - Chris Britton presented APOT project.
- Mercy Redding:
  - Trauma survey is scheduled for next week.
  - They are continuing their ED intensive 12-hour course for their ED nurses, which includes MCI and triage drills.
  - They're working on a project for pediatric transfers when there's bad weather.
  - Working on a goal to get all of their RNs to become MICNs.
  - MMCR/St. E: Heidi Henderson and Kevin Baird presented on VAN score project.
- Sutter Auburn Faith
  - Dr. Iwai presented a unique case which allowed for discussion by the Committee.

I. S-SV EMS Agency Reports

- **EMS Data System**
  - There is a procedure schematron – with a limited procedure list which will be available until 8/1/24. The State will also be implementing their own medication and procedure list within a year or so. Jeff is sending out an update to the schematron today, please make sure it's applied to your system by August 1st.
  - Jeff created a new interactive dashboard. Imports are listed on the dashboard.
  - The State is cracking down on compliance.

- S-SV is working on a new patient specialty registry which will be in addition to the State registry. This will be for Stroke, STEMI and Trauma and should be available by October.

- **EMS Quality Management**
  - There were a couple of changes to the app: new calculators (which are connected to the referenced peds protocols), the search function will be improved (they are currently working on this), pain calculators were added.
  - The focus this year is airway management and pain skills.
  - 350 Medics, to date, have completed the mandatory annual Regional Training Module.
  - Working on an MCI spreadsheet which will be looking at a clinical standpoint as well.
  - Brittany asked providers for airway reports, it was sent only to ALS ground providers and currently only have 19 of 36 audits returned.

- **Regional Specialty Committees**
  - The most recent Trauma QI meeting was in May.
  - The next STEMI QI meeting is in September.
  - There is a new registry coming that will include all the specialties.

- **Operations**
  - All of the FY2024-25 annual provider permits are done. Ambulance inspections have begun and will continue over the next few months.
  - There is a new licensed management system that is in the very last stages of completion. This is a third-party management system that should be completed in the next week or so. This will house all the certifications for EMTs, Medics, MICNs, and EMRs. Applicants can create an account and should make things easier for everyone.
  - S-SV is doing a website refresh currently. The website will be more user-friendly. This should be live in the next few days.
  - A new MCI protocol/plan is in the works. This should be a much simpler process that it currently is. It will be brought to the next REMAC meeting for review.
  - The State EMS Authority is in the process of renumbering all of the current EMS regulations. As the come up, S-SV EMS will make the changes. They haven't added any language but have moved a few things. They will also be updating all of the other regulations. They are also working on the 'Chapter 1' regulations.
  - Mary Thomas is the new RDMHS for S-SV EMS.
  - There was an ambulance strike team deployment on the Butte County Fire. They were in place for about 24 hrs.
  - There is an Ambulance Strike Team leader class on 8/27, in Redding, at the Shield Training center. S-SV is currently working on cleaning up a list that was provided by the State, to make sure it's updated.
  - Updating the MCI plan/policy. Trent gave a quarterly MCI report.

- **Regional Executive Director's Report**
  - Continued discussions with the US Forest Service. Their current EMS contractor procurement process is in direct conflict with EMS Statutes and regulations in California. There was an incident last night where one of their out-of-state ambulances was turned away due to critical brake and drive line issues and didn't pass the inspection. S-SV is reaching out to the EMS Authority for an official legal position on these issues. Please reach out to John Poland with any questions.

J. Medical Director's Report

- The mandatory Regional Training Module is due by 12/31/24. Please encourage everyone to get this done.
- The National Pre-Hospital Pediatric Readiness Project – provider agencies should have received multiple emails regarding completing a survey. The information collected is vital to improve care going forward. S-SV doesn't get the complete information but can see if it has been completed. There are about 200 questions and will probably take about an hour to complete. The deadline for completing this is 7/31/24. If you need the link for this, please reach out to Brittany Pohley.
- Dr. Falck thanked everyone for their participation in this meeting today.

K. Next Meeting Date & Adjournment

- October 15, 2024, at 9:00 am.
- The meeting was adjourned at 11:34 am.

Sierra – Sacramento Valley EMS Agency Program Policy			
EMS Service Provider Permit			
	Effective: DRAFT	Next Review: DRAFT	**410**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish the criteria for when an EMS Service Provider Permit is required, the process for obtaining a permit, and the grounds for permit denial, suspension, or revocation.

AUTHORITY:

A. HSC, Division 2.5, § 1797, et seq.

B. CCR, Title 22, Division 6, Chapter 8, § 87465 and 87469.

C. CCR, Title 22, Division 9, Chapter's 2, 3, 4, 8 & 12.

D. CCR, Title 13, § 1100 et seq.

POLICY:

A. A permit is required to provide any of the following EMS services within the S-SV EMS jurisdictional region:

1. BLS, LALS, ALS and/or CCT ground ambulance transport services.

2. LALS and/or ALS non-transport services.

3. EMS aircraft services.

4. BLS, LALS and/or ALS special event/standby services.

B. Permits are issued on a temporary or annual basis as follows:

1. Temporary permits are only issued for BLS special event/standby services.

2. An annual permit is required for all other types of EMS services. Annual permit holders may also provide BLS special event/standby services without obtaining a temporary permit.

C. BLS non-transport public safety agencies, organizations that have an exclusive operating agreement (EOA) with S-SV EMS, and EMS services provided as a result of an automatic or mutual aid request are exempt from the permit requirement.

PROCEDURE:

A. Temporary EMS Service Provider Permit:

1. Permit applications may be obtained from S-SV EMS. Completed applications, including all required supporting documentation, shall be submitted to S-SV EMS at least seven (7) working days prior to the event. Incomplete applications will not be processed.

2. Approved permit holders shall ensure that all personnel providing BLS special event/standby services have appropriate credentials and training to provide such services. This training shall include instructions to immediately call 9-1-1 and request an S-SV EMS authorized emergency transport provider if EMS transportation is necessary.

3. Approved permit holders shall have all necessary medical equipment and supplies available on site to provide BLS patient assessment and treatment.

B. Annual EMS Service Provider Permit:

1. Permit applications may be obtained from S-SV EMS. Completed applications, including all required supporting documentation *and associated fees*, shall be submitted/*paid* to S-SV EMS. Incomplete applications will not be processed. Completed applications will be processed within 30 calendar days of submission.

2. Permit holders shall submit a completed renewal application, including all required supporting documentation, to S-SV EMS ~~on an annual basis~~ *by May 31st of each year*. Renewal applications will be provided *by S-SV EMS to current permit holders* at least 30 calendar days prior to the application due date.

3. Upon receipt of a completed permit application, S-SV EMS will do the following:

- Perform a review of the application and all supporting documentation.
- Perform a background investigation of applicant (if required).
- Review the application and proposed services for compliance with State law, regulations and S-SV EMS requirements.
- Perform an inspection of vehicles and/or stations (as applicable) to verify compliance with S-SV EMS requirements.
  - Initial applicant inspections are required prior to service implementation.
  - Renewal applicant inspections will occur annually.

- Issue an EMS Service Provider Permit if all requirements are met and there are no grounds for denial or issue a written notice of permit denial if applicable.
  - *All initial and renewal EMS service provider permits will receive an expiration date of June 30th of the following calendar year.*

C. Denial, Suspension, or Revocation of an S-SV EMS Service Provider Permit:

1. A determination by S-SV EMS that an applicant or permit holder meets any of the following conditions may result in denial, suspension, or revocation of an EMS Service Provider Permit:

   - Failure to provide a complete application.
   - The applicant proposes to operate a service within an area where another organization has been granted an EOA to provide such service.
   - The applicant has previously had an application, permit, or agreement denied, suspended, or revoked, and the status of such denial, suspension, or revocation directly affects their present ability to provide adequate services.
   - The applicant/permit holder has a criminal record which reasonably indicates they would be unlikely to fulfill the responsibilities of providing such services.
   - There is reasonable cause to believe that the applicant/permit holder will not provide services in a manner that will promote the health and welfare of individuals within the S-SV EMS region.
   - Failure to comply with applicable State laws, regulations and/or S-SV EMS requirements.
   - The applicant/permit holder does not have the required medical equipment/ supplies for their units.
   - Failure to maintain required performance standards.
   - Failure to pay required permit and/or monitoring fees.
   - The applicant/permit holder or their personnel exhibit unprofessional conduct.

2. If an EMS Service Provider Permit is denied, S-SV EMS will provide written notice of the reason for denial, and specific recommendations to fulfill compliance requirements (if any) within 30 calendar days of receiving a completed application.

   - If a public safety agency's permit application to provide LALS and/or ALS service is not timely approved or is denied, an appeal shall be conducted in conformance with the administrative adjudication proceedings set forth in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the California Government Code. A final decision rendered pursuant to this appeal may be further appealed to a court of competent jurisdiction.
   - If a private provider's EMS service provider permit application is not timely approved or is denied, an appeal may be made to the S-SV EMS JPA Governing Board of Directors. The decision rendered by the S-SV EMS JPA Governing Board of Directors shall be final.

3. If an EMS Service Provider Permit is suspended or revoked, S-SV EMS will provide written notice of the reason for the suspension or revocation. This written notice will include the effective date of such suspension or revocation and any requirements necessary to become compliant (if applicable).

Sierra – Sacramento Valley EMS Agency Program Policy			
Ambulance Patient Diversion			
	Effective: DRAFT	Next Review: DRAFT	**508**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish circumstances/requirements for hospital diversion of ambulance patients.

AUTHORITY:

A. HSC, Division 2.5, § 1797.67, 1797.88, 1797.220 & 1798.

B. CCR, Title 22, Chapter 4, § 100169 and 100170.

C. CCR, Title 13, § 1105(c).

DEFINITIONS:

A. **Diversion –** The closure of a hospital's emergency department (ED) from receiving ambulance patients, including any specialty services.

B. **Internal Disaster –** An unforeseeable physical or logistical situation/circumstance (fire, flood, facility damage, loss of critical utilities, hazmat, highly infectious patient, active shooter, bomb threat, patient surge resulting from an unprecedented incident, etc.) that curtails routine patient care and renders continued ambulance patient delivery unsafe.

POLICY:

A. Ambulance patient diversion often causes significant impacts on the EMS system as well as patients/family members and has a high potential to negatively impact patient care. Diversion must only be considered when conditions exist that negatively and profoundly impact the hospital's ability to provide safe/timely patient care, and after all appropriate diversion avoidance measures have been taken.

B. Causes for ambulance patient diversion include any of the following:

1. Inoperable Computed Tomography (CT) Scanner Diversion: If the CT scanner is inoperative, patients with neurological signs/symptoms of a possible acute stroke or head injury may be diverted to the next closest hospital providing similar services.

2. Trauma Diversion: Trauma receiving centers may divert patients meeting trauma triage *criteria* under ~~one~~ *either* of the following circumstances:
   - Critical diagnostic/treatment equipment failure.
   - The trauma services medical director/designee determines their hospital is unable to care for additional trauma patients.

3. STEMI Diversion: STEMI receiving centers may divert suspected STEMI patients under ~~one~~ *either* of the following circumstances:
   - Critical diagnostic/treatment equipment failure or scheduled maintenance.
   - The STEMI services medical director/designee determines their hospital is unable to care for additional STEMI patients.

~~4. Patient Surge Limited Diversion: An S-SV EMS hospital may divert patients originating from outside the S-SV EMS region, when the hospital determines that continuing to accept these patients will negatively impact their ability to care for S-SV EMS patients (including when the diversion criteria from the LEMSA where the transport originated is met).~~
   - ~~The following types of patients shall not be diverted by an S-SV EMS hospital on limited diversion, when they are the time closest hospital to the incident location:~~
     - ~~Cardiac arrest~~
     - ~~Unmanageable airway~~
     - ~~Shock, not responsive to field treatment.~~
     - ~~Third trimester OB patients with imminent delivery.~~
     - ~~Trauma patients meeting trauma triage criteria (if the hospital is a designated trauma receiving center and is not on trauma diversion).~~
     - ~~Suspected STEMI patients (if the hospital is a designated STEMI receiving center and is not on STEMI diversion).~~
     - ~~Suspected acute stroke patients (if the hospital is a designated stroke receiving center and has an operable CT scanner).~~
   - ~~Prior to initiating a limited diversion, the hospital shall obtain S-SV EMS Duty Officer (DO) approval, and notify any applicable EMS dispatch center(s).~~

5. Patient Surge ~~Complete~~ Diversion: If a hospital is unable to safely care for additional patients due to a surge event, they may request/initiate ~~complete~~ ambulance patient diversion ~~as follows~~ *pursuant to the following procedures*:
   - Hospital staff/administration must exercise measures to resolve the conditions resulting in the need to initiate diversion, including but not limited to:
     - Increase in ED and/or other hospital staff.
     - Activation of backup patient care/diagnostic areas.
     - Cancellation of elective surgical procedures, expedited patient discharges and patient transfers to other facilities (when appropriate).
   - Diversion authorization must be obtained from all of the following entities:
     - ED supervisor/designee or house supervisor/designee.
     - ED physician director/designee.

- Trauma and/or STEMI physician director/designee (if applicable).
- Hospital CEO/designee.
- S-SV EMS Duty Officer (DO).

- The S-SV EMS DO will complete the following prior to authorizing a diversion request:
  - Review the information from the requesting hospital to confirm that appropriate diversion avoidance measures have occurred, and that diversion is necessary.
  - Contact the ED supervisor of the next closest hospital to assess their current status and what impact the diversion would have on their facility.
- Any of the following will result in denial of a diversion request:
  - The hospital did not submit an 'Ambulance Patient Diversion Form'.
  - The hospital has not taken adequate diversion avoidance measures.
  - The next closest hospital is unable to absorb the anticipated additional impact resulting from approving the diversion request.
- *The following types of patients shall not be diverted by a hospital on patient surge diversion, when they are the time closest hospital/specialty patient receiving center to the incident location:*
  - *Cardiac arrest*
  - *Unmanageable airway*
  - *Shock, not responsive to field treatment.*
  - *OB patients with imminent delivery.*
  - *Trauma patients meeting trauma triage criteria (if the hospital is a designated trauma receiving center and is not on trauma diversion).*
  - *Suspected STEMI patients (if the hospital is a designated STEMI receiving center and is not on STEMI diversion).*
  - *Suspected acute stroke patients (if the hospital is a designated stroke receiving center and has an operable CT scanner).*

6. Internal Disaster:
   - Any hospital may initiate diversion during an internal disaster incident.

C. EMResource Utilization:

Any hospital that initiates diversion shall update their status on EMResource as follows:

1. Inoperable CT Scanner:
   - Update EMResource status to 'Advisory', indicate the CT scanner is inoperable.
   - Update EMResource status to 'Open' when the issue has been resolved.

2. Trauma Diversion:
   - Update EMResource status to 'Trauma Diversion'.
   - Update EMResource status to 'Open' when the issue has been resolved.

3. STEMI Diversion:
   - Update EMResource status to 'STEMI Diversion'.
   - Update EMResource status to 'Open' when the issue has been resolved.

4. Patient Surge ~~Limited or Complete~~ Diversion:
   - Update EMResource status to 'Diversion' and add appropriate comments.
   - Update EMResource status to 'Open' when the issue has been resolved.

5. Internal Disaster:
   - Update EMResource status to 'Internal Disaster' and add appropriate comments. The S-SV EMS DO may also update the status of a hospital on internal disaster when requested/necessary.
   - Update EMResource status to 'Open' when the issue has been resolved.

D. Documentation

Any hospital that initiates diversion shall complete and submit the 'Ambulance Patient Diversion Reporting Form' (508-A) to S-SV EMS as follows:

1. Inoperable CT Scanner: Complete/submit the form by the end of the next business day (only if CT scanner is inoperable ≥24 hours, otherwise no reporting is required).

2. Trauma Diversion: Complete/submit the form by the end of the next business day.

3. STEMI Diversion: Complete/submit the form by the end of the next business day.

4. ~~Patient Surge Limited Diversion: Complete/submit form by the end of the next business day.~~

5. Patient Surge ~~Complete~~ Diversion: Completed/submit the form prior to initiating patient diversion. An updated form shall be submitted every three (3) hours until the incident is resolved.

6. Internal Disaster: Complete/submit the form as soon as possible.

E. Additional Diversion Procedures:

1. If a hospital is on patient surge ~~complete~~ diversion, and an adjacent hospital requests to initiate a similar type of diversion, both hospitals will be required to submit an updated 'Ambulance Patient Diversion Form' describing their current status/census. If the S-SV EMS DO determines that both hospitals have taken appropriate diversion avoidance measures, and that diversion by both hospitals would unreasonably impact the EMS system, both hospitals will be required to re-open/remain open to ambulance patients.

2. Any hospital on patient surge diversion is required to re-open in the event of a confirmed MCI or declared disaster requiring patient distribution to their facility.

~~3. A hospital will only be allowed to remain on patient surge limited diversion for a maximum of three (3) hours in a 24-hour period.~~

4. A hospital will only be allowed to remain on patient surge diversion for a maximum of six (6) hours total (re-evaluated by the S-SV EMS DO every 3 hours), at which point they will be required to re-open for a minimum of a subsequent six (6) hours.

5. Hospitals shall come off diversion immediately upon resolution of the issue.

6. The S-SV EMS DO shall retain authority to update the EMResource status of any hospital as needed to reflect their appropriate approved status.

	S-SV EMS Ambulance Patient Diversion Form	508-A

S-SV EMS Notification

• Email completed form to Dutyofficer@ssvems.com.
• The S-SV EMS Duty Officer must also be notified by telephone for any diversion event:
  • Primary: (916) 625-1702 (during business hours) or 916-625-1710 (after business hours)
  • Backup #1: (530) 906-0079, Backup #2: (712) 229-2164

Hospital Information	
Hospital:	Contact name:
Contact telephone #:	Contact email:

Notification Type			
☐ Planned diversion	☐ Pre-diversion	☐ Initial diversion	☐ Ongoing diversion

Diversion Type	
☐ Pre-diversion notification only	☐ Specialty patient diversion (STEMI, stroke, trauma)
☐ Code 2 ambulance patient diversion only	☐ Diversion of all ambulance patients

Diversion Reason		
☐ Internal disaster	☐ Patient surge event	☐ Other reason
☐ Stroke services unavailable	☐ STEMI services unavailable	☐ Trauma services unavailable

Describe the Reason for Planned/Anticipated/Current Diversion	
Submission date:	Submission time:

Note: Page 2 must be completed for any patient surge pre-diversion or diversion notification

	S-SV EMS Ambulance Patient Diversion Form	508-A

Hospital Notifications & Diversion Avoidance Actions Taken (check all that apply)	
☐ ED supervisor/designee notification	☐ ED physician director/designee notification
☐ Trauma/STEMI director/designee notification	☐ CEO/designee notification
☐ Increase in ED ancillary staff	☐ Increase in ED nursing staff
☐ Increase in ED mid-level staff	☐ Increase in ED physician staff.
☐ Increase in other staff (Med/Surge, ICU, etc.)	☐ Cancellation of elective surgical procedures
☐ Activation of backup ED patient care areas.	☐ Activation of additional inpatient beds.
☐ Expedited patient discharges	☐ Patient transfers to other facilities.
☐ Activation of the Hospital Patient Surge Capacity Plan and Hospital Incident Command System	

Additional Notes

Current ED Census & Hospital Bed Availability	
Staffed ED Beds:	Occupied ED Beds:
ED Waiting Room Pts:	ED Psych Pts:
ED Admit Hold Pts:	Available Med/Surg Beds:
Available ICU Beds:	Available Pedi Beds:
Available ORs:	

On-Duty ED Staffing		
Nursing Staff:	Mid-Level Staff:	Physician Staff:

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

PURPOSE:

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

AUTHORITY:

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

California Code of Regulations, Title 22, Division 9.

California Code of Regulations, Title 13.

California Vehicle Code, Section 2418.5.

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

POLICY:

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

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

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

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

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

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

IO Equipment (one of the following sets)

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

OR

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

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

Medications (continued)	ALS Transport	ALS Non-Transport
Sodium Bicarbonate (50 mEq/50 mL)	2	1
Controlled Substances	**ALS Transport**	**ALS Non-Transport**
Controlled Substances Locking Storage Container	1	1
Controlled Substances Tracking Sheet	1	1
Carpuject Holder (only if utilizing capuject supplied medications)	1	1
Fentanyl (50 mcg/1 mL concentration)	400 mcg minimum 1000 mcg maximum	400 mcg minimum 1000 mcg maximum
Ketamine (50 mg/1 mL concentration)	200 mg minimum 1000 mg maximum	200 mg minimum 1000 mg maximum
Midazolam (5 mg/1 mL concentration)	20 mg minimum 60 mg maximum	20 mg minimum 60 mg maximum

Sierra – Sacramento Valley EMS Agency Program Policy			
COVID-19 Testing Sample Collection By EMS Personnel			
	Effective: DRAFT	Next Review: DRAFT	**807**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To allow EMT, AEMT and/or paramedic personnel (collectively referred to as 'EMS personnel') to collect COVID-19 testing samples.

AUTHORITY:

A. HSC, Division 2.5.

B. CCR, Title 22, Division 9.

POLICY:

A. Any organization desiring to utilize EMS personnel to collect COVID-19 testing samples must be approved by S-SV EMS.

B. EMS personnel must have completed S-SV EMS approved didactic and skills training, and be functioning under the oversight of a local public health department or prehospital service provider in order to collect COVID-19 testing samples.

C. Any organization utilizing EMS personnel to collect COVID-19 testing samples is responsible for ongoing QI monitoring of this optional skill.

D. Any organization desiring to utilize EMS personnel to collect COVID-19 testing samples shall submit a written request to S-SV EMS for approval. The written request shall include the following:

1. A letter of intent to utilize EMS personnel to collect COVID-19 testing samples, including a description of the need to utilize EMS personnel for this purpose.

2. A description of the geographic area and setting where EMS personnel will be utilized to collect COVID-19 testing samples.

3. Name and credentials of the individual(s) who will provide the required training to EMS personnel to collect COVID-19 testing samples.

E. Approval or disapproval to utilize EMS personnel to collect COVID-19 testing samples will be made by S-SV EMS as soon as possible after receipt of a written request.

F. Any entity approved by S-SV EMS to utilize EMS personnel to collect COVID-19 testing samples shall comply with the following:

1. Provide adequate training and skills competency testing to all EMS personnel who will be collecting COVID-19 testing samples.

2. Maintain copies of training sign in sheets and skills competency verification documentation for all EMS personnel trained to collect COVID-19 testing samples. Training documentation is subject to review by S-SV EMS representatives upon request.

3. Provide all currently recommended PPE to EMS personnel collecting COVID-19 testing samples.

4. Notify S-SV EMS, by the next business day, of any unusual event or potential patient harm involving the collection of COVID-19 testing samples by EMS personnel.

Sierra – Sacramento Valley EMS Agency Program Policy			
EMS Personnel Administration Of Intramuscular Influenza &/Or COVID-19 Vaccine			
	Effective: DRAFT	Next Review: DRAFT	**808**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To allow EMT, AEMT and/or paramedic personnel (collectively referred to as 'EMS personnel') to administer intramuscular (IM) influenza and/or COVID-19 vaccines to patients ≥12 years of age.

AUTHORITY:

A. HSC, Division 2.5.

B. CCR, Title 22, Division 9.

POLICY:

A. Any organization desiring to utilize EMS personnel to administer influenza and/or COVID-19 vaccines must be approved by S-SV EMS.

B. EMS personnel must have completed S-SV EMS approved didactic and skills training, and be functioning under the oversight of a local public health department or prehospital service provider in order to administer influenza and/or COVID-19 vaccines.

C. Any organization utilizing EMS personnel to administer influenza and/or COVID-19 vaccines is responsible for ongoing QI monitoring of this optional skill.

D. Licensed medical staff (RN or higher) must be on-site at all times when EMS personnel are administering influenza and/or COVID-19 vaccines.

E. Any organization utilizing EMS personnel to administer influenza and/or COVID-19 vaccines shall comply with the following:

1. Ensure that all EMS personnel administering influenza and/or COVID-19 vaccines have received adequate, S-SV EMS approved training.

2. Maintain copies of training records for all EMS personnel trained to administer influenza and/or COVID-19 vaccines.

3. Notify S-SV EMS, by the end of the next business day, of any unusual event involving administration of influenza and/or COVID-19 vaccines by EMS personnel.

PROCEDURE:

A. Vaccine Administration Procedure:

1. Assess the need for the vaccine utilizing current guidance provided by the local public health department. Give the patient a vaccine information sheet, using the appropriately translated sheet for non-English speaking clients.

2. Screen for vaccine contraindications/precautions, and complete the screening questionnaire prior to vaccine administration.

   - Vaccine contraindications:
     - Do not administer vaccines to a person who has an allergic reaction or a serious systemic or anaphylactic reaction to a prior dose of that vaccine or to any of its components. Refer to vaccine manufacturer guidance for a list of vaccine components. Manufacturer package inserts (accessed at: www.immunize.org/fda) also contains a list of ingredients.
   - Precautions for use of vaccines (refer to a physician):
     - Moderate or severe acute illness with or without fever.
     - History of Guillain-Barré syndrome within 6 weeks of a previous vaccination.
     - People with egg allergies can receive any licensed, recommended age-appropriate influenza vaccine (IIV, RIV4, or LAIV4) that is otherwise appropriate. People who have a history of severe egg allergy (those who have had any symptom other than hives after exposure to egg) should be vaccinated in a medical setting, supervised by a health care provider who is able to recognize and manage severe allergic reactions.
   - Be prepared for management of a medical emergency related to the administration of vaccine. Follow applicable S-SV EMS policies/protocols as necessary.

3. Collect/review the Vaccine Consent/Record of Administration form and confirm consent.

4. To prevent syncope, individuals should be vaccinated while they are seated or lying down.

5. Always maintain aseptic technique when administering vaccines.

6. Equipment required:

   - Vaccine.
     - Vaccine may come as prefilled/ready to administer or require other injection supplies.
       - **EMT & AEMT personnel are not authorized to reconstitute vaccines, or draw up vaccines in the administration syringe.**
   - 23-25 g, 1-inch needle (and appropriate size syringe if necessary).
     - For larger patients, 1.5-inch needle length may be more appropriate. See below for additional information.

Needle Gauge/Length and Injection Site Guidance			
Pt. gender, age, weight	**Needle Gauge**	**Needle Length**	**Injection Site**
Female/Male 12-18yo	22-25 g	5/8-1” 1-1½”	Deltoid muscle of arm
Female/Male <130 lbs	22-25 g	5/8-1”	Deltoid muscle of arm
Female/Male 130-152 lbs	22-25 g	1"	Deltoid muscle of arm
Female 153-200 lbs	22-25 g	1-1½”	Deltoid muscle of arm
Male 153-260 lbs	22-25 g	1-1½”	Deltoid muscle of arm
Female 200+ lbs	22-25 g	1½”	Deltoid muscle of arm
Male 260+ lbs	22-25 g	1½”	Deltoid muscle of arm

7. Wash hands, don gloves and other appropriate PPE based on situation.

8. Check vaccine expiration date

   - Do not use vaccine if expired, discolored, solid or particulate matter is visible in the vial or syringe, or cold chain has not been adequately maintained.

9. Cleanse the area of the deltoid muscle with the alcohol prep. Deltoid landmarks: 2-3 finger widths down from the acromion process; bottom edge is imaginary line drawn from axilla.

10. Insert the needle at a 90-degree angle into the muscle.

11. Inject entire vaccine into the muscle.

12. Withdraw the needle, and using the alcohol prep, apply slight pressure to the injection site.

13. Do not recap or detach needle from syringe. All used syringes/needles should be placed in puncture-proof containers.

14. Monitor for any symptoms of allergic reaction.

    - Individuals with a history of anaphylaxis should be monitored for 30 minutes after vaccine administration.
    - All other individuals should be monitored for 15 minutes after vaccine administration.

15. Document the following additional information on the Vaccine Consent/Record of Administration form:

    - Date of vaccination.
    - Injection site.
    - Vaccine manufacturer
    - Vaccine lot number.

16. Advise when to return for subsequent vaccination, if appropriate.

17. Complete/submit appropriate documentation:

    - Ensure a Vaccine Consent/Record of Administration form is completed and submitted to local public health for each vaccinated patient.
    - If accessible, record the vaccine information in the patient's medical record and/or their personal immunization record card.
    - Report the vaccination to the appropriate state/local Immunization Information System (IIS), if available.
    - Report all adverse events following the administration of a vaccine to the federal Vaccine Adverse Event Reporting System (VAERS). To submit a VAERS report online, go to https://vaers.hhs.gov/reportevent.html. Further assistance is available at (800) 822-7967.

Skills Checklist for Vaccine Administration

During the COVID-19 pandemic, the CDC recommends additional infection control measures for vaccination (see www.cdc.gov/vaccines/pandemic-guidance/index.html).

The Skills Checklist is a self-assessment tool for healthcare staff who administer immunizations. To complete it, review the competency areas below and the clinical skills, techniques and procedures outlined for each area. Score yourself in the Self-Assessment column. If you check **Needs to Improve**, you indicate further study, practice, or change is needed. When you check **Meets or Exceeds**, you indicate you believe you are performing at the expected level of competence, or higher.

Supervisors: Use the Skills Checklist to clarify responsibilities and expectations for staff who administer vaccines. When you use it to assist with performance reviews, give staff the opportunity to score themselves in advance. Next, observe their performance as they administer vaccines to several patients, and score in the Supervisor Review columns. If improvement is needed, meet with them to develop a Plan of Action (see bottom of page 3) to help them achieve the level of competence you expect; circle desired actions or write in others.

The DVD "Immunization Techniques: Best Practices with Infants, Children, and Adults" helps ensure that staff administer vaccines correctly. It may be ordered online at www.immunize.org/dvd. Another helpful resource is CDC's Vaccine Administration eLearn course, available at www.cdc.gov/vaccines/hcp/admin/resource-library.html.

		Self-Assessment		Supervisor Review		
COMPETENCY	CLINICAL SKILLS, TECHNIQUES, AND PROCEDURES	NEEDS TO IMPROVE	MEETS OR EXCEEDS	NEEDS TO IMPROVE	MEETS OR EXCEEDS	PLAN OF ACTION
A **Patient/Parent Education**	1. Welcomes patient/family and establishes rapport.					
	2. Explains what vaccines will be given and which type(s) of injection(s) will be done.					
	3. Answers questions and accommodates language or literacy barriers and special needs of patient/parents to help make them feel comfortable and informed about the procedure.					
	4. Verifies patient/parents received Vaccine Information Statements (VISs) for indicated vaccines and has had time to read them and ask questions.					
	5. Screens for contraindications (if within employee's scope of work).					
	6. Reviews comfort measures and aftercare instructions with patient/parents, and invites questions.					
B **Medical and Office Protocols**	1. Identifies the location of the medical protocols (e.g., immunization protocol, emergency protocol, reference material).					
	2. Identifies the location of epinephrine, its administration technique, and clinical situations where its use would be indicated.					
	3. Maintains up-to-date CPR certification.					
	4. Understands the need to report any needlestick injury and to maintain a sharps injury log.					
	5. Demonstrates knowledge of proper vaccine handling, e.g., maintains vaccine at recommended temperature and protects MMR from light.					

CONTINUED ON THE NEXT PAGE ▶

Adapted from California Department of Public Health, Immunization Branch

Immunization Action Coalition Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org | Technical content reviewed by the Centers for Disease Control and Prevention
www.immunize.org/catg.d/p7010.pdf • Item #P7010 (8/20)

		Self-Assessment		Supervisor Review		
COMPETENCY	**CLINICAL SKILLS, TECHNIQUES, AND PROCEDURES**	**NEEDS TO IMPROVE**	**MEETS OR EXCEEDS**	**NEEDS TO IMPROVE**	**MEETS OR EXCEEDS**	**PLAN OF ACTION**
C **Vaccine Preparation**	1. Performs proper hand hygiene prior to preparing vaccine.					
	2. When removing vaccine from the refrigerator or freezer, looks at the storage unit's temperature to make sure it is in proper range.					
	3. Checks vial expiration date. Double-checks vial label and contents prior to drawing up.					
	4. Prepares and draws up vaccines in a designated clean medication area that is not adjacent to areas where potentially contaminated items are placed.					
	5. Selects the correct needle size for IM and Subcut based on patient age and/or weight, site, and recommended injection technique.					
	6. Maintains aseptic technique throughout, including cleaning the rubber septum (stopper) of the vial with alcohol prior to piercing it.					
	7. Shakes vaccine vial and/or reconstitutes and mixes using the diluent supplied. Inverts vial and draws up correct dose of vaccine. Rechecks vial label.					
	8. Prepares a new sterile syringe and sterile needle for each injection. Checks the expiration date on the equipment (syringes and needles) if present.					
	9. Labels each filled syringe or uses labeled tray to keep them identified.					
D **Administering Immunizations**	1. Rechecks the provider's order or instructions against the vial and the prepared syringes.					
	2. Utilizes proper hand hygiene with every patient and, if it is office policy, puts on disposable gloves. (If using gloves, changes gloves for every patient.)					
	3. Demonstrates knowledge of the appropriate route for each vaccine.					
	4. Positions patient and/or restrains the child with parent's help.					
	5. Correctly identifies the injection site (e.g., deltoid, vastus lateralis, fatty tissue over triceps).					
	6. Locates anatomic landmarks specific for IM or Subcut injections.					
	7. Preps the site with an alcohol wipe, using a circular motion from the center to a 2" to 3" circle. Allows alcohol to dry.					

CONTINUED ON THE NEXT PAGE ▶

		Self-Assessment		Supervisor Review		
COMPETENCY	**CLINICAL SKILLS, TECHNIQUES, AND PROCEDURES**	**NEEDS TO IMPROVE**	**MEETS OR EXCEEDS**	**NEEDS TO IMPROVE**	**MEETS OR EXCEEDS**	**PLAN OF ACTION**
D **Administering Immunizations** (continued)	8. Controls the limb with the non-dominant hand; holds the needle an inch from the skin and inserts it quickly at the appropriate angle (90° for IM or 45° for Subcut).					
	9. Injects vaccine using steady pressure; withdraws needle at angle of insertion.					
	10. Applies gentle pressure to injection site for several seconds (using, e.g., gauze pad, bandaid).					
	11. Uses strategies to reduce anxiety and pain associated with injections.					
	12. Properly disposes of needle and syringe in "sharps" container.					
	13. Properly disposes of vaccine vials.					
E **Records Procedures**	1. Fully documents each vaccination in patient chart: date, lot number, manufacturer, site, VIS date, name/initials.					
	2. If applicable, demonstrates ability to use state/local immunization registry or computer to call up patient record, assess what is due today, and update computerized immunization history.					
	3. Asks for and updates patient's vaccination record and reminds them to bring it to each visit.					

Plan of Action

Circle desired next steps and write in the agreed deadline for completion, as well as date for the follow-up performance review.

a. Watch video on immunization techniques and review CDC's Vaccine Administration eLearn, available at www.cdc.gov/vaccines/hcp/admin/resource-library.html.
b. Review office protocols.
c. Review manuals, textbooks, wall charts, or other guides.
d. Review package inserts.
e. Review vaccine storage and handling guidelines or video.
f. Observe other staff with patients.
g. Practice injections.
h. Read Vaccine Information Statements.
i. Be mentored by someone who has demonstrated appropriate immunization skills.
j. Role play (with other staff) interactions with parents and patients, including age appropriate comfort measures.
k. Attend a skills training or other appropriate courses/training.
l. Attend healthcare customer satisfaction or cultural competency training.
m. Renew CPR certification.

Other _____

File the Skills Checklist in the employee's personnel folder.

_____
PLAN OF ACTION DEADLINE

_____
DATE OF NEXT PERFORMANCE REVIEW

_____ _____
EMPLOYEE SIGNATURE DATE

_____ _____
SUPERVISOR SIGNATURE DATE

Sierra – Sacramento Valley EMS Agency Program Policy			
EMS Student Field Training			
	Effective: DRAFT	Next Review: DRAFT	**1007**
	Approval: Troy M. Falck, MD – Medical Director		DRAFT
	Approval: John Poland – Executive Director		DRAFT

PURPOSE:

To establish requirements for field training of EMT, AEMT and paramedic students (EMS students) in the S-SV EMS region.

AUTHORITY:

A. HSC, Division 2.5, § 1797.170, 1797.171, 1797.172, 1797.200, 1797.202, 1797.204, 1797.206, 1797.208, 1797.213, 1797.218, 1797.220, and 1798.

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

POLICY:

A. ALS prehospital provider agencies shall provide field training to EMS students, in accordance with CCR Title 22, S-SV EMS policies and provider agency agreements.

1. An EMT training course shall consist of not less than 24 hours (with a maximum of 48 hours, unless otherwise approved by the applicable training program) of supervised clinical experience.

   - Prior to beginning the supervised clinical experience, the student shall have successfully completed the didactic and skills portions of the training program.
   - The supervised clinical experience may be conducted at an acute care hospital, an ALS prehospital provider agency, or a combination of both.
   - The supervised clinical experience shall include a minimum of 10 patient contacts, wherein a patient assessment and other EMT skills (S-SV EMS policy reference No. 801) are performed and evaluated.

2. An AEMT training course shall consist of not less than 40 hours (with a maximum of 120 hours, unless otherwise approved by the applicable training program) of field internship with an ALS prehospital provider agency.

   - Prior to beginning the field internship, the student shall have successfully completed the didactic, skills and hospital clinical education portions of the training program.

- During the field internship, the student shall demonstrate competency in the AEMT scope of practice (S-SV EMS policy reference No. 802).
- During the field internship, the student shall have a minimum of 15 ALS patient contacts, and shall demonstrate competency as the team leader while delivering EMS patient care at least five (5) times.

3. A paramedic training course shall consist of not less than 480 hours (with a maximum of 720 hours, unless otherwise approved by the applicable training program) of field internship with an ALS prehospital provider agency.

   - Prior to beginning the field internship, the student shall have successfully completed the didactic, skills and hospital clinical education portions of the training program.
   - During the field internship, the student shall demonstrate competency in the paramedic scope of practice (S-SV EMS policy reference No. 803).
   - During the field internship, the student shall have a minimum of 40 ALS patient contacts.
     - An ALS patient contact shall be defined as the student performance of one or more ALS skills, except cardiac monitoring and CPR, on a patient.
     - For at least half of the ALS patient contacts, the student shall be required to provide the full continuum of care, beginning with initial patient contact upon arrival at the scene through transfer of care to hospital personnel.
     - The student shall have a minimum of 20 experiences performing the role of team lead during the field internship. A team lead shall be defined as a student who, with minimal to no prompting by the preceptor, successfully takes charge of EMS operation in the field including, at least, the following:
       - Lead coordination of field personnel,
       - Formulation of field impression,
       - Comprehensively assessing patient conditions and acuity,
       - Directing and implementing patient treatment,
       - Determining patient disposition, and
       - Leading the packaging and movement of the patient.
     - When available, up to 10 of the required ALS patient contacts may be satisfied through the use of high-fidelity adult simulation patient contacts.
     - The field internship must be completed within six (6) months from the end of the clinical education portion of the paramedic training program.

4. EMS students are prohibited from being assigned to a field training supervisor/ preceptor who may have a conflict of interest as identified by the supervisor/ preceptor, the student, the training program, the ALS prehospital provider agency, or S-SV EMS

5. No more than one (1) EMS student of any level shall be assigned to an ALS prehospital provider response vehicle at any time.

B. EMS training programs shall enter into written agreements with ALS prehospital provider agencies to facilitate field training of their students.

1. ALS prehospital provider agencies and/or field training supervisors shall not charge field training fees to EMT training programs/students.

2. ALS prehospital provider agencies may charge field internship training fees to AEMT and/or paramedic training programs/students to cover costs associated with providing field internship training, under the following conditions:

- The fees are reasonable, uniform and directly related to the costs of providing field internship training to AEMT and/or paramedic students.
- The ALS prehospital provider agency has a written policy that addresses the process for collection and distribution of field internship training fees.
- In order to prevent conflicts of interest, AEMT and paramedic students are prohibited from making payments of any kind or offering gratuities directly to field training preceptors.

C. EMS students shall be supervised by a qualified field training supervisor/preceptor throughout all aspects of their field training.

D. EMS training programs shall adequately monitor the field training of their students, in coordination with applicable ALS prehospital provider agencies. A paramedic training program shall conduct and document a minimum of one (1) on-site observation of the paramedic student during the field internship training.

E. Each patient contact by an EMS student shall be adequately documented by the field training supervisor/preceptor and the student in a standardized format (as required/ directed by the training program).

F. All field training supervisors/preceptors shall be authorized by the ALS prehospital provider agency, in coordination with the applicable EMS training program, and shall meet the following minimum qualifications:

1. EMT student field training supervisor minimum qualifications:

- Possess a current California paramedic license and S-SV EMS Paramedic Accreditation.
- Not be under an active investigation by the ALS prehospital provider agency, S-SV EMS or the California EMS Authority.
- Not be under an active clinical performance improvement plan or clinical education assignment.
- Be functioning as a paramedic for an ALS prehospital provider agency at the time the field training is conducted.

2. AEMT and/or paramedic preceptor minimum qualifications:

    - Possess a current California paramedic license and S-SV EMS Paramedic Accreditation.
    - Be working in the field as a licensed paramedic for the last two (2) years.
    - Be working in the S-SV EMS region as a paramedic for the last 12 months.
    - Not be under an active investigation by the ALS prehospital provider agency, S-SV EMS or the California EMS Authority.
    - Not be under an active clinical performance improvement plan or clinical education assignment.
    - Have completed a field preceptor training program, approved by S-SV EMS in accordance with CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions. The field preceptor training shall include a curriculum that will result in preceptor competency in the evaluation of AEMT and/or paramedic students during the internship phase of the training program and the completion of the following:
        - Conduct a daily field evaluation of students.
        - Conduct cumulative and final field evaluations of all students.
        - Rate students for evaluation using written field criteria.
        - Identify ALS contacts and requirements for graduation.
        - Identify the importance of documenting student performance.
        - Review the field preceptor requirements contained in this policy and CCR Title 22.
        - Assess student behaviors using cognitive, psychomotor, and affective domains.
        - Create a positive and supportive learning environment.
        - Measure students against the standards of an entry level AEMT or paramedic (as applicable).
        - Identify appropriate student progress.
        - Counsel the student who is not progressing.
        - Identify training program support services available to the student and the preceptor.
        - Provide guidance and procedures to address student injuries or exposure to illness, communicable disease or hazardous material.

G. EMS student responsibilities:

- Students shall complete all requirements established by the training program and ALS prehospital provider agency prior to the start of their field training.
- Students shall comply with all instructions and direction of their field supervisor/preceptor for the clinical care and operation of the EMS system.
- Students shall adhere to all S-SV EMS policies/protocols.
- Students shall abide by the dress code and appearance standards established by the training program and/or ALS prehospital provider agency.

- Students shall wear adequate identification with their name and the phrase "Student" or "Intern" while performing their field training.
- Students shall only conduct their field training with their assigned field training supervisor(s)/preceptor(s) and assigned ALS prehospital provider agency.
- Students shall not fulfill the minimum staffing requirements of an ambulance or fire apparatus.
- Students shall not function as an AEMT or paramedic student while on duty as an EMT.
- Students shall actively participate in training program required evaluations with their field training supervisor/preceptor.
- Students shall report (to applicable ALS prehospital provider agency management personnel or to S-SV EMS) any conduct of their field training supervisor/preceptor or themselves that may or did result in patient harm, or that would or did have an adverse operational impact on the EMS system.

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

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

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

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

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

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

Sierra – Sacramento Valley EMS Agency Treatment Protocol

Non-Traumatic Pulseless Arrest

C-1

Approval: Troy M. Falck, MD – Medical Director | Effective: DRAFT

Approval: John Poland – Executive Director | Next Review: DRAFT

MANUAL CHEST COMPRESSIONS

- Rate: 100-120/min
- Depth: 2 inches – allow full chest recoil
- Minimize interruptions (≤10 secs)
- Rotate compressors every 2 mins
- Perform CPR during AED/defibrillator charging
- Resume CPR immediately after shock

MECHANICAL CHEST COMPRESSION DEVICES

Indications

- Adult pt (≥15 yo)

Contraindications

- Pt does not fit in the device
- 3rd trimester pregnancy

ⓘ Use in accordance with manufacturer indications/ contraindications

ⓘ Apply following completion of at least one manual CPR cycle, or at the end of a subsequent cycle

DEFIBRILLATION & GENERAL PT MANAGEMENT

- Analyze rhythm/check pulse after every 2 min CPR cycle
- Biphasic manual defibrillation detail:
  - Follow manufacturer recommendations
  - If unknown, start at 200 J (subsequent doses should be equivalent or higher)
- Movement of pt may interrupt CPR or prevent adequate depth and rate of compressions
- Consider resuscitation on scene up to 20 mins
- Go to ROSC protocol (C-2) if ROSC is obtained

ADVANCED AIRWAY MANAGEMENT

- Consider/establish advanced airway at appropriate time during resuscitation
- Do not interrupt chest compressions to establish an advanced airway
- Waveform capnography (if available) shall be used on all pts with an advanced airway in place
  - An abrupt increase in $PETCO_2$ is indicative of ROSC
  - Persistently low $PETCO_2$ levels (<10 mmHG) suggest ROSC is unlikely

TREAT REVERSIBLE CAUSES

- **H**ypovolemia
- **H**ypoxia
- **H**ydrogen Ion (acidosis)
- **H**ypo-/hyperkalemia
- **H**ypothermia
- **T**amponade, cardiac
- **T**ension pneumothorax
- **T**hrombosis, pulmonary
- **T**hrombosis, cardiac
- **T**oxins

ⓘ Refer to Hypothermia & Avalanche/Snow Immersion Suffocation Resuscitation Protocol (E-2) or Traumatic Pulseless Arrest Protocol (T-6) as appropriate

ⓘ Contact the base/modified base hospital for consultation & orders as appropriate

ⓘ Consider early transport of pts who have reversible causes that cannot be adequately treated in the prehospital setting

TERMINATION OF RESUSCITATION

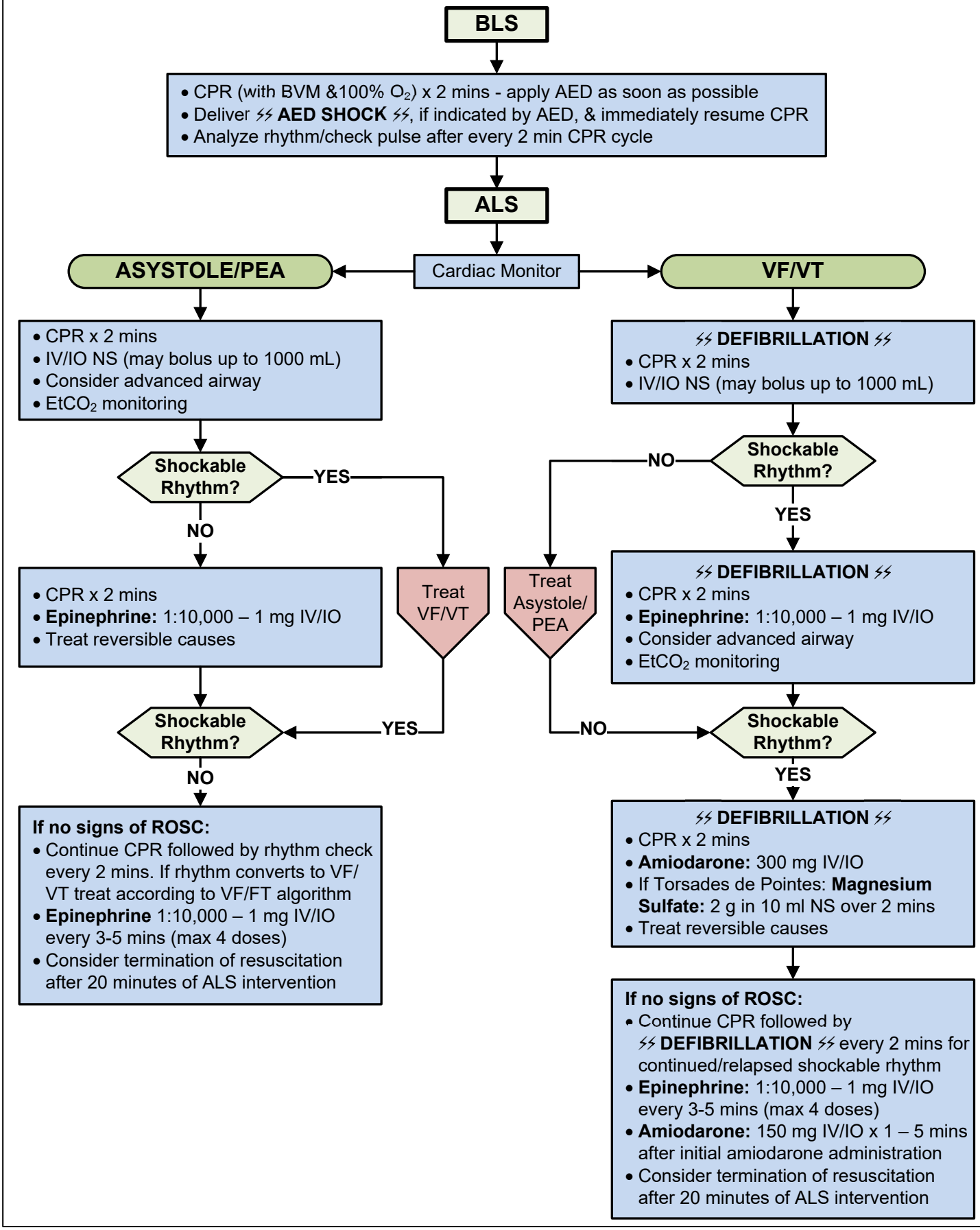
Base/Modified Base Hospital Physician Order**

- If resuscitation attempts do not obtain ROSC, consider termination of resuscitation efforts
- BLS termination of resuscitation criteria (all):
  (1) Arrest not witnessed by EMS
  (2) No AED shocks delivered
  (3) No ROSC after 3 rounds of CPR/AED analysis
- ALS Termination of Resuscitation Criteria (all):
  (1) Arrest not witnessed by EMS
  (2) No effective bystander CPR was provided, or effective CPR cannot be maintained
  (3) No AED shocks or defibrillations delivered
  (4) No ROSC after full ALS care

**In the event of communication failure, EMS personnel may terminate resuscitation without a base/modified base hospital physician order on a pt who meets ALS termination of resuscitation criteria.

SEE PAGE 2 FOR TREATMENT ALGORITHM

Non-Traumatic Pulseless Arrest



Sierra – Sacramento Valley EMS Agency Treatment Protocol	C-4
Tachycardia With Pulses	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

- **Unstable pts with persistent tachycardia require immediate cardioversion.**
- **It is unlikely that symptoms of instability are caused primarily by the tachycardia if the HR is <150/min.**

BLS

- Manage airway & assist ventilations as necessary
- Assess V/S, including SpO_2 - reassess V/S every 3 - 5 min if possible
- O_2 at appropriate rate if hypoxemic (SpO_2 <94%), short of breath, or signs of heart failure/ shock

ALS

- Cardiac monitor, 12-lead ECG at appropriate time (do not delay therapy)
- IV/IO NS at appropriate time (may bolus up to 1000 mL for hypotension)

Persistent tachycardia causing any of the following?
- Hypotension
- Acutely altered mental status
- Signs of shock
- Ischemic chest discomfort
- Acute heart failure

YES

Synchronized Cardioversion
- Initial synchronized cardioversion doses:
  - Narrow regular: 50 - 100 J
  - Narrow irregular: 120 - 200 J
  - Wide regular: 100 J
- Consider pre-cardioversion sedation/pain control*
- If no response to initial shock, increase dose in a stepwise fashion for subsequent attempts
- If rhythm is wide-irregular or monitor will not synchronize, & pt is critical, treat as VF with unsynchronized defibrillation doses (protocol C-1)

NO

Wide QRS (≥0.12 seconds)?

NO

Valsalva Maneuver

If no response to Valsalva Maneuver, consider:

Adenosine:
- First dose: 6 mg rapid IV/IO push
- Second dose 9if rhythm does not convert in 1 – 2 mins): 12 mg rapid IV/IO push
- Flush IV/IO line with 20 mL NS after each dose

YES

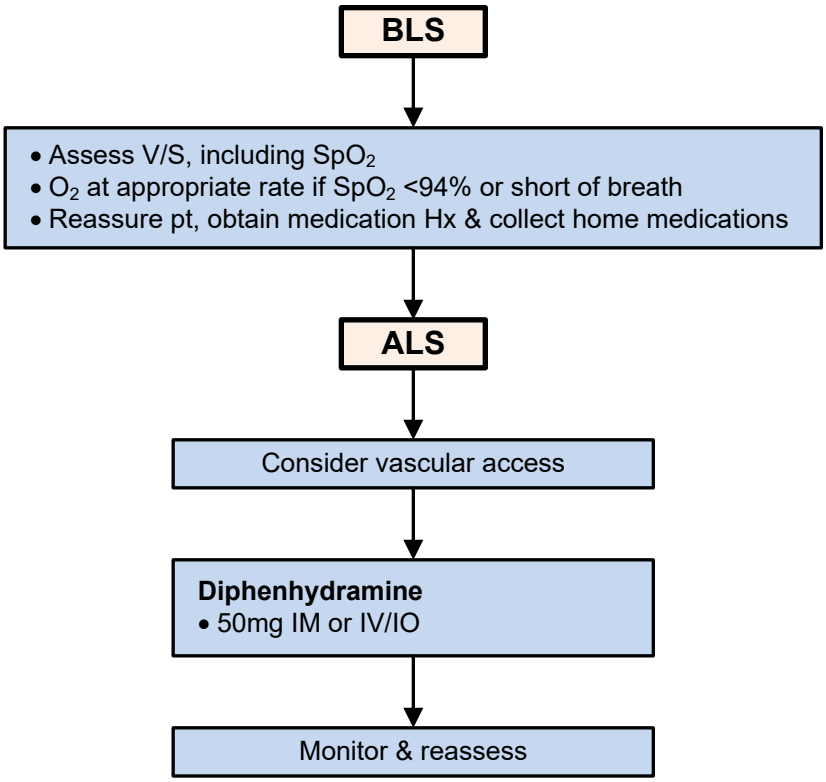
- ***Amiodarone:*** *150mg IV/IO over 10 minutes IV push or IV infusion in 100 ml D5W or NS at a rate of 15mg/min*
- *If Torsades de Pointes w/pulses, consider:* ***Magnesium Sulfate:*** *2 g in 100 ml NS over 15 mins*
- Contact base/modified base hospital for consultation if necessary

***Pre-Cardioversion Sedation/Pain Control**
- Consider one of the following for pts in need of sedation/pain control:
  - **Midazolam:** ~~2~~ – 5 mg IV/IO
  - **OR**
  - **Fentanyl:** ~~25~~ – 50 mcg, or 25 mcg for pts ≥65 yo IV/IO

**** For pts ≥65yo Midazolam dosing is limited to 2mg. Fentanyl dosing is limited to 25mcg.**

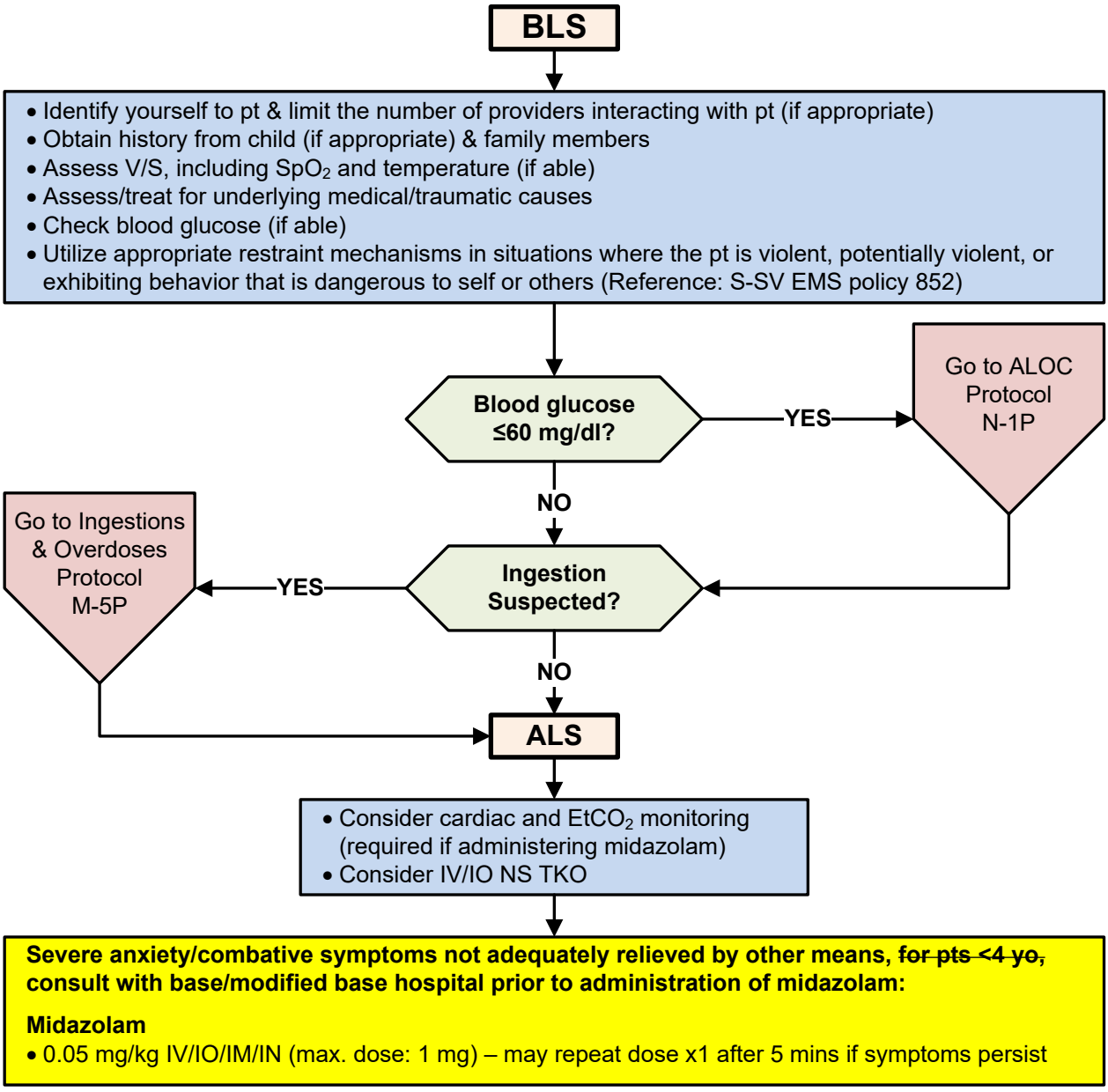
Sierra – Sacramento Valley EMS Agency Treatment Protocol	M-3
Phenothiazine/Dystonic Reaction	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

- **Assessment:**
  - History includes possible ingestion of phenothiazine
  - Symptoms often mistaken for a seizure disorder or tetany
- **Signs & Symptoms:**
  - Facial grimaces
  - Protruding tongue/jaw muscle spasm
  - Oculogyric crisis (circular movement of the eyeballs)
  - Spasms of the back muscles, causing the head and legs to bend backward and the trunk to arch up
  - Anxiety/restlessness
  - Torticollis (twisting of the neck)



Sierra – Sacramento Valley EMS Agency Treatment Protocol	M-11P
Pediatric Behavioral Emergencies	
Approval: Troy M. Falck, MD – Medical Director	Effective: 12/01/2024
Approval: John Poland – Executive Director	Next Review: 04/2027

- Pediatric behavioral emergencies occur when the presenting problem includes some disorder of thought or behavior that is disturbing or dangerous to the pt or others. Psychiatric emergencies are a subset of behavioral emergencies.
- Crisis in pediatrics may be precipitated by social factors and/or instability in the home or community.
- Avoid judgmental statements and encourage pt to help with their own care.
- Consider dimming the lights and removing non-essential adults when appropriate.
- Assess for the presence of other conditions that may mimic behavioral emergencies, for example:
  - Diabetes/hypoglycemia - Trauma/TBI - Seizure disorders - Hypoxia - Ingestion/Overdose
- Major psychiatric disorders that may predispose to behavioral emergencies in children include:
  - Mood disorders (Depression, Bipolar Disorder) - Thought disorders (Schizophrenia)
  - Developmental disorders (Autism) - Anxiety disorders (PTSD)
  - Other disorders (ADD, ADHD, Oppositional Defiant Disorder, Reactive Attachment Disorder, etc.)



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

Cincinnati Prehospital Stroke Scale (CPSS)

Component	Normal Result	Abnormal Result
Facial Droop (Ask pt to show teeth or smile)	Both sides of face move equally	One side of face does not move as well as the other side
Arm Drift (Ask pt to close eyes & hold both arms out with palms up)	Both arms move the same, or both arms do not move	One arm does not move, or one arm drifts down compared with the other
Speech (Ask pt to say "you can't teach an old dog new tricks")	Pt uses correct words with no slurring	Pt slurs words, uses the wrong words, or is unable to speak

BLS

- Assess V/S, including SpO_2
- O_2 at appropriate rate if hypoxemic (SpO_2 <94%) or short of breath
- Perform CPSS assessment

Suspect stroke for either of the following:

- New onset symptoms with abnormal CPSS
- New onset altered state (GCS <14) with unidentifiable etiology
- *CPSS is normal, but patient/bystander report stroke symptoms within previous 24 hours*

If stroke suspected:

- Determine time of onset of symptoms (pt last known normal)
  - When possible, obtain and relay to the receiving hospital the name/contact information of the individual who can verify the time of onset of symptoms (pt last known normal)
- Check blood glucose (if glucometer available)
- Transport as soon as possible (scene time should be ≤10 mins)

ALS

- Consider advanced airway if GCS ≤8 or need for airway protection
- Cardiac monitor, consider 12-lead EKG (do not delay transport to perform 12-lead EKG)
- Obtain blood draw if requested by stroke receiving center
- IV/IO NS TKO (may bolus up to 1000 mL)

Are both the following present?
- Onset of symptoms ≤24 hrs (including wake-up stroke*)
- ≤45 minute transport time to a stroke receiving center

NO

- Transport to closest appropriate hospital
- Contact base/modified base hospital for destination consultation if necessary

YES

- Transport to closest stroke receiving center
- Advise of "Stroke Alert" & time pt. last known normal
- Provide pt. identifying information if requested by stroke receiving center

***Wake-up stroke definition:** Pt awakens with stroke symptoms that were not present prior to falling asleep

Sierra – Sacramento Valley EMS Agency Treatment Protocol	OB-G1
Childbirth	
Approval: Troy M. Falck, MD – Medical Director	Effective: 12/01/2021
Approval: John Poland – Executive Director	Next Review: 11/2024

APGAR Score

	Sign/Score	0	1	2
A	Appearance	Blue/Pale	Peripheral cyanosis	Pink
P	Pulse Rate	None	<100	>100
G	Grimace	None	Grimace	Cries
A	Activity	Limp	Some motion	Active
R	Respiration	Absent	Slow/irregular	Good/strong cry

- Assess V/S, including SpO_2
- O_2 at appropriate rate if SpO_2 <94% or short of breath
- Estimate blood loss
- Consider vascular access at appropriate time (may bolus up to 1000 mL)

Presenting Part

Prolapsed Cord

Rapid transport & early hospital contact

Protect umbilical cord
- Place mother in knee-chest position
- Insert gloved hand into vagina & gently push presenting part off cord
- Cover exposed cord with wet saline dressing

Head

Allow delivery
- Dry/provide warmth
- Assure open/clear airway
- Refer to Neonatal Resuscitation Protocol (P-2) if necessary

Breech or Footling

Rapid transport & early hospital contact

- Avoid compression of cord by presenting part
- Allow delivery to progress until baby's waist appears
- Rotate baby to face down position (do not pull)
- If head does not deliver in 3 mins, insert gloved hand into vagina to create an air passage for infant
- As mother bears down, sweep head out of vagina

After delivery
- Calculate Apgar Score at 1 & 5 mins after delivery
- Clamp & cut umbilical cord
  - Delay clamping cord for 2 mins for uncomplicated births not requiring resuscitation
  - Double clamp cord, cut with sterile scissors between clamps, 6" from baby
- Transport, do not wait for placenta delivery
- After delivery of placenta, ~~gently~~ massage fundus until firm
- *If severe post-partum hemorrhage is present, consider base/modified base hospital order for TXA administration*

Sierra – Sacramento Valley EMS Agency Treatment Protocol	OB-G2
Obstetric Emergencies	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

Obstetric emergencies can be high-acuity but low-frequency situations that can rapidly escalate, and may include one or more of the following:

- Premature labor – Regular uterine contractions or cervical dilation prior to the 37th week of gestation
- Placenta Previa – Placenta covers the cervical opening (painless, often profuse, bright red bleeding)
- Abruptio Placenta – Separation of placenta from the uterine wall (severe abdominal pain/abdominal rigidity)
- Eclampsia – Seizures secondary to a pregnancy-related high blood pressure disorder

BLS

- Determine gestational age
- Assess V/S, including SpO_2
- O_2 at appropriate rate if SpO_2 <94% or short of breath
- Transport patients > 20 weeks pregnant in left lateral recumbent position

Premature Labor

- For patients < 20 weeks gestation, transport to the closest appropriate facility
- For patients 20 – 37 weeks gestation, consult with closest base/modified base hospital for destination determination
- Consider vascular access

Placenta Previa/Abruptio Placenta

ALS

- Rapid transport to the closest appropriate facility
- IV/IO NS to maintain SBP ≥90 mmHg
- If severe hemorrhage, consider base/modified base hospital order for TXA administration

Eclampsia

ALS

- IV/IO NS at appropriate flow rate

Active seizure:

- **Midazolam**
  - 10 mg IM/IN if vascular access not already established
    OR
  - 5 mg IV/IO if vascular access already established
  - May repeat same dose x 1 after 5 mins of continued seizure activity

Post-seizure:

- **Magnesium Sulfate:** 6 g IV/IO in 100 ml NS infused over 15 mins
- Rapid transport to the closest appropriate facility

Sierra – Sacramento Valley EMS Agency Treatment Protocol **Hemorrhage**	**T-4**
Approval: Troy M. Falck, MD – Medical Director	Effective: 06/01/2024
Approval: John Poland – Executive Director	Next Review: 04/2027

Approved Commercial Tourniquet Devices:

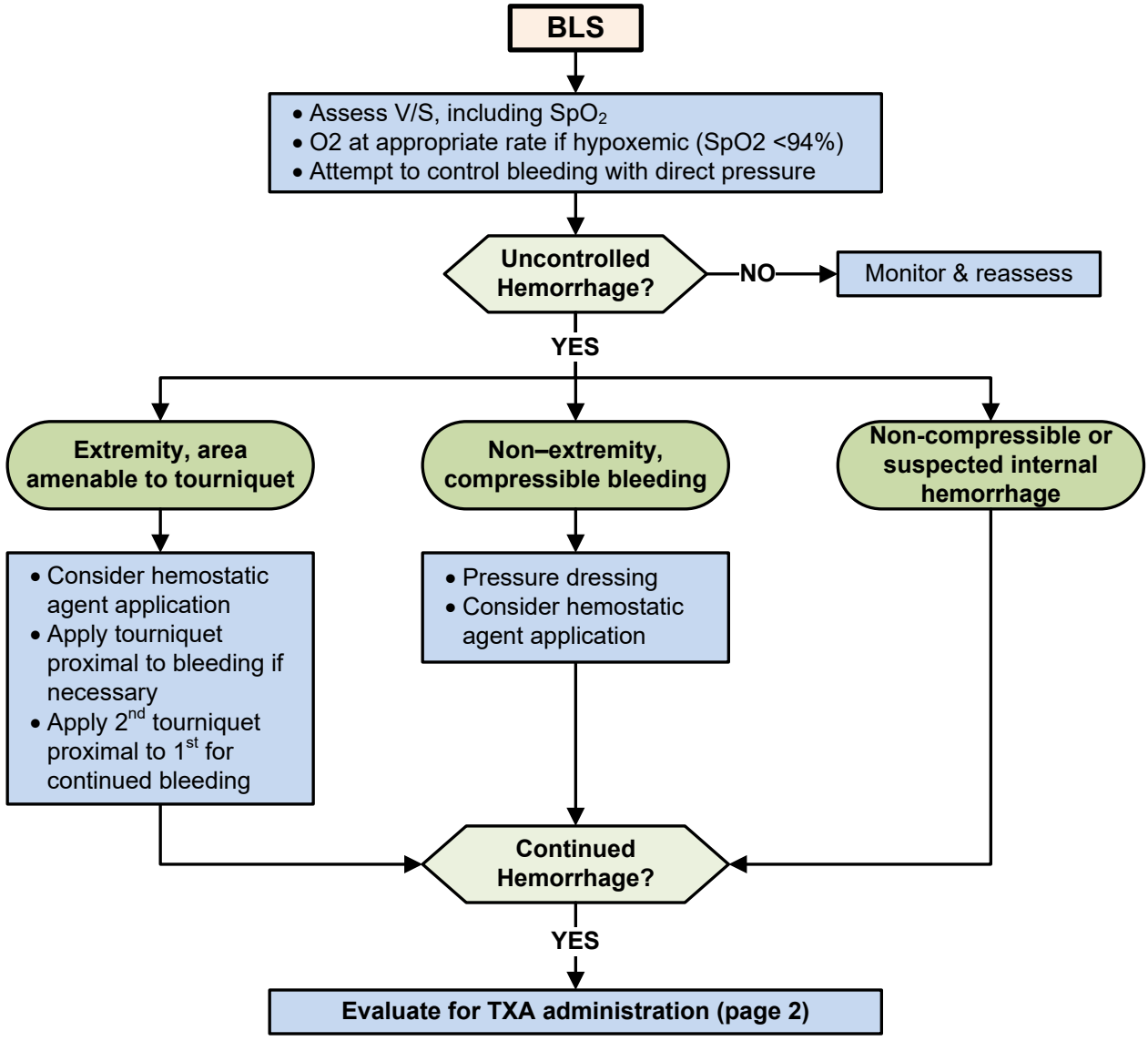
- Combat Application Tourniquet
- Emergency and Military Tourniquet
- Mechanical Advantage Tourniquet
- SAM XT Extremity Tourniquet
- Special Ops. Tactical Tourniquet
- RECON Medical Tourniquet

Tourniquet Utilization Notes:

- Tourniquets applied by lay rescuers or other responders shall be evaluated for appropriateness and may be adjusted or removed if necessary – improvised tourniquets should be removed by prehospital personnel.
- If application is indicated and appropriate, a commercial tourniquet should not be loosened or removed by prehospital personnel unless time to definitive care will be greatly delayed (>2 hrs).

Approved Hemostatic Agents:

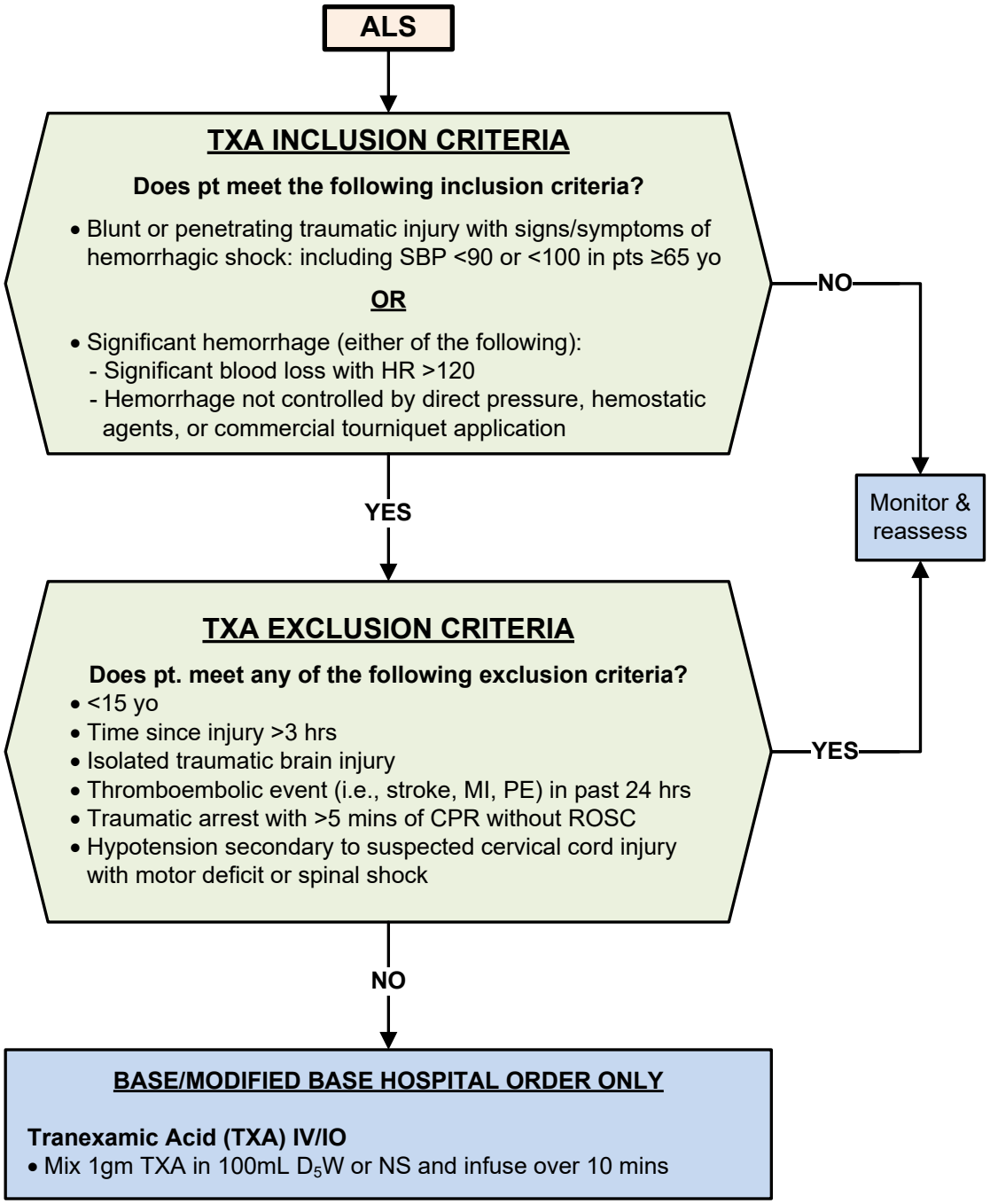
- QuikClot EMS 4x4 & Combat Gauze
- HemCon ChitoGauze XR PRO
- HemCon ChitoGauze XR2 PRO
- HemCon ChitoGauze OTC
- HemCon Bandage PRO
- HemCon OneStop Bandage



Tranexamic Acid (TXA) Administration

TXA Administration Notes:

- Routes other than IV/IO (e.g., nebulized, topical) may be considered **(with base/modified base hospital order only)** for bleeding from *post-partum hemorrhage,* epistaxis, lacerations, or oral trauma.



Sierra – Sacramento Valley EMS Agency Treatment Protocol	G-1
Multiple Patient Incidents	
Approval: Troy M. Falck, MD – Medical Director	Effective: DRAFT
Approval: John Poland – Executive Director	Next Review: DRAFT

DEFINITIONS

Control Facility (CF): An acute care hospital or EMS dispatch center responsible for situation status reporting and patient dispersal during a MCI or URVI.

EMS Surge Incident: An incident that does not overwhelm prehospital resources but has the potential to overwhelm hospital resources with multiple patients.

Multiple Casualty Incident (MCI): An incident that requires more prehospital and/or hospital resources to adequately manage patients than those available during a routine response. A MCI is categorized by the following levels:

LEVEL 1 MCI: Approximately 5-14 patients, expected duration ≤1 hour

LEVEL 2 MCI: Approximately 15-49 patients, expected duration ≥1 hour

LEVEL 3 MCI: 50+ patients, expected duration ≥1 hour

Unified Response to Violent Incident (URVI): An evolving event primarily managed by law enforcement agencies involving the use of force or violence on a group of people (e.g. mass shooting, bombing, riots, etc.). These incidents present a significantly higher threat of injury or loss of life to first responders, victims and the public.

EMS SURGE ALERT

When:

- Three (3) or more ground or air transport resources are requested to respond to an incident; or
- Three (3) or more patients are identified after arrival at the scene of an incident; or
- Multiple patients are released at scene who may arrive at a hospital by private vehicle.
- A URVI.

Who:

- Dispatch center or first dispatched ground transport resource.

Why:

- To provide early notification to the CF for situation status reporting and hospital polling.

MCI ALERT

When:

- An incident that requires more EMS system resources to manage patients than those available during a routine response; or
- The number of patients from a single incident overwhelms the CF or closest appropriate receiving hospital.

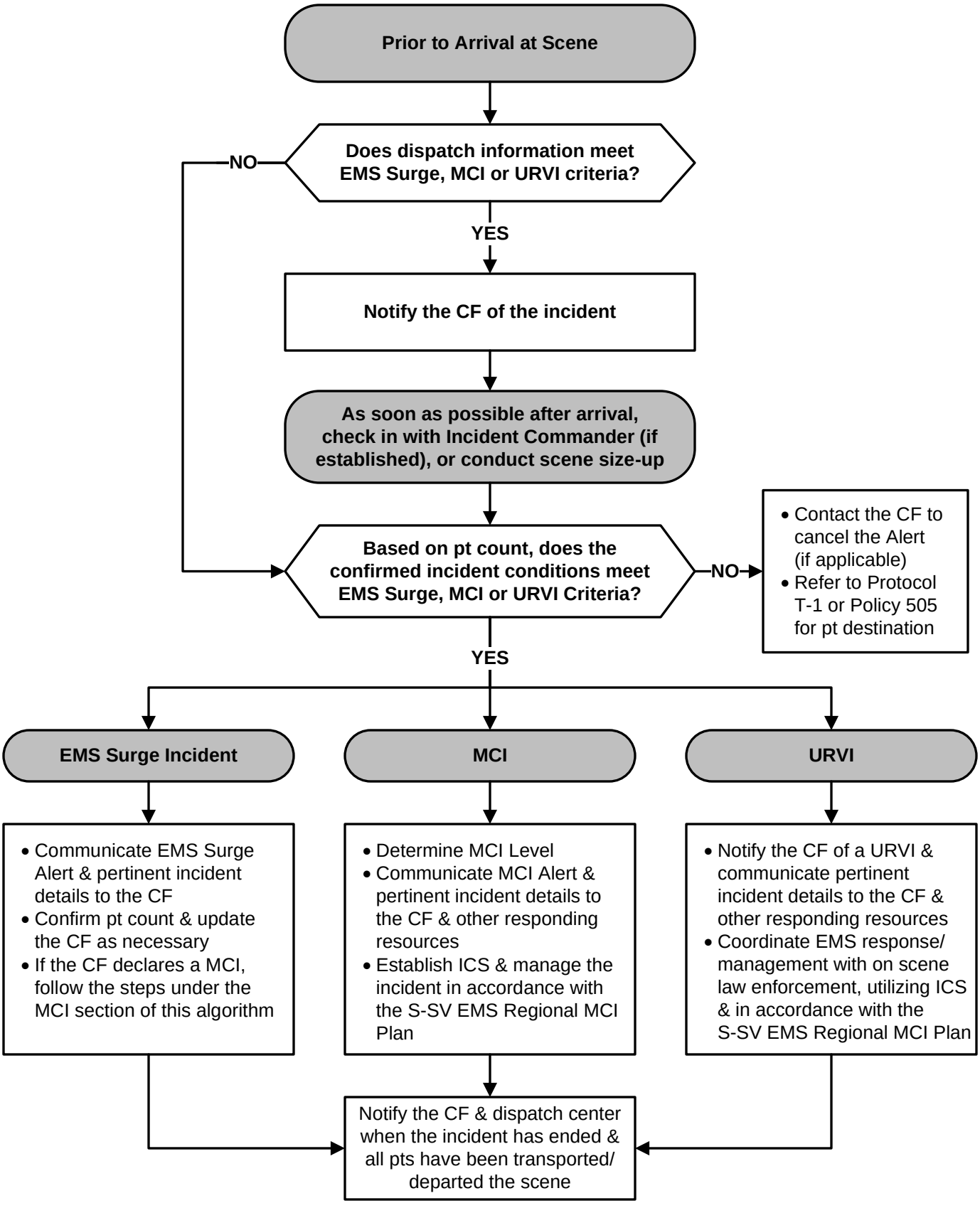
Who:

- Dispatch center, prehospital resources, or CF.

Why:

- To provide early notification for situation status reporting, hospital polling and initiation of the Regional MCI Plan.

Multiple Patient Incidents



REGIONAL MULTIPLE CASUALTY INCIDENT (MCI) PLAN

Sierra-Sacramento Valley EMS Agency

Updated: October 2024

CONTENTS

ADMINISTRATIVE

PURPOSE

- The S-SV EMS Regional MCI Plan is intended to establish minimum standards/ guidelines for managing these types of incidents and does not prevent local agencies from developing additional policies, protocols or procedures that do not conflict with the S-SV EMS Regional MCI plan.
- The ICS organizational structure is designed to be developed/expanded/contracted in a modular fashion, based on the size/scope of the incident and changing incident conditions. This plan contains standardized positions, procedures, checklists, and forms to more efficiently and effectively utilize regional resources during an MCI.

AUTHORITY

- California Health and Safety Code, Section 1797.151, 1798, and 1798.220.
- California Code of Regulations, Sections 100147 and 100169.

TRAINING/EDUCATION

- Initial Training:
  - Who: Prehospital EMS personnel and MICNs.
  - Course: S-SV EMS Regional MCI Training course.
  - When: Course completion valid for (2) years.
- Refresher Training:
  - Who: Prehospital EMS personnel and MICNs.
  - Course: S-SV EMS Regional MCI Refresher Training course.
  - When: Course completion valid for (2) years.
- EMS system participants are responsible for ensuring that their personnel complete the initial and ongoing MCI training/education.

CONCEPTS OF OPERATIONS

ACTIVATION

- Activation of the MCI plan may be made by a first responder agency, ambulance provider, or hospital. If sufficient information is provided, activation may be made prior to on-scene arrival.
- As the number of patients increases, the focus shifts from individual incident management to system sustainability and performance. Activation levels are based on factors such as size, type, location, and other regional incidents that may impact both the EMS and hospital system.

POSITIONS & RESPONSIBILITIES

- Overall on-scene operations shall be under the direction/control of the Incident Commander (IC).
- The IC shall establish incident objectives that prioritize the four (4) T's: Triage, Treatment, Transport, and Tracking.
- Incident positions critical to success are:
  - Incident Commander (IC).
  - Triage Unit Leader.
  - Transportation Unit Leader.
  - Medical Communications Coordinator.
- If there are minimal resources available, the Medical Communications Coordinator may also initially fill the position of Transportation Unit Leader. The expectation is when additional resources arrive on scene, the Transportation Unit Leader ICS position should be handed off to the appropriate designee, as determined by the IC.
- The Medical Communications Coordinator ICS position should remain assigned to the person that made initial contact with the Control Facility (CF). Minimal hand off will allow for consistent communications throughout the incident.
- The expectation is that when an EMS Paramedic Field Supervisor arrives on scene, they will check in with the IC and receive an ICS position when appropriate.
- Each EMS system participant has specific responsibilities during an MCI response. Depending on the nature, size, and complexity of the event, certain activities may be modified from normal daily operating procedures.
- Due to the unique aspects of multi patient incidents, the first paramedic on scene will not be able to effectively perform the same patient health care management responsibilities as they would during a single incident. The first arriving/initial paramedic is expected to receive an ICS position from the IC. The position assigned will depend on the size and needs of the incident, as determined by the IC.
- For MCIs involving multiple pediatric victims or multiple family members, consider a position to assist with family reunification at a designated area.

RESOURCES

- Resources should typically function within their pre-assigned responsibilities, i.e.- fire service personnel should focus efforts on incident command, patient triage, and disentanglement/extrication, while ground ambulance providers should focus on patient treatment and rapid transportation.
- Aside from safety hazard mitigation, the priority of the first resource on scene is completing a scene size up and obtaining an approximate patient count.
- Upon arrival at the incident, resources must check in with the IC or their assigned ICS supervisor.
- Typically, the first arriving ambulance will not be utilized for transport as those personnel will hold ICS positions/responsibilities.
- The positions of Transport Unit Leader and Medical Communications Coordinator should remain in close physical proximity to the IC to maintain effective communication and effective/efficient scene management.
- If a HEMS provider is assigned to an MCI, they will typically transport their assigned patient(s) to the furthest hospital. They may also be assigned patients and receiving hospital destinations based on clinical needs.

COMMUNICATIONS

- EMResource shall be used for notification/situational awareness purposes, and to quickly obtain bed availability from appropriate receiving hospitals.
- Patient destination is determined in coordination between the on-scene Medical Communications Coordinator and the CF. Level 3 incidents may include assistance from the S-SV EMS Duty officer if necessary.

DOCUMENTATION

PATIENT CARE REPORTS (PCRs)

- EMS PCRs shall be completed for all victims (patients and individuals determined to be deceased on-scene), according to applicable S-SV EMS policies, unless this requirement is waived by S-SV EMS on an incident specific basis.
- Patient triage tag numbers should be documented on the applicable PCR(s).

ICS FORMS

- EMS personnel shall complete additional ICS paperwork if requested by the IC, based on the nature/size of the incident.
- Patient Tracking Worksheet (Appendix H).
  - This worksheet shall be utilized to track all patients during an MCI.
  - Copies of completed patient tracking worksheets shall be submitted to S-SV EMS as soon as possible (either during or immediately following the conclusion of the event as appropriate based on specific incident circumstances).
- Patient Transportation Resource Staging Log (Appendix F).
  - This log shall be utilized by the Ground Ambulance Coordinator and/or HEMS Coordinator (as applicable) to track patient transportation resource availability and activities anytime a ground ambulance and/or HEMS staging area is established.
- ICS 214 Activity Log (Appendix I).
  - This log is used to record details of notable activities at any ICS level including:
    - Single resources.
    - Ambulance strike team/task force resources.
  - These logs provide basic incident activity documentation and are used as reference for after action reports.
  - These logs can be initiated/maintained by personnel in various ICS positions, as necessary/appropriate.
  - Personnel should document how relevant incident activities are occurring/ progressing, or any notable events/communications.

MCI FEEDBACK/REPORTING FORM

- An MCI Details/Feedback Form (Appendix J) shall be submitted to S-SV EMS within seven (7) calendar days of the incident by the following EMS providers:
  - Prehospital ground and air transport providers.
  - Control Facility (CF) and receiving facilities.
  - Incident Commander
  - Prehospital non-transport/first responder providers (recommended/optional).
- S-SV EMS will evaluate the incident details/documentation and determine if additional formal after-action review/follow-up is necessary.

APPENDIX A – MCI LEVELS

MULTIPLE-PATIENT INCIDENT LEVELS			
EMS SURGE INCIDENT	**LEVEL 1 MCI 5 - 15 PATIENTS**	**LEVEL 2 MCI 15 - 49 PATIENTS**	**LEVEL 3 MCI 50+ PATIENTS**
• An incident that does not overwhelm prehospital resources but has the potential to overwhelm hospital resources with multiple patients. • Three (3) or more ground or air transport resources are requested to respond to a single incident. • Multiple patients are released at scene who may arrive at a hospital(s) by private vehicle. • Three (3) or more patients are identified after arrival at the scene of an incident. • A Unified Response to Violent Incident (URVI).	• Single event, generally handled with local resources. • Can be declared enroute to the incident, with adequate dispatched information, or on scene.	• Simultaneous minor to moderate incidents or single moderate to large scale incident. • Requires modifications to the routine EMS system to support the incident. • Will likely require mutual aid/assistance. • Notification of the S-SV EMS Duty Officer required. • May require MHOAC Program notification.	• Catastrophic events producing excessive numbers of patients that overwhelm local and routine mutual aid resources. • Requires modifications to the routine EMS system to support the incident, including significant use of mutual aid resources. • Notification of the S-SV Duty Officer and MHOAC Program required.
EXAMPLES			
• Dispatched to a multiple vehicle collision at a high rate of speed. • Report of active shooter. • Hazmat incident with unknown patient count. • Structure fire with possible victims.	• Vehicle accident involving high occupancy vehicles. • Multiple acute overdoses. • Multiple confirmed shooting victims. • Multiple patients requiring transport to specialty receiving centers.	• Public transit or school bus accident. • Commercial structure fire with possible victims. • Vehicle into a large public gathering. • Hazmat incident at a public gathering.	• Catastrophic explosion with widespread damage. • Commercial aircraft crash. • Catastrophic earthquake.

APPENDIX B – PROVIDER RESPONSIBILITIES

CONTROL FACILITY (CF)

PRIMARY AREA(S) OF RESPONSIBILITY

- Coordinate patient distribution with on-scene Medical Communications Coordinator and receiving hospitals.

LEVEL 1 MCI	LEVEL 2 MCI	LEVEL 3 MCI
✓ Confirm location, type of incident and initial patient count. ✓ Complete EMResource event notice and receiving hospital polling. ✓ Coordinate appropriate patient distribution with on scene Medical Communications Coordinator.	✓ All Level 1 MCI responsibilities. ✓ Consider activating the hospital's surge plan.	✓ All Level 2 MCI responsibilities. ✓ Coordinate with the S-SV EMS Agency Duty Officer for regional/statewide bed availability as necessary.

RECEIVING HOSPITALS

PRIMARY AREA(S) OF RESPONSIBILITY

- Provide timely MCI patient receiving capability information to the Control Facility (CF) and receive/treat EMS transported patients.

LEVEL 1 MCI	LEVEL 2 MCI	LEVEL 3 MCI
✓ Respond to the CF generated EMResource event hospital bed availability poll within 5 minutes. ✓ Make internal notifications and institute appropriate emergency department procedures per hospital protocol. ✓ Monitor EMResource for CF generated incident updates and patient destination assignments.	✓ All Level 1 MCI responsibilities. ✓ Assess ability to handle additional patients. ✓ Consider activating the hospital's surge plan.	✓ All Level 2 MCI responsibilities.

S-SV EMS AGENCY DUTY OFFICER

PRIMARY AREA(S) OF RESPONSIBILITY

- Take any appropriate actions to ensure objectives are met. This may include suspension of hospital diversion, policy modification or suspension, modified dispatch procedures, etc.
- Assume the role of MHOAC or notify the MHOAC Program (as applicable) and possibly assume the Medical Health Branch Director ICS position.
- Coordinate medical mutual aid requests with the applicable Regional Disaster Medical Health Coordinator/Specialist (RDMHC/S) Program.

LEVEL 1 MCI	LEVEL 2 MCI	LEVEL 3 MCI
✓ Monitor the incident. ✓ Offer EMS system support as needed/requested.	✓ All Level 1 MCI responsibilities. ✓ Consider activation of the MHOAC Program. ✓ Make necessary notifications. ✓ Consider notifying the applicable OES coordinator for possible EOC activation.	✓ All Level 2 MCI responsibilities. ✓ Activate the MHOAC Program. ✓ Notify the applicable OES coordinator in order to establish an EOC. ✓ Perform ICS role as needed/requested by IC.

PUBLIC SAFETY AGENCIES

PRIMARY AREA(S) OF RESPONSIBILITY

- Overall on-scene incident management.

LEVEL 1 MCI	LEVEL 2 MCI	LEVEL 3 MCI
✓ Establish incident command. ✓ Fill appropriate ICS positions, guided by the 'Level 1 MCI Initial Response Organization Chart' (Appendix C). ✓ Fill additional positions as needed. ✓ Communicate with dispatch and all incoming units. ✓ Ensure early notification to the applicable Control Facility (CF), in coordination with ambulance provider agency personnel (as applicable). ✓ Consider additional resource needs if MCI escalates/expands.	✓ All Level 1 MCI responsibilities. ✓ Scale ICS positions according to the size of the incident. ✓ Fill appropriate additional ICS positions, guided by the 'Level 2/3 MCI Initial Response Organization Chart' (Appendix C). ✓ Evaluate current medical supply needs and consider requesting MCI Disaster Cache(s) or other additional resources.	✓ All Level 2 MCI responsibilities. ✓ Fill appropriate additional ICS positions, guided by the 'Level 2/3 MCI Initial Response Organization Chart' (Appendix C).

GROUND AMBULANCE PROVIDER AGENCIES

PRIMARY AREA(S) OF RESPONSIBILITY

- Assume/manage appropriate ICS positions, as assigned by the IC.
- Patient treatment and transportation to assigned hospital(s).

LEVEL 1 MCI	LEVEL 2 MCI	LEVEL 3 MCI
✓ Ensure early notification to the applicable Control Facility (CF), in coordination with the IC. ✓ Ensure response from an on-duty Paramedic Field Supervisor (if available). ✓ Evaluate the need for additional EMS/ transportation resources, in coordination with the IC.	✓ All Level 1 MCI responsibilities. ✓ Ensure response from an on-duty Paramedic Field Supervisor (if available). ✓ A Paramedic Field Supervisor may fill an appropriate ICS position, as assigned by the IC. ✓ Remain assigned to the incident until released by the IC/designee. ✓ Consider initiating internal disaster plans for extended operations. ✓ Consider recalling off-duty personnel to support extended medical operations.	✓ All Level 2 MCI responsibilities. ✓ Initiate internal disaster plans for extended operations. ✓ Recall personnel for extended operations.

HEMS PROVIDER AGENCIES

PRIMARY AREA(S) OF RESPONSIBILITY

- Patient treatment and transportation to assigned hospital(s).
- Provide clinical care on scene as appropriate/necessary.

LEVEL 1 MCI	LEVEL 2 MCI	LEVEL 3 MCI
✓ Monitor incident enroute. ✓ Provide aircraft availability if requested. ✓ Initiate/maintain contact with the IC/designee. ✓ Confirm patient/destination assignment with the IC or Transportation Unit Leader (as applicable) once on-scene.	✓ All Level 1 MCI responsibilities. ✓ Consider cancelling non-emergency HEMS activity. ✓ Remain in contact with other possible aircraft responding to the incident. ✓ Remain assigned to the incident until released by the IC/designee. ✓ Consider initiating internal disaster plans for extended operations. ✓ Consider recalling off-duty personnel to support extended medical operations.	✓ All Level 2 responsibilities. ✓ Initiate internal disaster plans for extended operations. ✓ Recall personnel for extended operations.

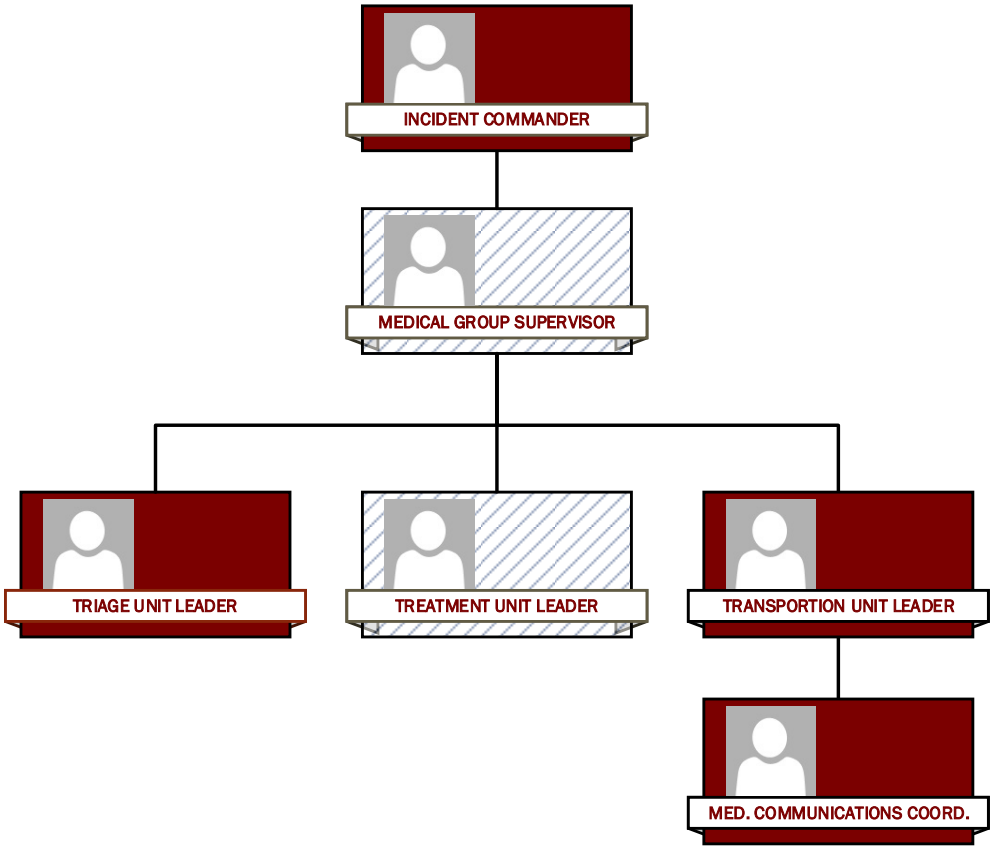
APPENDIX C – MCI ORGANIZATIONAL CHARTS

The following organizational charts are intended to provide the Incident Commander (IC) with a basic, expandable system to manage multiple-casualty incidents of varying complexity. The degree of organizational structure should be driven by the Incident needs, as determined by the IC. These charts may also be referenced by any responder so they may be able to anticipate their position and expectation prior to arrival on scene.

INITIAL RESPONSE ORGANIZATION
LEVEL 1 MCI

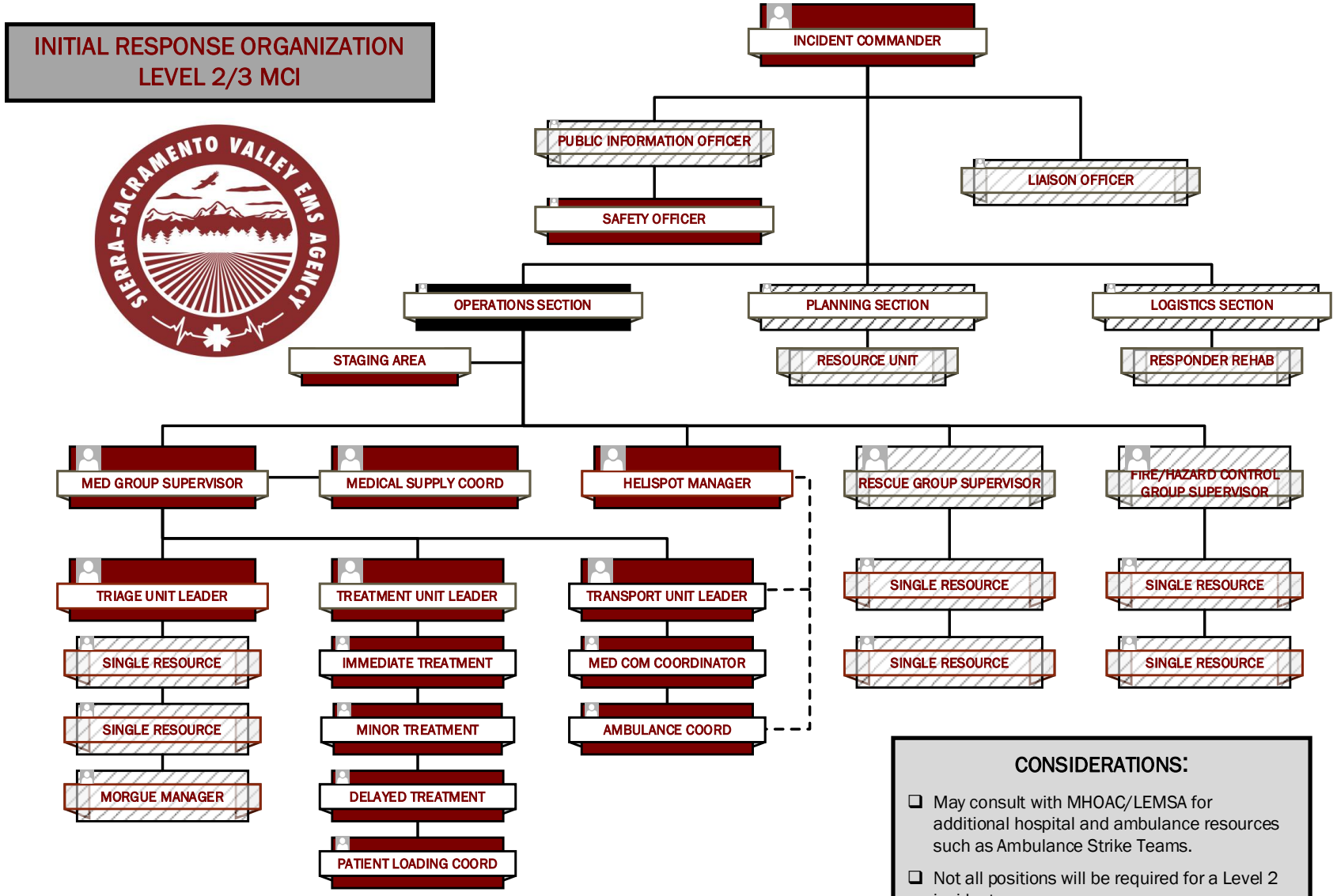
CONSIDERATIONS:

- ❑ Declare MCI
- ❑ Assume command
- ❑ Scene survey, size-up, initial resource order
- ❑ Assess scene hazards including need for decontamination
- ❑ At a minimum, assign Triage Unit Leader and Transportation Unit Leader (Transportation Unit Leader will assume the Medical Communication Coordinator position until additional resources are available)
- ❑ Begin START/JUMPSTART triage
- ❑ Establish appropriate treatment areas
- ❑ Complete patient tracking forms



Initial Response Organization: The Incident Commander manages initial response resources as well as all Command and General Staff responsibilities. All arriving resources shall check in with the Incident Commander for assignment. Positions in red shall be assigned prior to assigning other positions. As additional ALS resources become available, the Transportation Unit Leader and/or Triage Unit Leader positions may be re-assigned. The Medical Communications Coordinator position should not be transferred after communication with the hospital has been established. The Incident Commander, Transportation Unit Leader and Medical Communication Coordinator should remain in close physical proximity throughout the event.

INITIAL RESPONSE ORGANIZATION
LEVEL 2/3 MCI

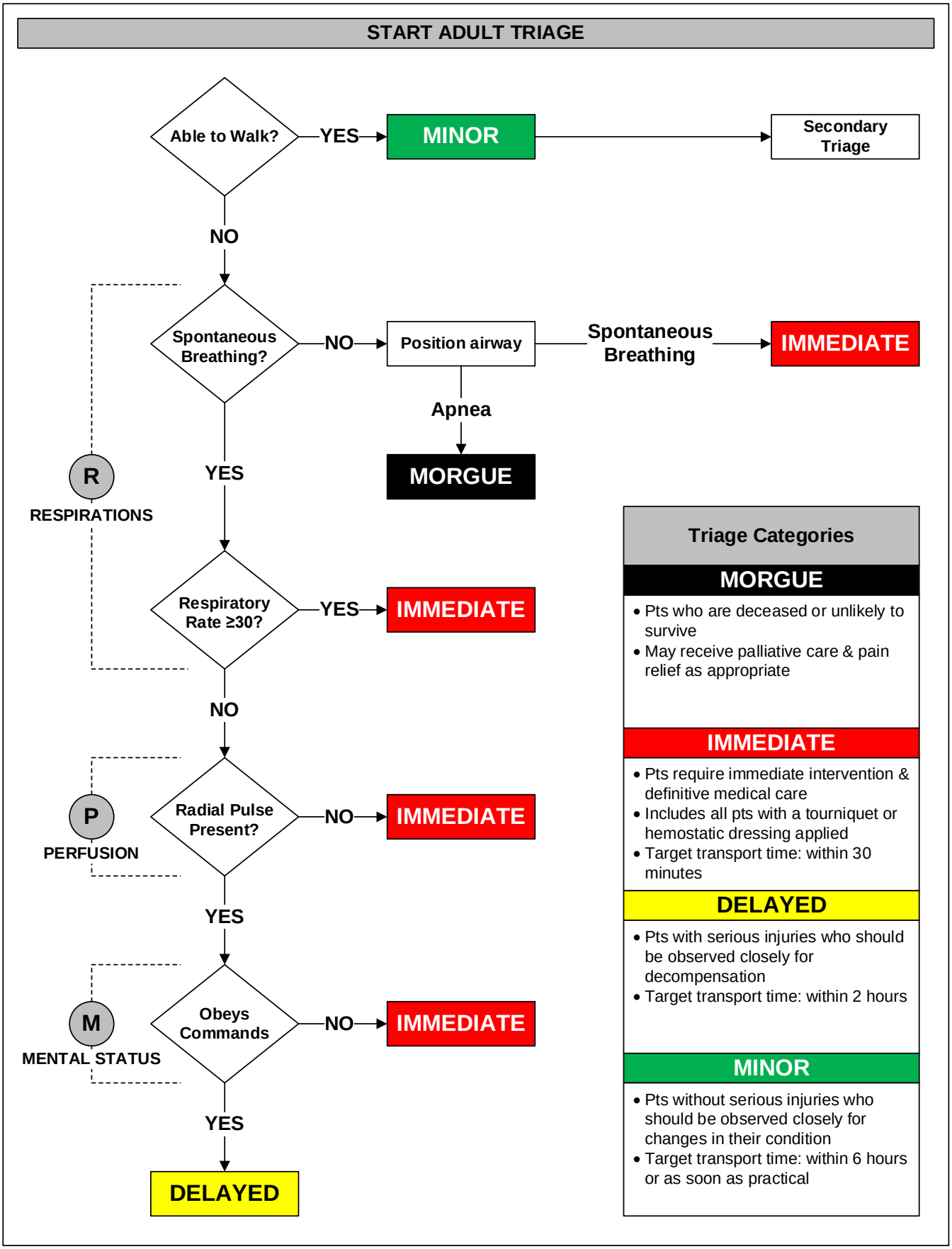


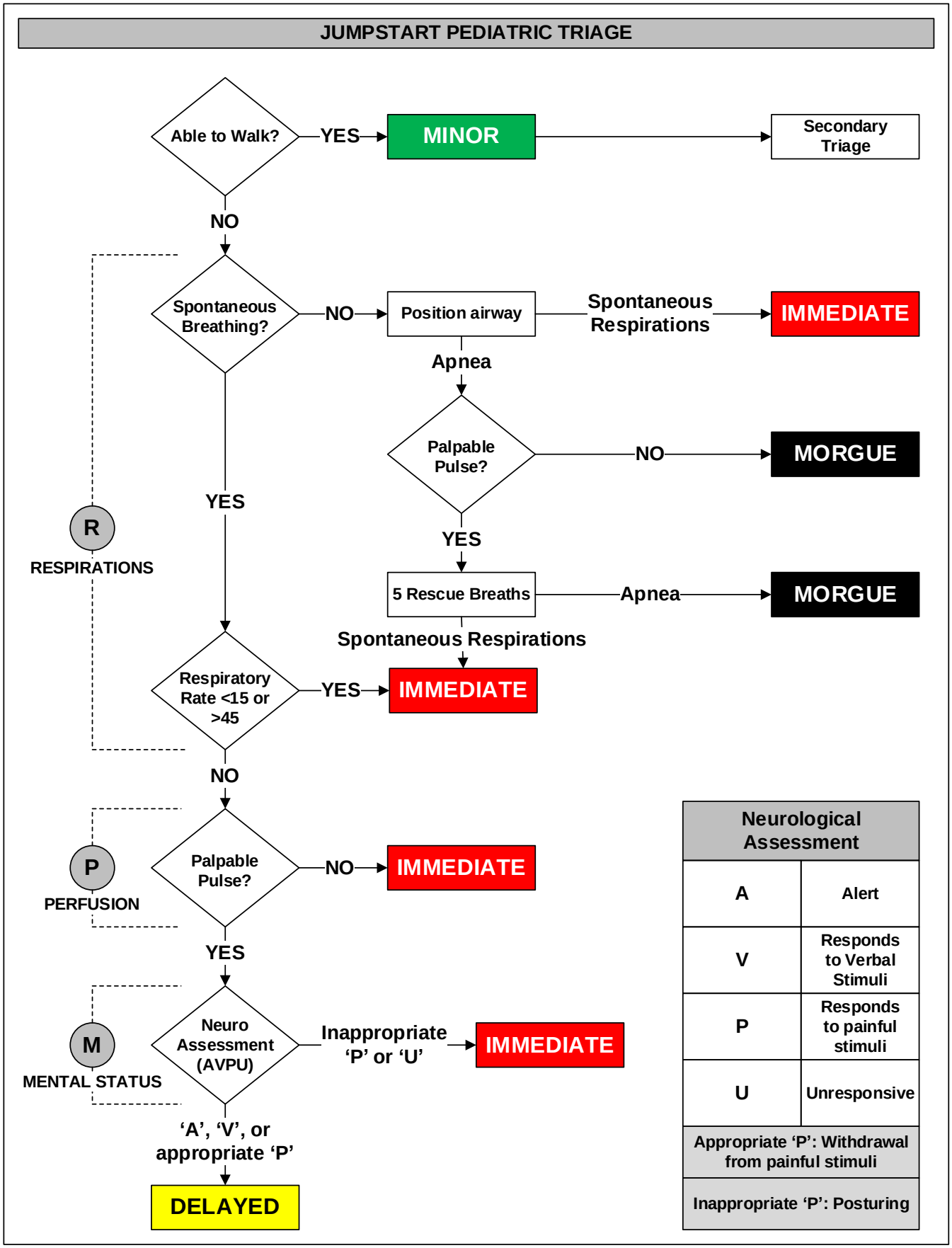
CONSIDERATIONS:

- ❑ May consult with MHOAC/LEMSA for additional hospital and ambulance resources such as Ambulance Strike Teams.
- ❑ Not all positions will be required for a Level 2 incident.

Multi-Group Response: All positions within the Medical Group are now filled. Rescue Group may be established to free entrapped victims. Fire/Hazard Control Group may be established to control any fire or hazardous conditions.

APPENDIX D – START & JUMPSTART TRIAGE ALGORITHMS


START ADULT TRIAGE
Able to Walk?
YES
MINOR
Secondary Triage
NO
Spontaneous Breathing?
NO
Position airway
Spontaneous Breathing
IMMEDIATE
Apnea
MORGUE
R
RESPIRATIONS
YES
Respiratory Rate ≥30?
YES
IMMEDIATE
NO
P
PERFUSION
Radial Pulse Present?
NO
IMMEDIATE
YES
M
MENTAL STATUS
Obeys Commands
NO
IMMEDIATE
YES
DELAYED
Triage Categories
MORGUE
• Pts who are deceased or unlikely to survive
• May receive palliative care & pain relief as appropriate
IMMEDIATE
• Pts require immediate intervention & definitive medical care
• Includes all pts with a tourniquet or hemostatic dressing applied
• Target transport time: within 30 minutes
DELAYED
• Pts with serious injuries who should be observed closely for decompensation
• Target transport time: within 2 hours
MINOR
• Pts without serious injuries who should be observed closely for changes in their condition
• Target transport time: within 6 hours or as soon as practical


JUMPSTART PEDIATRIC TRIAGE
Able to Walk?
YES
MINOR
Secondary Triage
NO
Spontaneous Breathing?
NO
Position airway
Spontaneous Respirations
IMMEDIATE
Apnea
Palpable Pulse?
NO
MORGUE
YES
YES
R
RESPIRATIONS
5 Rescue Breaths
Apnea
MORGUE
Spontaneous Respirations
Respiratory Rate <15 or >45
YES
IMMEDIATE
NO
P
PERFUSION
Palpable Pulse?
NO
IMMEDIATE
YES
M
MENTAL STATUS
Neuro Assessment (AVPU)
Inappropriate 'P' or 'U'
IMMEDIATE
'A', 'V', or appropriate 'P'
DELAYED
Neurological Assessment
A
Alert
V
Responds to Verbal Stimuli
P
Responds to painful stimuli
U
Unresponsive
Appropriate 'P': Withdrawal from painful stimuli
Inappropriate 'P': Posturing

APPENDIX E – MCI ICS POSITION JOB SHEETS

TRIAGE UNIT LEADER

Description:

The Triage Unit Leader supervises Triage Personnel. The Triage Unit Leader assumes responsibility for providing triage management and movement of patients from the triage area. When triage has been completed and all patients have been moved to treatment areas, the Triage Unit Leader may be reassigned.

Responsibilities:

- ✓ Determines initial patient count.
  - Notifies IC of initial patient count as soon as determined.
  - If Medical Communications Coordinator and/or Transportation Unit Leader have been established, also notifies these positions of initial patient count.
- ✓ Informs IC or appropriate ICS supervisor of needs.
- ✓ Implements triage process.
  - Utilize START (adult)/Jump START (pediatrics) criteria.
- ✓ Assures triage tags are utilized for all patients.
- ✓ Receives/maintains all triage tag stubs until they are passed to the Treatment Unit Leader.
- ✓ Coordinates movement of patients from the triage area to the treatment area if different location.
- ✓ Gives periodic status updates to the IC or appropriate ICS supervisor.
- ✓ At the completion of START/Jump START triage, patients may be re-triaged as time and resources permit.

Who is Appropriate for This Position?

- ✓ **Fire Department EMT or Paramedic (Preferred).**
- ✓ Ground ambulance EMT or Paramedic.

Equipment Needed

- ✓ ICS vest.
- ✓ Radio/cell phone for CF communications.
- ✓ Patient Tracking Worksheet.

TRANSPORTATION UNIT LEADER

Description:

The Transportation Unit Leader supervises the Medical Communications Coordinator, Ground Ambulance Coordinator, and Air Ambulance Coordinator (if applicable). They are responsible for coordination of patient transportation and maintenance of records relating to patient's identification, condition, and destination. The responsibilities of this position may initially be assigned to/managed by the Medical Communications Coordinator. Upon arrival of additional resources, the Transportation Unit Leader position shall be handed off to an appropriate designee (in coordination with the IC). Depending on the size/complexity of the incident, this position may need to be upgraded to Group Supervisor level as determined by the IC.

Responsibilities:

- ✓ Designates ambulance staging area(s).
- ✓ Establishes communication with Medical Communications Coordinator, Ground/Air Ambulance Coordinators.
- ✓ Directs transportation of patients as determined by the Medical Communications Coordinator.
- ✓ Assures the documentation of patient information and destinations.
- ✓ Coordinates the establishment of the Helispot(s).
- ✓ Requests additional medical transportation resources as needed from IC or appropriate ICS supervisor

Who is Appropriate for This Position?

- ✓ **Paramedic Field Supervisor (Preferred).**
- ✓ ALS non-transport provider paramedic.
- ✓ Ground ambulance provider paramedic.

Equipment Needed

- ✓ ICS vest.
- ✓ Patient Tracking Worksheet.

TREATMENT UNIT LEADER

Description:

The Treatment Unit Leader supervises treatment area managers and the Patient Loading Coordinator. The Treatment Unit Leader assumes responsibility for re-triage, treatment, preparation for transport, and movement of patients to the loading locations.

Responsibilities:

- ✓ Directs/supervises the Immediate, Delayed, and Minor Treatment Areas and the Patient Loading Coordinator.
- ✓ Establishes communication with the Transportation Unit Leader (when applicable) and Patient Loading Coordinator.
- ✓ Ensures proper patient decontamination and notifications (when applicable).
- ✓ Ensures continued re-triage and movement of patients within the treatment areas when necessary.
- ✓ Coordinates movement of patients from the Triage Area to the Treatment Area(s).
- ✓ Assigns treatment personnel, in coordination with the IC or appropriate ICS supervisor.
- ✓ Requests sufficient medical caches/supplies.
- ✓ Coordinates movement of patients to the patient loading area(s).
- ✓ Gives periodic status updates to the appropriate ICS supervisor.
- ✓ Requests special medical resources through the IC.

Who is Appropriate for This Position?

- ✓ **Ground ambulance paramedic (preferred for Level 1 MCIs).**
- ✓ **Paramedic Field Supervisor (preferred for Level 2/3 MCIs).**
- ✓ ALS non-transport provider paramedic.
- ✓ EMT/AEMT (if paramedic personnel are not available or ETA is extended).

Equipment Needed

- ✓ ICS vest.
- ✓ Treatment Area Worksheets.

MEDICAL COMMUNICATIONS COORDINATOR

Description:

The Medical Communications Coordinator establishes communication with the appropriate Control Facility (CF) to determine patient destination assignments. They should remain near the IC or appropriate ICS supervisor. The Medical Communications Coordinator should not be assigned additional ICS positions or be involved in triage or treatment of patients. The position of Medical Communications Coordinator is crucial to the success of the tracking of patients from the scene to hospitals. This position should be established as early as possible.

Responsibilities:

- ✓ Establishes communication with the appropriate CF.
- ✓ Provides pertinent basic patient information to the CF as follows:
  - Patient Age.
  - Patient Gender.
  - Triage Category.
  - Triage Tag #.
- ✓ Receives basic patient information and triage information from the Triage Unit Leader and re-triage information from the Treatment Unit Leader (if applicable).
- ✓ Receives patient destinations from the CF.
- ✓ Works with the Transportation Unit Leader to coordinate patient transportation needs.

Who is Appropriate for This Position?

- ✓ **Ground ambulance paramedic (preferred).**
- ✓ Paramedic Field Supervisor.
- ✓ ALS non-transport provider paramedic.
- ✓ Ground ambulance EMT/AEMT.

Equipment Needed

- ✓ ICS vest.
- ✓ Radio/cell phone for CF communications.
- ✓ Patient Tracking Worksheet.

GROUND AMBULANCE COORDINATOR

Description:

The Ground Ambulance Coordinator manages the ground ambulance staging area(s) and dispatches ground ambulances as requested.

Responsibilities:

- ✓ Establishes appropriate staging area for ground ambulance resources and communicates the location of the staging area(s) to the IC or appropriate ICS supervisor.
- ✓ Establishes route of travel from staging area to the patient loading area
- ✓ Establishes communications/mode of contact with ambulance personnel in the ground ambulance staging area(s).
- ✓ Establishes/maintains communication with the Medical Communications Coordinator.
- ✓ Provides ambulance resources upon request from the Medical Communications Coordinator or appropriate ICS position.
- ✓ Ensures the necessary equipment/personnel to manage patient needs is provided in each ambulance.
- ✓ Requests additional ground ambulance resources through the IC or appropriate ICS position, based on incident needs.
- ✓ Considers the use of alternative transportation resources, when necessary, in conjunction with Medical Communications Coordinator and the Control Facility (CF).
- ✓ Provides an inventory of medical supplies available in the ground ambulance staging area.

Who is Appropriate for This Position?

- ✓ **BLS fire department/district personnel (preferred).**
- ✓ Ground ambulance EMT.
- ✓ Other fire department/district personnel.

Equipment Needed

- ✓ Patient Transportation Resource Staging Log.

HEMS COORDINATOR

Description:

The HEMS Coordinator communicates with the Transportation Unit Leader and Ground Ambulance Coordinator. They coordinate patient air transportation needs with the Helispot Manager.

Responsibilities:

- ✓ Establishes communication with the Transportation Unit Leader to determine hospital destinations.
- ✓ Coordinates patient loading from ground ambulances with the Helispot Manager.
- ✓ Confirms type of HEMS resources/patient capabilities with the Helispot Manager and provides this information to the Medical Communications Coordinator and the Transportation Unit Leader.

Who is Appropriate for This Position?

- ✓ **BLS fire department/district personnel (preferred).**
- ✓ Other fire department/district personnel.

Equipment Needed

- ✓ Patient Transportation Resource Staging Log.

PATIENT LOADING COORDINATOR

Description:

The Patient Loading Coordinator is responsible for coordinating with the Transportation Unit Leader (or Group Supervisor if established), the transportation of patients out of the Treatment Areas.

*Note: During a level 1 MCI, this position may be held by the Treatment Unit Leader

Responsibilities:

- ✓ Establishes communication with treatment area managers and the Transportation Unit Leader.
- ✓ Verifies prioritization of patients for transport.
- ✓ Advises the Medical Communications Coordinator when patients are ready for transport.
- ✓ Coordinates transportation of patients with the Medical Communications Coordinator.
- ✓ Coordinates ambulance loading with treatment managers and ambulance personnel.

Who is Appropriate for This Position?

- ✓ **BLS fire department/district personnel (preferred).**
- ✓ Other fire department/district personnel.

Equipment Needed

- ✓ N/A

MEDICAL GROUP SUPERVISOR

Description:

The Medical Group Supervisor reports to the IC on smaller incidents and the Medical Branch Director on larger incidents. The Medical Group Supervisor supervises the Triage Unit Leader, Treatment Unit Leader, Transportation Unit Leader, and Medical Supply Coordinator if applicable.

Responsibilities:

- ✓ Supervises Triage, Treatment, and Transportation Unit Leaders.
- ✓ Ensures that proper medical care is rendered at the treatment areas.
- ✓ Determines resources and supplies needed for the medical aspect of the incident.
- ✓ Establishes direct communication with the Transportation Unit Leader.

Who is Appropriate for This Position?

- ✓ **Paramedic Field Supervisor (preferred).**
- ✓ ALS non-transport provider fire captain.
- ✓ ALS non-transport provider paramedic
- ✓ Ground ambulance paramedic.

Equipment Needed

- ✓ ICS vest.
- ✓ Appropriate ICE forms.

MEDICAL BRANCH DIRECTOR

Description:

The Medical Branch Director is responsible for implementing the Incident Action Plan (IAP) within the medical branch. They supervise the medical group(s) and Transportation Unit/Group.

Responsibilities:

- ✓ Reviews/modifies group assignments as needed.
- ✓ Provides input to the Operations Section Chief for the IAP.
- ✓ Supervises Medical Branch activities and confers with the Safety Officer.
- ✓ Reports to the Operations Section Chief on branch activities.

Who is Appropriate for This Position?

- ✓ **S-SV EMS Agency Duty Officer (preferred).**
- ✓ Fire department/district Battalion Chief.

Equipment Needed

- ✓ ICS vest.
- ✓ Appropriate ICE forms.

APPENDIX F – PATIENT TRANSPORTATION RESOURCE STAGING LOG

PATIENT TRANSPORTATION RESOURCE STAGING LOG

Incident Name			Ground Ambulance/HEMS Coordinator		
Provider Agency	**Unit ID**	**Unit Type**	**Staging Time In**	**Staging Time Out**	**Unit Disposition**

APPENDIX G – TREATMENT AREA LOGS

IMMEDIATE TREATMENT AREA LOG

INCIDENT NAME:	
INCIDENT DATE:	
TREATMENT MANAGER NAME:	

TRIAGE TAG #	AGE	GENDER	INJURIES	TRANSPORT TIME

DELAYED TREATMENT AREA LOG

INCIDENT NAME:	
INCIDENT DATE:	
TREATMENT MANAGER NAME:	

TRIAGE TAG #	AGE	GENDER	INJURIES	TRANSPORT TIME

MINOR TREATMENT AREA LOG

INCIDENT NAME:	
INCIDENT DATE:	
TREATMENT MANAGER NAME:	

TRIAGE TAG #	AGE	GENDER	INJURIES	TRANSPORT TIME

MORGUE AREA LOG

INCIDENT NAME:	
INCIDENT DATE:	
TREATMENT MANAGER NAME:	

TRIAGE TAG #	AGE	GENDER	INJURIES	TRANSPORT TIME

APPENDIX H – PATIENT TRACKING WORKSHEET

Patient Tracking Worksheet (837-B) - Updated 10-2024

Incident Name/Location	Incident Date	Form Completed By	Contact Telephone #

Triage Status	Triage Tag # (Last 4) Patient Name (First & Last)	Age Sex	Primary Injury Type	County of Origin Code	Transport Destination	Trans. Unit ID	Trans. Time	ETA	CF Advised
I D M		M F U							
I D M		M F U							
I D M		M F U							
I D M		M F U							
I D M		M F U							

County of Origin Codes

Butte **(XBU)** Colusa **(XCO)** Glenn **(XGL)** Lassen **(XLS)** Modoc **(XMO)** Nevada **(XNE)** Placer **(XPL)** Plumas **(XPU)**
Shasta **(XSH)** Sierra **(XSI)** Siskiyou **(XSK)** Sutter **(XSU)** Tehama **(XTE)** Trinity **(XTR)** Yuba **(XYU)**

Submit completed worksheets via email to Dutyofficer@ssvems.com

APPENDIX I – ICS 214 ACTIVITY LOG

ACTIVITY LOG (ICS 214)

1. Incident Name:	2. Operational Period: Date From: Date To: Time From: Time To:	
3. Name:	4. ICS Position:	5. Home Agency (and Unit):

6. Resources Assigned:

Name	ICS Position	Home Agency (and Unit)

7. Activity Log:

Date/Time	Notable Activities

8. Prepared by: Name: _____ Position/Title: _____ Signature: _____

ICS 214, Page 1 Date/Time: _____

ACTIVITY LOG (ICS 214)

1. Incident Name:	**2. Operational Period:** Date From: Date To: Time From: Time To:

7. Activity Log (continuation)**:**

Date/Time	Notable Activities

8. Prepared by: Name: ________________ Position/Title: ________________ Signature: ________________

ICS 214, Page 2 Date/Time: ________________________________

ICS 214
Activity Log

Purpose. The Activity Log (ICS 214) records details of notable activities at any ICS level, including single resources, equipment, Task Forces, etc. These logs provide basic incident activity documentation, and a reference for any after-action report.

Preparation. An ICS 214 can be initiated and maintained by personnel in various ICS positions as it is needed or appropriate. Personnel should document how relevant incident activities are occurring and progressing, or any notable events or communications.

Distribution. Completed ICS 214s are submitted to supervisors, who forward them to the Documentation Unit. All completed original forms must be given to the Documentation Unit, which maintains a file of all ICS 214s. It is recommended that individuals retain a copy for their own records.

Notes:

- The ICS 214 can be printed as a two-sided form.
- Use additional copies as continuation sheets as needed, and indicate pagination as used.

Block Number	Block Title	Instructions
1	**Incident Name**	Enter the name assigned to the incident.
2	**Operational Period** • Date and Time From • Date and Time To	Enter the start date (month/day/year) and time (using the 24-hour clock) and end date and time for the operational period to which the form applies.
3	**Name**	Enter the title of the organizational unit or resource designator (e.g., Facilities Unit, Safety Officer, Strike Team).
4	**ICS Position**	Enter the name and ICS position of the individual in charge of the Unit.
5	**Home Agency** (and Unit)	Enter the home agency of the individual completing the ICS 214. Enter a unit designator if utilized by the jurisdiction or discipline.
6	**Resources Assigned**	Enter the following information for resources assigned:
	• Name	Use this section to enter the resource's name. For all individuals, use at least the first initial and last name. Cell phone number for the individual can be added as an option.
	• ICS Position	Use this section to enter the resource's ICS position (e.g., Finance Section Chief).
	• Home Agency (and Unit)	Use this section to enter the resource's home agency and/or unit (e.g., Des Moines Public Works Department, Water Management Unit).
7	**Activity Log** • Date/Time • Notable Activities	• Enter the time (24-hour clock) and briefly describe individual notable activities. Note the date as well if the operational period covers more than one day. • Activities described may include notable occurrences or events such as task assignments, task completions, injuries, difficulties encountered, etc. • This block can also be used to track personal work habits by adding columns such as "Action Required," "Delegated To," "Status," etc.
8	**Prepared by** • Name • Position/Title • Signature • Date/Time	Enter the name, ICS position/title, and signature of the person preparing the form. Enter date (month/day/year) and time prepared (24-hour clock).

APPENDIX J – MCI FEEDBACK/REPORTING FORM

MCI FEEDBACK/REPORTING FORM

REPORTING ENTITY	
Reporting Agency:	Reporting Person:
Telephone:	Email Address:
INCIDENT INFORMATION (COMPLETE AS APPLICABLE TO YOUR AGENCY'S ROLE)	
Incident Date:	Incident Name:
Incident Location:	
Dispatch Time:	First Unit On Scene Time:
First Transport Unit On Scene Time:	Supervisor On Scene Time:
Incident End Time:	
First Responder Agencies:	
Ground Transport Agencies:	
# of Ground Ambulances:	
EMS Aircraft Agencies:	
Other Transport Resources:	
Incident Commander:	Transportation Unit Leader:
Triage Unit Leader:	Med. Communications Coord.:
Treatment Unit Leader:	Were MCI ID Vests Used? ☐ Yes ☐ No
Were Triage Tags Used? ☐ Yes ☐ No	Were Pt. Tracking Sheets Used? ☐ Yes ☐ No

Number & Type Of Patients			
IMMEDIATE:	DELAYED:	MINOR:	DECEASED:
# Of Adult Patients:		# Of Pediatric Patients:	
# Of Patients Transported:		# Of Patients Refusing Transport:	

Hospital Information (CF = Control Facility)	
CF Name:	Initial CF Contact Time:
Initial CF Notification Received From (Dispatch, Field, etc.):	
Number Of CF Staff Assigned:	CF Pt. Dispersal Officer:
Receiving Facilities Utilized:	

MCI COMMENTS/ISSUES/SUGGESTIONS/OBSERVATIONS (REQUIRED)