

Stanislaus County

Emergency Medical Services Agency



Field Treatment Book

Selected Policies

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New Protocols



CORONARY ISCHEMIA CHEST PAIN

ADULT

BLS Procedures

Assess Vitals.
Obtain spO2.
Oxygen. Titrate to SPO2 to 94% or higher.
Provide calming measures.

Aspirin 324 mg PO.

Assist with Nitroglycerin 0.4 mg Sublingual.

- May assist if patient has existing Nitroglycerin prescription.
- Do not administer if SBP less than 100 mmHg.
- May repeat every 5 minutes.
- Max of 3 total doses (1.2mg total)

ALS Standing Orders

Follow BLS procedure if applicable.

Obtain ECG & 12-lead.

- Shall obtain 12-lead within 10 minutes of patient contact or document the reason for delay in PCR.
- If accurately obtained 12-lead ECG interpretation reveals *****ACUTE MI/SUSPECTED***** or manufacturer equivalent, expedite transport to SRC, and transmit ECG to STEMI Receiving Center.

IV/IO Access as needed.

Utilize ETC02 for patients receiving narcotics.

Nitroglycerin 0.4 mg Sublingual.

- May repeat every 5 minutes.
- Max of 3 total doses (1.2 mg), including NTG taken by patient, or NTG assisted by BLS.

Utilizing Paramedic judgment, refer to “Pain Management” protocol if pain persists after Nitroglycerin administration.

Contraindications

Nitroglycerin

- SBP less than 100mmHg
- PDE-5 inhibitors within 24 hours
 - PDE-5 inhibitors include Sildenafil (Viagra), Avanafil (Stendra), Tadalafil (Cialis), Vardenafil (Levitra and Staxyn), or equivalent.

Special Considerations

- Accurate 12-Lead ECG means minimal to no artifact, with a steady and straight baseline tracing.
- Repeat ECG’s may be necessary to achieve an accurate 12-Lead ECG
- Female, geriatric, and diabetic patients often have atypical pain/discomfort. Have a high index of suspicion for these patients and perform early 12-Lead ECG

Base Hospital Orders Only

Contact Base Hospital physician for treatment that exceeds written protocol



Medical Arrest	
ADULT	PEDIATRIC
Primary Direction	
<ul style="list-style-type: none"> In the absence of factors requiring rapid transport (e.g., unsafe scene), all attempts should be made to perform resuscitative efforts on scene for a MINIMUM of 20 minutes or until ROSC is achieved. Transport pediatrics after 10 minutes of on-scene ALS interventions. Movement and transport of patients interrupts CPR and prevents adequate depth and rate of compressions. 	
BLS	
Compression depth 2" - 2.5"	Compression depth of at least 1/3 the diameter of the chest size
<u>Operating with less than 3 EMS personnel.</u>	
<p>Provide High Performance CPR</p> <ul style="list-style-type: none"> If Mechanical Compression Device is utilized, minimize pauses, and follow guidelines under General Protocols 554.00. <p>Automated External Defibrillator (AED)</p> <ul style="list-style-type: none"> Follow AED prompts, shock if indicated. <p>Once compressions and AED are deployed</p> <ul style="list-style-type: none"> Passive Oxygenation via Non-rebreather mask 15 LPM. OPA and bilateral NPAs. 	
<u>Operating with 3 or more EMS personnel *OR* after 8 minutes of resuscitation</u>	
<ul style="list-style-type: none"> High Performance CPR. Ventilate BVM with 100% Oxygen. 1 ventilation every 6-8 seconds. Establish Agency approved appropriately sized Supraglottic Airway (SGA) device. <p><i>Consider earlier ventilations for pediatrics, as most medical cardiac arrests in pediatrics are hypoxia driven.</i></p>	
ALS	
<p>Cardiac monitor (Defibrillation Pads). EtCO2.</p> <p>IV/IO Access (Humeral IO for adults is preferred over tibia IO).</p> <p>Identify and treat any potential reversible causes.</p> <p>Transmit Code Report via Physio Control Monitor – Required for all cardiac arrests.</p>	
Ventricular Fibrillation (VF)/Pulseless Ventricular Tachycardia (VT)	
<p>Manual Defibrillation on a 2-minute cycle.</p> <ul style="list-style-type: none"> Pre-charge the monitor at least 15 seconds before pulse check, continue compressions during charging. Minimize pause to less than 10 seconds. Switch compressors every 2 minutes if not using mechanical compression device. 	

<p>Defibrillate using manufacturer recommended energy dose.</p> <ul style="list-style-type: none"> Repeat as necessary at every pulse check. Increase dose per manufacturer recommendation. <p>Epinephrine (1:10,000) 1 mg IV/IO</p> <ul style="list-style-type: none"> Repeat every 3 - 5 minutes. Max dose 3 mg. <p>Amiodarone 300 mg (first dose) Slow push IV/IO</p> <ul style="list-style-type: none"> Repeat x 1 in 3 - 5 minutes with 150 mg. Flush with NS 10 mL. <p style="text-align: center;"><u>OR</u></p> <p>Lidocaine 1.5 mg/kg IV/IO</p> <ul style="list-style-type: none"> Repeat x 1 in 3-5 minutes. 	<p>Defibrillate 2 J/kg.</p> <ul style="list-style-type: none"> Repeat every 2 minutes at 4 J/kg. <p>Epinephrine (1:10,000) 0.01 mg/kg IV/IO</p> <ul style="list-style-type: none"> Repeat every 3 - 5 minutes. No Max. <p>Amiodarone 5 mg/kg Slow Push IV/IO</p> <ul style="list-style-type: none"> Max single dose 300 mg. May repeat x 1 in 3 - 5 minutes. Flush with NS 10 mL.
Asystole/Pulseless Electrical Activity (PEA)	
Address reversible causes based on applicable protocols	
<p>Epinephrine (1:10,000) 1 mg IV/IO</p> <ul style="list-style-type: none"> Repeat every 3 - 5 minutes. Up to a Max of 3 mg. <p>Calcium Chloride 1 gm IV/IO</p> <ul style="list-style-type: none"> Administer over 2 minutes. Only If Hyperkalemia highly suspected. <u>Do not use for prolonged downtime.</u> 	<p>Epinephrine (1:10,000) 0.01 mg/kg IV/IO</p> <ul style="list-style-type: none"> Repeat every 3 - 5 minutes. No Max.
Airway Considerations	
<ul style="list-style-type: none"> BLS airway or SGA is the preferred method of airway management during cardiac arrest unless advanced airway is indicated. See General Protocols (554.00) for advanced airway management options. 	
Consideration in Pregnancy Greater Than 20 Weeks Gestations	
<ul style="list-style-type: none"> Place patient 25 degrees left lateral on backboard for CPR. IV/IO should be above the diaphragm. Pregnant patients are more prone to hypoxia so oxygenation and airway management should be prioritized. Consider early SGA or ETT. Do not interrupt CPR to perform procedures. Prepare for early transport after 4 minutes of CPR. 	
Termination of Resuscitation (TOR)	
<p style="text-align: center;"><u>After a minimum of 20 minutes of resuscitation, consider TOR in the following conditions:</u></p> <ul style="list-style-type: none"> Persistent asystole. PEA less than 40 BPM. Patient remains pulseless with no signs of life (unreactive pupils, developing lividity). If resuscitative efforts are terminated, personnel shall confirm and document the patient's cardiac rhythm in 2 separate ECG Leads and document rhythm strips of at least 6 second duration. 	
<p style="text-align: center;"><u>Special Considerations</u></p> <ul style="list-style-type: none"> Consider transport to a STEMI Center if patient has persistent narrow complex PEA greater than 100, or persistent V-Tach/V-Fib after 20 minutes of CPR and a mechanical CPR device is available. This policy does not apply to Mass Casualty Incidents. 	
<p style="text-align: center;"><u>Base Hospital Orders</u></p> <p style="text-align: center;">Contact Base Hospital for additional treatment or transport decisions.</p>	



PAIN MANAGEMENT	
ADULT	PEDIATRIC
BLS	
<p>Secure Airway. Assess Vitals. Oxygen. Titrate to SPO2 to 94% or higher. Provide calming measures. Treat underlying cause for pain: reposition, bandage, splint, traction, cold pack, elevation</p>	
ALS	
<p>Follow BLS procedure if applicable. IV/IO Access as needed. Obtain ECG. Utilize ETCO2 for patients receiving narcotics.</p>	
Non-Narcotic Medications	
<p>Acetaminophen 15 mg/kg IV Infusion/PO</p> <ul style="list-style-type: none"> Administer over 15 minutes. Total max dose 1,000 mg. Single Dose Only. <p>Ketorolac (Toradol) 15 mg IV OR 30 mg IM</p> <ul style="list-style-type: none"> Slow IV push over 2 minutes. Single dose only. 	<p>Acetaminophen 15 mg/kg IV Infusion/PO</p> <ul style="list-style-type: none"> Administer over 15 minutes. Single max dose 1,000 mg. Single Dose Only. <p>Ketorolac (Toradol) 0.5 mg/kg IV/IM</p> <ul style="list-style-type: none"> Slow IV push over 2 minutes. Single max dose 15 mg. Single dose only.
Narcotic Medications	
<p>Fentanyl 50 mcg IV/IM/IN</p> <ul style="list-style-type: none"> Single max dose is 50 mcg. Slow IV push may repeat every 5 minutes. IM/IN may repeat every 10 minutes. Total max dose 200 mcg. <p style="text-align: center;"><u>OR</u></p> <p>Morphine 5 mg IV/IM</p> <ul style="list-style-type: none"> Single max dose 5mg. Slow IV push, may repeat every 5 minutes. IM may repeat every 10 minutes. Total max dose 10 mg. <p>Ketamine 0.3 mg/kg IV</p> <ul style="list-style-type: none"> 30 mg max dose. Mix in 50 or 100 mL bag of NS or D5W. Infuse over 5 minutes. May repeat once after 10 minutes. 	<p>Fentanyl 1 mcg/kg IV/IM/IN</p> <ul style="list-style-type: none"> Single max dose 50 mcg. Slow IV push. IV dose - may repeat weight-based dose every 5 minutes x4, not to exceed a total of 4 mcg/kg or 200 mcg. IM/IN may repeat once in 10 minutes. <p style="text-align: center;"><u>OR</u></p> <p>Morphine 0.1 mg/kg IV/IM</p> <ul style="list-style-type: none"> Single max dose 5 mg. IV may repeat once in 5 minutes. IM may repeat once in 10 minutes. Total max dose 10 mg.
Contraindications	
<p>Fentanyl/Morphine</p> <ul style="list-style-type: none"> SBP less than normal for pediatric age. SBP less than 100 mmHg for adult. Pain Scale less than 5. ALOC secondary to possible acute TBI. Respiration less than 12. <p>Ketamine</p> <ul style="list-style-type: none"> GCS less than 15. Pregnancy. Age less than 15 years old. Pain Scale less than 5. 	<p>Ketorolac (Toradol)</p> <ul style="list-style-type: none"> Age greater than 65 or less than 2. Active bleeding / G.I. bleeding. Acute Trauma. Pregnancy. Allergic to NSAIDS. Asthma. Coagulation disorder. Anticoagulation medications. Acute Coronary Chest Pain. <p>Acetaminophen</p> <ul style="list-style-type: none"> Liver disease or transplant.
Special Considerations	
<ul style="list-style-type: none"> Consider administering ondansetron per Nausea and Vomiting protocol. Non-narcotic medications may be used with narcotic medications for severe pain. May administer Ketamine in addition to a narcotic. 	
Base Hospital Orders	
<p>Stanislaus County EMS Agency Contact Base Hospital physician for pain management that exceeds written protocol Field Treatment Book Selected Policies</p>	



SYMPTOMATIC BRADYCARDIA	
ADULT	PEDIATRIC
BLS Procedures	
<p>Secure Airway. Assess Vitals. Obtain SpO₂. Oxygen. Titrate to SpO₂ of 94% or higher Assist Ventilations, if needed If significant ALOC, accompanied with poor skin signs, initiate CPR (Pediatric HR less than 60 bpm)</p>	
ALS Standing Orders	
<p>Follow BLS procedures if applicable. Obtain ECG & 12-lead. IV/IO Access <ul style="list-style-type: none"> Only treat bradycardia that creates severe associated signs and symptoms. Consider a 250mL fluid bolus before more advanced intervention if the patient's condition is stable. Utilize ETCO₂ for patients receiving narcotics.</p>	
Symptomatic Bradycardia – Hemodynamically Stable	
HR less than 50 bpm Associated symptoms: Chest Pain, Shortness of Breath, Acute ALOC, Syncope	HR less than 60 bpm Associated symptoms: Chest Pain, Shortness of Breath, ALOC, Syncope
<p>Normal Saline 250 mL IV/IO</p> <ul style="list-style-type: none"> May repeat to a max of 1000 mL <p>Consider Atropine 1 mg IV/IO</p> <ul style="list-style-type: none"> If effective, repeat every 3 minutes to keep HR greater than 50 bpm. Total max dose of 3 mg. If no response, do not repeat dose. 	<p>Normal Saline 20 mL/kg IV/IO</p> <ul style="list-style-type: none"> May repeat as necessary to achieve target blood pressure. <p>Provide Supportive Care</p> <ul style="list-style-type: none"> <u>Bradycardia cases in pediatrics are often secondary to hypoxia.</u> Provide oxygen support.
Symptomatic Bradycardia – Hemodynamically Unstable	
HR less than 50 bpm Associated symptoms, <u>AND</u> hypotension (less than 90 mmHg)	HR less than 60 bpm Associated symptoms with signs of poor perfusion, <u>AND</u> hypotension
<p>Consider Atropine</p> <p>Transcutaneous Pacing (TCP)</p> <ul style="list-style-type: none"> Pace at 70 bpm, increase joules until confirmed mechanical capture. <p>*If no hemodynamic response after successful pacing, administer push dose epinephrine*</p> <p>Push Dose Epinephrine 20 mcg IV/IO</p> <ul style="list-style-type: none"> May repeat every 3 mins. <p>Midazolam 2 mg IV/IO/IN – Sedation</p>	<p>Assist Ventilations with BVM & O₂</p> <p>CPR (for patients without signs of puberty)</p> <p>Epinephrine 0.01 mg/kg</p> <ul style="list-style-type: none"> May repeat every 3-5 minutes, until signs of poor perfusion have improved. <p>Consider Atropine 0.02 mg/kg IV/IO</p> <ul style="list-style-type: none"> May repeat every 3-5 minutes. Minimum dose 0.1 mg, Max initial dose 0.5 mg.
Special Considerations	
<ul style="list-style-type: none"> Consider reversible causes (H's and T's). For suspected overdose, refer to Overdose Protocol. 	
Base Hospital Orders Only	
Contact Base Hospital for treatment exceeding written protocol.	



TACHYCARDIA WITH PULSES	
ADULT	PEDIATRIC
BLS Procedures	
Secure Airway. Assess Vitals. Obtain spO2. Oxygen. Titrate SPO2 to 94% or higher. Provide calming measures.	
ALS Standing Orders	
Follow BLS procedures if applicable. Obtain ECG & 12-lead. IV/IO Access <ul style="list-style-type: none"> IF NO ASSOCIATED CHEST PAIN OR SOB. <ul style="list-style-type: none"> Administer 250 mL (adults) or 20 mL/kg (peds) fluid bolus if patient's condition is stable. Utilize ETCO2 for patients receiving narcotics.	
Narrow QRS – Stable (With associated Chest Pain or SOB)	
SVT - HR Greater than 150	SVT 2yrs and older – HR greater than 180 bpm Under 2yrs – HR greater than 220 bpm
Attempt Valsalva maneuver. Adenosine 6 mg IV/IO <ul style="list-style-type: none"> Rapid push immediately followed with 10 mL NS flush. <p style="text-align: center;">*If no conversion*</p> Adenosine 12 mg IV/IO <ul style="list-style-type: none"> Rapid push immediately followed with 10 mL NS flush. May repeat once if no conversion. 	Attempt Valsalva maneuver. Adenosine 0.1 mg/kg IV/IO <ul style="list-style-type: none"> Rapid push immediately followed by 10 mL NS flush. Total max dose 6 mg <p style="text-align: center;">*If no conversion*</p> Adenosine 0.2 mg/kg IV/IO <ul style="list-style-type: none"> Rapid push immediately followed by 10 mL NS flush. Single max dose 12 mg May repeat once if no conversion.
Wide QRS – <u>Stable</u> (No ALOC or Signs of Cardiogenic Shock)	
Amiodarone 150 mg IV/IO <ul style="list-style-type: none"> Infusion over 10 minutes May repeat once if patient remains in wide QRS tachycardia 	Provide supportive care, watch for signs of Unstable Tachycardia
Wide/Narrow QRS - <u>Unstable</u> (With ALOC or Signs of Cardiogenic Shock)	
Hypotension = systolic blood pressure below 90 Synchronized Cardioversion 200j <ul style="list-style-type: none"> May repeat as necessary. Consider sedation prior to cardioversion. <p style="text-align: center;">*If wide QRS & refractory to cardiovert <u>OR</u> post successful cardiovert*</p> Amiodarone 150 mg IV/IO <ul style="list-style-type: none"> Infusion over 10 minutes May repeat once if patient remains in wide QRS tachycardia. Midazolam 2 mg IV/IO/IN	Hypotension = 0-9 yrs. old - Systolic blood pressure below 70 + (2 x age in yrs.) 10 or older - Systolic blood pressure below 90 Synchronized Cardioversion 1j/kg <ul style="list-style-type: none"> May repeat at 2j/kg, as necessary. Consider sedation prior to cardioversion. Midazolam 0.1 mg/kg IV/IO/IN <ul style="list-style-type: none"> Single max dose 2 mg
Special Considerations	
<ul style="list-style-type: none"> Utilize half dose of Adenosine, if accessing PICC or Central line. For Narrow QRS Tachycardic patients with no associated chest pain or SOB, rhythm recognition is more important than intervention. 	
Base Hospital Orders Only	
<ul style="list-style-type: none"> Contact Base Hospital for treatment exceeding written protocol. Contact Base hospital for consultation of uncertain rhythm. 	



Traumatic Cardiac Arrest	
ADULT	PEDIATRIC
Primary Direction	
<p>To provide guidelines for rapid, systematic patient assessment and intervention in the setting of traumatic cardiac arrest.</p> <ul style="list-style-type: none"> • Cardiac medications (Epinephrine, Amiodarone) have limited or no benefit in the setting of traumatic cardiac arrest. • Interventions take priority over chest compressions in agonal or pulseless conditions. <ul style="list-style-type: none"> ○ Airway management. ○ Needle decompression. ○ Hemorrhage control. ○ Fluid resuscitation. 	
BLS	
<p>Do not initiate resuscitation if patient meets "Obviously Dead" criteria per Determination of Death Policy (570.20)</p> <p>If patient does not meet "Obviously Dead" criteria, then initiate resuscitative efforts and transport immediately to closest Trauma Center.</p> <ul style="list-style-type: none"> • Resuscitative efforts. <ul style="list-style-type: none"> ○ Control major bleeding – direct pressure, hemostatic gauze, and/or tourniquet (if applicable). ○ Initiate chest compressions. ○ Initiate basic and/or advanced airway techniques and ventilate with BVM with 100% oxygen. ○ Apply chest seal or occlusive dressing to penetrating wound of the thorax. • <u>If estimated transport time (drive time) of the traumatic arrest patient exceeds 20 minutes, then terminate resuscitation.</u> 	

ALS

Do not initiate resuscitation if patient meets “Obviously Dead” criteria per Determination of Death Policy (570.20)

If traumatic arrest with **Asystole or PEA with a rate less than 40**:

- Do not attempt resuscitation.
- Terminate Resuscitation if already initiated.

If traumatic arrest not meeting above criteria:

If transport time (drive time) to Trauma Center is **less than 20 minutes**, initiate resuscitative efforts and transport immediately to closest Trauma Center:

- **Initiate chest compressions.**
- **Control major bleeding** – direct pressure, hemostatic gauze, and/or tourniquet (if applicable).
- **Perform bilateral chest needle decompression** (if signs of blunt or penetrating trauma to thoracoabdominal region).
- **Initiate basic and/or advanced airway** techniques and ventilate with BVM with 100% oxygen.
- **Insert two large bore IV/IO** and initiate fluid bolus of 500 mL. May repeat x2.
- **Consider TXA** if patient arrested within 5 minutes of initiating compressions and/or ROSC achieved, and patient continues to be hypotensive.
- **Apply chest seal or occlusive dressing** to penetrating wound of the thoracoabdominal region.

If transport time (drive time) to Trauma Center is **greater than 20 minutes** begin resuscitation, focusing on the following:

- **Initiate chest compressions.**
- **Control major bleeding** – direct pressure, hemostatic gauze, and/or tourniquet (if applicable).
- **Perform bilateral chest needle decompression** if signs of blunt or penetrating trauma to thoracoabdominal region.
- **Initiate basic and/or advanced airway** techniques and ventilate with BVM with 100% oxygen.
- **Insert two large bore IV/IO** and initiate fluid bolus.
- If ROSC is achieved, then transport patient to closest Trauma Center.
- **If ROSC is not achieved after 10 minutes, then terminate resuscitative efforts.**

Special Considerations

- SMR precautions are secondary to resuscitation and controlling airway.

Base Hospital Orders

Contact Base Hospital for additional treatment or transport decisions.

Adult Treatment Guidelines





POLICY: 554.00
TITLE: General Protocols

EFFECTIVE: 9/16/2020
REVIEW: 9/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 7

GENERAL PROTOCOLS

- I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
To serve as the treatment standard for Emergency Medical Responders (EMRs), Emergency Medical Technicians (EMTs), and Paramedics in treating patients.
- III. PROTOCOL
 - A. These are the treatment protocol standards for the Stanislaus County Emergency Medical Services Region. This document is divided into three major sections:
 1. **General Procedures**
 - a. Contains individual treatment procedures that can be found throughout Stanislaus County EMS Agency protocols.
 - b. “ALS” or Advanced Life Support procedures are procedures performed by a Stanislaus County EMS Agency accredited Paramedic.
 - c. “BLS” or Basic Life Support procedures are procedures performed by an individual providing care for an Stanislaus County EMS Agency approved or recognized provider. We do not certify all individuals providing BLS care in our system.
 - d. “
 2. **Treatment Protocols**
 - a. Adult – Patient’s age 15 and older
 - b. Pediatric –Patient’s age 14 and younger
 3. **Field Specific Policies**
 - a. Medication Index
 - b. Procedure Index

MEDICAL CONTROL

I. STANDING ORDERS

- A. **Standing Orders** are “treatments a licensed and accredited ALS, and/or certified EMT, and/or certified EMR provider can perform without Base Hospital permission”.
- B. The following are considered **Standing Orders**:
 - 1. All BLS skills and treatment
 - 2. All ALS skills and treatment **EXCEPT** those limited to **Base Physician Orders**

II. BASE PHYSICIAN ORDERS

- A. Base Physician Orders are treatment procedures that require a direct order from a Base Hospital Physician. The Base Hospital Physician may order any medications or procedures within the local paramedic scope of practice regardless of the treatment protocol. Verbal orders **MUST** be signed by the Base Physician and maintained in the patient medical record. The paramedic must call the base hospital to which they are transporting the patient. The physician’s name must be documented in the Pre-Hospital Patient Care Report.
- B. An MICN may RELAY a verbal “Base Physician Order” from the Base Physician in accordance with any of the approved protocols.

III. ALS WITHOUT BASE HOSPITAL CONTACT FORM

- A. If a paramedic cannot make Base Hospital Physician Contact, a paramedic can perform treatments listed under “Base Physician Order”.
- B. Documentation on an “ALS without Base Hospital Contact Form” must be completed listing any “Base Physician Order” treatments performed. The form must be forwarded to the Mountain-Valley EMS Agency within 24 hours of the call’s occurrence.

VASCULAR ACCESS

- A. Pre-Vascular Access Device (PVAD) – (e.g., arteriovenous shunt, tunneled catheters, and Peripherally Inserted Central Catheters (PICC lines)
 - 1. A PVAD should only be used when a life-threatening condition requires immediate fluid therapy or IV medications.
 - 2. A Base Hospital MICN or Physician should be consulted if the paramedic is unfamiliar with the type of indwelling catheter.
 - 3. Aseptic technique must be followed.
 - 4. Attempt to withdraw and discard 5 cc of blood from the device prior to infusion. If unable to withdraw, proceed with the infusion.
 - 5. Use a Huber-type non-coring needle, whenever possible.
 - 6. Follow manufacturer recommended settings and insertion techniques

TRANSPORT

I. TRANSPORT

A. Crew judgement based on clinical presentation, weather and roadway conditions

II. Patient Destination:

A. All patients who wish to be transported by ambulance to the hospital should be transported.

B. Patients should be transported to the closest hospital appropriate for their medical needs within a reasonable transport time or as specified in the patient treatment protocols.

C. During a declared MCI– patient destination will be at the direction of the Medical Group Supervisor based on location and availability of services.

D. Patients, not meeting specialty care criteria, i.e. Stroke, STEMI and/or Trauma will be transported to the hospital of their preference within a reasonable request. It is recommended the crew consult with their on-duty supervisor to confirm transports to facilities outside of the county that are not a routine destination.

E. If there are multiple patients in one ambulance, all patients will be transported to the same receiving facility.

RESPIRATORY GUIDELINES

A. Endotracheal Intubation:

1. Oral endotracheal intubation, stomal endotracheal intubation, and placement of a King-Tube (perilaryngeal airway) or I-Gel (Supraglottic airway) as a rescue airway are standing orders in patients who require advanced airway management. The I-Gel rescue airway, an approved Supraglottic airway device, may be inserted in any patient that fits on to a length based tape designed to estimate weight and/or medication doses (ie: Broselow) only if unable to adequately ventilate with BVM using the jaw thrust method and BLS airway adjuncts. **Endotracheal intubation shall not be performed on any patient that fits on a length based tape designed to estimate weight and/or medication doses (ie: Broselow).**
2. Paramedics must not attempt any form of tracheal intubation more than three (3) times per patient. An attempt to intubate is defined as placement of the laryngoscope blade in a patient's mouth **with the intent to intubate**. A Bougie shall be used as an adjunct to intubation at any time during the intubation procedure. If a total of three attempts are unsuccessful, paramedics will insert an alternative airway (in adults) or use BLS airway techniques (in adults or pediatrics).
3. When appropriate, pediatric patients shall have the appropriate sized I-Gel (Supraglottic airway) inserted following the manufacturers procedure for placing and using the device..
4. Correct tube placement must be confirmed and documented by at least three of the following indicators; Visualize ET tube passing through vocal cords, ET tube fogs with ventilations,, equal breath sounds, absent epigastric sounds, and chest rise and fall. All patients must be assessed immediately after intubation with an end-tidal CO₂ detector, colorimetric or continuous waveform. The number of centimeters at which the tube is secured, confirmatory indicators, and color change or waveform reading must be documented on the Prehospital Care Report. All intubated patients must be continuously assessed using ETCO₂ waveform capnography. Any significant movement, emesis or change in clinical condition should be reassessed using waveform capnography and physical examination. If, at any time, capnography indicates that the tube is not in communication with the trachea, the airway must be immediately removed and re-intubation attempted.
5. All ET tubes and rescue airways should be secured using a commercially available device designed to secure ET tubes. Rescue airways should be secured according to manufacturer recommendations.

MECHANICAL CHEST COMPRESSION DEVICE

- I. If available, the approved mechanical chest compression device shall be deployed by an EMT level or higher on any patient that meets the indications listed in this policy when the device is available, and the approved training has been completed.
- II. **Indications:**
 - A. Patients 15 years of age or older
 - B. Medical and/or Traumatic cardiac arrest where manual CPR is indicated
- III. **Contraindications:**
 - A. Patients 14 years of age or younger
 - B. If unable to correctly position the device due to size of the patient's chest.
- IV. **Procedure:**
 - A. Initiate resuscitative measures according to "Cardiac Arrest Algorithms" 554.11
 - B. DO NOT attempt placement of the mechanical chest compression device until the third (3rd) cycle of manual compressions and at least three (3) rescuers are available to limit interruptions in chest compressions. DO NOT delay any interventions such as: Defibrillation, Intravenous or Intraosseous access, and medication administration for placement of the mechanical chest compression device.
 - C. Limit interruption in chest compressions to 10 seconds or less
 - D. Remove all clothing from the front and back of patient's torso.
 - E. Follow all manufacturer recommendations for application and use of the mechanical compression device.
 - F. Defibrillation can be performed with the mechanical chest compression device in place. There is no need to stop the device for the purpose of defibrillation.
 - G. In the event of disruption or malfunction of the mechanical chest compression device, immediately revert to manual CPR.
 - H. If a cardiac arrest patient is transported, the mechanical chest compression device shall remain in place to continue or resume CPR as necessary.
 - I. Personnel that deploy a mechanical chest compression device shall ensure that a person trained and qualified to use the device accompanies the patient to the hospital, even if they are not the primary patient caregiver.
 - J. All mechanical compression devices will be set at a rate of 100-120 compressions per minute. Changes will only be made with approval of the Stanislaus County EMS Agency Medical Director.

- K. Any device purchased prior to September 1, 2018, follow manufacturer recommendations for operation.

V. **Mechanical Chest Compression Device Maintenance :**

- A. The periodic preventative maintenance of all devices shall meet or exceed the criteria recommended by the manufacturer.
- B. Providers shall immediately remove from service any device suspected of malfunctioning. Any malfunctioning device shall not be placed back into service until properly serviced or repaired by the manufacturer's authorized service program.
- C. Device maintenance records shall be subject to review and inspected by Stanislaus County EMS Agency upon request.

VI. **Quality Improvement:**

- A. Documentation and data related to the use of the mechanical chest compression device shall be provided to Stanislaus County EMS Agency upon request.
- B. All patient contacts involving the use of the mechanical chest compression device shall undergo chart review by the provider QI personnel. Chart review shall include evaluation for appropriate clinical use and adherence to Stanislaus County EMS Agency policies and treatment protocols.
- C. Any concerns or issues involving the use of the mechanical chest compression device shall be reported to Stanislaus County EMS Agency as soon as possible.



POLICY: 554.10
 TITLE: Congestive Heart Failure

EFFECTIVE: 10/21/2020
 REVIEW: 10/2025
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

CONGESTIVE HEART FAILURE

I. AUTHORITY

Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II. PURPOSE

To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. DEFINITIONS

- A. Mild Respiratory Distress describes a patient who is typically able to speak full sentences; whose blood pressure and pulse may be elevated; might be weak and diaphoretic; have a normal mental status; no cyanosis.
- B. Moderate Respiratory Distress describes a patient who is generally able to speak just a few words; whose blood pressure and pulse are likely elevated; who might be weak and diaphoretic; have a normal mental status; circumoral and digital cyanosis may be present.
- C. Severe Respiratory Distress describes a patient who is unable to speak; whose blood pressure and pulse will be elevated or depressed; whose mental status is typically altered; central cyanosis likely.

Note: Patients with congestive heart failure typically have a cardiac history, are generally older patients, and they are commonly on medications including beta blockers, diuretics, ACE inhibitors, digoxin, or calcium channel blockers. In addition, the CHF patient typically presents with physical findings including hypertension, peripheral edema, jugular venous distension, and a more sudden onset of wheezes, rales, or rhonchi, or some combination of all three. It is VERY UNLIKELY for a patient to have symptomatic CHF without a blood pressure >150 systolic. In these patients, oxygen (CPAP for Moderate/Severe) and direct vasodilators such as Morphine and Nitrates will be more efficacious than indirect venodilators such as Furosemide.

IV. PROTOCOL

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing, assess vital signs q 5 minutes and report findings to incoming Advanced Life Support providers
Oxygen Administration	Provide oxygen if appropriate and be prepared to support ventilations with a BVM
Position	Sitting (as tolerated.)
EMT STANDING ORDERS	
Note	Must perform items in EMR standing orders if applicable
Pulse Oximetry	Report initial reading to paramedic if applicable.
Position	Sitting (as tolerated.)

Mentation	for Altered Level of Consciousness, check blood sugar and refer to 554.31 Altered Level of Consciousness
APPLY CPAP	If available and patient condition is Moderate or Severe respiratory distress, start at 5 cm H ₂ O, titrate up as patient tolerates and as patient condition warrants, to a max of 10 cm H ₂ O. CPAP is contraindicated in Patients that cannot maintain their own airway and/or an SBP < 90mmHg. Continue to record vital signs q 5 minutes including pulse oximetry readings.
PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMT standing orders if applicable
Cardiac Monitor	Identify rhythm and perform 12 Lead EKG – If interpretation results reveal ***ACUTE MI/SUSPECTED***, expedite transport to SRC as directed if transport time is less than 60 minutes. It is preferable to obtain 12 lead prior to Nitro administration or transport. Repeat post-treatment if patient symptomatic and condition persists.
Apply C-PAP	If available and patient condition is Moderate or Severe respiratory distress, start at 5 cm H ₂ O, titrate up as patient tolerates and as patient condition warrants, to a max of 10 cm H ₂ O. CPAP is contraindicated in Patients that cannot maintain their own airway and/or a SBP < 90mmHg. Continue to record vital signs q 5 minutes including pulse oximetry readings.
Nitroglycerine spray	0.4mg SL if systolic BP 120 – 150 mmHg 0.8mg SL if systolic BP 150 – 200 mmHg 1.2mg SL if systolic BP > 200 mmHg Recheck BP after each NTG dose. Repeat doses are based on systolic BP as outlined above. Repeat SL NTG every 5 minutes until clinical improvement or systolic BP 100 mmHg or less. Do not administer if systolic BP is less than 100 mmHg.
Nitroglycerine Paste	If CPAP is employed, apply 1 inch of NTG paste to anterior chest wall If CPAP is NOT employed, recheck BP after each NTG dose. Repeat SL doses are based on systolic BP as outlined above. Repeat NTG every 5 minutes until clinical improvement or systolic BP 100 mmHg or less. Do not administer if systolic BP is less than 100 mmHg.
Albuterol	2.5mg (3ml unit dose) via handheld nebulizer/in line nebulization if the patient is wheezing
IV/IO access	Saline Lock is preferable. Be cautious on fluid administration
Morphine	Consider 2.0 mg slow IV/IO if systolic BP > 100 mmHg for patients in severe distress. May repeat ONCE.
Push Dose EPINEPHRINE	0.2ML IV/IO of 1:10,000 every 5 minutes to maintain systolic BP > 90 mmHg

Clinical PEARLS:

- Intravenous access is preferred over Intraosseous unless patient is unstable.
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage.
- Patients in Amador, Calaveras and Mariposa counties meeting STEMI criteria shall be transported to closest facility if transport time to STEMI receiving facility is > 60 minutes and there are not contraindications to Thrombolytics.
- EMS shall acquire 12 lead EKG on any suspected cardiac patient within 10 minutes of patient contact. If unable to obtain within 10 minutes the reason for delay shall be documented in the Patient Care Report.

- CPAP is only indicated on patients in moderate and severe respiratory distress and do not have contraindications. Contraindications to CPAP include: Patients < 15 years old, patients less <4 feet tall, patients with an altered mental status, patients without an intact gag reflex and patients with systolic blood pressure < 90mmHg



Stanislaus County
Emergency Medical Services Agency

**POLICIES AND
 PROCEDURES**

POLICY: 554.21
 TITLE: Airway Obstruction

 EFFECTIVE: 12/23/20
 REVIEW: 12/2025
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 2

AIRWAY OBSTRUCTION

- I. AUTHORITY: Health and Safety Code, Division 2.5 California Code of Regulations Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.
- III. DEFINITIONS: Partial Obstruction: Stridor, coughing forcefully, able to speak, still passing some air.
 Complete Obstruction: Cyanosis, silent cough, unable to speak, no air movement.
- IV. PROTOCOL: Consider the cause of the airway partial or complete obstruction, support ABC's.

EMR STANDING ORDERS

Patient Assessment	Circulation, Airway and Breathing, assess vitals q 5 minutes
Oxygen Administration	Provide oxygen if appropriate

EMT STANDING ORDERS

Note	Must perform items in EMR standing orders if applicable
Pulse Oximetry	Record reading

Paramedic STANDING ORDERS

Note	Must perform items in EMR and EMT standing orders if applicable
Monitor	Treat heart rhythm as appropriate
IV/IO Access	TKO
Needle Cricothyrotomy	If unable to manage airway by any other method, a catheter-over-needle, maximum gauge of 10, attached to a 50 psi transtracheal oxygen ventilation system.

Clinical PEARLS:

- **PARTIAL OBSTRUCTION-**
 - Foreign body-** Observe patient, supportive care
 - Angioedema-** Position of comfort. Paramedics-Consider nebulized saline with the highest flow rate tolerated. Avoid visualization of throat/airway unless tracheal intubation required.
 - Trauma-**Suction; supportive care.
 - Anaphylaxis-**Refer to Allergic Reaction Policy 554.43
- **COMPLETE OBSTRUCTION**
 - Foreign body-** Abdominal thrusts (chest thrusts for pregnant patients). Paramedics- laryngoscopy and removal with Magill Forceps.
 - Angioedema-** Position of comfort. Paramedics-Consider nebulized saline with the highest flow rate tolerated. Avoid visualization of throat/airway unless endotracheal intubation required.
 - Trauma- Aggressive suctioning, supportive care, secure airway as appropriate**
- **UNCONSCIOUS PATIENT**
 - CPR-Refer to Cardiac Arrest Algorithm
- Intravenous access is preferred over Intraosseous unless patient is unstable
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage



POLICY: 554.23
 TITLE: Tension Pneumothorax

EFFECTIVE: 12/23/20
 REVIEW: 12/2025
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 2

TENSION PNEUMOTHORAX

- I. AUTHORITY
 Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
 To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.
- III. PROTOCOL
 Physical signs may include: Systolic BP < than 90, altered level of consciousness, chest pain, decreased breath sounds, increased resonance on side of collapsed lung, Jugular Venous Distension (JVD), tracheal deviation away from side of collapsed lung, asymmetrical chest motion and/or crepitus.

Multi-system trauma and scene conditions often make diagnosis difficult. Remember, **this is a rapid obstructive shock**, NOT a respiratory problem

EMR STANDING ORDERS

Patient Assessment	Circulation, Airway and Breathing, assess vitals q 5 minutes
Oxygen Administration	Provide oxygen if appropriate
Bleeding control	Direct pressure with appropriate bandage. Apply occlusive dressing as needed

EMT STANDING ORDERS

Note	Must perform items in EMR standing orders if applicable
Pulse Oximetry	Report initial reading to paramedic if applicable

PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMR and EMT standing orders if applicable
Monitor	Treat heart rhythm as appropriate
Needle Thoracostomy	10 or 12 gauge or approved NCD kit. Minimum 3.25-inch length inserted into affected side in the second intercostal space, mid-clavicular line. Perform on other side if no response to treatment and the tension pneumothorax physiology persists. Secure catheter
IV/IO Access	Two large bore IV/IO. If systolic BP is < than 90, give 250 ml boluses to systolic until BP 90 mmHg. Reassess after each bolus
Observe	Continue to monitor for signs of recurrence of a tension pneumothorax and for obstruction or dislodgement of thoracostomy catheter

Clinical PEARLS:

- Needle Thoracostomy may only be performed on second intracoastal, mid-clavicular site
- Record and document pulse oximetry readings pre and post procedure
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage
- Intravenous access is preferred over Intraosseous unless patient is unstable



POLICY: 554.24
TITLE: Respiratory Distress

EFFECTIVE: 12/23/20
REVIEW: 12/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

RESPIRATORY DISTRESS

I. AUTHORITY

Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II. PURPOSE

To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.

III. DEFINITIONS

- A. Mild Respiratory Distress describes a patient who is typically able to speak full sentences; whose blood pressure and pulse may be elevated; might be weak and diaphoretic; have a normal mental status; no cyanosis.
- B. Moderate Respiratory Distress describes a patient who is generally able to speak just a few words; whose blood pressure and pulse are likely elevated; who might be weak and diaphoretic; have a normal mental status; circumoral and digital cyanosis may be present.
- C. Severe Respiratory Distress describes a patient who is unable to speak; whose blood pressure and pulse will be elevated or depressed; whose mental status typically altered; central cyanosis likely.

Note: Sometimes patients do not fall clearly into a specific treatment protocol, especially for respiratory distress. Examples might include patients suffering from pneumonia. For those patients where a specific treatment protocol does not fit the patient's presentation, this protocol may be utilized.

IV. PROTOCOL

EMR STANDING ORDERS

Patient Assessment	Circulation, Airway, Breathing. Assess vitals q 5 minutes and place patient in position of comfort
Oxygen Administration	Provide oxygen if appropriate.
Position	Sitting (as tolerated).

EMT STANDING ORDERS	
Note	Must perform items in EMR standing order if applicable
Temp	Record and document temperature
Pulse Oximetry	Record reading pre and post oxygen administration.
CPAP	Consider CPAP for patients in moderate and severe respiratory distress. If available, start at 5 cm H2O titrate up as patient tolerates and as patient condition warrants, to a max of 10 cm H2O
PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMR and EMT Standing orders if applicable
Monitor	Treat heart rhythm as appropriate
Albuterol	5mg (6ml unit dose) via handheld/mask nebulizer/in line nebulization continuously if still wheezing
IV/IO Access	TKO

Clinical PEARLS:

- Consider sepsis as an underlying condition
- Consider the use of ETCO2
- Intravenous access is preferred over Intraosseous unless patient is unstable
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage
- Consider Epinephrine 0.3mg of 1:1000 IM, if age <40 years old and systolic BP <180mm Hg.
- Acquire 12 lead if cardiac event is suspected
- Obtain and report home O2 level
- CPAP is only indicated on patients in moderate and severe respiratory distress and does not have any contraindications. Contraindications to CPAP include: Patients < 15 years old, patients less <4 feet tall, patients with an altered mental status, patients without an intact gag reflex and patients with systolic blood pressure < 90mmHg



POLICY: 554.31
TITLE: Altered Level of Consciousness

EFFECTIVE: 6/10/20
REVIEW: 6/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

ALTERED LEVEL OF CONSCIOUSNESS

- I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.
- III. PROTOCOL
Characterized by a Glasgow Coma Score less than 15, confusion or unconsciousness or a change from baseline.

<u>EMR Standing Orders</u>	
<u>Patient Assessment</u>	Circulation, Airway and Breathing, asses vitals q 5 minutes and consider trauma mechanism
<u>Oxygen Administration</u>	Maintain airway and provide oxygen as appropriate
<u>Bleeding Control</u>	Direct pressure with appropriate bandage

<u>EMT Standing Orders</u>	
<u>Note</u>	Must perform items in EMR standing orders as appropriate
<u>Glucometer</u>	Check blood sugar
<u>Pulse oximetry</u>	Report initial reading to paramedic if applicable
<u>Glucose</u>	Oral glucose if patient can protect airway and has a gag reflex if blood sugar is <60mg/dl
<u>Naloxone</u>	2 mg IN/IM if mental status and respiratory effort are depressed. Must be a strong suspicion of opiate overdose. Max. single dose of 2 mg, may repeat once in 3 minutes if there was response to initial dose

<u>Paramedic Standing Orders</u>	
<u>Note</u>	Must perform items in EMR and EMT standing orders as appropriate
<u>Monitor</u>	Treat heart rhythm as appropriate
<u>Temp</u>	Consider sepsis for any altered patient with a fever
<u>IV/IO Access</u>	TKO. If systolic BP is < 90mmHg, give 250ml fluid boluses to systolic BP 90-100 or a max of 2 liters. Shall reassess vitals/patient after each bolus
<u>Dextrose</u>	For blood sugar <60mg/dl and signs of hypoglycemia are present: D50W 25gms IV/IO. Recheck blood sugar after 5 minutes
<u>Glucagon</u>	If no IV/IO access immediately available with blood glucose <60 mg/dl, give one (1) unit IM. May repeat once. Recheck blood glucose 5 minutes after each dose.
<u>Naloxone</u>	2 mg IV/IO/IN/IM if mental status and respiratory effort are depressed. Must be a strong suspicion of opiate overdose. Max single dose of 2 mg, may repeat once in 3 minutes if there was response to initial dose. Max of two doses total
<u>Base Physician Contact-</u>	
Competent adults with normal vital signs, blood sugar, and mental status 10 minutes after ALS intervention, may be released at scene if a cause of their condition and its solution has been identified. Refer to Refusal of EMS Service Policy 570.35.	

Clinical PEARLS

- High index of suspicion of sepsis in a non-traumatic altered patient
- Intravenous access is preferred over Intraosseous unless patient is unstable
- Move patient to a safe area if the situation warrants
- Consider D-10W 250ml drip if D50w is unavailable and BG <60. Continue D-10W until patient symptoms improves
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage
- Naloxone- May use the prescribed grant administered aerosol 4mg doses if that's all that's available
- Naloxone must be administered prior to intubation if narcotic overdose is suspected



POLICY: 554.33
TITLE: Seizures

EFFECTIVE: 12/23/20
REVIEW: 12/2020
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 2

SEIZURES

- I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.
- III. PROTOCOL
An actively seizing patient who has been seizing for more than 5 minutes, or an actively seizing patient with recurrent seizures, with no reawakening in between seizures is defined as Status Epilepticus.

Seizures from any cause are managed similarly, including those caused by epilepsy, infection, fever, intoxication, poisoning, or eclampsia.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing. Assess Vitals q5 minutes
Airway Control	Prepare to suction if needed
Oxygen Administration	Provide oxygen if appropriate
Position	Place on left side if possible, protect patient from injury
EMT STANDING ORDERS	
Note	Must perform items in EMR standing orders if applicable
Glucometer	Check blood sugar
Pulse Oximetry	Report initial reading to paramedic
Temp	Consider sepsis for any altered patient

PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMR and EMT standing orders if applicable
Monitor	Treat rhythm as appropriate
IV/IO access	TKO
Midazolam	If Status Epilepticus-Intravenous or intraosseous give 2.0 mg initial dose, titrate 1 mg increments for seizure control, for max dose of 6 mg. If unable to establish IV/IO, give 5 mg intranasal (2.5 mg in each nares) or a one-time dose of 5 mg intramuscular
Dextrose	25 gms IV/IO push – if blood glucose < than 60 mg/dl. May repeat once. Recheck blood glucose in 5 minutes after each dose
Glucagon	If no IV/IO access immediately available with blood glucose < than 60 mg/dl, give one (1) unit IM. May repeat once. Recheck blood glucose in 5 minutes after each dose
Base Physician Orders	RELEASE-AT-SCENE Competent adults with normal vital signs, blood sugar, and mental status 10 minutes after ALS intervention, may be released if a cause of their condition and its solution has been identified. Refer to Refusal of EMS Service Policy 570.35.

Clinical PEARLS:

- Intravenous access is preferred over Intraosseous unless patient is unstable
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage



POLICY: 554.40
TITLE: Sepsis

EFFECTIVE: 4/10/19
REVIEW: 4/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

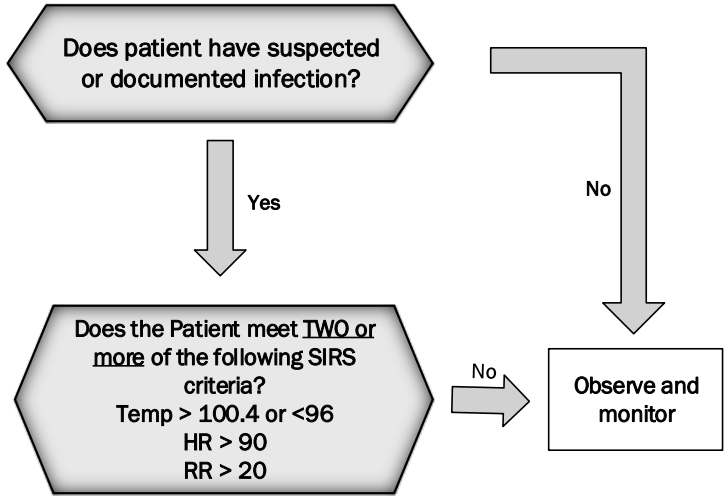
PAGE: 1 of 2

SEPSIS

- I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL
Sepsis is a life-threatening, systemic infection with treatment centering on early recognition, hospital notification, fluid replacement and early antibiotics.

Sepsis

Risk Factors <ul style="list-style-type: none"> • Age (elderly/newborn) • Diabetes • Immune compromise • Alcoholism/IV drug abuse • Malnutrition • Recent surgery • Indwelling devices (Foley, IV lines) • Renal Disease 	Signs/Symptoms <ul style="list-style-type: none"> • SIRS (Systemic Inflammatory Response Syndrome) which is two or more of the following: Temperature >100.4F or <96F Heart Rate > 90 Respiratory Rate > 20 	Differential <ul style="list-style-type: none"> • Hypovolemia • Hypothermia • Adrenal Crisis • Thyroid Storm • Anticholinergic Crisis • Overdose (eg: Aspirin)
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PEARLS

- "SIRS" means Systemic Inflammatory Response Syndrome.
- SIRS + Infection = SEPSIS
- Temperature is extremely useful in identifying SIRS
- Patient's with Sepsis are volume depleted, and can require significant boluses of fluid
- A numerical ETCO2 value should be documented as early as possible after first bolus is begun, and repeat measurement should be documented on hospital arrival as well.
- Finger stick lactate is not mandatory, only if proper equipment is available. One lactate value should be documented in the PCR.

A	Call "Sepsis Alert" to Receiving Hospital		
	Start IV	P	Start IO
Normal Saline bolus 500cc IV/IO. Reassess vitals and lung sounds after each 500cc bolus. May repeat 500cc boluses IV/IO until 20cc/kg is administered OR BP > 100 systolic AND HR < 90. Hold repeat boluses if signs of volume overload.			
<ul style="list-style-type: none"> • Obtain finger stick blood glucose 			
P	<ul style="list-style-type: none"> • Apply ETCO2 • Obtain finger stick lactate, if available • Push dose Epinephrine 0.2ml of 1:10,000 every 5 minutes to achieve systolic BP >90 mmHg 		

Stanislaus County EMS Agency Policy # 554.40



POLICY: 554.41
 TITLE: Non-Traumatic Shock

EFFECTIVE: 2/24/21
 REVIEW: 2/2026
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 2

NON-TRAUMATIC SHOCK

- I. AUTHORITY
 Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
 To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.
- III. PROTOCOL
 History may include: GI bleeding, vomiting, diarrhea, allergic reaction, fever, sepsis, anti-hypertensive overdose.

 Physical signs may be due to circulatory insufficiency (collapsed peripheral/neck veins, confusion, cyanosis, disorientation, thready pulse) or sympathetic compensation (pale, cold, clammy, mottled skin, rapid respirations, anxiety). Signs of compensation may be absent in the elderly, children, or patients taking vasoactive medications.
NOTE: A decreased blood pressure is a late sign of shock.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing. Assess vitals q5 minutes
Oxygen Administration	Provide oxygen if appropriate
Position	Place patient supine with legs elevated
EMT STANDING ORDERS	
Note	Must perform items in EMR standing orders if applicable
Pulse Oximetry	Report initial reading to paramedic if applicable
PARAMEDIC STANDING ORDERS	
Note	Must perform items in EMR and EMT standing orders if applicable
Monitor	Treat rhythm as appropriate

IV/IO Access	Two large bore access points. If systolic BP<90mmHg, give 500ml boluses to achieve systolic BP 90-100. Reassess the patient after each bolus. Max of 2000ml total
Push Dose Epinephrine	0.2ml of 1:10,000 IV/IO every 5 minutes to maintain systolic BP >90mmHg if unsuccessful after 1000ml of fluid. Consider early for patients with history of CHF
CONSIDER CAUSE	Cardiogenic – IV fluid boluses Septic shock-Refer to Sepsis 554.40 DKA-IV fluids, Refer to Blood Sugar Emergencies 554.42 Overdose-refer to Poisoning/Overdose 554.51 Hypovolemia – IV fluid boluses Hypoxia – Oxygenate/Ventilate and assist ventilations as necessary Anaphylaxis – refer to Allergic Reaction Policy 554.43

Clinical PEARLS:

- Continuous assessment for signs of fluid overload, especially for patients with known CHF
Consider Sepsis as underlying cause for tachycardic and hypotensive patients when no evidence of trauma is present.



POLICY: 554.42
 TITLE: Blood Sugar Emergencies

EFFECTIVE: 12/23/20
 REVIEW: 12/2025
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 2

BLOOD SUGAR EMERGENCIES

- I. AUTHORITY
 Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
 To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.
- III. PROTOCOL
 Blood sugar testing is the only accurate method to determine if a patient is hypoglycemic or hyperglycemic. Symptoms are not specific.
 - Hypoglycemia: Blood glucose < than 60mg/dl. Characterized by: ALOC, seizures, combativeness, disorientation, diaphoresis, shaking.
 - Hyperglycemia: Often triggered by an underlying infection. Characterized by: thirst and increased urination, confusion, dehydration, deep, and rapid respirations, nausea, vomiting, fruity odor on breath, missed insulin dose.

EMR STANDING ORDERS	
HYPOGLYCEMIA/HYPERGLYCEMIA	
Patient Assessment	Circulation, Airway, Breathing. Assess vitals q 5 minutes
Oxygen Administration	Provide oxygen if appropriate
EMT STANDING ORDERS	
HYPOGLYCEMIA/HYPERGLYCEMIA	
Note	Must perform items in EMR standing orders if applicable
Glucometer	Check blood sugar
Glucose	Oral glucose (one tube) 37.5 gram's if patient can protect airway and has a gag reflex if blood sugar is <60mg/dl. no repeat doses
Pulse Oximetry	Report initial reading to paramedic if applicable

PARAMEDIC STANDING ORDERS	
HYPOGLYCEMIA/HYPERGLYCEMIA	
Note	Must perform items in EMR and EMT standing orders if applicable
Monitor	Treat heart rhythm as appropriate
IV/IO Access	If blood sugar is too high to measure, the patient is clinically dehydrated (dry mucous membranes, poor skin turgor, tachycardia, etc), AND the patient is not on dialysis, CONSIDER 500 ml bolus of normal saline
Dextrose	For blood sugar <60mg/dl and signs of hypoglycemia are present: D50W 25gms IV/IO. Recheck blood sugar after 5 minutes
Glucagon	If no IV/IO access immediately available with blood glucose <60 mg/dl, give one (1) unit IM. May repeat once. Recheck blood glucose 5 minutes after each dose
Base Physician Orders	RELEASE-AT-SCENE: Competent adults with normal vital signs, blood sugar, and mental status 10 minutes after ALS intervention, may be released if a cause of their condition and its solution has been identified. Refer to Refusal of EMS Service Policy 570.35

Clinical PEARLS:

- Dextrose 10% IV Piggyback or IV drip, hang a 250 bag of 10% dextrose either piggyback to the normal saline bag or directly to IV hub/saline lock. Administer 100-200ml bolus. Reassess between boluses for improvements. If D-50 is not available
- Intravenous access is preferred over Intraosseous unless patient is unstable
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage



POLICY: 554.43
 TITLE: Allergic Reaction - Anaphylaxis

EFFECTIVE: 6/10/20
 REVIEW: 6/2025
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

ALLERGIC REACTION - ANAPHYLAXIS

- I. AUTHORITY
 Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
 To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL

STANDING ORDERS

ALLERGIC REACTION (Hives, Rash, Swelling): A local response to an antigen involving the skin (rash, hives, edema, etc) with normal vital signs. Any involvement of the respiratory system (wheezing, stridor), or oral/facial edema, will be treated as anaphylaxis. Remember that allergic reactions may escalate into anaphylaxis - reassess often and be prepared to treat for anaphylaxis.

- ASSESS** CAB
- REMOVE ALLERGEN** If possible (e.g. bee stinger) and apply ice to site.
- OXYGEN** Oxygen delivery as appropriate
- MONITOR** Treat rhythm as appropriate.
- IV/IO ACCESS** TKO
- DIPHENHYDRAMINE** 25 mg IV/IO push. May administer 25 mg IM if IV/IO access not promptly available.

ANAPHYLAXIS (Wheezing, stridor, hypotension, severe respiratory depression, oral swelling, altered mental status, chest tightness): A systemic response to an antigen involving two (2) or more organ systems **OR** any deterioration of vital signs.

- ASSESS** CAB
- REMOVE ALLERGEN** If possible (e.g. bee stinger) and apply ice to site.
- OXYGEN** Oxygen delivery as appropriate
- MONITOR** Treat rhythm as appropriate.
- EPINEPHRINE** 0.3 mg of 1:1000, IM. May repeat every 15 minutes
 (EMTs may use either Epinephrine by auto-injector OR an Agency approved Epinephrine injection kit. 0.3mg 1:1000. NO repeat doses permitted)
- IV/IO ACCESS** Two 14-16 gauge IVs.
 If systolic BP is less than 90mmHg, give 250 ml boluses to systolic BP 90-100. Reassess the patient after each bolus.

Consider 0.2ml of 1:10,000 IV/IO every 5 minutes to maintain systolic BP > 90mmHg

**PUSH DOSE
EPINEPHRINE**

DIPHENHYDRAMINE 50 mg IV/IO push. May administer 50 mg IM if IV/IO access not promptly available.

ALBUTEROL If wheezing or stridor: 3.0ml of 0.5% solution in 15ml saline (or 6 unit dose vials) continuous nebulization via hand-held nebulizer, mask, or in-line with CPAP over 1 hour, or until symptoms improve. If patient intubated, administer dose through in-line aerosolized method. Repeat as needed.



POLICY: 554.45
TITLE: Non-Traumatic Abdominal Pain

EFFECTIVE: 2/24/21
REVIEW: 2/2026
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

NON-TRAUMATIC ABDOMINAL PAIN

- I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.
- III. PROTOCOL
It is important to remember that serious medical conditions can produce symptoms like abdominal pain such as a cardiac event and sepsis, Ascites, Abdominal Aortic Aneurysm, Referred Pain, and Kidney Stones. Conduct a detailed exam to determine underlying cause and location.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing. Assess vitals q5 minutes
Oxygen Administration	Provide oxygen if appropriate
EMT STANDING ORDERS	
Note	If applicable must perform items in EMR standing orders
Pulse Oximetry	Report initial reading to paramedic if applicable
Glucometer	Obtain blood glucose level
PARAMEDIC STANDING ORDERS	
Note	If applicable must perform items in EMR and EMT standing orders
Monitor	Treat rhythm as appropriate

IV Access

Establish an IV and titrate to a systolic BP of 90 – 100 mmHg with 500ml boluses-max of 2000ml and/or if the assessment indicates any of the following:

- a. Hemodynamic Instability-Place patient supine with legs elevated
- b. Concurrent respiratory compromise
- c. Glasgow Coma Score of < than or equal to 13
- d. Significant Hemorrhage
- e. Suspected Ectopic Pregnancy
- f. Heart rate > 120

Pain Management

Refer to Pain Management Protocol 554.44

Clinical PEARLS:

- Consider 12 lead acquisition



POLICY: 554.46
 TITLE: Nausea or Vomiting

EFFECTIVE: 2/24/21
 REVIEW: 2/2026
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 2

NAUSEA OR VOMITING

- I. AUTHORITY
 Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
 To serve as the treatment standard for EMR’s EMT’s and Paramedics in treating patients.
- III. PROTOCOL
 Nausea or Vomiting may be due to a viral illness (such as gastroenteritis), motion sickness brought on by vehicle movement, or medication side effects. However, it is important to remember that more serious medical conditions also produce nausea or vomiting such as stroke, head injuries, toxic ingestions, bowel obstruction, appendicitis and acute coronary syndrome. Generally, benign causes of nausea or vomiting do not have any associated pain complaints. Likewise, pain or alterations in level of consciousness with associated nausea or vomiting tend to have more serious etiologies.

EMR STANDING ORDERS	
Patient Assessment	Circulation, Airway, Breathing. Assess vitals q5 minutes
Oxygen Administration	Provide oxygen if appropriate
Suction	Be prepared to suction the airway if indicated
EMT STANDING ORDERS	
Note	If applicable must perform items in EMR standing orders
Pulse Oximetry	Report initial reading to paramedic if applicable
Glucometer	Obtain glucose level
PARAMEDIC STANDING ORDERS	
Note	If applicable must perform items in EMR and EMT standing orders
Monitor	Treat heart rhythm as appropriate

Consider IV Access

For prolonged history of vomiting with exam findings suggesting dehydration (dry mucous membranes, tachycardia, hypotension, poor skin turgor, delayed capillary refill), administer 500ml normal saline bolus. Recheck vitals. May repeat x1

CONSIDER ONDANSETRON

For severe nausea or persistent vomiting:
Administer 4mg IV/IM. May repeat every 10 minutes to a maximum of 12mg.

Note: administer IV dose over 1 minute (slow IV push). Ondansetron is contraindicated in patients with hypersensitivities to Ondansetron or similar medications such as Dolasetron (Anzemet®), Granisetron (Kytril®), Palonosetron (Aloxi®)

Clinical PEARLS:

- Rapid administration of Ondansetron has been associated with increased side effects, most notably syncope. Ondansetron must be administered SLOWLY over 1 minute.
- Other rare side effects of Ondansetron include headache, dizziness, tachycardia, sedation, or hypotension.
- Ondansetron is SAFE for use in pregnancy or breast-feeding mothers.
- Note color of emesis
- 12 lead acquisition if cardiac is suspected



POLICY: 554.51
TITLE: Poisoning/Overdose

EFFECTIVE: 2/24/21
REVIEW: 2/2026
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

POISONING/OVERDOSE

- I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, and Paramedics within their scope of practice.
- III. PROTOCOL
Be careful not to contaminate yourself and others, remove contaminated clothing, refer to Emergency Response Guide and bring in the container or label.

EMR STANDING ORDERS

Patient Assessment	Circulation, Airway, Breathing. Assess vitals q5 minutes
Oxygen Administration	Provide oxygen if appropriate
Suction	Be prepared to suction the airway

EMT STANDING ORDERS

Note	If applicable must perform items in EMR standing orders
Pulse Oximetry	Report initial reading to paramedic if applicable
Glucometer	Obtain blood glucose level if patient displays ALOC
Naloxone	If respirations are <10/min or systolic BP<90, give 2mg IM or IN. May repeat once in 3-5 minutes if high suspicion of narcotic overdose

PARAMEDIC STANDING ORDERS

Note	If applicable must perform items in EMR and EMT standing orders
Monitor	Treat heart rhythm as appropriate

IV/IO Access	If systolic BP is < 90mmHg, give 500ml boluses until systolic BP is 90-100mmHg. Reassess patient after each bolus. Max fluid 2000ml
NARCOTICS/OPIOIDS-SEDATIVES	
Naloxone	Only if respirations are < 10/min or systolic BP is < 90mmHg, give 2mg IV/IO/IM/IN. May repeat ONCE in 3-5 minutes if high suspicion of narcotic overdose.
TRICYCLIC ANTIDEPRESSANTS	
Sodium Bicarbonate	1mEq/kg IV/IO for: <ul style="list-style-type: none"> a. GCS < 15 b. HR > 100 c. Systolic BP < 90mmHg d. QRS widening > 0.12 e. High suspicion of tricyclic ingestion Repeat 0.5mEq/kg IV/IO every 5 minutes for persistent signs and symptoms.
BETA BLOCKER OVERDOSE	
Atropine	1mg IV/IO if BP < 90mmHg AND HR < 50/min with serious signs and symptoms. May repeat once in 5 mins.
Glucagon	1mg IM for serious signs and symptoms of Beta Blocker overdose only.
<u>CALCIUM CHANNEL BLOCKER OVERDOSE</u>	
Calcium Chloride	If Calcium Channel Blocker ingestion is suspected, give 100mg for BP < 90mmHg AND HR < 50/min AND serious signs and symptoms. May repeat in 5 minutes.
Atropine	1mg IV/IO if BP < 90mmHg AND HR < 50/min with serious signs and symptoms. May repeat once in 5 mins.
CAUSTICS/CORROSIVES/PETROLEUM DISTILLATES	
Remove Agent. If agent is dry, brush off then flush with copious amounts of water. If agent is liquid, flush with copious amounts of water. If eyes are contaminated, flush with water for a minimum of 20 minutes.	
Do not induce vomiting or give Activated Charcoal	
ORGANOPHOSPHATES	
Atropine	2mg slow IV/IO or IM. Repeat every 3 minutes as needed to control secretions, bronchorrhea, and dysrhythmias Signs and symptoms include- Salivation, Lacrimation, Urination, Defecation, GI upset, Emesis, and Muscle twitching
AMPHETAMINE OR COCAINE INTOXICATION WITH ACUTE AGITATION	
Midazolam	2mg IV/IO. Titrate 1mg increments to control agitation or psychosis (max dose of 6mg). If unable to establish IV access (after one attempt), give 5mg IM/IN. May repeat IM/IN dose once in 10 minutes if uncontrollable behavior continues.

Clinical PEARLS:

- Contact Base Hospital if any questions or if additional therapy/treatment is required. Any Poison Control Center consultation must be coordinated with Base Hospital.
- If Law enforcement administers Naloxone prior to arrival, EMS may administer additional Naloxone if suspected narcotic overdose
- ETCO₂ monitoring required for administration of Midazolam if tolerated by patient

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Executive Director

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EFFECTIVE DATE 7/01/2011
SUPERSEDES: _____
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REVIEW DATE: 7/01/2016
PAGE: 1 of 1

DYSTONIC REACTION TO PHENOTHIAZINE DRUGS

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard for EMT-Is and Paramedics within their scope of practice.
- III. PROTOCOL: Phenothiazines are prescribed for their antiemetic and anti-cholenergic properties. Phenothiazines include: chlorpromazine (Thorazine), metoclopramide (Reglan), prochlorperazine (Compazine) and promethazine (Phenergan)

A non-phenothiazine medication that can cause dystonic reactions is haloperidol (Haldol).

Symptoms might include restlessness; muscle spasms of the neck; jaw and back' movement of eyeballs (oculogyric crisis); frightened; facial grimace; protruding tongue, back arching (opisthotonus).

Phenothiazines are prescribed for their antiemetic and tranquilizing properties. Phenothiazines include: chlorpromazine (Thorazine), metoclopramide (Reglan), prochlorperazine (Compazine) and promethazine (Phenergan and Atarax).

NOTE: Phenothiazine reactions may occur at normal dosing levels. Activated charcoal is not necessary.

STANDING ORDERS

ASSESS	CAB
OXYGEN:	Oxygen delivery as appropriate
MONITOR:	Treat rhythm as appropriate.
IV/IO ACCESS:	TKO
DIPHENHYDRAMINE:	25mg IV/IO push. May repeat 25mg ONCE if needed. May administer 25mg IM if IV access not promptly available.

BASE PHYSICIAN ORDERS

RELEASE-AT-SCENE	Competent adults with normal vital signs, blood sugar, and mental status 10 minutes after ALS intervention, may be released if a cause of their condition and its solution has been identified. Refer to Refusal of EMS Service Policy 570.35.
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Medical Director

EFFECTIVE DATE 4/15/2016
SUPERCEDES: _____

REVIEW DATE: 4/2021
PAGE: 1 OF 1

NERVE AGENT EXPOSURE

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard for EMTs and Paramedics within their scope of practice.
- III. PROTOCOL: "Nerve Agent" means an extremely toxic organophosphate-type chemical, including GA (Tabun), GB (Sarin), GD (Soman), GF (Cyclosarin) and VX which attack the nervous system and interfere with chemicals that control nerves, muscles and glands. They are odorless, invisible and can be inhaled, absorbed through the skin or swallowed. This protocol applies to large-scale organophosphate poisonings. *General treatment centers on terminating the exposure, patient decontamination, Chempack deployment, airway support and pharmacological treatment.*

STANDING ORDERS	
DECONTAMINATE	Decontaminate prior to patient contact
ASSESS	CAB
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider intubation/perilaryngeal airway. Refer to General Procedures Protocol 554.00
POSITIONING	Position patient left lateral/recovery position
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	Rate as indicated. If systolic BP is <90mmHg, give 250cc boluses until systolic BP is 90-100mmHg. Reassess patient after each bolus.
DETERMINE LEVEL OF EXPOSURE	Mild: Rhinorrhea, Chest Tightness, Dyspnea, Bronchospasm Moderate: SLUDGEM Severe: SLUDGEM, Severe Dyspnea, Seizures, Agitation, Drowsiness, Coma, Staggering

Exposure/Symptoms	Treatment	
	Atropine	Pralidoxime (2-Pam)
Asymptomatic	None (monitor patient)	None (monitor patient)
Mild	Adult: 1 Auto Injector (2mg) IM. Pedi: DO NOT Administer	Adult: One (1) Auto-injector (600 mg) IM IF Signs and Symptoms do not resolve 5 minutes after Atropine administration. Pedi: DO NOT Administer
Moderate	Adult: 2 Auto-injectors (4mg) IM. Pedi: DO NOT Administer	Adult: 1 Auto-injector (600 mg) IM, may repeat 1x in 5-10 min. as needed. Peds: DO NOT Administer
Severe	Adult: 3 Auto-injectors (6 mg) IM. Peds: 0.02mg/kg IV/IO/IM, minimum dose 0.1mg, repeat as needed	Adult: 3 Auto-injectors (1.8 Gms) IM. <i>Do NOT repeat.</i> Peds: 20-40mg/kg IV/IO/IM, max 1 gram IM, repeat as needed

VALIUM (For Seizures)	Adult: 2.5-10mg slow IV/IO push to control seizures, may repeat once for recurrent seizures. Max dose 20mg. Pedi: 0.1-0.3 mg/kg slow IV/IO, may repeat at 0.05-0.1mg/kg IV/IO. Max dose 10mg.
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POLICY: 554.61
TITLE: Envenomation

EFFECTIVE: 4/10/19
REVIEW: 4/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 1

ENVENOMATION

- I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL

STANDING ORDERS

ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	TKO
IDENTIFY CAUSE	<p>Bee/Wasp/Yellow Jacket/Fire Ant sting Remove stinger. Refer to Allergic Reaction Policy 554.43</p> <p>Spider bite - Scorpion sting - Centipede sting No specific treatment.</p> <p>Snake envenomation Avoid movement of the affected extremity, keeping extremity at heart level. Splinting is unnecessary. Do not apply ice or constricting band. Monitor distal pulses. Circle any swelling around bite marks with a pen and note time. Measure the circumference of the extremity proximal to the bite and note time.</p> <p>Do not bring the snake to the emergency department!</p>
PAIN MANAGEMENT	Refer to Pain Management Protocol 554.44



POLICY: 554.62
 TITLE: Hypothermia

EFFECTIVE: 4/10/19
 REVIEW: 4/2024
 SUPERCEDES:

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HYPOTHERMIA

- I. AUTHORITY
 Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
 To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL
 Patients with mild hypothermia will not be comatose due to that illness. They will often be mildly confused or sleepy. Mental status may be more depressed if intoxication, head injury, shock, ketoacidosis or stroke has caused secondary mild hypothermia.

STANDING ORDERS

MILD HYPOTHERMIA

Verbally responsive or GCS less than or equal to 12

ASSESS	CAB
WARMING MEASURES	Remove wet clothing and cover patient with warm dry blankets.
OXYGEN	Oxygen delivery as appropriate
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	Warm IV fluid, rate as indicated.
CONSIDER	
ACCUCHECK	Test for glucose
DEXTROSE	25 gms IV/IO push – if blood glucose less than 60 mg/dl. May repeat once. Recheck blood sugar 5 minutes after each dose. Give oral glucose solution to patients who are awake and have an intact gag reflex.
GLUCAGON	1 unit IM – if no IV/IO access immediately available and blood glucose less than 60 mg/dl. May repeat once. Recheck blood glucose in 5 minutes.
NALOXONE	2 mg IN (IV/IO/IM if IN not available), only if respiratory rate less than 10/minute or systolic BP less than 90mmHg AND narcotic overdose is suspected: pinpoint pupils, track marks, drug paraphernalia, or history of narcotic use. May repeat ONCE in 3 minutes if inadequate response Narcan must be administered before intubating a symptomatic narcotic overdose

STANDING ORDERS CONTINUED

SEVERE HYPOTHERMIA

Verbally responsive or GCS greater than or equal to 12

ASSESS	CAB
WARMING MEASURES	Remove wet clothing and cover patient with warm dry blankets. *Sudden movement to patient may cause life-threatening arrhythmia*
SECURE AIRWAY	Intubate only if absolutely necessary . Spontaneous ventilations of 4-6 per minute may be adequate. Use the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Beyond BLS airway management refer to General Procedures Protocol 554.00
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Observe rhythm and pulses for one minute - if organized rhythm present, move gently . Treat dysrhythmias as appropriate. Severe bradycardia with pulses requires no antiarrhythmic therapy.
IV/IO ACCESS	Warm IV fluid, rate as indicated. Most severely hypothermic patients are volume-depleted.
	CONSIDER
ACCUCHECK	Test for glucose
DEXTROSE	25 gms IV/IO push – if blood glucose less than 60 mg/dl. May repeat once. Recheck Blood Sugar in 5 minutes after each dose. Give oral glucose solution to patients who are awake and have an intact gag reflex.
GLUCAGON	1 unit IM – if no IV/IO access immediately available and blood glucose less than 60 mg/dl. May repeat once. Recheck blood glucose in 5 minutes.
NALOXONE	2 mg IN (IV/IM/IO if IN not available), only if respiratory rate less than 10/minute or systolic BP less than 90mmHg AND narcotic overdose is suspected: pinpoint pupils, track marks, drug paraphernalia, or history of narcotic use. May repeat ONCE in 3 minutes if inadequate response Narcan must be administered before intubating a symptomatic narcotic overdose.
CARDIAC ARREST	Give only one dose of each drug during cardiac arrest, but continue normal CPR and defibrillation attempts.

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FROSTBITE

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard for EMT-Is and Paramedics within their scope of practice.
- III. PROTOCOL:

STANDING ORDERS

ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate
EVALUATE WARMING MEASURES	Evaluate all exposed at-risk body parts. Move patient to warm environment and wrap affected extremity with thick, un-warmed blankets or clothing. Do not rub affected extremity. Avoid chemical heat packs, radiant heat, or forced-air heating.
IV ACCESS	TKO
PAIN MANAGEMENT	Refer to Pain Management Protocol 554.44

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HEAT ILLNESS

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard for EMT-Is and Paramedics within their scope of practice.
- III. PROTOCOL:

Heat Exhaustion: Muscle cramping, fatigue, nausea, headache, normal or slightly elevated body temperature. Syncope or dizziness is almost universal.

Heat Stroke: Persistently altered level of consciousness and elevated body temperature (usually greater than 104% F or 40 C), tachycardia and hypotension. Sweating is variable.

STANDING ORDERS	
HEAT EXHAUSTION	
ASSESS	CAB
COOLING MEASURES	Place patient in a cool environment.
OXYGEN	Oxygen delivery as appropriate.
IV ACCESS TKO	If systolic BP less than 90 mmHg, give 250 ml fluid boluses until systolic BP 90-100. Reassess the patient after each bolus.
HEAT STROKE	
ASSESS	CAB
COOLING MEASURES	Remove heavy or insulating clothing and splash patient with water. Place ice packs on head, neck and in axilla and inguinal areas. Promote cooling by fanning. Use all available cooling measures.
OXYGEN	Oxygen delivery as appropriate.
IV/IO ACCESS	Two 14-16 gauge. If systolic BP less than 90 mmHg, give 250 ml fluid boluses until systolic BP 90-100. Reassess the patient after each bolus.
CONSIDER	
ACCUCHECK	Test for glucose.
DEXTROSE	25 gm IV/IO push - if blood glucose is less than 60 mg/dl. May repeat once. Recheck blood glucose in 5 minutes.
GLUCAGON	1 mg IM - if blood glucose is less than 60 mg/dl and no IV/IO access immediately available. May repeat once. Recheck blood glucose in 5 minutes.
MIDAZOLAM	If seizing 2mg initial dose IV/IO push. Titrate in 1mg increments for seizure control (maximum dose: 6mg). If unable to establish IV/IO after one attempt, give 5mg IM. May repeat once in 10 minutes if seizures continue.

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EFFECTIVE DATE 7/01/2011

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REVIEW DATE: 7/01/2016

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CHILDBIRTH

I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II. DEFINITIONS: Designated Hospital may include any of the following facilities:

- Sutter-Roseville Medical Center, Roseville
- U.C. Davis Medical Center, Davis
- Madera Children’s, Madera
- Regional Medical Center, Fresno
- San Joaquin General, Stockton
- Washoe Medical Center, Reno NV
- Doctors Medical Center, Modesto*
- Memorial Medical Center, Modesto*

*These facilities are considered equidistant for purposes of determining closest facility located in Modesto.

III. PURPOSE: To serve as a patient treatment standard for EMT-1s and Paramedics within their scope of practice.

IV. PROTOCOL:

STANDING ORDERS	
ALL DELIVERIES	
ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate
ROUTINE DELIVERY	
TRANSPORT	Transport with mother placed on left side.
DELIVER NEWBORN	As head is delivered clear airway if needed ,. Use hand on head to prevent explosive delivery. If cord is wrapped around neck and cannot be slipped over the newborn’s head, double clamp and cut between clamps. Complete delivery of newborn’s body. Dry newborn and keep warm. Place newborn on mother’s abdomen or breast. Double clamp and cut cord between clamps 6 – 8 inches from newborn.
ASSESS NEWBORN	Refer to Newborn Resuscitation Policy 555.10
FOLLOWING DELIVERY OF PLACENTA	Massage Fundus
BREECH PRESENTATION	
TRANSPORT	Code 3 while maintaining airway for newborn to a Designated Hospital.
CONSULT BASE PHYSICIAN	
DELIVER NEWBORN	For a buttocks presentation, allow newborn to deliver to waist. Support the limbs and torso. Use hand on torso to prevent explosive delivery. When legs and buttocks are delivered, the head can be assisted out. If the head does not deliver rapidly, insert gloved hand into vagina, palm towards baby’s face and cord between fingers to create an airway.

STANDING ORDERS CONTINUED

PROLAPSED CORD

TRANSPORT

Code 3 to a Designated Hospital.

POSITION

Place the mother supine in knee-chest position, face down.

PROTECT CORD

Insert gloved hand into vagina and gently push the presenting part off the cord. Cover exposed portion of cord with saline-soaked gauze. Do not attempt to push cord back into vagina.

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EFFECTIVE DATE: 4/15/2016
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REVIEW DATE: 4/2021
PAGE: 1 OF 1

SELECTIVE SPINAL MOVEMENT RESTRICTION (SSMR)

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard for EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL: The term Selective Spinal Movement Restriction (SSMR) describes the process to care for patients with possible unstable spinal injuries. The purpose of SSMR is to: reduce gross movement of the patient, prevent duplication of the damaging mechanism to the spine and regular reassessment of motor/sensory function.

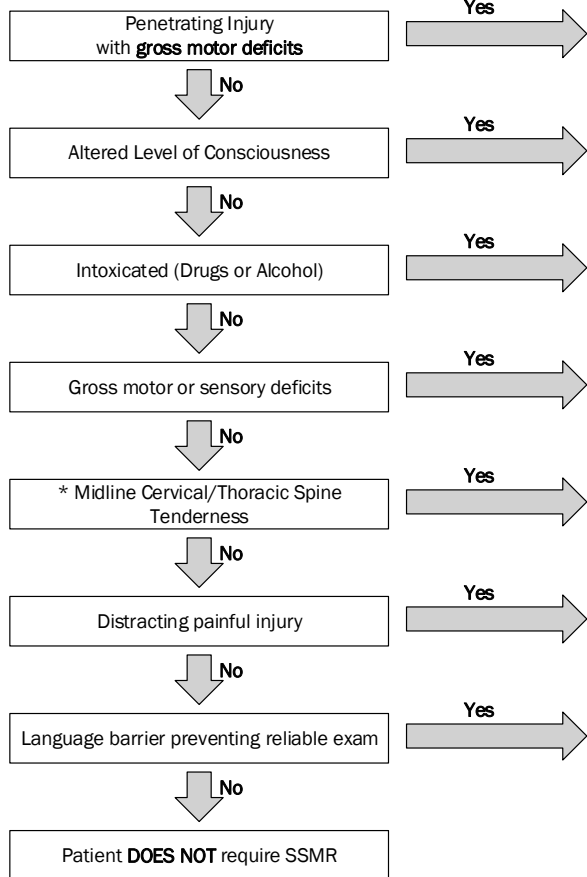
Selective Spinal Movement Restriction (SSMR) Algorithm

Criteria for Selective Spinal Movement Restriction (any one)

- Midline thoracic or cervical spinal tenderness on palpation
- Altered level of consciousness
- Suspected drug/alcohol intoxication
- Abnormal neurologic finding (paresthesias, weakness, paralysis)
- Distracting injury (ie: blunt thoracic trauma or long bone fracture)
- Inability to effectively communicate (language barrier)

PEARLS

- A rigid cervical collar **should not be placed or shall be removed** if the
 1. collar creates airway compromise
 2. appropriate sized collar is unavailable
 3. collar increases pain
 4. patient's anatomy precludes fitting a collar (ie: severe curvature of the spine)
 5. patient is combative and fighting application of the collar
- Patients already immobilized should remain immobilized.
- Patients with penetrating injuries do not require SSMR unless they meet specific criteria in the algorithm
- Long spine boards (LSB) **should be avoided** in ambulatory patients
- Elderly or kyphotic individuals requiring SSMR may require vacuum immobilization devices
- SSMR does not take precedence over airway or cardiovascular stabilization
- Leave helmets and shoulder pads in place unless they interfere with resuscitation



APPLY SELECTIVE SPINAL MOVEMENT RESTRICTION

Stanislaus County EMS Agency Policy # 554.80

*Ambulatory patients and those that can self-extricate, are cooperative, can follow instructions and who have only midline cervical or thoracic pain may be placed in a rigid collar and secured to the ambulance cot (no LSB necessary)



POLICY: 554.81
 TITLE: Burns

EFFECTIVE: 04/10/19
 REVIEW: 04/2024
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Burns

I. AUTHORITY

Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II. PURPOSE

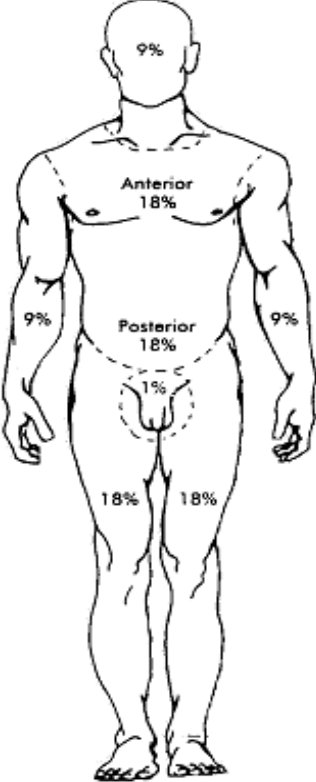
To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.

III. PROTOCOL

STANDING ORDERS

MOVE PATIENT	To a safe environment
ASSESS	CAB
COOLING PROCESS	<p><u>Tar Burns</u>: Cool with water and transport. Do not attempt to remove tar.</p> <p><u>Thermal Burns</u>: Cool with water for up to 5 minutes to stop the burning process.</p>
OXYGEN	Oxygen delivery as appropriate
SECURE AIRWAY/ INTUBATE	Consider EARLY intubation if ineffective ventilation/oxygenation, or if patient is unconscious. Otherwise, use the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Beyond BLS airway management refer to General Protocol 554.00
IV/IO ACCESS	<p>Superficial Burns: TKO</p> <p>Partial and full-thickness burns: 0.5 ml times patient weight in kg times % of burn = IV/IO fluid per hour. If systolic BP less than 90mmHg, give 250 ml boluses until systolic BP 90-100. Reassess patient after each bolus.</p> <p>Major Burns: Two 14-16 gauge IV/IO in patients with major burns (greater than 9%) TKO. If systolic BP less than 90mmHg, give 250 ml boluses to systolic BP 90-100. Reassess the patient after each bolus.</p> <p>IV site in order of preference:</p> <ol style="list-style-type: none"> 1. unburned upper extremity, or external jugular 2. unburned lower extremity 3. burned upper extremity 4. burned lower extremity

MONITOR	Treat rhythm as appropriate.
DRESS BURNS	Cover with dry dressing and keep patient warm.
PAIN MANAGEMENT	Refer to Pain Management Protocol 554.44
TRANSPORT	To nearest facility if patient is unstable (airway difficulty, hypotension) or according to Trauma Triage and Patient Destination Policy 553.25 if stable.



<u>Adult Body Part</u>	<u>% of Total Body Surface</u>
Arm (shoulder to fingertips)	9 (x2)
Head/Neck	9
Groin	1
Leg	18 (x2)
Anterior trunk	18
Posterior trunk	18

The patient's palm (hand including fingers) is about 0.9% of the patient's body surface area.



POLICY: 554.82
TITLE: Traumatic Shock

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 1

Traumatic Shock

I. AUTHORITY

Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II. PURPOSE

To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.

III. PROTOCOL

STANDING ORDERS

ASSESS	CAB
SECURE AIRWAY/INTUBATE	Use simplest effective method while maintaining SSMR. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Beyond BLS airway management refer to General Procedures Protocol 554.00
OXYGEN	Oxygen delivery as appropriate.
SPINE IMMOBILIZATION	If indicated, refer to General Procedures Protocol 554.00
UNCONTROLLED HEMORRHAGE	Place a tourniquet for uncontrolled extremity hemorrhage. Pack truncal penetrating injuries with Hemostatic dressings if applicable
POSITION	Do not use Trendelenberg (feet elevated) position. If patient is pregnant place patient on left side, or tilt spine board 30° to left.
IV/IO ACCESS	Two 14-16 gauge IV/IO, wide-open until systolic BP 80 mmHg or 2L infused, then TKO. If systolic BP remains less than 80mmHg, give 250 ml boluses until systolic BP reaches 80 mmHg. Reassess the patient after each bolus.
TENSION PNEUMOTHORAX	Refer to Tension Pneumothorax Protocol 554.23



POLICY: 554.84
TITLE: Head-Neck-Facial Trauma

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Head-Neck-Facial Trauma

I. AUTHORITY

Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9

II. PURPOSE

To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.

III. PROTOCOL

STANDING ORDERS

ASSESS	CAB
SECURE AIRWAY	Use simplest effective method while maintaining SSMR. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Beyond BLS airway management refer to General Procedures Protocol 554.00
SPINE IMMOBILIZATION	If indicated refer to 554.80 Selective Spinal Movement Restriction
OXYGEN	Oxygen delivery as appropriate.
POSITION	Elevate the head of brain injured patients, if patient exhibits no signs of shock. If patient is pregnant, place patient on left side, or tilt spine board 30 degrees to left.
IV/IO ACCESS	TKO. For suspected TBI, if systolic BP is less than 80mmHg, give 250 boluses to SBP reaches 100 mmHg. Reassess patient after each bolus.
PAIN MANAGEMENT	Refer to Pain Management Protocol 554.44.
DRESS & SPLINT	Dress and splint as indicated. Consider hemostatic dressing as appropriate.
CONSIDERATIONS	Avulsed Tooth - Place tooth in milk, normal saline, saline soaked gauze or a commercial "tooth saver." Eye Injuries - cover with a non-contact dressing, such as a paper cup. Do not apply direct pressure to eye and <u>do not</u> attempt to replace partially torn globe. Impaled Object - immobilize and leave in place. Remove object if it interferes with CPR, extrication, or ventilation.



POLICY: 554.85
 TITLE: Chest Trauma

EFFECTIVE: 02/13/2019
 REVIEW: 02/2024
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 1

Chest Trauma

- I. AUTHORITY
 Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
 To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL

STANDING ORDERS

ABCs

SECURE AIRWAY	Use simplest effective method while maintaining SSMR. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Beyond BLS airway management refer to General Procedures Protocol 554.00
SPINE IMMOBILIZATION	If indicated refer to 554.80 Selective Spinal Movement Restriction
OXYGEN	Oxygen delivery as appropriate
POSITION	If patient is pregnant place patient on left side, or if in spinal immobilization, tilt spine board 30 degrees to the left.
IV/IO ACCESS	TKO
DRESS WOUNDS	Use hemostatic dressing if applicable
CONSIDERATIONS	<p>Impaled Object - Immobilize and leave in place. Remove object if it interferes with CPR, ventilation or extrication.</p> <p>Flail Chest - Observe for tension pneumothorax. Consider assisted ventilation.</p> <p>Penetrating Chest Injury- Cover wound. Dress wound loosely. Use appropriate chest seal device, or tape occlusive dressing on three sides over the wound. Continuously re-evaluate patient for the development of a tension pneumothorax.</p> <p>Tension Pneumothorax - Perform needle thoracostomy or remove any occlusive dressing covering an open chest wound. Refer to the Tension Pneumothorax Protocol 554.23.</p> <p>Cardiac Tamponade - If systolic BP less than 80mmHg, administer 250 cc fluid boluses until systolic BP reaches 80 mmHg. Reassess the patient after each bolus. Refer to the Traumatic Shock Protocol 554.82.</p> <p>Cardiac Contusion - Monitor for dysrhythmias. Refer to Cardiac Protocols.</p>

BASE PHYSICIAN ORDERS

PAIN MANAGEMENT	Refer to Pain Management Protocol 544.44
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POLICY: 554.86
TITLE: Abdominal Trauma

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 1

Abdominal Trauma

- I. AUTHORITY
Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL

STANDING ORDERS

ASSESS	CAB
SECURE AIRWAY	Use simplest effective method while maintaining SSMR. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable Beyond BLS airway management refer to General Procedures Protocol 554.00
SPINE IMMOBILIZATION	If indicated, refer to 554.80 Selective Spinal Movement Restriction
OXYGEN	Oxygen delivery as appropriate
POSITION	If patient is pregnant place patient on left side, or tilt spine board 30 degrees to the left.
IV/IO ACCESS	TKO. If systolic BP less than 80mmHg, give 250 ml fluid boluses until systolic BP 80-100. Reassess the patient after each bolus.
DRESS WOUNDS	Use Hemostatic dressings if applicable
CONSIDERATIONS	<p>Impaled Object - Immobilize and leave in place. Remove object only if it interferes with CPR, extrication, or ventilation.</p> <p>Eviscerating Trauma - Cover eviscerated organs with saline-soaked gauze. Do not attempt to replace organs into the abdominal cavity.</p> <p>Genital Injuries - Cover open genitalia wound with saline soaked gauze. If necessary apply direct pressure to control bleeding. Treat amputation the same as extremity amputation: refer to Extremity Trauma Policy 554.87</p>

BASE PHYSICIAN ORDERS

PAIN MANAGEMENT	Refer to Pain Management Protocol 544.44
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POLICY: 554.87
 TITLE: Extremity Trauma

EFFECTIVE: 02/13/2019
 REVIEW: 02/2024
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

Extremity Trauma

- I. AUTHORITY
 Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE
 To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL

STANDING ORDERS

ASSESS	CAB
SECURE AIRWAY	Use simplest effective method while maintaining SSMR. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable Beyond BLS airway management refer to General Procedure Protocol 554.00
SPINE IMMOBILIZATION	If indicated Refer to 554.80 Selective Spinal Movement Restriction
OXYGEN	Oxygen delivery as appropriate
HEMORRHAGE CONTROL	<ul style="list-style-type: none"> • Control bleeding with direct pressure • Use a tourniquet if bleeding is uncontrolled • Elevate and splint injured extremity in position of comfort
DRESS & SPLINT	Dress and splint as indicated. Consider hemostatic dressing or tourniquet as appropriate.
IV/IO ACCESS	TKO. If systolic BP is less than 80mmHg, give 250 boluses to SPB reaches 80 mmHg. Reassess patient after each bolus
PAIN MANAGEMENT	Refer to Pain Management Protocol 554.44
CONSIDERATIONS	<p>Fracture/Dislocation – Open or closed femur fractures may be splinted with traction or cardboard splints after gentle realignment with manual traction (pain management should be administered to facilitate muscle relaxation). Check neuro-vascular status prior to and after each extremity manipulation. Splint dislocations in position found. If the extremity is pulseless, attempt to place it in normal anatomic position by gentle in-line traction.</p> <p>Amputations - If partial amputation, splint in anatomic position and elevate the extremity. Wrap completely amputated parts in dry sterile gauze, then place parts in a sealed and dry container. Place container on ice, if possible.</p>
BASE PHYSICIAN ORDERS	
PAIN MANAGEMENT	Refer to Pain Management Protocol 554.44

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
 Executive Director

EFFECTIVE DATE 4/15/16
 SUPERCEDES: _____

SIGNATURE ON FILE IN EMS OFFICE
 Medical Director

REVIEW DATE: 4/2021
 PAGE: 1 of 1

ADULT MEDICATION CHARTS

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard for Paramedics within their scope of practice.
- III. PROTOCOL:

DOPAMINE DRIP CHART FOR ADULTS

FOR A CONCENTRATION OF **1600 µg** of DOPAMINE PER MILLILITER SOLUTION
 Two 5 ml ampules of Dopamine (200 mg of dopamine per ampule) mixed in 250 ml of NS.

Body Weight	kg	50	55	60	65	70	75	80	85	90	95	100	105	110
	lbs	110	121	132	143	154	165	176	187	198	209	220	231	242
µg/min.	10µg	19	21	23	25	27	29	31	32	34	36	38	40	42
	15µg	29	32	34	37	40	43	46	49	52	54	57	60	63
	20µg	38	42	46	50	53	57	61	65	69	73	76	80	84
FLOW RATE IN DROPS PER MINUTE based on a microdrip calibration of 60 drops equal to 1.0 milliliter														



POLICY: 554.89
TITLE: Tranexamic Acid (TXA) Administration

EFFECTIVE: 6/1/2020
REVIEW: 6/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 2

TRANEXAMIC ACID (TXA) ADMINISTRATION

- I. AUTHORITY California Health and Safety Code, Division 2.5 EMS, Sections 1797.220 and 1797.221
- II. DEFINITIONS
Tranexamic Acid (TXA) is a Lysine analogue that works to inhibit the formation of plasmin, which is a molecule responsible for clot degradation. It therefore stabilizes clots and slows down bleeding. It has recently been shown in multiple studies to reduce mortality in trauma patients meeting specific physiologic criteria or who have signs of massive trauma.
- III. PURPOSE
To serve as a patient treatment standard for Paramedics within their scope of practice
- IV. POLICY
Within 3 hours of a traumatic event, the prehospital use of TXA should be considered for all blunt or penetrating trauma to the trunk (thorax, abdomen, or back) in patients 15 years of age or older with one or more systolic blood pressure readings less than 90 mmHg.

Contraindications:

- Any patient <15 years of age
- Any patient more than 3 hours post injury
- Documented cervical cord injury with motor deficits
- Isolated traumatic brain injury
- Thromboembolic event (i.e. stroke, MI, PE, DVT) in the past 24 hours
- Traumatic arrest with greater than 5 minutes of CPR without ROSC

GENERAL ASSESMENT:	CAB
OXYGEN:	Oxygen delivery as appropriate to maintain O2 saturation 92-98%
MONITOR	
PULSE OXIMETRY	
IV/IO ACCESS	Preferably 16-18-gauge access
TXA	Administer 1 gram in 100ml of NS over 10 minutes (<u>DO NOT ADMINISTER IV PUSH: This will cause hypotension</u>) no repeat dose allowed. If IO route, deliver under pressure.
TXA BAND	Place appropriate band on patient identifying the administration of TXA
REASSESS	Assess and document vital signs every five minutes for duration of transport

Pediatric Treatment Guidelines





POLICY: 555.00
 TITLE: General Pediatric

EFFECTIVE: 7/1/2018
 REVIEW: 7/2023
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

GENERAL PEDIATRIC

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

PEDIATRIC MEASUREMENTS - VITAL SIGNS								
AGE	cm length	Weight (kg)**	Average Systolic BP	Pulse/Minute	Resp./Minute			Broselow Tape Color
Preemie	≤53	< 2.5	60 - 70	> 120	60			White
Term NB	50 - 57	2.5 - 4	60 - 70	> 120	30 - 50			White
3 months	58 - 65	5 - 6	70 - 80	80-160	30 - 50			Pink
6 months	66 - 74	7	80 - 100	80-160	30 - 50			Pink - Red
1 year	75 - 86	10	80 - 100	80-160	24 - 40			Purple
2 year	87 - 100	12 - 14	94	80-130	24 - 32			Yellow
4 year	100 - 113	16 - 18	98	80-120	22 - 28			White
6 year	114 - 132	20 - 22	102	70-115	22 - 28			Blue
8 year	127 - 135	25 - 26	106	70-110	20 - 24			Orange
10 year	133 - 142	30 - 34	110	70-110	20 - 24			Orange-Grn
12 year	138 - 150	34 - 41	114	65-110	16 - 22			Green
13 year	155 - 165	41 - 50	118	65-110	16 - 22			X
14 year	161 - 170	50 - 56	122	65-110	16 - 22			X

**** Estimated Weight based upon predefined formula. To be used as a guide only and is NOT intended to replace the known or actual patient weight.**

Formulas for Systolic BP: 50th percentile BP for age over 2 → *Systolic BP = 90 + (2 x age in yrs)*

Lower BP Limit → *Systolic BP = 70 + (2 x age in yrs)*

Formula for Weight: *kg = (2 x age in yrs) + 10*

Abnormal Vital Signs

	<u>Respiration</u>	<u>Pulse</u>	<u>Blood Pressure</u>
Infant	> 90	> 190	< 60
Toddler	> 30	> 160	< 75
School Age	> 25	> 120	< 85
Adolescent	> 20	> 110	< 90



POLICY: 555.10
TITLE: Newborn Resuscitation

EFFECTIVE: 7/1/2018
REVIEW: 7/2023
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 3

NEWBORN RESUSCITATION

- I. AUTHORITY : Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

STANDING ORDERS	
ASSESS	CAB
SUCTION	Open airway. Suction mouth and nasopharynx with bulb syringe
WARM	Dry and keep warm with thermal blanket or dry towel. Stimulate by drying vigorously, including the head and back. If not already performed: clamp and cut cord.
ASSESS	Evaluate breathing and heart rate. Perform APGAR score at 1 and 5 minutes after delivery if time allows. Do not delay resuscitative measures to score patient.
HEART RATE greater than 100	
ASSESS COLOR	If peripheral cyanosis is present: administer 100% oxygen via blow-by or mask.
REASSESS	Heart rate and respirations every 60 seconds while enroute.
HEART RATE 80 – 100	
OXYGEN	100% via mask.
STIMULATE	
REASSESS	If heart rate remains less than 100 after 30 seconds of oxygen and stimulation, begin assisted ventilation with 100% oxygen via bag-valve mask at 40 breaths per minute.
REASSESS	Heart rate and respirations every 60 seconds while enroute.
HEART RATE 60 – 80	
OXYGEN	Assist ventilations with 100% oxygen via bag-valve mask at 40 breaths per minute.
CPR	If no increase in heart rate following ventilations, start compressions at 120 per minute. If patient's heart rate is increasing, continue ventilations without compressions for an additional 15 - 30 seconds.
SECURE AIRWAY/ INTUBATE	If compressions and ventilations fail to increase patients heart rate. Ventilate with 100% oxygen via BVM using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider placement of an I-Gel- only if unable to establish adequate ventilation and oxygenation

	using a BVM and airway adjuncts. Refer to Policy 554.00 – General Protocols.
IV/IO	TKO
EPINEPHRINE	0.01 mg/kg of 1:10,000, if heart rate fails to increase above 80.
REASSESS	Heart rate and respirations every 60 seconds while enroute.

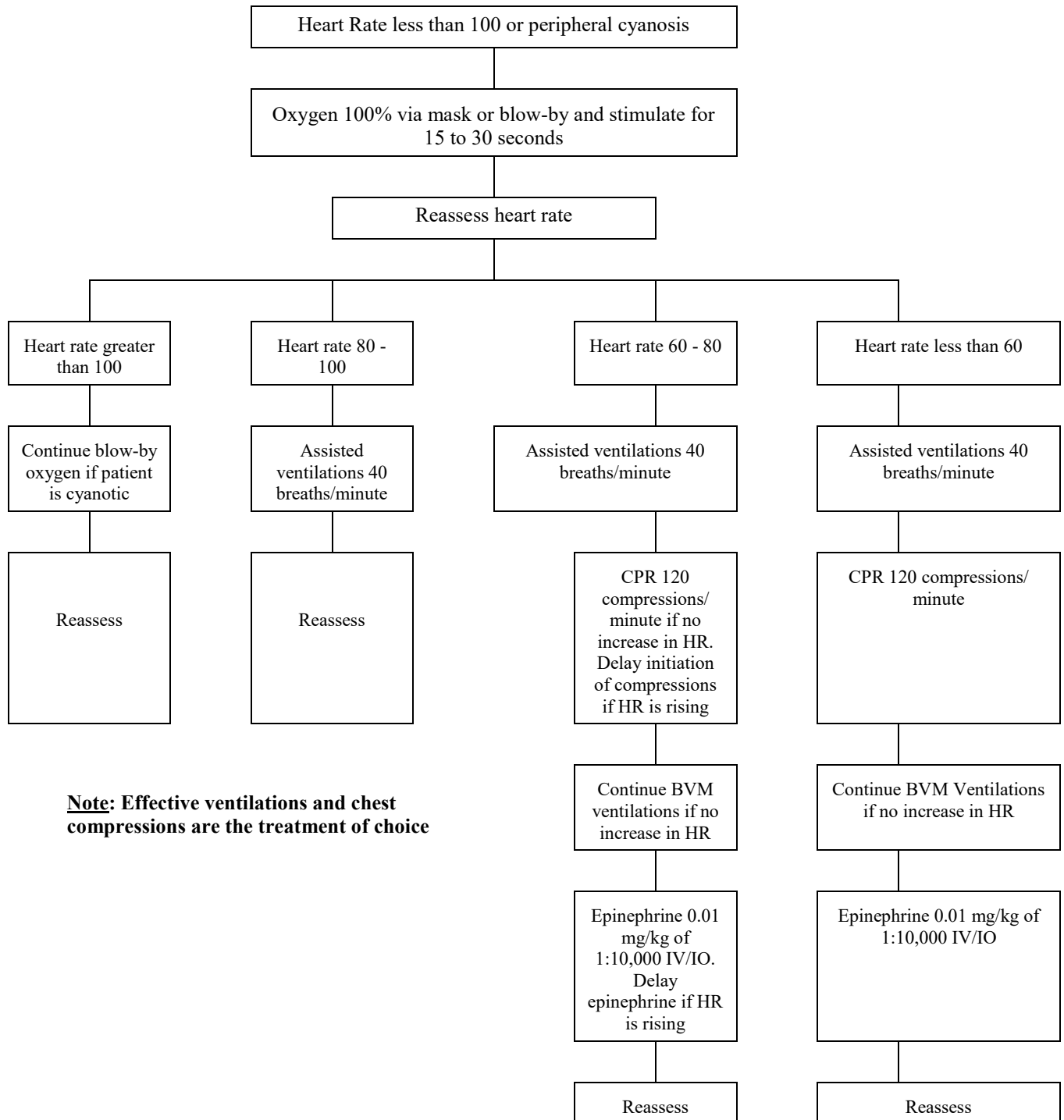
STANDING ORDERS CONTINUED

HEART RATE less than 60

OXYGEN	Assist ventilations with 100% oxygen via bag-valve mask at 40 breaths per minute.
CPR	120 compressions per minute.
SECURE AIRWAY	If compressions and ventilations fail to increase patients heart rate. Ventilate with 100% oxygen via BVM using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider placement of an I-Gel - only if unable to establish adequate ventilation and oxygenation using a BVM and airway adjuncts. Refer to Policy 554.00 – General Protocols.
IV/IO	TKO
EPINEPHRINE	0.01 mg/kg of 1:10,000 IV/IO, if heart rate fails to increase above 80.
REASSESS	Heart rate and respirations every 60 seconds while enroute.

ALGORITHM CHART FOLLOWS

NEWBORN RESUSCITATION ALGORITHM SUMMARY





POLICY: 555.16
TITLE: Pediatric Airway Management

EFFECTIVE: 7/1/2018
REVIEW: 7/2023
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 1

PEDIATRIC AIRWAY MANAGEMENT

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

BLS & ALS

- A. Perform routine ALS/BLS medical care as directed in Policy 554.00 – General Protocols.
- B. The approved airway management procedure for the unconscious pediatric patient consists of the simplest method of BLS interventions to maintain oxygen saturation >94% via the following:
 - 1. If gag present and BVM alone insufficient, place NPA
 - 2. If gag is not present and BVM insufficient, place OPA
 - 3. If unable to ventilate with BVM and airway adjunct, may place additional (i.e. both NPA and OPA).

ALS

- 4. If airway obstruction is suspected, may use Laryngoscope with blade of choice to visualize airway to facilitate removal of Foreign Body obstruction with Magill forceps.
- 5. If no airway obstruction, continue ventilation using simplest method of BLS interventions to maintain oxygen saturation >94%.
- 6. If unable to ventilate using BLS interventions and no obstruction:
 - a) For Pediatric patients 14 years of age or younger: Place supraglottic airway and ventilate at rate of 1 ventilation every 3 seconds.
 - b) Monitor capnography



POLICY: 555.21
 TITLE: Pediatric Airway Obstruction

EFFECTIVE: 7/1/2018
 REVIEW: 7/2023
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC AIRWAY OBSTRUCTION

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. DEFINITIONS:
 - Partial Obstruction**: Stridor, coughing forcefully, able to speak/cry, still passing some air
 - Complete Obstruction**: Cyanosis, silent cough, unable to speak/cry, no air movement.
- IV. PROTOCOL: Transport patient immediately to the closest receiving hospital if unable to clear obstruction or otherwise establish an airway. All patients should be transported to a receiving hospital regardless of airway maneuvers.

Needle Cricothyrotomy is contraindicated in pediatric patients.

STANDING ORDERS

ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate.
CONSIDER IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
CONSIDER CAUSE and SEVERITY	

PARTIAL OBSTRUCTION

Foreign Body	Observe patient; supportive care.
Croup/Epiglottitis	Position of comfort. Consider nebulized saline with the highest flow rate tolerated. Avoid visualization of throat/airway.
Trauma	Suction; supportive care.
Anaphylaxis	Refer to Policy 555.42 – Pediatric Allergic Reaction.

STANDING ORDERS CONTINUED

COMPLETE OBSTRUCTION

Foreign Body	Abdominal thrusts, chest thrusts, laryngoscopy and removal with Magill Forceps.
Croup/ Epiglottitis	Position of comfort. Consider nebulized saline with the highest flow rate tolerated. Avoid visualization of throat/airway unless foreign body obstruction removal is required.
Trauma	Aggressive suctioning; supportive care, secure airway as appropriate. Refer to Policy 554.00 – General Protocols.
Anaphylaxis	Refer to Allergic Reaction Policy 555.42.

UNCONSCIOUS PATIENT

CPR

SECURE AIRWAY

Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.



POLICY: 555.22
TITLE: Pediatric Respiratory Arrest

EFFECTIVE: 7/1/2018
REVIEW: 7/2023
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 1

PEDIATRIC RESPIRATORY ARREST

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

STANDING ORDERS

ASSESS	CAB
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
ACCUCHECK	Test for glucose. Refer to Policy 555.31 – PED ALOC, if blood sugar less than 60 mg/dL.
CONSIDER	
AIRWAY OBSTRUCTION	Refer to Policy 555.21 – Pediatric Airway Obstruction.
NALOXONE	0.1 mg/kg IV/IO/IM, if mental status and respiratory effort are depressed, the patient is not a newborn and there is a strong suspicion of opiate overdose. Maximum single dose 2 mg. May repeat once in 3 minutes if partial response to treatment.



POLICY: 555.23
 TITLE: Pediatric Respiratory Distress

EFFECTIVE: 7/1/2018
 REVIEW: 7/2023
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC RESPIRATORY DISTRESS

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

STANDING ORDERS

ASSESS	CAB
POSITION	Place patient in position of comfort, usually in parent’s lap or arms. Minimize handling and examination to prevent crying and agitation. Avoid laying the patient down. A parent should be allowed to accompany the child to the hospital in order to ease the child’s fears.
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate.

EPIGLOTTITIS

History of upper respiratory infection. Tends to occur in patients age 3 to 6, but some cases occur in children less than 2 years of age. Hx and PE: high fever, sore throat, and pain on swallowing, shallow breathing, dyspnea, inspiratory stridor, drooling, and a red swollen epiglottis: (**Do Not** attempt to visualize airway. If the patient is crying, the epiglottis may be visible posterior to the base of the tongue).

COMPLETE OBSTRUCTION

VENTILATE	With bag valve mask or approved ventilator and 100% oxygen. If unable to ventilate (no rise and fall of the chest), then consider visualizing the airway for a Foreign Body Obstruction, place an I-Gel if possible. Notify Emergency Department of possible surgical candidate.
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.

ASTHMA - BRONCHIOLITIS - CROUP

<u>Asthma:</u>	Patient or family history of asthma or reactive airway disease. Age usually greater than 1 year; tachypnea; patient sitting up and leaning forward; nonproductive cough, accessory respiratory muscle usage and wheezing (wheezing may not be present if the patient has insufficient air movement).
<u>Bronchiolitis:</u>	Age generally less than 1 year, prominent expiratory wheezing and crackles; history of recent upper respiratory infection and fever.
<u>Croup:</u>	Occurs mostly at night during the fall and winter months. History: Mild cold or other infection. Age between 6 months and 4 years, harsh - barking cough, inspiratory stridor.
ALBUTEROL	3.0 ml of 0.5% solution in 15 ml saline (or 6 unit-dose vials) via nebulizer over 1 hour or until symptoms improve. Repeat as needed.

CONSIDER

SALINE NEBULIZER For croup patients.

BASE PHYSICIAN ORDERS

EPINEPHRINE 0.01 mg/kg of 1:1000 IM, (max. dose 0.5 mg) for wheezing or stridor, if patient is not a neonate. May repeat once in 20 minutes.



POLICY: 555.31
 TITLE: Pediatric Altered Level of Consciousness

EFFECTIVE: 6/10/20
 REVIEW: 6/2025
 SUPERCEDES:

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PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMRs, EMTs and Paramedics within their scope of practice.
- III. PROTOCOL: Characterize by a Glasgow Coma Score less than 15, mental confusion, unconsciousness, or a change from baseline.

<u>EMR Standing Orders</u>	
<u>Patient Assessment</u>	Circulation, Airway and Breathing, assess vitals q 5 minutes and consider trauma mechanism
<u>Oxygen Administration</u>	Provide oxygen if appropriate
<u>Bleeding control</u>	Direct pressure with appropriate bandage

<u>EMT Standing Orders</u>	
<u>Note</u>	Must perform items in EMR standing orders as appropriate
<u>Glucometer</u>	Check blood sugar
<u>Pulse oximetry</u>	Report initial reading to paramedic if applicable
<u>Glucose</u>	Oral glucose if patient can protect airway and has a gag reflex and blood sugar <60mg/dl with signs of hypoglycemia
<u>Naloxone</u>	0.1mg/kg IN/IM if mental status and respiratory effort are depressed and the child is not a newborn. There MUST be a strong suspicion of opiate overdose. Max. single dose of 2 mg, may repeat once in 3 minutes if there was response to initial dose

<u>Paramedic Standing Orders</u>	
<u>Note</u>	Must perform items in EMR and EMT standing orders as appropriate
<u>Monitor</u>	Treat heart rhythm as appropriate
<u>Temp</u>	Consider sepsis for any altered pediatric with a fever

<u>IV/IO Access</u>	Fluid as appropriate using Micro-Drip (60gtts/min) set. Use Broselow tape for reference
<u>Dextrose</u>	For blood sugar <60mg/dl: D50W 1mg/kg IV/IO for patients over 2 years of age or D25W 2mg/kg IV/IO for patients under 2 years of age. May repeat once
<u>Glucagon</u>	<u>0.05 mg/kg IM if blood glucose <60mg/dl and IV/IO access is not immediately available. May repeat once. Recheck blood glucose in 5 minutes.</u>
<u>Naloxone</u>	0.1mg/kg IV/IO/IN/IM if mental status and respiratory effort are depressed and the child is not a newborn. There MUST be a strong suspicion of opiate overdose. Max. single dose of 2 mg, may repeat once in 3 minutes if there was response to initial dose

Clinical PEARLS

- High index of suspicion of sepsis in a non-traumatic altered pediatric
- Intravenous access is preferred over Intraosseous unless patient is unstable
- Move patient to a safe area if the situation warrants
- Consider D-10W 4-6ml/kg drip if D25w and D50w is unavailable
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage

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 Medical Director

EFFECTIVE DATE 7/01/2011
 SUPERSEDES:
 REVISED:
 REVIEW DATE: 7/2016
 PAGE: 1 of 1

PEDIATRIC SEIZURES

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMTs and Paramedics within their scope of practice.
- III. PROTOCOL: Status Seizures means an actively seizing child who has been seizing for more than ten (10) minutes or an actively seizing child with recurrent seizures, with no reawakening in between seizures.

STANDING ORDERS	
ASSESS	CAB
OXYGEN	Oxygen delivered as appropriate.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
ACCUCHECK	Test for glucose.
DEXTROSE	If blood glucose is less than 60mg/dl: D50W 1 ml/kg IV/IO for patient greater than 2 years of age or D25W 2 ml/kg IV/IO for patients less than 2 years of age. May repeat once. Give oral glucose to patients who are awake and have an intact gag reflex. Recheck blood glucose in 5 minutes.
GLUCAGON	0.05 mg/kg IM if blood glucose is less than 60mg/dl and no IV/IO access immediately available. May repeat once. Recheck blood glucose in 5 minutes.
STATUS SEIZURES	
MIDAZOLAM	0.1 mg/kg IV/IO (maximum dose: 5 mg) OR If unable to establish IV after one attempt, give 0.2 mg/kg IM (Maximum dose: 5 mg). May repeat once in 10 minutes if seizures continue.



POLICY: 555.41
 TITLE: Pediatric Non-Traumatic Shock

EFFECTIVE: 4/25/19
 REVIEW: 4/2024
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 1

PEDIATRIC NON-TRAUMATIC SHOCK

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMTs and Paramedics within their scope of practice.
- III. PROTOCOL: History may include: GI bleeding, vomiting, diarrhea, allergic reaction, and septicemia.

Physical signs may be due to circulatory insufficiency (collapsed peripheral/neck veins, confusion, cyanosis, disorientation, thready pulse) or sympathetic compensation (pale, cold, clammy, mottled skin, rapid respirations, anxiety). Signs of compensation may be absent in children or if taking vasoactive medications. **NOTE:** a decreased blood pressure is a late sign of shock.

STANDING ORDERS

ASSESS	CAB
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to General Procedures Protocol 554.00.
OXYGEN	Oxygen delivered as appropriate.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	With micro drip tubing and volume control chamber. Give 20 ml/kg fluid boluses until Broselow tape BP target. Reassess after each bolus.
CONSIDER CAUSE	Cardiogenic - IV fluid boluses. Hypovolemia - IV fluid boluses. Hypoxia - oxygenate. Anaphylaxis - refer to Allergic Reaction Policy 555.42 Overdose - refer to Poisoning Policies 555.51-555.56 Tension pneumothorax - refer to Traumatic Shock Policy 555.82
ACCUCHECK	Test for glucose
DEXTROSE	If blood glucose less than 60mg/dl: D50W 1 ml/kg IV/IO for patient over 2 years of age or D25W 2 ml/kg IV/IO for patients under 2 years. May repeat once. Give oral glucose to patients who are awake and have an intact gag reflex. Recheck blood glucose in 5 minutes.
GLUCAGON	0.05 mg/kg IM if blood glucose is less than 60mg/dl and no IV/IO access immediately available. May repeat once. Recheck blood glucose in 5 minutes.
PUSH DOSE EPINEPHRINE	0.5-2.0mL of 10mcg/mL concentration EPINEPHRINE if low systolic BP. May repeat every 1-2 minutes to length based tape systolic BP target.



POLICY: 555.42
 TITLE: Pediatric Allergic Reaction

EFFECTIVE: 6/10/20
 REVIEW: 6/2025
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC ALLERGIC REACTION

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

STANDING ORDERS	
ASSESS	CAB
REMOVE ALLERGEN	If possible (e.g. bee stinger) and apply ice to site.
OXYGEN	Oxygen delivered as appropriate.
MONITOR	Treat rhythm as appropriate.
MILD REACTION (hives, rash, swelling)	
IV ACCESS	TKO with microdrip tubing and volume control chamber.
DIPHENHYDRAMINE	1 mg/kg IV/IO/IM (maximum dose 25 mg) for severe itching.
SEVERE REACTION/ANAPHYLAXIS (wheezing, stridor, hypotension, severe respiratory depression, oral swelling, altered mental status)	
EPINEPHRINE	0.01 mg/kg of 1:1,000 IM (maximum dose 0.3 mg). (EMTs may use EITHER Epinephrine by auto-injector OR an Agency approved Epinephrine injection kit. 0.15 mg 1:1000. NO repeat doses permitted.)
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
DIPHENHYDRAMINE	1 mg/kg IV/IO/IM (maximum dose 50 mg) for severe itching.
ALBUTEROL	If wheezing or stridor: 3.0 ml in 15 ml saline (or 6 unit dose vials) via nebulizer over 1 hour, or until symptoms improve. Repeat as needed.
BASE PHYSICIAN ORDERS	
PUSH DOSE EPINEPHRINE	0.5 – 2.0 mL of 10 mcg/mL concentration EPINEPHRINE if low systolic BP. May repeat every 1-2 minutes to length based tape systolic BP target.



POLICY: 555.51
 TITLE: Pediatric Poisoning/Overdose

EFFECTIVE: 4/10/19
 REVIEW: 4/2024
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC POISONING/OVERDOSE

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

Contact Base Hospital if any questions or if additional therapy/treatment is required. Any Poison Control Center consultation must be coordinated with Base Hospital.

STANDING ORDERS	
ASSESS	CAB
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Beyond BLS airway management - refer to General Protocol 554.00.
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	Rate as indicated with micro drip tubing and volume control chamber. Give 20 ml/kg fluid boluses until Broselow tape BP target. Reassess after each bolus.
NARCOTIC/OPIOIDS-SEDATIVES:	
Characterized by: respiratory depression, hypotension, stupor, coma, and pinpoint pupils. The only reasons to treat narcotic intoxication are to reverse respiratory depression and occasionally, shock.	
NALOXONE	0.1 mg/kg IV/IO/IN/SQ/IM, if mental status and respiratory effort are depressed and the child is not a neonate. Maximum single dose 2 mg. May repeat in 3 minutes if a partial response to treatment.
CYCLIC ANTIDEPRESSANT	
Cyclic antidepressant toxicity has a high fatality rate, even in patients who are awake and alert at the scene. The severity of an overdose can be easily underestimated. A cyclic antidepressant overdose is characterized by a <u>rapid</u> deterioration in mental status, rapid onset of apnea, fever, dilated pupils, flushed skin, and dry mucous membranes. These are usually associated with respiratory depression and tachycardia. Widened QRS complexes and associated ventricular arrhythmias are generally signs of a life-threatening ingestion. Types of cyclic drugs include: amitriptyline (elavil, efraton, triavil, limbitrol), amoxapine (asendin), desipramine (norpramin), doxepin (sinequan), imipramine (tofranil), maprotiline (ludiomil), nortriptyline (aventyl, pamelor), trimipramine (surmontil), and protriptyline (vivactyl).	
SODIUM BICARBONATE	1 mEq/kg IV/IO for any of the above signs of cyclic antidepressant intoxication. May repeat 0.5 mEq/kg slow IV/IO push every 5 minutes as needed.

CONSIDER

MIDAZOLAM

If seizing: 0.1 mg/kg IV/IO (maximum dose: 5 mg). If unable to establish IV/IO after one attempt, give 0.2 mg/kg IM (maximum dose: 5 mg). May repeat once in 10 minutes if seizures continue. Most cyclic overdose seizures are short-lived and do not require the administration of Midazolam.

STANDING ORDERS CONTINUED

CAUSTICS/CORROSIVES/PETROLEUM EXPOSURES

Alkalis: sodium hydroxide (caustic soda), drain cleaners, potassium hydroxide, ammonium hydroxide (fertilizers), lithium hydroxide (photographic chemicals, alkaline batteries), calcium hydroxide (lime).

Acids: hydrofluoric acid (which may have a delayed onset of symptoms); sulfuric acid (battery acid) and hydrochloric acid.

Oxidizers: bleach, potassium permanganate.

Petroleum Substances: typically have an odor similar to gasoline, may cause alteration of mental status, pulmonary edema, vomiting, lung injury. Generally more viscous agents (motor oil) are less toxic.

REMOVE AGENT

Remove contaminated clothing.
If agent is dry, brush off. If agent is liquid, flush with copious amounts of water.
If the eyes are contaminated flush with saline for at least 20 minutes.

NOTE

Avoid the use of epinephrine in petroleum distillate ingestions unless indicated for life-threatening cardiac dysrhythmias.

IF INGESTED, DO NOT INDUCE VOMITING OR GIVE ACTIVATED CHARCOAL!

ORGANOPHOSPHATE POISONING

PROTECT YOURSELF FROM CONTAMINATION!

Organophosphate poisonings may cause bronchospasm, an increase in pulmonary and nasal secretions, constricted pupils, vomiting, diarrhea, urinary incontinence, diaphoresis and cardiac dysrhythmias including both bradycardia and AV blocks.

Remember the most spectacular signs by the following mnemonic: (Salivation, Lacrimation, Urination, Defecation, Gastric upset and Emesis - **SLUDGE**.)

Other useful mnemonics are, "**MUDDLES**:" Miosis, Urination, Defecation, Diaphoresis, Lacrimation, Emesis, Salivation; and "**THE KILLER BEES**": Bronchorrhea and Bradycardia.

REMOVE AGENT

If agent is dry, brush off, then flush with copious amounts of water. If agent is liquid, flush with copious amounts of water. Remove and isolate contaminated clothing. All of the patient's secretions are toxic - flush off prior to transport. If possible, save container label.

ATROPINE

0.05mg/kg IV/IO-IM. Repeat every 3 minutes as needed to control secretions, bronchorrhea and dysrhythmias.

BASE PHYSICIAN ORDERS

**PUSH DOSE
EPINEPHRINE**

0.5 – 2.0 mL of 10 mcg/mL concentration EPINEPHRINE if low systolic BP. May repeat every 1-2 minutes to length based tape systolic BP target.



POLICY: 555.52
TITLE: Pediatric Dystonic Reactions to Phenothiazine Drugs

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

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PAGE: 1 of 1

PEDIATRIC DYSTONIC REACTION TO PHENOTHIAZINE DRUGS

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL: History of ingestion of phenothiazine with restlessness (akathesias), muscle spasms of the neck, jaw and back, movement of eyeballs (oculogyric crisis), frightened, small pupils, facial grimace, protruding tongue, opisthotonus (back arching).

Phenothiazines are prescribed for their antiemetic and tranquilizing properties. Phenothiazines include: chlorpromazine (Thorazine), metoclopramide (Reglan), prochlorperazine (Compazine), promethazine (Phenergan and Atarax).

Another medication that can cause dystonic reactions include: haloperidol (Haldol).

NOTE: Phenothiazine reactions may occur at normal dosing levels and administration of charcoal is not necessary.

STANDING ORDERS

ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
DIPHENHYDRAMINE	1 mg/kg IV/IO push (maximum dose 25 mg) or IM if IV/IO access not promptly available. May repeat if needed.

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EFFECTIVE DATE: 7/01/2011
SUPERSEDES: _____
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REVIEW DATE: 7/2016
PAGE: 1 OF 1

PEDIATRIC ENVENOMATION

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

STANDING ORDERS

ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber.
IDENTIFY CAUSE	<ul style="list-style-type: none">A. Bee/Wasp/Yellow Jacket/Fire Ant sting Remove stinger. Refer to Allergic Reaction Policy 555.42B. Spider bite - Scorpion sting - Centipede sting No specific treatment.C: Snake envenomation Avoid movement of the affected extremity, keeping extremity at heart level. Splinting is unnecessary. Do not apply ice or constricting band. Monitor distal pulses. Circle any swelling around bite marks with a pen and note time. Measure the circumference of the extremity proximal to the bite and note time. Do not bring the snake to the emergency department.
PAIN MANAGEMENT	Refer to Pain Management Protocol 555.44



POLICY: 555.62
 TITLE: Hypothermia - Pediatric
 EFFECTIVE: 02/13/2019
 REVIEW: 02/2024
 SUPERCEDES:

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HYPOTHERMIA - PEDIATRIC

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL: Patients with mild hypothermia will not be comatose due to that illness. They will often be mildly confused or sleepy. Mental status may be more depressed if intoxication, head injury, shock, ketoacidosis or stroke have caused secondary mild hypothermia.

STANDING ORDERS	
MILD HYPOTHERMIA (88-95 F. / 31-35 C)	
ASSESS	CAB
WARMING MEASURES	Remove wet clothing and cover patient with warm dry, blankets.
OXYGEN	Warmed, humidified oxygen, if available.
MONITOR	Treat rhythm as appropriate.
IV/IO ACCESS	Warm IV fluid, TKO with microdrip tubing and volume control chamber. Avoid cold fluids.
CONSIDER	
ACCUCHECK	Test for glucose.
DEXTROSE	If blood glucose less than 60mg/dl: D50W 1 ml/kg IV/IO for patient over 2 years or D25W 2 ml/kg IV/IO for patients under 2 years. May repeat once. Give oral glucose solution to patients who are awake and have an intact gag reflex. Recheck blood glucose in 5 minutes.
GLUCAGON	0.05 mg/kg IM - if blood glucose less than 60 mg/dl and no IV/IO access immediately available. May repeat once. Recheck blood glucose in 5 minutes.
NALOXONE	0.1 mg/kg IV/IO/IN/IM, only if respiratory rate less than 10/minute or systolic BP below Broselow tape target, AND narcotic overdose is suspected, (i.e. pin-point pupils, track marks, drug paraphernalia, history of narcotic use, etc.) May repeat once in 3 minutes if partial response to treatment.

SEVERE HYPOTHERMIA
(less than 88 F / less than 31C)

ASSESS	CAB
WARMING MEASURES	Remove wet clothing and cover patient with warm dry, blankets.
SECURE AIRWAY	As appropriate.. Spontaneous ventilations of 4-6 per minute may be adequate. Refer to General Procedures Protocol 554.00.
OXYGEN	Warm, humidified oxygen.
MONITOR	Observe rhythm and pulses for one minute - if organized rhythm present move gently . Treat dysrhythmia as appropriate.
IV/IO ACCESS	Warm IV fluid, TKO with microdrip tubing and volume control chamber. Avoid cold fluids.
CONSIDER	
ACCUCHECK	Test for glucose.
DEXTROSE	If blood glucose less than 60 mg/dl: D50W 1 ml/kg IV/IO for patient over 2 yrs or D25W 2 ml/kg IV/IO for patients under 2 years. May repeat once. Give oral glucose solution to patients who are awake and have an intact gag reflex. Recheck blood glucose in 5 minutes.
GLUCAGON	0.05 mg/kg IM - if blood glucose less than 60 mg/dl and no IV/IO access immediately available. May repeat once. Recheck blood glucose in 5 minutes.
NALOXONE	0.1 mg/kg IV/IO/IN/IM, only if respiratory rate less than 10/minute or systolic BP below Broselow tape target, AND narcotic overdose is suspected, (i.e. pin-point pupils, track marks, drug paraphernalia, history of narcotic use, etc.) May repeat once in 3 minutes if partial response to treatment.
CARDIAC ARREST	Severe bradycardia with pulses requires no arrhythmic therapy. Give only one dose of each drug during cardiac arrest but continue normal CPR and defibrillation attempts.

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EFFECTIVE DATE: 71/01/2011

SUPERSEDES: _____

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REVIEW DATE: 71/01/2016

PAGE: 1 OF 1

FROSTBITE - PEDIATRIC

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard of EMTs and Paramedics within their scope of practice.
- III. PROTOCOL: Skin is white or cyanotic, numb or burning, and does not re-color with touch.

STANDING ORDERS	
ASSESS	CAB
EVALUATE	All exposed at-risk body parts.
WARMING PROCEDURES	Move patient to warm environment and wrap affected extremity with thick, unwarmed blanket or clothing. Do not rub affected extremity. Avoid chemical heat packs, radiant heat, or forced-air heating.
IV/IO ACCESS	Warm IV fluid, TKO with microdrip tubing and volume control chamber. Avoid cold fluids.
PAIN MANAGEMENT	Refer to Pain Management Protocol 555.43



POLICY: 555.64
 TITLE: Heat Illness (Pediatric)

EFFECTIVE: 7/1/2018
 REVIEW: 7/2023
 SUPERCEDES:

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HEAT ILLNESS (PEDIATRIC)

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as the treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

Heat Exhaustion: Muscle cramping, fatigue, nausea, headache, normal or slightly elevated body temperature. Syncope or dizziness is almost universal.

Heat Stroke: Persistently altered level of consciousness and elevated body temperature (usually greater than 104° F or 40° C), tachycardia and hypotension. Sweating is variable.

STANDING ORDERS	
HEAT EXHAUSTION	
ASSESS	CAB
OXYGEN	Oxygen delivery as appropriate.
COOLING MEASURES	Place patient in a cool environment.
HEAT STROKE	
ASSESS	CAB
SECURE AIRWAY	Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.
COOLING MEASURES	Remove heavy or insulating clothing and splash patient with water. Place ice packs on head, neck and in axilla and inguinal areas. Promote cooling by fanning. Use all available cooling measures.
OXYGEN	Oxygen delivery as appropriate.
IV/IO ACCESS	Two large bore cannulas with volume control chambers. Give 20 ml/kg boluses until length based tape systolic BP target. Reassess the patient after each bolus.
CONSIDER	
ACCUCHECK	Test for glucose.
DEXTROSE	If Blood glucose is less than 60 mg/dl: D50W 1ml/kg IV/IO for patients greater than 2 years of age, or D25W 2ml/kg IV/IO who are less than 2 years of age. May repeat once. Give oral glucose to patients who are awake and have an intact gag reflex. Recheck blood glucose in 5 minutes.
GLUCAGON	0.05 mg/kg IM if blood glucose is less than 60 mg/dl and no IV/IO access immediately available. Maximum dose 1 mg. May repeat once. Recheck blood glucose in 5 minutes

MIDAZOLAM

If seizing: 0.1 mg/kg IV/IO (maximum dose 5 mg.) If unable to establish IV after one attempt, give 0.2 mg/kg IM (maximum dose 5 mg.) May repeat once in 10 minutes if seizures continue.



POLICY: 555.81
 TITLE: Burns - Pediatric

EFFECTIVE: 7/1/2018
 REVIEW: 7/2023
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

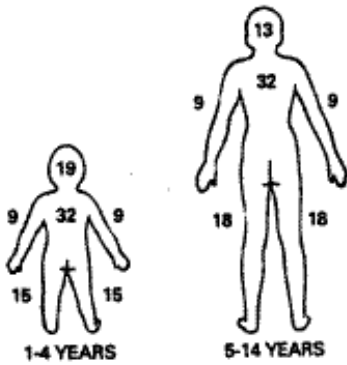
BURNS - PEDIATRIC

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard of EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

STANDING ORDERS	
MOVE PATIENT	To a safe environment
ASSESS	CAB
COOLING PROCESS	<u>Tar</u> Burns: Cool with water and transport. Do not attempt to remove tar. <u>Thermal</u> Burns: Cool with water for up to 5 minutes to stop the burning process.
OXYGEN	Oxygen delivery as appropriate.
SECURE AIRWAY/ INTUBATE	Consider EARLY placement of an I-Gel if ineffective ventilation/oxygenation, or if patient is unconscious. Otherwise, use the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.
IV/IO ACCESS	Superficial burns: TKO. Partial and full-thickness burns: 0.5 ml x patient weight in kg x % burn = IV fluid per hour. If systolic BP less than length based tape target, give 20 ml/kg boluses until SBP reaches target. Reassess patient after each bolus. IV site in order of preference: <ol style="list-style-type: none"> 1. unburned upper extremity, or external jugular 2. unburned lower extremity 3. burned upper extremity 4. burned lower extremity
MONITOR:	Treat rhythm as appropriate.
DRESS BURNS	Cover with dry dressing and keep patient warm.
PAIN MANAGEMANT	Refer to Pain Management Protocol 555.43
TRANSPORT	To nearest facility if patient is unstable (airway difficulty, hypotension) or according to Trauma Triage and Patient Destination Policy 553.25 if stable.

<u>Burn Area</u>	<u>Age in years</u>			
	<u>1</u>	<u>1-4</u>	<u>5-9</u>	<u>10-14</u>
Head	19	17	13	11
Neck	2	2	2	2
Anterior Trunk	13	13	13	13
Posterior Trunk	18	18	18	18
Genitalia	1	1	1	1
Upper Extremity (each)	9	9	9	9
Lower Extremity (each)	14.5	15.5	17.5	18.5

The patient's palm (hand minus fingers) is about 1% of the patient's body surface area.





POLICY: 555.82
TITLE: Pediatric Traumatic Shock

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

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PEDIATRIC TRAUMATIC SHOCK

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard of EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

STANDING ORDERS

ASSESS	CAB
SECURE AIRWAY	Using the simplest effective method while maintaining c-spine. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.
OXYGEN	Oxygen delivery as appropriate
SPINE IMMOBILIZATION	If indicated, refer to Policy 554.80 – Selective Spinal Movement Restriction.
CONTROL OBVIOUS BLEEDING	Consider tourniquet for uncontrolled extremity hemorrhage.
IV/IO ACCESS	Start two large-bore cannulas with volume control chambers. Give 20 ml/kg fluid boluses. Repeat x 2. Reassess the patient after each bolus administration.
DRESS & SPLINT	Consider tourniquet or hemostatic dressing for uncontrolled hemorrhage. Dress and splint as indicated.
CONSIDER	
PAIN MANAGEMENT	Refer to Pain Management Protocol 555.43
TENSION PNEUMOTHORAX	For tension pneumothorax, on affected side in second intercostal space in midclavicular line. Perform on other side if no response to treatment and tension pneumothorax physiology persists. Secure catheter to chest.
ACCUCHECK	Test for glucose.



POLICY: 555.84
TITLE: Pediatric Head-Neck-Facial Trauma

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 1

PEDIATRIC HEAD – NECK – FACIAL TRAUMA

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

STANDING ORDERS	
ASSESS	CAB
SPINE IMMOBILIZATION	If indicated, refer to Policy 554.80 – Selective Spinal Movement Restriction.
OXYGEN	Oxygen deliver as appropriate
POSITION	Elevate the heads of brain injured patients, if patient exhibits no signs of shock.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber
DRESS & SPLINT	Dress and splint as indicated. Consider hemostatic dressing as appropriate.
PAIN MANAGEMENT	Refer to Pain Management Protocol 555.43
CONSIDERATIONS	<p>Avulsed Tooth - Place tooth in milk, normal saline, saline soaked gauze or a commercial "tooth saver."</p> <p>Eye Injuries - Cover with a non-contact dressing, such as a paper cup. Do not apply direct pressure to eye and <u>do not</u> attempt to replace partially torn globe.</p> <p>Impaled Object - Immobilize and leave in place. Remove object only if it interferes with CPR, extrication or ventilation.</p>



POLICY: 555.85
TITLE: Pediatric Chest Trauma

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC CHEST TRAUMA

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
II. PURPOSE: To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
III. PROTOCOL:

STANDING ORDERS

Table with 2 columns: Category (ASSESS, SECURE AIRWAY/INTUBATE, SPINE IMMOBILIZATION, OXYGEN, IV/IO ACCESS, DRESS & SPLINT, CONSIDERATIONS) and Description (CAB, Using the simplest effective method while maintaining c-spine, etc.)

BASE PHYSICIAN ORDERS

Table with 2 columns: PAIN MANAGEMENT, Refer to Pain Management Protocol 555.43



POLICY: 555.86
 TITLE: Pediatric Abdominal Trauma

EFFECTIVE: 02/13/2019
 REVIEW: 02/2024
 SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC ABDOMINAL TRAUMA

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

STANDING ORDERS

ASSESS

CAB

SECURE AIRWAY/INTUBATE

Use simplest effective method while maintaining c-spine. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Refer to Policy 554.00 – General Protocols.

SPINE IMMOBILIZATION

If indicated, refer to General Procedures Protocol 554.80 – Selective Spinal Movement Restriction.

OXYGEN

Oxygen delivery as appropriate.

IV/IO ACCESS

TKO with microdrip tubing and volume control chamber. If signs of shock, give 20 ml/kg fluid bolus until length based tape systolic BP target. Reassess patient after each bolus.

DRESS & SPLINT

Dress and splint as indicated. Consider hemostatic dressings as appropriate.

CONSIDERATIONS

Impaled Object - Immobilize and leave in place. Remove object only if object interferes with CPR, extrication, or ventilation.

Eviscerating Trauma - Cover eviscerated bowels and organs with saline soaked gauze. Do not attempt to replace bowels or organs into the abdominal cavity.

Genital Injuries - Cover genitalia with saline soaked gauze. If necessary apply direct pressure to control bleeding. Treat amputation the same as extremity amputation, refer to Extremity Trauma Policy 555.87.

BASE PHYSICIAN ORDERS

PAIN MANAGEMENT

Refer to Pain Management Protocol 555.43



POLICY: 555.87
TITLE: Pediatric Extremity Trauma

EFFECTIVE: 02/13/2019
REVIEW: 02/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PEDIATRIC EXTREMITY TRAUMA

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard for EMRs, EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

STANDING ORDERS

ASSESS	CAB
SPINE IMMOBILIZATION	If indicated, refer to Policy 554.80 – Selective Spinal Movement Restriction.
OXYGEN	Oxygen delivery as appropriate
HEMORRHAGE CONTROL	<ul style="list-style-type: none"> • Control bleeding with direct pressure • Consider tourniquet if bleeding uncontrolled • Elevate and splint injured extremity in position of comfort
DRESS & SPLINT	<ul style="list-style-type: none"> ▪ Splint dislocations in position found. ▪ Check neurovascular status prior to and after each extremity manipulation. ▪ Control bleeding with direct pressure. ▪ Cover exposed bone with saline soaked gauze. ▪ Angulated long bone fractures may be realigned with gentle axial traction for splinting. ▪ In cases involving major multi-system trauma, consider "splinting the whole body" by strapping the patient to a back board, rather than splinting each individual extremity. ▪ Consider hemostatic dressings or tourniquet as appropriate.
IV/IO ACCESS	TKO with microdrip tubing and volume control chamber. If signs of shock, give 20 ml/kg fluid bolus until Broselow Tape systolic BP target. Reassess patient after each bolus.
MORPHINE	Refer to Pain Management Protocol 555.43
CONSIDERATIONS	Amputations - If partial amputation, splint in anatomic position and elevate the extremity. Wrap completely amputated parts in dry sterile gauze, then place in a sealed, dry container. Place container in ice, if possible.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE 4/15/2016
SUPERCEDES: _____

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 4/2021
PAGE: 1 of 2

PEDIATRIC MEDICATION CHART

- I. AUTHORITY: Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Division 9
- II. PURPOSE: To serve as a patient treatment standard for EMTs, AEMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

DO NOT EXCEED ADULT TOTALS
c = concentration

	Premie	NB	3 Mos.	6 Mos.	1 Year	2 year	4 Year	6 Year	8 Year	10 Year	12 Year	13 Year	14 Year
Avg. Body Length (centimeters)	0 to 53	56	63	70	77	84	92	105	120	140	150	160	166
Average Body Weight (kilograms)	< 2.5	2.5 - 4	6	7	10	12	16	20	25	34	41	50	56
Adenosine c = 3 mg/ml dose = 0.1 mg/kg	-	0.25 - 0.4 mg	0.6 mg	0.7 mg	1 mg	1.2 mg	1.6 mg	2.0 mg	2.5 mg	3.4 mg	4.1 mg	5.0 mg	5.6 mg
Albuterol 1 unit dose (3 ml of 0.083% nebulizer solution)	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit	1 unit
Atropine IV c = 0.1 mg/ml dose = 0.02 mg/kg (cardiac dose)	-	.1 mg	0.12 mg	0.14 mg	0.2 mg	0.24 mg	0.32 mg	0.4 mg	0.5 mg	0.68 mg	0.82 mg	1.0 mg	1.12 mg
Dextrose (D50W diluted to D25W) dose = 2 ml/kg	2 - 5 ml	5 - 8 ml	12 ml	14 ml	20 ml	24 ml	-	-	-	-	-	-	-
Dextrose (D50W) dose = 1 ml/kg	-	-	-	-	-	-	16 ml	20 ml	25 ml	34 ml	41 ml	50 ml	50 ml
Fentanyl IN c = 50 mcg/ml dose = 1.5 mcg/kg	3.75 mcg	3.75 - 6 mcg	9 mcg	10.5 mcg	15 mcg	18 mcg	24 mcg	30 mcg	37.5 mcg	51 mcg	61.5 mcg	75 mcg	84 mcg
Fentanyl IM/IV/IO c = 50 mcg/ml dose = 1 mcg/kg	2.5 mcg	2.5 - 4 mcg	6 mcg	7 mcg	10 mcg	12 mcg	16 mcg	20 mcg	25 mcg	34 mcg	41 mcg	50 mcg	56 mcg
Midazolam IV c = 5 mg/ml dose = 0.1 mg/kg	0.1 - 0.25 mg	0.25 - 0.4 mg	0.6 mg	0.7 mg	1 mg	1.2 mg	1.6 mg	2 mg	2 mg	2 mg	2 mg	2 mg	2 mg
Diphenhydramine c = 10 mg/ml dose = 1 mg/kg	1 - 2.5 mg	2.5 - 4 mg	6 mg	7 mg	10 mg	12 mg	16 mg	20 mg	25 mg	34 mg	41 mg	50 mg	50 mg

	Premie	NB	3 Mos.	6 Mos.	1 Year	2 year	4 Year	6 Year	8 Year	10 Year	12 Year	13 Year	14 Year
Avg. Body Length (centimeters)	0 to 53	56	63	70	77	84	92	105	120	140	150	160	166
Average Body Weight (kilograms)	< 2.5	2.5 - 4	6	7	10	12	16	20	25	34	41	50	56
Dopamine	FOR A CONCENTRATION OF 800 µg of DOPAMINE PER MILLILITER SOLUTION: One 5 ml ampule of Dopamine (200 mg of dopamine per ampule) mixed in 250 ml of NS												
10µg IV/IO	1	3	4	5	7	9	12	15	19	25	31	37	42
15µg IV/IO	2	4	7	8	11	13	18	22	28	38	46	56	63
20µg IV/IO	3	6	9	10	15	18	24	30	37	51	61	75	84
Epinephrine 1:10,000 IV/IO dose = 0.01 mg/kg	0.01 - 0.025 mg	0.025 - .04 mg	0.06 mg	0.07 mg	0.1 mg	0.12 mg	0.16 mg	0.2 mg	0.25 mg	0.34 mg	0.41 mg	0.5 mg	0.56 mg
Epinephrine 1:1000 SQ dose = 0.01 mg/kg	-	-	0.06 mg	0.07 mg	0.1 mg	0.12 mg	0.16 mg	0.2 mg	0.25 mg	0.34 mg	0.41 mg	0.5 mg	0.56 mg
Fluid Challenge dose = 20 ml/kg	20 - 50ml	50 - 80ml	120 ml	140 ml	200 ml	240 ml	320 ml	400 ml	500 ml	680 ml	820 ml	1000 ml	1000 ml
Glucagon c = 1 mg/ml or 1 unit/ml dose = 0.05 mg/kg (up to 1 mg)	0.3 mg	0.3 mg	0.3 mg	0.35 mg	0.5 mg	0.6 mg	0.8 mg	1 mg	1 mg	1 mg	1 mg	1 mg	1 mg
Lidocaine IV c = 20 mg/ml dose = 1 mg/kg	-	2.5 - 4 mg	6 mg	7 mg	10 mg	12 mg	16 mg	20 mg	25 mg	34 mg	41 mg	50 mg	56 mg
Morphine c = 10 mg/ml dose = 0.1 mg/kg	-	0.25 - 0.4 mg	0.6 mg	0.7 mg	1 mg	1.2 mg	1.6 mg	2.0 mg	2.5 mg	3.4 mg	4.1 mg	5 mg	5.6 mg
Naloxone c = 1 mg/ml dose = 0.1 mg/kg (up to 2 mg)	0.1 - 0.25 mg	0.25 - 0.4 mg	0.6 mg	0.7 mg	1 mg	1.2 mg	1.6 mg	2 mg	2 mg	2 mg	2 mg	2 mg	2 mg
Sodium Bicarbonate c = 1 mEq/ml dose = 1 mEq/kg	1 - 2.5 mEq	2.5 - 4 mEq	6 mEq	7 mEq	10 mEq	12 mEq	16 mEq	20 mEq	25 mEq	34 mEq	41 mEq	50 mEq	50 mEq

Miscellaneous Policies





POLICY: 236.00
TITLE: EMT Scope of Practice

EFFECTIVE: 10/9/19

REVIEW: 10/2024
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 4

EMT SCOPE OF PRACTICE

- I. AUTHORITY
Division 2.5, California Health and Safety Code, Sections 1797.170; Title 22, California Code of Regulations, Division 9, Chapter 2, Section 100063.
- II. DEFINITIONS
- A. "Agency" means the Stanislaus County EMS Agency.
- B. "Basic Life Support" or "BLS" means care provided by prehospital providers that includes first aid, cardiopulmonary resuscitation and other non-invasive care; which includes airway adjuncts.
- C. "Emergency Medical Technician or "EMT" means a person who has successfully completed a basic EMT course which meets the requirements of Title 22, California Code of Regulations, Chapter 2, and is certified in the State of California as an EMT.
- D. "Region" means the geographic jurisdiction of Stanislaus County Emergency Medical Services Agency.
- III. PURPOSE
To define the EMT's scope of practice approved by the Agency Medical Director for use within the Region.
- IV. POLICY
During training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfer, a supervised EMT student or certified EMT is authorized to do any of the following in accordance with the written policies and procedures of the Agency:
- A. Evaluate the ill and injured.
- B. Render Basic Life Support, rescue and emergency medical care to patients.
- C. Obtain diagnostic signs to include, but not limited to, temperature, blood pressure, pulse and respiration rates, pulse oximetry, level of consciousness, and pupil status.
- D. Perform cardiopulmonary resuscitation (CPR), including the use of mechanical adjuncts to basic cardiopulmonary resuscitation.

- E. Administer oxygen.
- F. Use of the following adjunctive airway and breathing aids:
 - 1. Oropharyngeal airway;
 - 2. Nasopharyngeal airway;
 - 3. Perilaryngeal and supraglottic airways (such as King Tube or iGel);
 - 4. Suction devices;
 - 5. Basic oxygen delivery devices for supplemental oxygen therapy including, but not limited to, humidifiers, partial rebreathers, and venturi masks; and
 - 6. Manual and mechanical ventilating devices designed for pre hospital use including continuous positive airway pressure (CPAP) and/or bag valve mask.
- G. Administer naloxone by intranasal and/or intramuscular routes for suspected narcotic overdose.
- H. Administer epinephrine by auto-injector for suspected anaphylaxis and/or severe asthma.
- I. Administer epinephrine by an agency approved injection kit for anaphylaxis
- J. Perform finger stick blood glucose testing
- K. Use various types of stretchers and body immobilization devices.
- L. Provide initial prehospital emergency care of trauma patients, including, but not limited to:
 - 1. Bleeding control through the application of tourniquets
 - 2. Use of state approved hemostatic dressings
 - 3. Spinal movement restriction
 - 4. Extremity splinting
 - 5. Traction splinting
 - 6. Extrication of entrapped persons
 - 7. Provide field triage
 - 8. Transport patients
 - 9. Apply mechanical patient restraint
- M. Administer the following over the counter medications by mouth:
 - 1. Oral glucose or sugar solutions; and
 - 2. Aspirin (324 mg)
- N. Set up for ALS procedures, under the supervision of a Paramedic.
- O. Perform automated external defibrillation
- P. Assist patients with the administration of physician prescribed devices, including but not limited to, patient operated medication pumps, metered dose inhalers, sublingual nitroglycerin, and self-administered emergency medications, including epinephrine devices.

In cases of assistance with nitroglycerin tablets or spray, the EMT shall monitor administration to ensure that doses are given at the prescribed times and in the prescribed amounts. If no specific directions are noted on the prescription, the EMT shall ensure that doses are given at five (5) minute intervals and that no more than a total of three (3) doses are given. Blood pressure will be taken and recorded prior to each dose. The EMT should not assist with the administration of medication when blood pressure is less than 100 mmHg

systolic OR either the patient complains of or the patient assessment shows an altered level of consciousness.

- Q. During inter-facility transport, the EMT may monitor, maintain a preset rate of flow and turn off if necessary, glucose solutions or isotonic balanced salt solutions including Ringer's Lactate for volume replacement, medication delivery, or to maintain intravenous access. The IV solution may not contain any medications. The only action an EMT may take is to monitor the rate or turn off the infusion if infiltration of the IV occurs.
- R. EMTs may transfer and monitor patients with the following invasive tubes and other medical adjuncts:
1. Nasogastric Tubes
 - a. Nasogastric tubes shall be clamped. No form of suction shall be allowed during transport.
 - b. A nasogastric tube shall be secured to the nose appropriately and shall also be secured to the patient's clothing to prevent accidental dislodgement or patient discomfort.
 - c. Any tubing shall be clamped, and no feedings shall be infused during transport to prevent the possibility of aspiration.
 - d. Unless contraindicated by medical condition, any patient fed within the last two (2) hours shall be placed on the gurney in semi-fowler's position to help prevent the possibility of aspiration.
 2. Abdominal Tubes (Gastrostomy tubes, ureterostomy tubes, wound drains, etc.) EMT's shall check that abdominal tubes are secured in place in an appropriate fashion, the integrity of the drainage system is intact and drainage bags are emptied prior to transfer, with the time noted. Drainage amount and characteristics shall be noted.
 - a. Drainage bags shall be secured to the patient in an appropriate fashion to prevent dislodgement, disconnection or backflow.
 - b. Any dressing drainage shall be noted and charted.
 - c. Dislodged tubes shall not be reinserted. A clean, dry dressing shall be applied to the site. Time and circumstances of dislodgement shall be noted on the PCR.
 3. Foley Catheters
 - a. Catheters shall be checked prior to transfer to assure that the catheter is appropriately secured to the patient, the system is intact, and the drainage bag is secured to prevent dislodgement, disconnection and backflow.
 - b. If the drainage system becomes disconnected or dislodged during transport, the EMT will clamp the Foley if disconnected, but in no circumstances shall the catheter be reinserted if dislodged.
 4. Tracheostomy Tubes
 - a. Tracheostomy tubes shall be checked to assure they are secured to the patient in an

appropriate fashion.

- b. EMTs may suction **at the opening only** to remove secretions the patient is unable to clear. Amount and characteristic of secretions shall be noted.
- c. If the inner cannula becomes dislodged or is expelled, the EMT shall rinse it in sterile saline and gently reinsert it or allow the patient to reinsert it if capable.



POLICY: 256.00
TITLE: Emergency Medical Technician-Paramedic Scope of Practice

EFFECTIVE: 12/12/18
REVIEW: 12/2023
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 3

EMERGENCY MEDICAL TECHNICIAN-PARAMEDIC SCOPE OF PRACTICE

I. AUTHORITY

Division 2.5, California Health and Safety Code, sections 1797.206; 1797.214; 1797.218; 1797.220 and; 1797.221. Title 22, California Code of Regulations, sections 100144 and 100145.

II. DEFINITIONS

- A. "Advanced Emergency Medical Technician (AEMT)" means a California certified EMT with additional training in limited advanced life support (LALS) according to the standards prescribed by Chapter 3 of the Title 22, California Code of Regulations, Division 9.
- B. "Agency" means the Stanislaus County Emergency Medical Services Agency.
- C. "Emergency Medical Technician" or "EMT" means a person who has successfully completed an EMT course which meets the requirements of Title 22, California Code of Regulations, Chapter 2, and who is certified as an EMT in the state of California.
- D. "Emergency Medical Technician Paramedic" or "EMT-P" or "Paramedic" or "Mobile Intensive Care Paramedic" means an individual who is educated and trained in all elements of prehospital advanced life support, who is licensed by the state of California as a paramedic and accredited by the Agency Medical Director.

III. PURPOSE

To define the Emergency Medical Technician-Paramedic scope of practice approved for use within the Stanislaus County EMS Agency member counties.

IV. POLICY

- A. A Paramedic may perform any activity identified in the scope of practice of an EMT or an AEMT.
- B. As part of the State approved basic scope of practice, a Paramedic student or an accredited Paramedic, as part of the organized emergency medical services system in the region, while caring for patients in a hospital as part of his/her training or continuing education under direct supervision of a physician, registered nurse, or physician assistant, or while at the scene of a medical emergency or during transport, or during interfacility transfer, may perform the following procedures or administer the following medications in accordance with the written policies and procedures of the Agency:
 - 1. Utilize electrocardiographic devices and monitor electrocardiograms, including 12-lead electrocardiograms (ECG)

2. Perform defibrillation, synchronized cardioversion and external cardiac pacing .
3. Visualize the airway by use of the laryngoscope and remove foreign body(ies) with Magill forceps.
4. Perform pulmonary ventilation by use of lower airway multi-lumen adjuncts, the esophageal airway, perilaryngeal airways, stomal intubation, and adult oral endotracheal intubation.
5. Utilize mechanical ventilation devices for continuous positive airway pressure (CPAP)/bi-level positive airway pressure(BPAP) and positive end expiratory pressure (PEEP) in spontaneously breathing patient.
6. Institute intravenous (IV) catheters, saline locks, needles, or other cannulae (IV lines) in peripheral veins; and monitor and administer medications through pre-existing vascular access.
7. Institute intraosseous (IO) needles or catheters.
8. Administer intravenous or intraosseous glucose solutions or isotonic balanced salt solutions, including Ringer's lactate solution.
9. Obtain venous blood samples.
10. Use glucose-measuring device.
11. Utilize Valsalva's maneuver.
12. Perform percutaneous needle cricothyrotomy.
13. Perform needle thoracostomy.
14. Monitor thoracostomy tubes.
15. Monitor and adjust IV solutions containing potassium equal to or less than 40 mEq./L.
16. Administer approved medications by the following routes: intravenous, intramuscular, subcutaneous, inhalation, transcutaneous, , sublingual, , oral or topical.
17. Administer, using prepackaged products when available, the following medications:
 - a. 10% 25% and 50% Dextrose
 - b. Activated Charcoal
 - c. Adenosine
 - d. Aerosolized or Nebulized beta-2 specific bronchodilators;
 - e. Amiodarone
 - f. Aspirin
 - g. Atropine Sulfate
 - h. Calcium Chloride
 - i. Diazepam
 - j. Diphenhydramine Hydrochloride
 - k. Dopamine Hydrochloride

- l. Epinephrine
 - m. Fentanyl
 - n. Glucagon
 - o. Ipratropium bromide
 - p. Lorazepam
 - q. Midazolam
 - r. Lidocaine Hydrochloride
 - s. Magnesium sulfate
 - t. Morphine Sulfate
 - u. Naloxone Hydrochloride
 - v. Nitroglycerine Preparation
 - w. Ondansetron
 - x. Pralidoxime Chloride
 - y. Sodium Bicarbonate
- C. As part of the State approved expanded scope of practice, a Paramedic student or an accredited Paramedic, as part of the organized emergency medical services system in the region, while caring for patients in a hospital as part of his/her training or continuing education under direct supervision of a physician, registered nurse, or physician assistant, or while at the scene of a medical emergency or during transport, or during interfacility transfer, may perform the following procedures or administer the following medications in accordance with the written policies and procedures of the Agency:
1. Perform pediatric oral endotracheal intubation only if the paramedic is working for an CAMTS(Commission on Accreditation of Medical Transport Systems) approved program.
 2. Administration of Ketamine for acute traumatic or burn injury in accordance with Stanislaus County EMS Agency policy 554.47
 3. Intravenous infusion of Heparin and Nitroglycerine – (Inter-Facility Transfer only – requires prior approval pursuant to Stanislaus County EMS Agency Policy #552.62)
- D. Base Hospital Physicians may order any medication or procedure within the local paramedic scope of practice for any patient condition regardless of the treatment protocols.
- E. Any skill that is not identified in this policy shall not be performed by paramedics, or paramedic students, even if they are directly supervised by a physician or registered nurse.

POLICY: 412.20
TITLE: EMS Transfer of Patient Care

EFFECTIVE: 11/01/2021
REVIEW: 11/2026
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 3

EMS TRANSFER OF PATIENT CARE

I. AUTHORITY

Division 2.5, Health and Safety Code, Section 1797.220

II. DEFINITIONS

- A. **Primary Paramedic** means the first Paramedic that makes patient contact at the scene of an emergency and has the lead responsibility to provide patient assessment and patient care until such responsibility is transferred to another Paramedic or EMT or Flight Nurse.
- B. **Paramedic** means a currently licensed and accredited on-duty paramedic.
- C. **Flight Nurse** means a Registered Nurse functioning as a member of an air ambulance crew.
- D. **EMT** means a state certified Emergency Medical Technician
- E. **Air Ambulance** - Means any rotor or fixed wing aircraft specially constructed, modified or equipped, and used for the primary purposes of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has a minimum of two (2) attendants certified in advanced life support.
- F. **Rescue Aircraft** – means an aircraft whose usual function is not prehospital emergency patient transport, but which may be utilized in compliance with local EMS policy, for prehospital emergency patient transport when use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft includes ALS rescue aircraft, BLS rescue aircraft and Auxiliary rescue aircraft.
- G. **Basic Life Support Ambulance**: An emergency ambulance staffed with a minimum of two (2) Emergency Medical Technicians (EMTs)

III. PURPOSE

To ensure that a mechanism exists for appropriate transfer of patient care between Paramedics, EMTs, Flight Nurses, and Rescue Aircraft personnel.

IV. POLICY

- A. The Primary Paramedic shall provide other assisting Paramedics, Flight Nurses, EMT's or Rescue Aircraft personnel who arrive on scene with all appropriate patient care information.
- B. All Paramedics and Flight Nurses on scene have a duty to provide the Primary Paramedic with recommendations, based upon Stanislaus County EMS Agency treatment policies, and patient care assistance to ensure the best possible patient care as logistics permit and circumstances require.
- C. Paramedics are authorized to transfer the role of Primary Paramedic to another Paramedic, EMT, Flight Nurse, or Rescue Aircraft personnel when patient condition permits.
- D. A Paramedic may transfer patient care to Rescue Aircraft personnel under the following conditions:
1. An air ambulance is not readily available.
 2. It is determined that rapid transport is a prime therapeutic intervention for the patient.
 3. If Rescue Aircraft personnel are qualified at less than the Paramedic level, Base Hospital contact shall be made to determine whether or not the Rescue Aircraft will transport the patient.
 4. If Base Hospital contact cannot be made, the Incident Commander in concert with the highest medically qualified person on scene, will decide whether the Rescue Aircraft will transport the patient.
- E. In systems that are approved by the Agency to use a BLS tiered response, a Paramedic may transfer patient care to a Basic Life Support Ambulance staffed with two (2) EMTs when the following conditions are met:
1. The Paramedic assessment reveals a stable patient that in the Paramedic judgment leaves no index of suspicion that would require ALS treatment.
 2. No ALS interventions have been started. Skills and medications within the EMT scope of practice DO NOT constitute ALS interventions.
 3. Patient does not meet the unstable definitions as outlined below and as defined in EMS Agency policy 954.20 Stanislaus County BLS Tiered Response System
 - Potentially unstable adult patient:
 - Cardiac Arrest
 - Heart Rate < 50 or > 120
 - Systolic Blood Pressure < 90mmHg
 - Respiratory Rate > 24
 - O₂ sat < 94% (88% for COPD patients)- if patient is on home oxygen, as measured on usual oxygen flow rate
 - Any patient that meets trauma activation criteria per EMS Agency Policy 553.25 Trauma/Burn Triage and Patient Destination
 - Potentially unstable pediatric patient: Pediatric patients will be evaluated using the PAT - Pediatric Assessment Tool. This tool assesses the patient, under the age of 14, according to the following three components: appearance, work of breathing and circulation.

- Appearance: Using the mnemonic TICLS. Patient is unstable if there is any abnormality of the following.
 - Tone
 - Interactiveness
 - Consolability
 - Look/gaze
 - Speech/cry
- Work of Breathing: Presence of any of the following implies abnormal work of breath and therefore potential instability.
 - Stridor
 - Wheezing
 - Grunting
 - Tripod positioning
 - Retractions
 - Nasal flaring
 - Apnea/gasping
- Circulation of the Skin: Presence of any of the following indicates abnormal circulation or poor perfusion.
 - Pale
 - Mottled
 - Cyanotic
- Failing any one point within the three components of the PAT assessment will indicate a potentially unstable pediatric patient and therefore necessitate an ALS level of response

V. PROCEDURE

- A. A Primary Paramedic that decides to transfer care to another Paramedic, EMT or Flight Nurse shall:
 - 1. Only transfer primary patient care when merited by logistical or operational considerations.
 - 2. Provide complete patient assessment and treatment information to the Paramedic, EMT or Flight Nurse accepting responsibility for the patient.
 - 3. Ensure the completion of a patient care record per Agency policy.
- B. The Primary Paramedic shall maintain the lead responsibility and accompany the patient during transport when requested by the EMT or receiving Paramedic due to the patient's condition or complexity of treatment.
- C. Disagreements between Paramedics or between Paramedics, EMT's and Flight Nurses regarding the correct course of patient treatment shall be resolved:
 - 1. In consultation with the Base Hospital, if still on scene.
 - 2. Through their respective provider agency's QI program.
 - 3. If unresolved, by submitting an Unusual Occurrence Report Form to the EMS Agency.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

EFFECTIVE DATE: 4/15/2016
SUPERCEDES: _____

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

REVIEW DATE: 4/2021
PAGE 1 OF 5

CONTROLLED SUBSTANCES

I. AUTHORITY

Division 2.5, California Health and Safety Code, sections 1797.220 and 1798(a) and; Title 22, California Code of Regulations, section 100146, section 100167, section 100168 (b)(1).

II. DEFINITIONS

- A. "Advanced Life Support Provider" means an agency authorized by Stanislaus County EMS Agency to provide ALS services
- B. "ALS" means Advanced Life Support as defined in section 1797.52 of Health and Safety Code, Division 2.5.
- C. "Back-up ALS Unit" means a fully stocked, equipped and operational ALS unit intended to be put in service on an as-needed basis that is not currently staffed by a Paramedic who is responsible for the Controlled Substances on that unit.
- D. "BLS" means Basic Life Support as defined in section 1797.60 of Health and Safety Code, Division 2.5.
- E. "Controlled Substances" means Morphine Sulfate, Fentanyl and Midazolam.
- F. "In-Service ALS Unit" means any ALS unit that is currently operational and staffed by a Paramedic, who is responsible for the Controlled Substances on that ALS unit.
- G. "Out-of Service ALS Unit" means any ALS unit that is neither currently operational nor staffed by a Paramedic who is responsible for the Controlled Substances on that ALS unit.

III. PURPOSE

To provide maximum security for Controlled Substances on ALS units while ensuring that a minimum necessary requirement for Controlled Substances on ALS ambulances are met.

IV. POLICY

- A. All Advanced Life Support personnel and Advanced Life Support Service Providers are responsible for the security of Controlled Substances in accordance with this policy.
- B. Advanced Life Support Providers shall have a physician in the role of Medical Director. This Medical Director may purchase Controlled Substances with Drug Enforcement Agency Form 222 from a pharmacy or pharmaceutical supply agency and supply these Controlled Substances to the Advanced Life Support Service Provider.

V. PROCEDURE

A. Supply

- 1. Each authorized in-service ALS unit shall be stocked with the following Controlled Substances in the amounts listed:

- a. **Morphine sulfate:**

- Minimum amount on hand: 20 mg**
 - Maximum amount on hand: 60 mg**

AND/OR

- b. **Fentanyl:**

- Minimum amount on hand: 200mcg**
 - Maximum amount on hand: 400mcg**

- c. **Midazolam:**

- Minimum amount on hand: 20 mg**
 - Maximum amount on hand: 40 mg**

- 2. ALS Service Providers shall provide written notification to the Agency of the number of units to be stocked with Controlled Substances.
- 3. All Controlled Substances shall be supplied in single-unit dose (tamper-evident, when possible) containers, protected from light, and maintained within the manufacturer suggested temperature range whenever possible. Providers shall address the stocking of single-unit dose tamper evident containers in their Provider Controlled Substance Policy.

B. Storage and Access

- 1. All Controlled Substances will be secured under double lock (two separate locking mechanisms) at all times except when being administered to a patient.
- 2. Access to keys allowing access to Controlled Substances shall be limited to the Paramedic assigned to an in-service ALS unit. These keys should be passed from the

off-going Paramedic to the on-coming Paramedic when the Controlled Substance Log entry is completed for that shift change.

- a. At no time shall Controlled Substance storage box keys be in the possession of off-duty personnel.
- b. A duplicate set of unmarked keys may be kept by the ALS Service Provider. Duplicate keys must be kept in a locked compartment, on company grounds, with access by no more than three (3) management personnel approved by the Agency. A complete list of personnel with access to the duplicate Controlled Substance keys must be submitted to the Agency. This list must be updated within three (3) days of having someone removed or added to the list.
- c. All Controlled Substance keys must be engraved "Do Not Duplicate."
- d. If any key which allows access to Controlled Substances or to the duplicate set(s) of keys is lost or stolen, an Unusual Occurrence Report (UOR) shall be filed with the Agency or his/her designee within 24 hours of discovery. The Agency will evaluate the report and decide the appropriate action necessary to resolve the situation.

C. Initial ALS Unit Stocking Procedures

1. Controlled Substances shall be purchased by the ALS Provider physician Medical Director and assigned to its ALS response vehicles according to Drug Enforcement Agency regulations.
2. The person having the prescription filled and the Paramedic responsible for Controlled Substances must sign the Controlled Substance Log at the time the prescription is placed in an ALS unit.

D. Resupply of Controlled Substances

1. When a Controlled Substance is used in the field, resupply shall be provided from the supply provided by the ALS Provider physician Medical Director.
 - a. Unused drugs must be wasted in the presence of the Emergency Department Registered Nurse and the ALS personnel seeking resupply. The Registered Nurse and the ALS personnel must co-sign to document the wasting of the unused drugs.

E. Exchange of Controlled Substances

1. Controlled Substances, soon to expire Controlled Substances, or damaged Controlled Substance containers must be replaced by the ALS Provider physician Medical Director. The broken or out-dated drug must be presented to receive a replacement.
2. If damage to a Controlled Substance container has caused a loss of the substance or the substance is being exchanged due to findings resulting from an examination; a UOR shall be filed with the Agency within twenty-four (24) hours of findings. The

Agency will investigate the UOR and report their findings to the ALS provider management and Medical Director.

F. Record Keeping/Shift Change

1. Each ALS unit will maintain a standardized written record of Controlled Substance inventory (Controlled Substance Log) and keep it in the locked storage compartment with the Controlled Substances. The Controlled Substance Log shall be available to the Agency and ALS Provider physician Medical Director for routine inspection, and shall be maintained by the ALS Provider for a period of three (3) years in compliance with the State Board of Pharmacy.
2. At each crew change, the off-going Paramedic responsible for Controlled Substances shall count and examine the Controlled Substance(s) and date, time and sign the Controlled Substance Log over to the on-coming Paramedic responsible for Controlled Substances. The on-coming Paramedic will confirm the count and condition and accept responsibility for the Controlled Substances by signing the Controlled Substance Log. Signing the Controlled Substance Log confirms that the count and supply listed is correct and accurate at that time. A copy of the Controlled Substance Logs shall be made available to the Agency immediately upon request.

G. Inventory Discrepancies

1. If at any time the Controlled Substance count is incorrect and the missing substance(s) cannot be accounted for, the Paramedic responsible for Controlled Substances on that unit shall:
 - a. Immediately inform his/her supervisor of the incident.
 - b. Immediately notify the Agency Duty Officer.
 - c. File an Unusual Occurrence Report with the Agency within twenty-four (24) hours of findings.
 - d. Be prohibited from going off duty until their supervisor and the Agency Duty Officer are notified.

H. Removing an ALS Unit from Service

1. The security and responsibility for Controlled Substances on out-of-service and back-up ALS units is as follows:
 - a. When an ALS unit is taken out-of-service or is being placed on back-up, the Paramedic responsible for Controlled Substances shall count and examine the Controlled Substances, enter the date and time, and sign the Controlled Substance Log. The Paramedic must also note on the Controlled Substance Log that the ALS unit is out-of-service or on back-up. A second ALS Provider staff person must also verify the count and accuracy of the Controlled Substance Log. This second person must either be another Paramedic, or a member of the ALS Service Provider's staff that has been

approved by the Agency. This staff person must either be the sole resupply person or an assigned administrative staff person for the ALS Service Provider.

- b. The Controlled Substances and the Controlled Substance Log shall be kept in the permanent key locked storage compartment, located in the ALS unit. The outside doors of the ALS unit shall remain locked, while the unit is unattended.
- c. The Controlled Substance keys for that ALS unit shall be kept by the ALS Service Provider staff person as described in H.1.A.

2. Upon request, the Agency may allow ALS service providers to utilize alternate procedures than are specified in Section V, Letter D. Alternate procedures shall be written as company policy and must have the written approval of the Agency. The Agency shall have the authority to enforce alternate procedures as Agency policy.

I. Placing an ALS Unit in Service

1. The responsibility of Controlled Substances on out-of-service and back-up ALS units rests solely with the ALS Service Providers. ALS Service Providers are required to have a company policy and procedure that addresses the following:
 - a. The storage of Controlled Substances on out-of-service ALS units leaving company grounds.
 - b. The procedure for turning over Controlled Substance storage compartment and lock box keys to the on-coming crew when the unit has been out-of-service or unstaffed on back-up.
2. If an ALS stocked unit is placed in-service as a BLS unit, the responsibility for the Controlled Substances on that unit remains with the ALS Service Provider. The keys which allow access to the Controlled Substances must remain under the control of the ALS Service management.
3. Current ALS Service Providers must submit their company's Controlled Substance Policy and Procedure to the Agency for review and approval, within sixty (60) days of the effective date of this policy. New ALS service providers must submit the above policy for review and approval prior to the providing of service. Agency staff shall be available to assist ALS providers in establishing company policies that will meet Agency approval.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 11/9/11
SUPERSEDES: _____
REVISED: 11/2011
REVIEW DATE: 11/2016
PAGE: 1 of 5

EMS AIRCRAFT REQUEST/CANCELLATION

I. AUTHORITY

Division 2.5 of the California Health and Safety Code, Section 1797.220, California Code of Regulations, Title 22., Prehospital Emergency Medical Services, Chapter 8., Prehospital EMS Aircraft Regulations, Title 21, Public Works Chapter 2.5 Division of Aeronautics (Department of Transportation), Public Utilities Code Section 21662.1., and Federal Aviation Regulations

II. DEFINITIONS

Reference the EMS Aircraft Definitions Policy #441.00.

III. PURPOSE

The purpose of this policy is to specify the appropriate procedure to request and/or cancel the dispatch of an EMS aircraft.

IV. POLICY

- A. The EMS Agency shall designate a County Air Resource Center (C.A.R.C.) in each county to be the primary coordination point for all EMS Aircraft requests for all field emergencies. Unless otherwise specified, this center shall be the EMS Ground Ambulance Dispatch Center for the county.
- B. Each C.A.R.C. shall adopt a plan for requesting EMS aircraft that ensures that they are the primary coordination point for all EMS aircraft field requests in the county.
- C. Each C.A.R.C. shall install and utilize EMSsystem to track availability of EMS Aircraft.
- D. Each C.A.R.C. shall install and utilize a data system to document data requirements of this policy.
- E. Requests for EMS aircraft resources may be made:
 - 1. for field emergencies by medical or public safety personnel as identified in Section V (E.1), by contacting the applicable C.A.R.C.; or,
 - 2. for interfacility transfers from personnel at a licensed acute care hospital who shall call directly to the Air Ambulance Dispatch (A.A.D.) of their choice.

- F. When requested, each C.A.R.C. shall request the closest appropriate EMS aircraft.
 - 1. In the event two air ambulances are co-located or nearly co-located, the C.A.R.C. shall have a policy to rotate calls between those providers which must be approved by the Agency. If closest EMS Aircraft Provider is not available, the C.A.R.C. will request the next closest available provider.
 - 2. If an EMS Aircraft Provider has turned down the flight due to weather considerations, the C.A.R.C. shall notify other EMS Aircraft Providers requested to take the flight that another provider declined to respond based upon weather conditions.

 - G. The C.A.R.C. shall:
 - 1. maintain a master listing of all Regionally authorized EMS aircraft
 - 2. act as the communication coordination point between responding EMS ground units and the EMS Aircraft responding to the scene of the field emergency
 - 3. maintain records of all EMS Aircraft utilization within its jurisdiction
 - 4. have a method to determine the closest EMS Aircraft Provider to an incident
 - 5. have the capacity and check EMS system for current updates of the location of all authorized EMS aircraft as they are provided by the air ambulance providers.

 - H. The C.A.R.C. shall request EMS aircraft dispatch in conjunction with the dispatch of all appropriate first responders and ground ambulances by any of the following methods:
 - 1. Simultaneous Dispatch
 - 2. On Scene Request
 - 3. EMS unit request while en route to an emergency

 - I. Interfacility transfers utilizing EMS aircraft shall be requested/canceled by physicians or hospital personnel at either of the two acute care facilities initiating and receiving the patient transfer.
- V. Procedure
- A. When requested, each C.A.R.C. shall request the closest appropriate EMS aircraft provider and provide the necessary information as outlined in this policy.

 - B. The minimum data to be recorded by the C.A.R.C. for each EMS aircraft request shall include:
 - 1. Incident number
 - 2. date requested
 - 3. time requested
 - 4. agency that requested service
 - 5. agency that canceled service

6. estimated time of arrival of aircraft

C. Required Information for Request of EMS Aircraft

1. The EMS Aircraft shall be requested by the C.A.R.C. as soon as the following essential information is received from the reporting party:
 - a. requesting agency
 - b. location
 - c. number of patients - if known
 - d. type of incident
 - e. extent of injuries or illness, if known

2. Before completing a call, dispatchers at the C.A.R.C. shall attempt to obtain the following information from individuals/organizations requesting EMS aircraft services and pass the information on to the responding EMS Aircraft.
 - a. Landing site information (if possible)
 - (1) coordinates
 - (2) landmarks identifiable from the air
 - (3) designated landing zones
 - (4) cross streets
 - (5) township
 - b. Terrain and obstacles
 - c. Weather conditions
 - (1) wind direction and speed
 - (2) visibility
 - (3) temperature
 - d. Responding EMS services (air or ground)
 - (1) ground frequencies and PLs on which they may be contacted

D. Simultaneous EMS Aircraft Dispatch Criteria

1. C.A.R.C.s or authorized EMS dispatch agencies shall simultaneously dispatch the closest ground ambulance and request that the closest air ambulance respond to those incidents within the simultaneous dispatch zone when the information received from the calling party indicates the incident involves a:
 - a. Gun shot wound
 - b. Stabbing to head, neck, or torso
 - c. Fall greater than 20 feet
 - * d. Motorcycle accident
 - * e. Auto vs. pedestrian
 - ** * f. Motor vehicle accidents with high speed potential
 - g. Explosions
 - h. Electrocution
 - i. Multi-Casualty Incident
 - j. Industrial/Agricultural/Logging Accident with Major Injuries

* Unless low speed and only minor injuries are specified.

** Each county should identify their areas of high speed potential.

E. On Scene Request Criteria

1. An EMS aircraft and ALS ground unit shall be dispatched upon request of any on-scene fire or law enforcement agency, ambulance personnel, other first responders, , clinic, physician's office, or any public safety officer if any of the following conditions are present:
 - a. Potential life or limb threatening injuries where transport time to the appropriate medical facility would be significantly reduced by use of the helicopter.
 - b. Unavailability of an ALS ground ambulance.
 - c. Any other incident where additional ALS assistance is needed.
2. During any scene call in which a medical facility, clinic, or physician's office requests air transport to a destination not consistent with agency policy, the base hospital shall be contacted and approve the destination request.

F. En route Request Criteria

1. Responding emergency personnel that have knowledge of the scene or additional information beyond that provided by the C.A.R.C., may ask that an EMS aircraft be dispatched. After assessing the scene the emergency personnel shall immediately cancel or ask for a continued response by the EMS Aircraft.

G. Cancellation of EMS Aircraft

1. All EMS aircraft cancellations shall be coordinated by the C.A.R.C.
2. Cancellation of EMS aircraft service may occur due to:
 - a. Pilot Judgment: The pilot may cancel the mission due to weather conditions or pilot judgment. The Air Ambulance Dispatch shall immediately notify the C.A.R.C. of the reason for cancellation.

The C.A.R.C. shall request another EMS Aircraft if the reason for cancellation by the original pilot is due to:

- 1) lack of pilot's specific knowledge of unsafe conditions at the scene of the emergency
- 2) inclement weather en route to the emergency
- 3) inclement weather at the EMS Aircraft provider's base of operations

The C.A.R.C. shall inform the subsequent EMS aircraft provider(s) of the circumstances of the original mission cancellation. The C.A.R.C. shall relay all information concerning the cancellation and/or dispatch of another EMS aircraft to the Incident Commander,

- b. Poor weather conditions at the scene: The C.A.R.C. will not request additional EMS Aircraft if the reason for cancellation is due to inclement weather at the scene of an emergency.
- c. Lack of emergency medical need: The Paramedic, EMT, or recognized first responder working within the EMS system who cancels the assigned EMS aircraft because of lack of medical need shall be on scene and have

knowledge of the patient's medical condition. Cancellation shall be effected by contacting the C.A.R.C. with information including the reason for cancellation and identification of the Air Operations Director, IC, or Medical Group Supervisor.

- d. Logistical and/or safety considerations: The Incident Commander (IC) or his designee may cancel the air ambulance when he feels that landing the helicopter would be unsafe, or there is no appropriate landing zone, or there is no patient. Alternate landing zones should be considered. Cancellation shall be effected by contacting the C.A.R.C. with information including the reason for cancellation and IC identification. The C.A.R.C. shall then call the A.A.D. to cancel the air ambulance.
3. C.A.R.C. Dispatchers will cancel an EMS aircraft mission only after documenting:
- a. Pilot Judgment: Verify from the pilot the reason for cancellation.
 - b. Lack of medical need: Verify from the EMS provider the following:
 - (1) The name of the agency canceling the mission.
 - (2) Confirm that the agency canceling the mission is on scene.
 - c. Logistical and/or safety considerations: Verify from the calling party the following information:
 - (1) The Incident Commander canceling the mission.
 - (2) The logistical and/or safety consideration why the mission is canceled.
 - (3) Verification as to whether a medical need still exists.
 - (4) Alternate landing sites.

WHENEVER THE DISPATCHER CANNOT COMPLETELY VERIFY THAT ALL CRITERIA FOR CANCELLATION ARE MET, THE MISSION WILL NOT BE CANCELED. C.A.R.C. Dispatchers, however, shall notify the A.A.D. of the dispatched EMS Aircraft that an unverified request for cancellation has been received. Cancellation of EMS aircraft will occur only when verified cancellations are obtained.

---END OF POLICY 445.00---



POLICY: 522.20
TITLE: Stroke Triage, Treatment and Destination

EFFECTIVE: 10/22/20
REVIEW: 10/2025
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 6

Stroke Triage, Treatment and Destination

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.67, 1798, 1798.101, 1798.105, and 1798.170, California Code of Regulations, Title 22, Division 9

II. DEFINITIONS

- A. ALS - means Advanced Life Support, as defined in Section 1797.52, Division 2.5 of the Health and Safety Code.
- B. **Cincinnati Prehospital Stroke Scale (CPSS)** - means a validated prehospital screening tool used to identify the presence of a stroke in a patient. The scale tests for facial droop, arm drift and speech. If any one of these three tests show positive findings, the patient is considered to have an abnormal CPSS.
- C. **Emergency Medical Services (EMS)** - means the services utilized in responding to a medical emergency.
- D. **SCEMSA** - means Stanislaus County EMS Agency.
- E. **SCEMSA Stroke Criteria** - means a patient stroke assessment using the Cincinnati Prehospital Stroke Scale and the VAN (vision, aphasia, neglect) resulting in a positive finding in either assessment tool.
- F. **Primary Stroke Center (PSC)** - means a hospital designated to stabilize and treat acute stroke patients, providing initial acute care. PSCs are able to appropriately use t-PA/alteplase and other acute therapies such as stabilizations of vital functions, provision of neuroimaging procedures, and management of intracranial and blood pressures. Based on patient needs and the hospital's capabilities, they either admit patients or transfer them to a comprehensive stroke center.
- G. **Quality Improvement (QI)** - means a method of evaluation of services provided, which includes defined standards, evaluation methodologies and utilization of evaluation results for continued system improvement. Such methods may include, but are not limited to, a written plan describing the program objectives, organizations, scope and mechanisms for overseeing the effectiveness of the program.
- H. **Stroke** - means a condition of impaired blood flow to a patient's brain resulting in brain dysfunction.
- I. **Stroke Alert** - means a notification from the transporting ground or air ambulance to a PSC

or CSC that a patient meeting SCEMSA Stroke criteria is being transported to their facility. A Stroke Alert must be made as soon as possible after stroke criteria is confirmed..

- J. **Comprehensive Stroke Center (CSC)** – refers to a hospital that has received comprehensive status through American Heart Association (AHA) and Joint Commission review. CSC sites have availability of advanced imaging techniques including Computed Tomography Angiogram/Perfusion (CTA/CTP), Transcranial Doppler (TCD). These facilities have 24/7 availability of personnel, imaging, operating room and endovascular facilities allowing for the management of large ischemic strokes, intracerebral hemorrhage and subarachnoid hemorrhage.
- K. **VAN (vision, aphasia, neglect) Assessment** - means a prehospital screening tool used to identify the presence of large vessel occlusive stroke. The patient is deemed to have a positive VAN assessment with any arm weakness and at least one of the following; vision change, aphasia or neglect on exam. A VAN negative exam is either no arm muscle weakness OR the presence of arm muscle weakness without vision, aphasia or neglect findings.
- L. **Large Vessel Occlusion (LVO)** – refers to the site of an ischemic clot within the brain leading to stroke symptoms. LVO strokes may benefit from transport to a CSC facility per SCEMSA Stroke Destination Policy.

III PURPOSE

To rapidly identify suspected acute stroke patients, provide treatment and prompt transport, to the appropriate Primary Stroke Center (PSC) or Comprehensive Stroke Center (CSC) for rapid evaluation and treatment.

IV. POLICY

A. STROKE SYSTEM TRIAGE

- 1. Appropriate triage of the suspected acute stroke patient using stroke alert criteria relies on rapid prehospital care:
 - a. Recognition of signs and symptoms of stroke using CPSS and VAN assessment for LVO.
 - b. Determination of time last known well without stroke symptoms within the past 24 hours by a reliable historian.
- 2. Stroke Alert notification to PSC or CSC to report positive stroke assessment findings.

- B. **TREATMENT PROTOCOL**: Characterized by weakness or paralysis on one side of the body or face, slurred speech, speech difficulty, trouble with balance, could struggle in naming objects, confusion, difficulty swallowing, headache, visual disturbances (double vision, blindness, paralysis of extra-ocular muscles). **Decreased level of consciousness is very rarely caused by an Ischemic stroke.**

EMR Standing orders	
<u>Patient Assessment</u>	Circulation, Airway and Breathing. Assess vitals every 5 minutes. Consider trauma mechanism and maintain patent airway
<u>Oxygen Administration</u>	Provide oxygen therapy if appropriate
<u>TLKW</u>	Attempt to obtain a specific time patient was last known well and report to transporting paramedic

EMT Standing orders	
<u>Note</u>	Must perform items in EMR standing orders if applicable.
<u>TLKW</u>	Attempt to obtain specific time patient was last known well and report to the transporting paramedic
<u>Glucometer</u>	Check blood sugar
<u>Glucose</u>	Oral glucose if patient can protect airway, has a gag reflex, and if blood sugar is <60mg/dl.
<u>Pulse Oximetry</u>	Consider if respiratory distress is observed or suspected, use pulse oximetry, and record initial reading before supplemental oxygen is given. Report initial reading to the transporting paramedic.
<u>Naloxone</u>	2mg IN/IM if mental status and respiratory effort are depressed. Must be a strong suspicion of opiate overdose. Max single dose of 2mg, may repeat dose once in 3 minutes if there was no response to initial dose. Max total dose of 4 mg.

Paramedic Standing Orders	
<u>Note</u>	Must perform items in EMR and EMT standing orders if applicable
<u>Monitor</u>	Treat heart rhythm as appropriate and obtain 12 lead EKG
<u>Temperature</u>	Consider sepsis for any altered patient with a fever
<u>IV/IO Access</u>	TKO. If systolic BP is < 90mmHg, give 250ml fluid boluses to systolic BP 90-100 or a max of 2 liters. Shall reassess vitals/patient after each bolus. If time permits, 2 IV sites are preferred.
<u>Dextrose</u>	For blood sugar <60mg/dl and signs of hypoglycemia are present: D50W 25gms IV/IO. Recheck blood sugar after 5 minutes
<u>Glucagon</u>	If no IV/IO access immediately available with blood glucose <60 mg/dl, give one (1) unit IM. May repeat once. Recheck blood glucose 5 minutes after each dose.
<u>Naloxone</u>	2 mg IV/IO/IN/IM if mental status and respiratory effort are depressed. Must be a strong suspicion of opiate overdose. Max single dose of 2 mg, may repeat once in 3 minutes if there was no response to initial dose. Max total dose of 4mg.
<u>Stroke scale</u>	Perform, document and report to receiving hospital the Cincinnati Prehospital Stroke scale. If Cincinnati Prehospital Stroke Scale is positive, paramedic shall perform, document and report a VAN positive or negative to the receiving hospital

C. DESTINATION

1. Suspected acute stroke patients shall be transported to the appropriate PSC or CSC within the following parameters:
 - a. If the patient has a positive Cincinnati Prehospital Stroke Scale assessment and is found to be **VAN positive** the patient may be transported directly to a CSC if the following criteria are met:
 - i. Last known well time is within 24 hrs.
 - ii. Transport time to the CSC will not exceed 60 minutes.
 - iii. Transport time will not take the patient out of the 4.5-hour window for thrombolytic therapy from onset of symptoms or TLKW.
 - b. If the patient has a positive Cincinnati Prehospital Stroke Scale assessment, and is found to be **VAN negative**, the following transport criteria shall be followed:
 - i. If the patient does not have a preference, the patient shall be transported to the nearest PSC or CSC
 - ii. If transport to a PSC or CSC is estimated to be greater than twenty (20) minutes, the patient shall be transported to the nearest ED facility capable of receiving stroke patients.
 - iii. All emergency rooms can receive stroke patients.
 - c. Unstable stroke patients shall be transported to the closest emergency department. Unstable stroke patients are defined as any ONE of the following:
 - i. Patients under CPR.
 - ii. Inability to ventilate and/or oxygenate the patient with BLS maneuvers.
2. A PSC/CSC may request advisory status through the EMS Duty Officer for incoming stroke patients only when:
 - a. The PSC/CSC is on internal disaster; or
 - b. Inoperable CT/MRI.
3. Patients may be taken directly to the CT scanner.
 - a. The patient is to remain on cardiac monitor if taken directly to the CT. The patient will remain on the cardiac monitor until Paramedic transfers patient care.
 - b. Paramedic will give report to the nurse, transfer patient directly from gurney to CT scanner platform and return to service.
 - c. If there is any delay, such as CT scanner not being readily available, the paramedic will not be expected to wait. The patient will be taken to a monitored bed and report given to a receiving nurse or physician as is customary.

D. STROKE ALERT/PATIENT REPORT

1. As soon as a suspected stroke patient is confirmed with CPSS and VAN assessments, the appropriate destination shall be determined, and a Stroke Alert promptly communicated to the PSC/CSC and/or the closest receiving facility. The Stroke Alert is to contain the following information:
 - a. Identify the call as a “Stroke Alert” and verify CT operability.
 - b. Provide estimated time of arrival (ETA).
 - c. Patient’s age and gender.
 - d. Give time patient was last seen without stroke symptoms (Last Known Well Time).
 - e. CPSS and VAN assessment result-negative or positive.
 - f. Blood Glucose and Vital Signs.
 - g. Treatment and response to treatment.
2. Electronic Patient Care Report(ePCR) documentation must include:
 - a. Time last known well CPSS and VAN assessment results, transport factors that determined patient destination
 - b. Blood glucose check
 - c. Neurological assessments

CINCINNATI PREHOSPITAL STROKE SCALE			
Sign/Symptom	How Tested	Normal	Abnormal
Facial Droop	Have the patient show their teeth, or smile.	Both sides of the face move equally.	One side of the face does not move as well as the other.
Arm Drift	The patient closes their eyes and extends both arms straight out for 10 seconds	Both arms move about the same, or both do not move at all.	One arm either does not move, or one arm drifts downward compared to the other.
Speech	The patient repeats "The sky is blue in Cincinnati."	The patient says the correct words with no slurring of words	The patient slurs words, says the wrong words, or is unable to speak.

V.A.N STROKE SCALE		
	Sign/Symptom	How Tested
Vision	Forced gaze to one side, Loss of vision, or uneven eyes.	Have patient follow your finger with their eyes moving to left, then right.
Aphasia	Difficulty naming objects or repeating simple phrase. (Usually seen with right sided CPSS positive patients)	Ask patient to name two easily identified objects (ie, pen and watch). Have patient repeat "The sky is blue in Cincinnati". DO NOT CONSIDER DYSARTHRIA (Slurring of words)
Neglect	Patient ignores left side of body. (Usually seen with left sided CPSS positive patients)	Have patient close their eyes, and touch individually the right arm, then left arm and confirm patient has sensation bilaterally. Then touch both arms simultaneously and note if patient no longer has sensation unilaterally.

Clinical PEARLS

- Time of onset must be within a 24-hour timeframe and confirmed by a reliable historian
- Do not hesitate to activate a Stroke Alert to the receiving hospital if the condition warrants
- High index of suspicion of hemorrhagic stroke in a non-traumatic altered patient
- History of previous stroke or neurological deficits
- Intravenous access is preferred over Intraosseous unless patient is unstable
- Move patient to a safe area if the situation warrants
- Consider D-10W 250ml drip if D50W is unavailable and Blood Glucose <60. Continue D-10W until patient symptoms improves
- Secure airway with simplest technique, i.e. BLS airway unless unable to manage
- Naloxone- May use the prescribed grant administered aerosol 4mg doses if that is all that is available
- Naloxone must be administered prior to intubation if narcotic overdose is suspected
- MICN- If Time Last Known Well is not reported via radio report, ask!
- MICN-confirm CT status when stroke alert is received

APPROVED: Signature On File In EMS Office
Executive Director

EFFECTIVE DATE 4/15/2016
SUPERCEDES:

Signature On File In EMS Office
Medical Director

REVIEW DATE: 4/2021
PAGE: 1 of 4

STEMI TRIAGE AND DESTINATION

I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.67, 1798, 1798.101, 1798.105, and 1798.170

II. DEFINITIONS

- A. “STEMI” means an acute myocardial infarction that generates a specific type of ST-segment elevation on a 12-lead ECG.
- B. “STEMI Alert” is a report from prehospital personnel that notifies a STEMI Receiving Center or STEMI Referral Hospital as early as possible that a patient has a specific computer-interpreted Prehospital 12-lead ECG indicating a STEMI.
- C. “STEMI Receiving Center (SRC)” is a hospital in the Stanislaus County EMS Agency region that has an interventional cardiology lab licensed by the Department of Health Services which provides emergent cardiac catheterization 24 hours a day, 7 days a week, 365 days a year, with an established quality assurance program and a written commitment by the hospital administration supporting the center’s interventional cardiology mission for STEMI patients.
- D. “STEMI Referral Hospital (SRH)” is any hospital in the Stanislaus County EMS Agency region that lacks the availability or continuous availability of 24/7/365 cardiac catheterization. These hospitals will have the ability to administer thrombolytics to a STEMI patient. These hospitals will also have written transfer policies for STEMI patients to STEMI Receiving Centers.
- E. “STEMI Patient” means a patient 18 years of age or greater who has received a 12 lead electrocardiogram in the pre-hospital environment that stipulates ***Acute MI Suspected*** or “ECG Suggestive of Acute MI” on the computer interpretation on the ECG.
- F. “Pre-Hospital Care Provider” means the ambulance service provider, fire service agency, or any other emergency service provider authorized by Stanislaus County EMS Agency.

- G. “ALS” means Advanced Life Support, as defined in Section 1797.52, Division 2.5 of the Health and Safety Code.

III. PURPOSE

To establish guidelines for prehospital personnel to identify and transport patients with acute ST-Elevation Myocardial Infarction (STEMI) who may benefit from the rapid response and specialized services of a STEMI Receiving Center (SRC).

IV. POLICY

This policy applies to adult patients with chest pain or symptoms suggestive of Acute Coronary Syndrome (ACS) with a 12-lead ECG demonstrating elevated ST-segments indicating a specific type of myocardial infarction.

V. TRIAGE

- A. Patients with chest pain or symptoms suggestive of Acute Coronary Syndrome (ACS) shall have a 12-lead ECG performed.
1. 12-lead ECG’s showing suspected STEMI will be transmitted to SRC by Pre-hospital Care Provider’s 12-lead ECG transmission device.
 2. Exceptions include patients who are not cooperative with the procedure or patients in whom the need for critical resuscitative measures preclude performance of 12-lead ECG.
 3. Paramedic shall review the 12-lead ECG tracing in all instances to assure that little or no artifact exists (steady baseline, lack of other electrical interference, complete complexes present in all 12 leads). Repeat ECG may be necessary to obtain an accurate tracing.
- B. If computerized interpretation of accurately performed 12-lead ECG indicates either ***Acute MI*** or ***Acute MI Suspected*** or ***STEMI***, the patient qualifies as a candidate for transport to a STEMI Receiving Center. Patients without these findings shall be transported per SCEMSA Policy 511.00.

Note: Hypotensive STEMI patients should be transported to the closest ED.

VI. DESTINATION

- A. With consent, a patient with an identified STEMI should be transported to a designated STEMI Receiving Center if estimated transport time is 60 minutes or less. If the patient has a preference or has a cardiologist associated with a designated STEMI Receiving Center, the patient shall be transported to their preferred hospital. If the patient does not have a preference, the patient shall be transported to the NEAREST STEMI Receiving Center.
- B. If transport time to a STEMI Receiving Center is estimated to be greater than sixty (60) minutes, the patient shall be transported to a designated STEMI receiving center in an

adjoining county if transport time is less than 60 minutes to that center. In cases where there is no SRC within 60 minutes the patient shall be transported to the nearest STEMI Referral Hospital.

- C. Unstable STEMI patients shall be diverted to the nearest emergency department. Unstable STEMI patients are defined as any ONE of the following:
 - 1. Patients under CPR
 - 2. Inability to ventilate and/or oxygenate the patient with BLS maneuvers.
- D. A STEMI Receiving Center may request advisory status for incoming STEMI patients only when:
 - 1. The STEMI Receiving Center is on internal disaster; or
 - 2. The Cardiac Catheterization laboratory is closed for repair or upgrade.

VII. STEMI ALERT/PATIENT REPORT

- A. The STEMI Alert should contain the following information:
 - 1. Situation:
 - a. Identification of the call as a “STEMI Alert.”
 - b. Estimated time of arrival in _____ minutes for STEMI.
 - c. Patient age and gender
 - d. Confirm ECG states ***Acute MI*** or ***Acute MI Suspected*** or ***STEMI***
 - e. If patient elects to go to a facility that is not a STEMI designation receiving center
 - f. Any urgent patient concerns
 - 2. Background:
 - a. Patient presenting complaint including any duration and presence/absence of chest pain, pressure, jaw pain, or SOB.
 - b. Pertinent past cardiac history including presence of a pacemaker
 - 3. Assessment:
 - a. General Impression

- b. Patient improved or worse since on scene
 - c. Pertinent vital signs and significant abnormal physical examination findings
4. Treatment:
- a. Prehospital treatment given and response to treatment

VIII. DOCUMENTATION

- A. A copy of the 12-lead ECG shall be delivered to the nurse or doctor caring for the patient at arrival in the Emergency Department
- B. A copy of the 12-lead ECG shall be generated for inclusion in the Prehospital Patient Care Report (PCR) or incorporated via electronic means into the record. The finding of STEMI on 12-lead ECG and confirmation of the STEMI Alert shall also be documented on the PCR.

APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director
SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 2/1998
SUPERSEDES:
REVISED: 8/2007
REVIEW DATE: 8/2012
PAGE: 1 of 2

INTRAVENOUS INFUSIONS OF HEPARIN & NITROGLYCERIN

- I. **AUTHORITY:** Health and Safety Code, Division 2.5,
California Code of Regulations, Title 22, Division 9
- II. **PURPOSE:** To provide a mechanism for EMT-Ps to monitor intravenous infusions of heparin and nitroglycerine during interfacility transfers

I. **POLICY:**

- A. Only those EMT-Ps who have successfully completed training program(s) approved by the Stanislaus County EMS Agency Medical Director on nitroglycerin and heparin infusions will be permitted to monitor them during interfacility transports.
- B. Only those ALS ambulance providers approved by the Stanislaus County EMS Agency Medical Director will be permitted to provide the service of monitoring nitroglycerin and/or heparin infusions during interfacility transports, from approved hospital(s) within their service area.

II. **PROCEDURE:**

A. **PRIOR TO TRANSFER:**

1. Patients that are candidates for paramedic transport will have pre-existing heparin and/or nitroglycerin drips in peripheral lines only.
2. Heparin and nitroglycerin drips will not be initiated immediately prior to transport.
3. Patients will have maintained stable vital signs for a period of time as determined by the transferring physician.
4. Patients will not have more than two medicated drips running, exclusive of potassium chloride (KCl).
5. All medication drips will be in the form of an IV piggyback monitored by a mechanical pump familiar to the EMT-P.
6. Transferring physicians must be aware of the general scope of practice of paramedics and the transport protocol parameters outlined below.
7. EMT-Ps are allowed to transport patients on heparin and nitroglycerin drips within the following parameters:
 - a. Nitroglycerin
 - (1) Infusion fluid will be D5W or NS. Medication concentration will be either 25 mg/ 250 cc or 50 mg/250 cc.

- (2) Physician orders regarding regulation of the drip rate will be within parameters as defined by the transferring physician, but in no case will changes be in greater than 5 mcg/minute increments every 10 minutes. In cases of severe hypotension, the orders should state that the nitroglycerine drip will be discontinued and the transferring hospital and base hospital is to be notified.
- (3) Absolute drip rates will not exceed 100 mcg/minute.

b. Heparin

- (1) Infusion fluid will be D5W or NS. Medication concentration will be 100 U/cc of IV fluid (25,000 U/250cc).
- (2) Drip rates will remain constant during transport. No regulation of the rate will be performed, except to turn off the infusion completely.
- (3) Drip rates will not exceed 1600 U/hour.

- 8 Patients will meet pre-established hospital criteria for hemodynamic stability.
9. The transferring physician or nurse on shall complete a “Heparin-Nitroglycerin Paramedic Transfer Checksheet,” which identifies the hemodynamic criterion utilized, and that all criteria for transfers as outlined in this section have been met.
10. Signed orders from the transferring physician will be obtained prior to transport and reviewed with the transporting paramedic(s).

B. DURING TRANSPORT

1. Heparin and nitroglycerin drips will not be initiated by prehospital personnel
2. All patients will be maintained on a cardiac monitor and a non-invasive blood pressure monitor that will record blood pressure readings every five (5) minutes.
3. If medication administration is interrupted (infiltration, accidental disconnection, malfunctioning pump, etc.), the EMT-P may restart the line as delineated in the transfer orders.
4. In cases of IV pump malfunction that cannot be corrected, the medication drip will be discontinued and the transferring hospital and base hospital will be notified.
5. In cases of severe hypotension, nitroglycerin drips will be discontinued and the transferring hospital and base hospital is to be notified
- 6 Vital signs will be monitored and documented every 5 minutes.
- 7 No other medication shall be given thru the same line.

- C. All calls will be audited by the ambulance provider agency and by the transferring hospitals. Audits will assess compliance with physician orders and regional protocols, including base hospital contact in emergency situations. Reports will be sent to the EMS Agency as requested.



POLICY: 553.25
TITLE: Trauma/Burn Triage & Patient Destination

EFFECTIVE: 4/13/17
REVIEW: 4/2022
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 5

Trauma/Burn Triage & Patient Destination

I. **AUTHORITY**

Division 2.5, California Health and Safety Code, Sections 1797.222, 1798.162, 1798.163
California Code of Regulations Section 100255.

II. **DEFINITIONS**

- A. **"Pediatric" or "pediatric patient"** means an individual age 14 and under.
- B. **"Pediatric Trauma Center"** means a designated facility identified by the Stanislaus County EMS Agency (SCEMSA) to receive pediatric trauma patients directly from the field, including:
1. UC Davis Medical Center (Level I)
 2. Children's Hospital, Oakland (Level I)
 3. Renown Regional Medical Center, Reno Nevada (Level II)
 4. Valley Children's Hospital, Madera (Level II)
- C. **"Trauma Center"** means a designated facility identified by the Stanislaus County EMS Agency (SCEMSA) to receive trauma patients directly from the field, including:
1. Doctors Medical Center (Level II)
 2. Memorial Medical Center, Modesto (Level II)
 3. "Trauma Centers" may be designated by other Local EMS Agencies and in some cases, may be the closer facility. If this is the case, trauma patients may be transported directly from the field, these include:
 - i. UC Davis Medical Center (Level I)
 - ii. Mercy San Juan (Level II)
 - iii. Sutter Roseville (Level II)
 - iv. Kaiser South Sacramento (Level II)
 - v. Renown Regional Medical Center (Level II)
 - vi. San Joaquin General (Level III)
- D. **"Trauma"** means physical injury or wound caused by significant external force, high-energy exchange, a rapid deceleration, or violence.

- E. **"Trauma Triage criteria"** means a guideline for assessing the severity of a person's potential injuries that is used to direct transportation of trauma patients to the appropriate Trauma Center.

III. PURPOSE

- A. To establish guidelines for identifying trauma patients and for determining their destination.
- B. To ensure appropriate utilization of resources within the Stanislaus County EMS system.

IV. POLICY

This policy shall serve to identify patients who are at risk for severe injury and determines the most appropriate destination for transport.

V. PROCEDURE

- A. Prehospital EMS Personnel SHALL notify the DCF **IMMEDIATELY** when it is determined that the patient meets trauma triage criteria to establish destination. This notification does not have to originate from the person actually caring for the patient, but may come from another member of the patient care team.

1. DCF notification SHALL include:

- a. age
- b. mechanism
- c. trauma triage criteria
- d. ETA

2. The DCF will immediately assign Trauma Center destination and will inform both pre-hospital EMS personnel and the receiving Trauma Center.

3. A full Base Hospital report to the destination Trauma Center from the pre-hospital provider must follow the DCF notification as soon as possible.

B. Triage Upgrade

A patient's triage status may always be upgraded if the patient's condition deteriorates during assessment or transport. A patient's triage status shall not be downgraded by a Nurse or Paramedic.

C. Destination Decisions

1. All injured patients (Adult & Pediatric) meeting trauma triage criteria shall be transported by the quickest, most appropriate means, ground or air.

- a. If a trauma patient meeting criteria is to be transported by air and environmental conditions do not allow for an air transport, a ground ambulance shall transport to the closest Level I or Level II Trauma Center unless the patient has a life-threatening condition

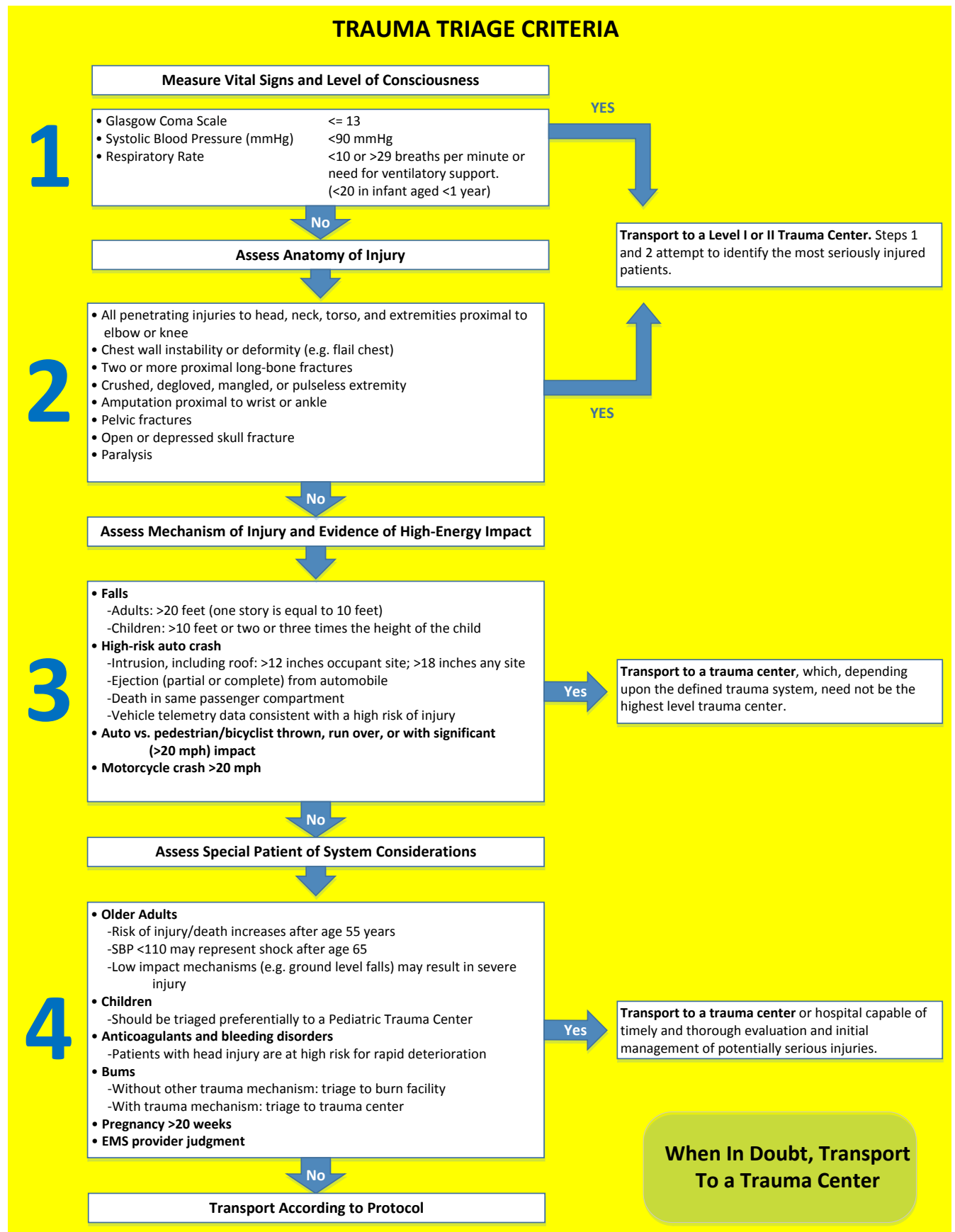
that overrides the need for expedient surgery. In these cases, trauma patients should be transported to the closest facility. This includes, but is not limited to, conditions such as:

- i. Obstructed airways
 - ii. Tension pneumothorax which has not been relieved or stabilized in the prehospital setting, or
 - iii. Situations where the patient meets criteria as outlined in policy 570.20 "Determination of Death". Such patients should be transported to the closest appropriate receiving facility or pronounced dead in the field if they meet the criteria outlined in policy 570.20.
- b. Pediatric patients meeting criteria to be transported to a Pediatric Trauma Center shall be transported by air ambulance if the environmental conditions allow. If air resources are unavailable and/or patient is not stable for transport to a Pediatric Trauma Center, transport to the closest adult Level I or II Trauma Center is acceptable.
2. If a Trauma Center is on Trauma Bypass, trauma patients will be transported to the next closest available Level I or Level II Trauma Center as directed by the DCF.
3. Patient Destination for Stanislaus County Trauma Centers:
The distribution of patients destined for a Stanislaus County Trauma Center shall be guided by the following:
- a. **All** trauma patients requiring transport by air or ground ambulance to a Level II Trauma Center in Stanislaus County will follow an alternating rotation of Trauma Centers. The Stanislaus County DCF will be contacted and will identify the Trauma Center destination. The DCF will contact the Trauma Center with the initial trauma notification. If a trauma patient requires a code three transport by ground ambulance the patient will be taken to the closest Level II Trauma Center in Stanislaus County (DCF contact must still occur).
 - b. In the event a Level II Trauma Center located within the SCEMSA region meets Trauma Bypass criteria as indicated in Policy 546.10, the facility will immediately notify the Stanislaus County DCF and update its facility status on EMResource to Advisory. When the Trauma Center goes off Trauma Bypass, the facility will immediately notify the DCF and update its status on EMResource.
 - c. Where response and transportation times permit, two patients requiring trauma activation should not be delivered to the same Trauma Center in the same ambulance (ground or air).
4. Any disputes regarding distribution of patients should be documented on

an Unusual Occurrence Report and faxed to SCEMSA within 72 hours for review.

D. Burn Triage Criteria:

1. A patient (adult or pediatric) whose primary injuries are burns may be transported directly to a Burn Center from the field. These injuries include:
 - a. Partial/full thickness (2nd or 3rd degree) burns involving greater than 15% TBSA without airway compromise
 - b. Patients with partial/full thickness (2nd or 3rd degree) burns greater than 10% TBSA without airway compromise with the following:
 - i. Greater than 60 years of age
 - ii. Associated trauma meeting Trauma Triage Criteria (and if transport can be completed within 60 minutes)
 - iii. Significant co-morbidities (e.g. COPD, major medical disorder, bleeding disorder or anticoagulant therapy, dialysis patients)
 - c. Partial/full thickness (2nd or 3rd degree) burns of face, perineum or circumferential burn to any body part
 - d. Significant electrical injuries with loss of consciousness, voltage in excess of 220, and/or open wounds
 - e. Electrical injuries resulting in a loss of distal pulses
 - f. Significant inhalation injury with successful intubation
 - g. Chemical burns with wounds >5% TBSA
2. All burns with airway compromise, wheezing, stridor, carbonaceous sputum, nasal singeing or significant facial edema must have an evaluation for intubation either by air ambulance personnel or by the emergency physician at the closest appropriate receiving facility prior to transport to the Burn Center, if the ground ambulance is unable to intubate the patient.



EFFECTIVE DATE: 7/01/2011

APPROVED: Signature On File In EMS Office
Executive Director

SUPERSEDES:

REVISED:

Signature On File In EMS Office
Medical Director

REVIEW DATE: 7/2016

PAGE: 1 of 10

REPORTING OF SUSPECTED ABUSE

I. AUTHORITY

Health and Safety Code, Division 2.5, Section 1798 and; Child Abuse; California Penal Code, Article 2.5; Elder Abuse: Chapter 1273, Statutes of 1983, SB 1210, Sections 9381(a) and 9382. Welfare and Institutions Code Chapter 11, Part 3, Division 9 and California Welfare and Institutions Code Section 15630.

II. DEFINITIONS

- A. "Elder" means any person residing in the state of California who is 65 years of age or older (WIC Section 15610.27)
- B. "Dependent Adult" means any person residing in the state of California, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23) Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3)
- C. "Reasonable Suspicion" means that it is objectively reasonable for a person to entertain a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on his or her training and experience, to suspect child abuse or neglect." (CA Penal Code, 11166)
- D. "Mandated Reporters" for **Suspected Child Abuse Cases** are defined under CA Penal Code Section 11165.7. Paragraph 20 of subdivision (a) states, "A firefighter, except for volunteer firefighters" and Paragraph 22 of subdivision (a) states, "Any emergency medical technician I or II, paramedic."

California Welfare and Institutions Code Section 15630 (a) defines "mandated reporter" for **Elder Abuse** as follows; "Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not he or she receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency.

- E. "EMS Personnel" means all EMTs and Paramedics providing care within the Emergency Medical Services System.
- F. "Designated Agency" means the agency designated by law to receive a copy of the "Suspected Child Abuse Report." The designated agencies are police or sheriff's department, county welfare or probation department, and district attorney's office.

III. PURPOSE

To describe reporting requirements for EMS personnel when child or elder abuse, sexual assault, or domestic violence is observed or is reasonably suspected.

IV. POLICY

EMS personnel are considered mandatory reporters responsible for reporting incidents of sexual abuse, domestic violence, or suspected abuse to children, dependent adults, or elderly people.

V. PROCEDURE

A. Abuse Reporting (Child, Dependent Adult, and Elder)

1. Suspected Child Abuse Report

- a. Immediately notify the appropriate law enforcement agency. The law enforcement officer assigned will act as a “clearinghouse” for taking the next steps and serves as the initial Child Protective Services contact.
- b. If no law enforcement officer is available, the reporter must follow the following steps AFTER THE APPROPRIATE LAW ENFORCEMENT AGENCY HAS BEEN CONTACTED:
- c. Make phone report to Child Protective Services Agency
 - 1) Stanislaus County – (209) 558-3665
 - 2) Calaveras County – (209) 754-6452, after hours (209) 754-6500
 - 3) Amador County – (209) 223-6550, after hours (209) 223-1075
 - 4) Alpine County – (530) 694-2235 then 1, after hours (866) 900-0525
 - 5) Mariposa County – (209) 966-7000
- d. Written Report must be followed within twenty-four (36) hours. The written report and instructions on “Suspected Child Abuse Report” is attached. **See attachment 1.**

2. Suspected Dependent Adult/Elder Abuse Report

- a. If the alleged abuse has occurred in a **long-term care facility**:
 - 1) Call Ombudsman Services of Northern California:
 - i. 1-800-896-4042
 - TTY 1-800-896-2512
- b. If the alleged abuse has occurred anywhere else:
 - 1) Call Adult Protective Services
 - i. Stanislaus County – (800) 336-4316
 - ii. Calaveras County - (209) 754-6452, after hours (209) 754-6500
 - iii. Amador County - (209) 223-6550, after hours (209) 223-1075
 - iv. Alpine County - (530) 694-2235 then 1, after hours (866) 900-0525
 - v. Mariposa County - (209) 966-7000
 - 2) Written report must be followed within twenty-four (48) hours. The written report and instructions on “Report of Suspected Elder Abuse” is attached. **See attachment 2.**

3. The identity of all persons reported under this article shall be confidential.

B. Sexual Assault

1. Sexual assault shall be reported in situations involving elder, dependent adult, child, or domestic violence.
2. Transport patients who have been sexually assaulted to nearest hospital or hospital of choice for evaluation and evidentiary exam.
3. Discourage any activity that would compromise evidence collection prior to transport such as bathing, brushing teeth, brushing hair, urinating, defecating or changing clothes.
4. Document essential elements:
 - a. Name of person making report
 - b. Name of victim
 - c. Present location of victim
 - d. Nature and extent of injury
 - e. Information that led reporting person to suspect sexual assault
 - f. Other information as requested.

C. Domestic Violence

1. Suspicion is to be reported immediately to the appropriate law enforcement agency.
2. The identity of all persons reported shall be confidential

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Attachment 1

DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM SS 8572

All Penal Code (PC) references are located in Article 2.5 of the PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The provisions of CANRA may be viewed at: <http://www.leginfo.ca.gov/calaw.html> (specify "Penal Code" and search for Sections 11164-11174.3). A mandated reporter must complete and submit the form SS 8572 even if some of the requested information is not known. (PC Section 11167(a).)

I. MANDATED CHILD ABUSE REPORTERS

- Mandated child abuse reporters include all those individuals and entities listed in PC Section 11165.7.

II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")

- Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department (not including a school district police or security department), the county probation department (if designated by the county to receive mandated reports), or the county welfare department. (PC Section 11165.9.)

III. REPORTING RESPONSIBILITIES

- Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof *within 36 hours* of receiving the information concerning the incident. (PC Section 11166(a).)
- No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC Section 11172(a).)

IV. INSTRUCTIONS

- SECTION A - REPORTING PARTY:** Enter the mandated reporter's name, title, category (from PC Section 11165.7), business/agency name and address, daytime telephone number, and today's date. Check yes-no whether the mandated reporter witnessed the incident. The signature area is for either the mandated reporter or, if the report is telephoned in by the mandated reporter, the person taking the telephoned report.

IV. INSTRUCTIONS (Continued)

- SECTION B - REPORT NOTIFICATION:** Complete the name and address of the designated agency notified, the date/time of the phone call, and the name, title, and telephone number of the official contacted.
- SECTION C - VICTIM (One Report per Victim):** Enter the victim's name, address, telephone number, birth date or approximate age, sex, ethnicity, present location, and, where applicable, enter the school, class (indicate the teacher's name or room number), and grade. List the primary language spoken in the victim's home. Check the appropriate yes-no box to indicate whether the victim may have a developmental disability or physical disability and specify any other apparent disability. Check the appropriate yes-no box to indicate whether the victim is in foster care, and check the appropriate box to indicate the type of care if the victim was in out-of-home care. Check the appropriate box to indicate the type of abuse. List the victim's relationship to the suspect. Check the appropriate yes-no box to indicate whether photos of the injuries were taken. Check the appropriate box to indicate whether the incident resulted in the victim's death.
- SECTION D - INVOLVED PARTIES:** Enter the requested information for: Victim's Siblings, Victim's Parents/Guardians, and Suspect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).
- SECTION E - INCIDENT INFORMATION:** If multiple victims, indicate the number and submit a form for each victim. Enter date/time and place of the incident. Provide a narrative of the incident. Attach extra sheet(s) if needed.

V. DISTRIBUTION

- Reporting Party:** After completing Form SS 8572, retain the yellow copy for your records and submit the top three copies to the designated agency.
- Designated Agency:** *Within 36 hours* of receipt of Form SS 8572, send **white copy** to police or sheriff's department, **blue copy** to county welfare or probation department, and **green copy** to district attorney's office.

ETHNICITY CODES

1 Alaskan Native	6 Caribbean	11 Guamanian	16 Korean	22 Polynesian	27 White-Armenian
2 American Indian	7 Central American	12 Hawaiian	17 Laotian	23 Samoan	28 White-Central American
3 Asian Indian	8 Chinese	13 Hispanic	18 Mexican	24 South American	29 White-European
4 Black	9 Ethiopian	14 Hmong	19 Other Asian	25 Vietnamese	30 White-Middle Eastern
5 Cambodian	10 Filipino	15 Japanese	21 Other Pacific Islander	26 White	31 White-Romanian

OSP 03 74570

SS 8572 (12/02)

SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

CASE NAME: _____

PLEASE PRINT OR TYPE

CASE NUMBER: _____

A. REPORTING PARTY	NAME OF MANDATED REPORTER		TITLE		MANDATED REPORTER CATEGORY			
	REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip				DID MANDATED REPORTER WITNESS THE INCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO			
	REPORTER'S TELEPHONE (DAYTIME) ()		SIGNATURE		TODAY'S DATE			
B. REPORT NOTIFICATION	<input type="checkbox"/> LAW ENFORCEMENT <input type="checkbox"/> COUNTY PROBATION		AGENCY					
	<input type="checkbox"/> COUNTY WELFARE / CPS (Child Protective Services)		ADDRESS Street City Zip		DATE/TIME OF PHONE CALL			
	OFFICIAL CONTACTED - TITLE				TELEPHONE ()			
C. VICTIM One Report Per Victim	NAME (LAST, FIRST, MIDDLE)			BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY	
	ADDRESS Street City Zip			TELEPHONE ()				
	PRESENT LOCATION OF VICTIM			SCHOOL		CLASS		GRADE
	PHYSICALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		DEVELOPMENTALLY DISABLED? <input type="checkbox"/> YES <input type="checkbox"/> NO		OTHER DISABILITY (SPECIFY)		PRIMARY LANGUAGE SPOKEN IN HOME	
	IN FOSTER CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: <input type="checkbox"/> DAY CARE <input type="checkbox"/> CHILD CARE CENTER <input type="checkbox"/> FOSTER FAMILY HOME <input type="checkbox"/> FAMILY FRIEND <input type="checkbox"/> GROUP HOME OR INSTITUTION <input type="checkbox"/> RELATIVE'S HOME				TYPE OF ABUSE (CHECK ONE OR MORE) <input type="checkbox"/> PHYSICAL <input type="checkbox"/> MENTAL <input type="checkbox"/> SEXUAL <input type="checkbox"/> NEGLECT <input type="checkbox"/> OTHER (SPECIFY)	
	RELATIONSHIP TO SUSPECT			PHOTO'S TAKEN? <input type="checkbox"/> YES <input type="checkbox"/> NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		
	VICTIMS SIBLINGS		NAME BIRTHDATE SEX ETHNICITY		NAME BIRTHDATE SEX ETHNICITY			
1. _____		3. _____		4. _____				
2. _____								
D. INVOLVED PARTIES	VICTIMS PARENTS/GUARDIANS		NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE		SEX	ETHNICITY
	ADDRESS Street City Zip			HOME PHONE ()		BUSINESS PHONE ()		
	NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE		SEX		ETHNICITY	
	ADDRESS Street City Zip			HOME PHONE ()		BUSINESS PHONE ()		
	SUSPECT'S NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE		SEX		ETHNICITY	
	ADDRESS Street City Zip			HOME PHONE ()		BUSINESS PHONE ()		
SUSPECT		OTHER RELEVANT INFORMATION						
E. INCIDENT INFORMATION	IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX <input type="checkbox"/> IF MULTIPLE VICTIMS, INDICATE NUMBER: _____							
	DATE / TIME OF INCIDENT			PLACE OF INCIDENT				
	NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)							

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY-District Attorney's Office; YELLOW COPY-Reporting Party

SS 8572 (12/02)

Attachment 2

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE GENERAL INSTRUCTIONS

PURPOSE OF FORM

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse of an elder or dependent adult. "**Elder**," means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). "**Dependent Adult**," means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

COMPLETION OF THE FORM

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse. Complete items with an asterisk (*) when a telephone report of suspected abuse is received as required by statute and the California Department of Social Services.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

REPORTING RESPONSIBILITIES

Mandated reporters (see definition below under "Reporting Party Definitions") shall complete this form for each report of a known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect, (self-neglect), isolation, and abandonment (see definitions in WIC Section 15610) involving an elder or a dependent adult. **The original of this report shall be submitted within two (2) working days of making the telephone report to the responsible agency as identified below:**

- The county Adult Protective Services (APS) agency or the local law enforcement agency (if abuse occurred in a private residence, apartment, hotel or motel, or homeless shelter).
- Long-Term Care Ombudsman (LTCO) program or the local law enforcement agency (if abuse occurred in a nursing home, adult residential facility, adult day program, residential care facility for the elderly, or adult day health care center).
- The California Department of Mental Health or the local law enforcement agency (if abuse occurred in Metropolitan State Hospital, Atascadero State Hospital, Napa State Hospital, or Patton State Hospital).
- The California Department of Developmental Services or the local law enforcement agency (if abuse occurred in Sonoma Developmental Center, Lanterman Developmental Center, Porterville Developmental Center, Fairview Developmental Center, or Agnews Developmental Center).

WHAT TO REPORT

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment has observed, suspects, or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect), or is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, abduction, or neglect, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days to the appropriate agency.

REPORTING PARTY DEFINITIONS

Mandated Reporters (WIC) "15630 (a) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter."

Care Custodian (WIC) "15610.17 'Care custodian' means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four-hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code. (b) Clinics. (c) Home health agencies. (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services. (e) Adult day health care centers and adult day care. (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders. (g) Independent living centers. (h) Camps. (i) Alzheimer's Disease Day Care Resource Centers. (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code. (k) Respite care facilities. (l) Foster homes. (m) Vocational rehabilitation facilities and work activity centers. (n) Designated area agencies on aging. (o) Regional centers for persons with developmental disabilities. (p) State Department of Social Services and State Department of Health Services licensing divisions. (q) County welfare departments. (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys. (s) The Office of the State Long-Term Care Ombudsman. (t) Offices of public conservators, public guardians, and court investigators. (u) Any protection or advocacy

GENERAL INSTRUCTIONS (Continued)

agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities. (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness. (v) Humane societies and animal control agencies. (w) Fire departments. (x) Offices of environmental health and building code enforcement. (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults."

Health Practitioner (WIC) "15610.37 'Health practitioner' means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner."

Officers and Employees of Financial Institutions (WIC) "15630.1. (a) As used in this section, "mandated reporter of suspected financial abuse of an elder or dependent adult" means all officers and employees of financial institutions. (b) As used in this section, the term "financial institution" means any of the following: (1) A depository institution, as defined in Section 3(c) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(c)). (2) An institution-affiliated party, as defined in Section 3(u) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(u)). (3) A federal credit union or state credit union, as defined in Section 101 of the Federal Credit Union Act (12 U.S.C. Sec. 1752), including, but not limited to, an institution-affiliated party of a credit union, as defined in Section 206(r) of the Federal Credit Union Act (12 U.S.C. Sec. 1786 (r)). (c) As used in this section, "financial abuse" has the same meaning as in Section 15610.30. (d)(1) Any mandated reporter of suspected financial abuse of an elder or dependent adult who has direct contact with the elder or dependent adult or who reviews or approves the elder or dependent adult's financial documents, records, or transactions, in connection with providing financial services with respect to an elder or dependent adult, and who, within the scope of his or her employment or professional practice, has observed or has knowledge of an incident that is directly related to the transaction or matter that is within that scope of employment or professional practice, that reasonably appears to be financial abuse, or who reasonably suspects that abuse, based solely on the information before him or her at the time of reviewing or approving the document, records, or transaction in the case of mandated reporters who do not have direct contact with the elder or dependent adult, shall report the known or suspected instance of financial abuse by telephone immediately, or as soon as practicably possible, and by written report sent within two working days to the local adult protective services agency or the local law enforcement agency."

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

IDENTITY OF THE REPORTER

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCO coordinators, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

FAILURE TO REPORT

Failure to report by mandated reporters (as defined under "Reporting Party Definitions") any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than \$1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to \$5,000, or by both imprisonment and fine.

Officers or employees of financial institutions (defined under "Reporting Party Definitions") are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding \$1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding \$5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter to the party bringing the action.

GENERAL INSTRUCTIONS (Continued)

EXCEPTIONS TO REPORTING

Per WIC Section 15630(b)(3)(A), a mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report a suspected incident of abuse where all of the following conditions exist:

- (1) The mandated reporter has been told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect).
- (2) The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
- (3) The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
- (4) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

Per WIC Section 15630(b)(4)(A), in a long-term care facility, a mandated reporter who the California Department of Health Services determines, upon approval by the Bureau of Medi-Cal Fraud and the Office of the State Long-Term Care Ombudsman (OSLTCO), has access to plans of care and has the training and experience to determine whether all the conditions specified below have been met, shall not be required to report the suspected incident of abuse:

- (1) The mandated reporter is aware that there is a proper plan of care.
- (2) The mandated reporter is aware that the plan of care was properly provided and executed.
- (3) A physical, mental, or medical injury occurred as a result of care pursuant to clause (1) or (2).
- (4) The mandated reporter reasonably believes that the injury was not the result of abuse.

DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency, the reporter shall send the original and one copy to the agency; keep one copy for the reporter's file.

Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.

DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS BUREAU.

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

**CONFIDENTIAL REPORT -
NOT SUBJECT TO PUBLIC DISCLOSURE**

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

DATE COMPLETED: _____

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.

A. VICTIM Check box if victim consents to disclosure of information [Ombudsman use only - WIC 15636(a)]

*NAME (LAST NAME FIRST)	*AGE	DATE OF BIRTH	SSN	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	ETHNICITY	LANGUAGE (✓ CHECK ONE) <input type="checkbox"/> NON-VERBAL <input type="checkbox"/> ENGLISH <input type="checkbox"/> OTHER (SPECIFY)
*ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMBUDSMAN)			*CITY	*ZIP CODE	*TELEPHONE ()	
*PRESENT LOCATION (IF DIFFERENT FROM ABOVE)			*CITY	*ZIP CODE	*TELEPHONE ()	

ELDERLY (65+) DEVELOPMENTALLY DISABLED MENTALLY ILL/DISABLED PHYSICALLY DISABLED UNKNOWN/OTHER LIVES ALONE LIVES WITH OTHERS

B. SUSPECTED ABUSER ✓ Check if Self-Neglect

NAME OF SUSPECTED ABUSER	<input type="checkbox"/> CARE CUSTODIAN (type)	<input type="checkbox"/> PARENT	<input type="checkbox"/> SON/DAUGHTER	<input type="checkbox"/> OTHER						
	<input type="checkbox"/> HEALTH PRACTITIONER (type)	<input type="checkbox"/> SPOUSE	<input type="checkbox"/> OTHER RELATION							
ADDRESS	*ZIP CODE	TELEPHONE ()	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	ETHNICITY	AGE	D.O.B.	HEIGHT	WEIGHT	EYES	HAIR

C. REPORTING PARTY: Check appropriate box if reporting party waives confidentiality to: All All but victim All but perpetrator

*NAME (PRINT)	SIGNATURE	OCCUPATION	AGENCY/NAME OF BUSINESS
RELATION TO VICTIM/HOW KNOWS OF ABUSE (STREET)	(CITY)	(ZIP CODE)	(E-MAIL ADDRESS)
			TELEPHONE ()

D. INCIDENT INFORMATION - Address where incident occurred:

*DATE/TIME OF INCIDENT(S)	PLACE OF INCIDENT (✓ CHECK ONE) <input type="checkbox"/> OWN HOME <input type="checkbox"/> COMMUNITY CARE FACILITY <input type="checkbox"/> HOSPITAL/ACUTE CARE HOSPITAL <input type="checkbox"/> HOME OF ANOTHER <input type="checkbox"/> NURSING FACILITY/SWING BED <input type="checkbox"/> OTHER (Specify)
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E. REPORTED TYPES OF ABUSE (✓ CHECK ALL THAT APPLY).

<p>1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.63)</p> <p>a. PHYSICAL <input type="checkbox"/> ASSAULT/BATTERY <input type="checkbox"/> CONSTRAINT OR DEPRIVATION <input type="checkbox"/> SEXUAL ASSAULT <input type="checkbox"/> CHEMICAL RESTRAINT <input type="checkbox"/> OVER OR UNDER MEDICATION</p> <p>b. <input type="checkbox"/> NEGLIGENCE c. <input type="checkbox"/> FINANCIAL d. <input type="checkbox"/> ABANDONMENT e. <input type="checkbox"/> ISOLATION</p> <p>f. <input type="checkbox"/> ABDUCTION g. <input type="checkbox"/> OTHER (Non-Mandated: e.g., deprivation of goods and services: psychological/mental)</p>	<p>2. SELF-NEGLECT (WIC 15610.57(b)(5))</p> <p>a. <input type="checkbox"/> PHYSICAL CARE (e.g., personal hygiene, food, clothing, shelter) b. <input type="checkbox"/> MEDICAL CARE (e.g., physical and mental health needs) c. <input type="checkbox"/> HEALTH and SAFETY HAZARDS d. <input type="checkbox"/> MALNUTRITION/DEHYDRATION e. <input type="checkbox"/> OTHER (Non-Mandated e.g., financial)</p>
<p>ABUSE RESULTED IN (✓ CHECK ALL THAT APPLY) <input type="checkbox"/> NO PHYSICAL INJURY <input type="checkbox"/> MINOR MEDICAL CARE <input type="checkbox"/> HOSPITALIZATION <input type="checkbox"/> CARE PROVIDER REQUIRED <input type="checkbox"/> DEATH <input type="checkbox"/> MENTAL SUFFERING <input type="checkbox"/> OTHER (SPECIFY) <input type="checkbox"/> UNKNOWN</p>	

F. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.). ✓ CHECK IF MEDICAL, FINANCIAL, PHOTOGRAPHS OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

G. TARGETED ACCOUNT

ACCOUNT NUMBER (LAST 4 DIGITS):	TYPE OF ACCOUNT: <input type="checkbox"/> DEPOSIT <input type="checkbox"/> CREDIT <input type="checkbox"/> OTHER	TRUST ACCOUNT: <input type="checkbox"/> YES <input type="checkbox"/> NO
POWER OF ATTORNEY: <input type="checkbox"/> YES <input type="checkbox"/> NO	DIRECT DEPOSIT: <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER ACCOUNTS: <input type="checkbox"/> YES <input type="checkbox"/> NO

H. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE. (family, significant others, neighbors, medical providers and agencies involved, etc.)

NAME	ADDRESS	TELEPHONE NO. ()	RELATIONSHIP
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I. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE. (If unknown, list contact person).

*NAME	IF CONTACT PERSON ONLY ✓ CHECK <input type="checkbox"/>	*RELATIONSHIP
*ADDRESS	*CITY	*TELEPHONE ()

J. TELEPHONE REPORT MADE TO: Local APS Local Law Enforcement Local Ombudsman Calif. Dept. of Mental Health Calif. Dept. of Developmental Services

NAME OF OFFICIAL CONTACTED BY PHONE	*TELEPHONE ()	DATE/TIME
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K. WRITTEN REPORT Enter information about the agency receiving this report. Do not submit report to California Department of Social Services Adult Programs Bureau.

AGENCY NAME:	ADDRESS OR FAX #	<input type="checkbox"/> Date Mailed: <input type="checkbox"/> Date Faxed:
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L. RECEIVING AGENCY USE ONLY Telephone Report Written Report

1. Report Received by:	Date/Time:
2. Assigned <input type="checkbox"/> Immediate Response <input type="checkbox"/> Ten-day Response <input type="checkbox"/> No Initial Face-To-Face Required <input type="checkbox"/> Not APS <input type="checkbox"/> Not Ombudsman	Approved by:
Assigned to (optional):	
3. Cross-Reported to: <input type="checkbox"/> CDHS, Licensing & Cert.; <input type="checkbox"/> CDSS-CCL; <input type="checkbox"/> CDA Ombudsman; <input type="checkbox"/> Bureau of Medi-Cal Fraud & Elder Abuse; <input type="checkbox"/> Mental Health; <input type="checkbox"/> Law Enforcement; <input type="checkbox"/> Professional Board; <input type="checkbox"/> Developmental Services; <input type="checkbox"/> APS; <input type="checkbox"/> Other (Specify)	Date of Cross-Report:
4. APS/Ombudsman/Law Enforcement Case File Number:	

SOC 341 (12/06)



Stanislaus County Emergency Medical Services Agency

Category	Facilities & Critical Care		
Policy #	570.20		
Title	Determination of Death in the Prehospital Setting		
EMS Director	Signature on file	Effective Date	6/1/2024
Medical Director	Signature on file	Review Date	1/1/2026
Signatures available upon request*		Revision Date	6/1/2026

I. AUTHORITY

California Health and Safety Code, Division 2.5, sections 1797.220, 1798, and 102850; and California Code of Regulations, Title 22, Division 9, sections 100107.

II. DEFINITIONS

A. "Obviously Dead" means a person who, in addition to absence of respiration, cardiac activity (pulseless), and neurologic reflexes (gag or corneal reflexes) has one or more of the following:

1. Decapitation
2. Massive crushing and/or penetrating injury with evisceration of the heart, lung or brain
3. Incineration
4. Decomposition of body tissue
5. Rigor mortis
6. Post-mortem lividity
7. Evidence of major blunt trauma
8. Pulseless, apneic trauma victims with extrication time greater than fifteen minutes, where no resuscitative measures can be performed prior to extrication.
9. Pulseless, apneic victims of a multiple victim incident where insufficient medical resources preclude initiating resuscitative measures.

B. "Traumatic Cardiac Arrest" means a patient who is pulseless and apneic secondary to a traumatic event and does not meet obviously dead criteria.

III. PURPOSE

To establish standards for authorized EMS personnel to follow in determining death of a patient in the prehospital setting.

IV. POLICY

EMS personnel shall not initiate nor perform CPR, basic life support, or advanced life support on patients determined to be obviously dead as defined in this policy.

V. PROCEDURE

A. When the initial patient assessment reveals "obvious death" and/or meets "Traumatic Cardiac Arrest" criteria:

1. A Patient Care Report (PCR) shall be completed for all patients not transported from the scene. All appropriate patient information must be included in the PCR and shall describe the patient assessment as well as the time the patient was determined to be obviously dead if applicable.
2. **Traumatic Cardiac Arrest patients:**
 - a. Briefly assess the patient and determine if the patient meets "Obviously Dead" criteria. If patient meets "Obviously Dead" criteria, do not initiate CPR. Base Hospital contact is not required for patients determined to be obviously dead.
 - 1) If a patient does not meet "Obviously Dead" criteria, follow the Traumatic Cardiac Arrest Protocol.

Special Considerations:

- 2) If EMS personnel are in doubt, CPR should be initiated.
- 3) If arrest is suspected to be medical (minor trauma not likely to be the cause of the arrest), follow Medical Arrest protocol and treat appropriately.
- 4) **Hanging Considerations:** Although hanging is part of trauma in most paramedic texts, the majority of EMS calls dealing with "hanging" are predominantly asphyxiation/strangulation cases. This means patients with a mechanism of injury of a hanging need spinal immobilization and trauma consideration; and shall be treated as a medical cardiac arrest if found pulseless and apneic.
- 5) **Electrocution Considerations:** Treat cardiac arrest patients resulting from an electrocution as a medical cardiac arrest unless there is evidence of significant traumatic injuries.
- 6) **Pediatric traumatic arrest patients shall be treated in the same manner as an adult and if transport is necessary, shall be transported to the closest Trauma Center.**

- B. EMS personnel shall notify the appropriate law enforcement agency when a patient has been determined to be dead and shall remain on scene until released by the law enforcement agency.
- C. Policies and procedures relating to medical operations during declared disaster situations or multiple casualty incidents will supersede this policy. (See Policies 810.00, and 820.00 for disaster policies)
- D. Crime Scene Responsibility, including presumed accidental deaths and suspected suicides:
 - 1. Authority for crime scene management belongs with law enforcement. To access the patient(s), it may be necessary to ask law enforcement officers for assistance to create a “safe path” that minimizes scene contamination.
 - 2. If law enforcement is not on scene, EMS personnel shall make every effort to preserve the integrity of the scene by minimizing access of unnecessary personnel to the scene until law enforcement arrives.



POLICY: 570.21
TITLE: Do Not Resuscitate (DNR)
Physician Orders for Life Sustaining Treatment (POLST)
End of Life Options (Aid-In-Dying Drug)

EFFECTIVE: 07/01/2017
REVIEW: 07/2022
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 10

Do Not Resuscitate (DNR)
Physician Orders for Life Sustaining Treatment (POLST)
End of Life Options (Aid-In-Dying Drug)

I. AUTHORITY

California Health and Safety Code, Division 1, Part 1.8, Section 442-443
California Health and Safety Code, Division 2.5, Section 1797.220 and 1798
California Probate Code, Division 4.7 (Health Care Decisions Law)

II. DEFINITIONS

- A. **Advance Health Care Directive (AHCD):** A written document that allows an individual to provide healthcare instructions and/or appoint an agent to make healthcare decisions when unable or prefer to have someone speak for them. AHCD is the legal format for healthcare proxy or durable power of attorney.
- B. **Aid-in-Dying Drug:** A drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to a terminal disease.
- C. **Basic Life Support (BLS) Measures:** The provision of treatment designed to maintain adequate circulation and ventilation for a patient in cardiac arrest without the use of drugs or special equipment. Examples include:
- Assisted Ventilation via a bag-valve-mask device
 - Manual or automated chest compressions
 - Automated External Defibrillator (AED)
- D. **Comfort Measures:** Medical interventions used to provide and promote patient comfort. Comfort measures applicable to the End of Life Option Act may include airway positioning and suctioning.
- E. **Do Not Resuscitate (DNR):** DNR is a request to withhold interventions intended to restore cardiac activity and respirations. For example:
- No chest compressions
 - No defibrillation
 - No endotracheal intubation
 - No assisted ventilation

- F. **End of Life Option Act:** California State law authorizes an adult, eighteen (18) years or older, who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease to make a request for an “aid-in-dying drug” prescribed for the purpose of ending his or her life in a humane and dignified manner.
- G. **Ombudsman:** The Office of the Ombudsman works independently as an intermediary to provide individuals with a confidential avenue to address complaints and resolve issues at the lowest possible level. The Office proposes policy and procedural changes when systemic issues are identified.
- H. **Patient Advocate:** Patient advocacy is an area of lay specialization in health care concerned with advocacy for patients, survivors, and care takers. The patient advocate may be an individual or an organization, often, though not always, concerned with one specific group of disorders.
- I. **Physician Orders for Life Sustaining Treatment (POLST):** A signed, designated physician order form that addresses a patient’s wishes about a specific set of medical issues related to end-of-life care. May be used for both adult and pediatric patients.
- J. **Prehospital Emergency Medical Services (EMS) Personnel:** Persons who have been certified as qualified to provide prehospital emergency medical care pursuant to California Health and Safety Code, Division 2.5.
- K. **Resuscitation: Intervention(s)** intended to restore cardiac activity and respirations, for example:
- Cardiopulmonary resuscitation (CPR)
 - Defibrillation
 - Drug therapy
 - Other life saving measures
- L. **Standardized Patient-Designated Directives:** Forms or medallion(s) that recognizes and accommodates patient’s wish to limit prehospital treatment at home or the scene of an incident, in healthcare facilities or during transport between facilities. Examples include:
- Statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form (Attachment 1)
 - Physician Orders for Life-Sustaining Treatment (POLST) (Attachment 2)
 - State EMS Authority-Approved DNR Medallion (V.C.2.b)
- M. **Supportive Measures:** Medical intervention(s) used to provide and promote patient comfort, safety, and dignity. Supportive measures applicable for POLST and AHCD may include but are not limited to:
- Airway maneuvers, including removal of foreign body
 - Suctioning
 - Oxygen administration
 - Hemorrhagic control
 - Oral hydration
 - Glucose administration
 - Pain control
- N. **Valid DNR Order for Patients in a Licensed Health Care Facility:**
- A written document in the medical record with the patient’s name and this statement “Do Not Resuscitate”, “No Code”, or “No CPR” that is signed and dated by a physician; or

- A verbal order to withhold resuscitation given by the patient's physician who is physically present at the scene and immediately confirms the DNR order in writing in the patient's medical record; or
- POLST with DNR checked; or
- AHCD when the instructions state resuscitation should be withheld/discontinued.

O. Valid DNR Order for Patients at a Location Other Than a Licensed Facility:

- Fully executed California Emergency Medical Services Authority and the California Medical Association approved DNR form signed and dated by the patient's physician; or
- A Medic Alert bracelet inscribed "Do Not Resuscitate EMS"; or
- A Physician Orders for Life-Sustaining Treatment (POLST) form; or
- A written, signed order in the patient's medical record.

III. PURPOSE

To establish criteria for prehospital EMS personnel when they encounter patients with Do Not Resuscitate (DNR) orders or Physician Orders for Life-Sustaining Treatment (POLST) and other patient designated end-of-life directives.

IV. PRINCIPLES

- A. The right of patients to refuse unwanted medical intervention is supported by California Statute.
- B. Withhold or discontinue patient resuscitation if a valid AHCD or standardized patient-designated directive is provided.
- C. If the patient's personal physician will sign the death certificate, invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient may be removed.
- D. Patients are encouraged to utilize one of the standardized patient-designated directives to ensure that end-of-life wishes are easily recognizable. If the patient is in a private home, the DNR or POLST should be readily accessible or clearly posted.
- E. Photocopies of all the patient-designated directives are acceptable.
- F. A conscious patient who is oriented to person, place, time and purpose may revoke their patient-designated directive at any time.

V. POLICY

- A. General Procedures for EMS Personnel:
 - 1. Confirm the patient is the person named in the patient-designated directive
 - 2. Initiate BLS measures immediately on patient in cardiopulmonary arrest pending verification of a valid patient-designated directive or the criteria for discontinuing measures outlined in Determination of Death in the Prehospital Setting Policy 570.20
 - 3. Begin resuscitation immediately and contact the base hospital for further direction if family members/caretakers disagree or object to withholding resuscitation, or if EMS personnel have any reservations regarding the validity of the DNR directive
 - 4. If the patient's condition deteriorates during transport, including Emergency 9-1-1 and Non-Emergency Inter-Facility Transfers (IFTs), and the patient has a valid DNR, transport the patient to the facility requested/designated by the physician or family member(s). If no facility is requested or designated then transport to the closest facility.

- B. Documentation of a DNR incident shall include, but is not limited to, the following:
1. Check the “DNR” box on the electronic Patient Care Report (ePCR);
 2. Describe the care given. Document the base hospital physician’s name, if consulted, and the date of the DNR directive;
 3. Note the removal of any invasive equipment;
 4. Document DNR orders written in the medical record of a licensed facility, including, the date signed, physician name, and other appropriate information or provide a copy of the DNR with the ePCR;
 5. When possible, provide a copy of the AHCD and/or other patient-designated directive with the ePCR.
- C. Directive-Specific Procedures
1. AHCD
 - a. A valid AHCD must be:
 - i. Completed by a competent person age 18 or older
 - ii. Signed, dated, and include the patient’s name
 - iii. Signed by two witnesses or a notary public
 - iv. Signed by a patient advocate or ombudsman if the patient is in a skilled nursing facility
 - b. If the situation allows, prehospital EMS personnel should make a good faith effort to review the AHCD and/or consult with the patient advocate.
 - c. Base hospital contact is required for any AHCD instructions other than withholding resuscitation.
 2. State EMS Authority approved DNR medallion(s)
 - a. A medallion or bracelet attached to the patient is considered the most accurate form of identification for anyone not in a licensed facility
 - b. Medallions are issued only after a copy of the DNR or POLST is received from an applicant. There are two (2) medallion providers approved in California:
 - i. Medic Alert Foundation



ii. Caring Advocates



- c. If the medallion is engraved “DNR,” treat in accordance with this policy
- d. If the medallion is engraved “DNR/POLST” and the POLST is available, treat as indicated on the POLST.
- e. If the medallion is engraved “DNR/POLST” and the POLST is **NOT AVAILABLE**, treat in accordance with the DNR until the valid POLST is produced.

3. Physician Orders for Life Sustaining Treatment (POLST)

- a. The POLST must be signed and dated by the physician, and the patient or the legally recognized decision maker. No witness to the signature is necessary.
- b. The POLST is designed to supplement, not replace an existing AHCD. If the POLST conflicts with the patient’s other health care instructions or advance directive, then the most recent order or instruction governs.
- c. Prehospital EMS personnel should see the written POLST unless the patient’s physician is present and issues a DNR order.
- d. There are different levels of care in Sections A and B of the POLST. Medical interventions should be initiated, consistent with the provider’s scope of practice and POLST instructions.
- e. Contact the base hospital for direction in the event of any unusual circumstance.

4. End of Life Option Act

A patient who has obtained an aid-in-dying drug has met extensive and stringent requirements as required by California law. The law offers protections and exemptions for healthcare providers but is not explicit about EMS response for End of Life Option Act patients. The following guidelines are provided for EMS personnel when responding to a patient who has self-administered and aid-in-dying drug:

- a. Within 48 hours prior to self-administering the aid-in-dying drug, the patient is required to complete a “Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner (Exhibit B).” However, there is no mandate for the patient to maintain the final attestation in close proximity of the patient. If a copy of the final attestation is available, EMS personnel should confirm the patient is the person named in the final attestation. This will normally require either the presence of a form of identification or a witness who can reliably identify the patient.

- b. There are no standardized “Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner” forms but the law has required specific information that must be in the final attestation. If available, EMS personnel should make a good faith effort to review and verify that the final attestation contains the following information:
 - i. The document is identified as a “Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner.”
 - ii. Patient’s name, signature and dated
- c. Provide comfort measures (airway positioning, suctioning) and/or BLS airway/ventilation measures
- d. Withhold resuscitative measures if patient is in cardiopulmonary arrest.
- e. The patient may at any time withdraw or rescind his or her request for an aid-in-dying drug regardless of the patient’s mental state. In this instance, EMS personnel shall provide medical care as per standard protocols. EMS personnel are encouraged to consult with their base hospital whenever possible.
- f. Family members may be at the scene of a patient who has self-administered an aid-in-dying drug. If there is objection to the End of Life Option Act, inform the family that comfort measures will be provided and consider Base Hospital contact for further direction.
- g. Obtain a copy of the final attestation and attach it with the EMS ePCR when possible.


Cross Reference Policies:

Policy 560.11 Documentation of Patient Contact

Policy 570.20 Determination of Death in Prehospital Setting

Policy 570.35 Refusal of EMS Service

Exhibit A
Physician Orders for Life-Sustaining Treatment (POLST)

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY		
 EMSA #111 B (Effective 1/1/2016)*	<h2>Physician Orders for Life-Sustaining Treatment (POLST)</h2>	
	<p>First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.</p>	
	Patient Last Name:	Date Form Prepared:
	Patient First Name:	Patient Date of Birth:
	Patient Middle Name:	Medical Record #: (optional)
A Check One	CARDIOPULMONARY RESUSCITATION (CPR): <i>If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.</i>	
	<input type="checkbox"/> Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B) <input type="checkbox"/> Do Not Attempt Resuscitation/DNR (Allow Natural Death)	
B Check One	MEDICAL INTERVENTIONS: <i>If patient is found with a pulse and/or is breathing.</i>	
	<input type="checkbox"/> Full Treatment – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. <input type="checkbox"/> <i>Trial Period of Full Treatment.</i> <input type="checkbox"/> Selective Treatment – goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. <input type="checkbox"/> <i>Request transfer to hospital only if comfort needs cannot be met in current location.</i> <input type="checkbox"/> Comfort-Focused Treatment – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location. Additional Orders: _____	
C Check One	ARTIFICIALLY ADMINISTERED NUTRITION: <i>Offer food by mouth if feasible and desired.</i>	
	<input type="checkbox"/> Long-term artificial nutrition, including feeding tubes. Additional Orders: _____ <input type="checkbox"/> Trial period of artificial nutrition, including feeding tubes. _____ <input type="checkbox"/> No artificial means of nutrition, including feeding tubes. _____	
D	INFORMATION AND SIGNATURES:	
	Discussed with: <input type="checkbox"/> Patient (Patient Has Capacity) <input type="checkbox"/> Legally Recognized Decisionmaker	
	<input type="checkbox"/> Advance Directive dated _____, available and reviewed → Health Care Agent if named in Advance Directive:	
	<input type="checkbox"/> Advance Directive not available Name: _____	
	<input type="checkbox"/> No Advance Directive Phone: _____	
	Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA) My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.	
	Print Physician/NP/PA Name:	Physician/NP/PA Phone #: Physician/PA License #, NP Cert. #:
	Physician/NP/PA Signature: (required)	
	Date:	
	Signature of Patient or Legally Recognized Decisionmaker I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.	
Print Name: Relationship: (write self if patient)		
Signature: (required)	Date:	
Mailing Address (street/city/state/zip):	Phone Number:	
FOR REGISTRY USE ONLY		
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED		

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY		
Patient Information		
Name (last, first, middle):	Date of Birth:	Gender: M F
NP/PA's Supervising Physician		Preparer Name (if other than signing Physician/NP/PA)
Name:	Name/Title:	Phone #:
Additional Contact <input type="checkbox"/> None		
Name:	Relationship to Patient:	Phone #:
Directions for Health Care Provider		
Completing POLST		
<ul style="list-style-type: none"> • Completing a POLST form is voluntary. California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences. • POLST does not replace the Advance Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts. • POLST must be completed by a health care provider based on patient preferences and medical indications. • A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known. • A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately. • To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy. • If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form. • Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible. 		
Using POLST		
<ul style="list-style-type: none"> • Any incomplete section of POLST implies full treatment for that section. <p><i>Section A:</i></p> <ul style="list-style-type: none"> • If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation." <p><i>Section B:</i></p> <ul style="list-style-type: none"> • When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture). • Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations. • IV antibiotics and hydration generally are not "Comfort-Focused Treatment." • Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment." • Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel. 		
Reviewing POLST		
It is recommended that POLST be reviewed periodically. Review is recommended when:		
<ul style="list-style-type: none"> • The patient is transferred from one care setting or care level to another, or • There is a substantial change in the patient's health status, or • The patient's treatment preferences change. 		
Modifying and Voiding POLST		
<ul style="list-style-type: none"> • A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line. • A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests. 		
<p>This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit www.caPOLST.org.</p>		
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED		

Exhibit B
Example of Final Attestation Form

FINAL ATTESTATION FORM

FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER, I _____, am an adult of sound mind and a resident of the State of California.

I am suffering from _____, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potentially associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I have received the aid-in-dying drug and am fully aware that this aid-in-dying drug will end my life in a humane and dignified manner.

INITIAL ONE:

_____ I have informed one or more members of my family of my decision and taken their opinions into consideration.

_____ I have decided not to inform my family of my decision.

_____ I have no family to inform of my decision.

My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

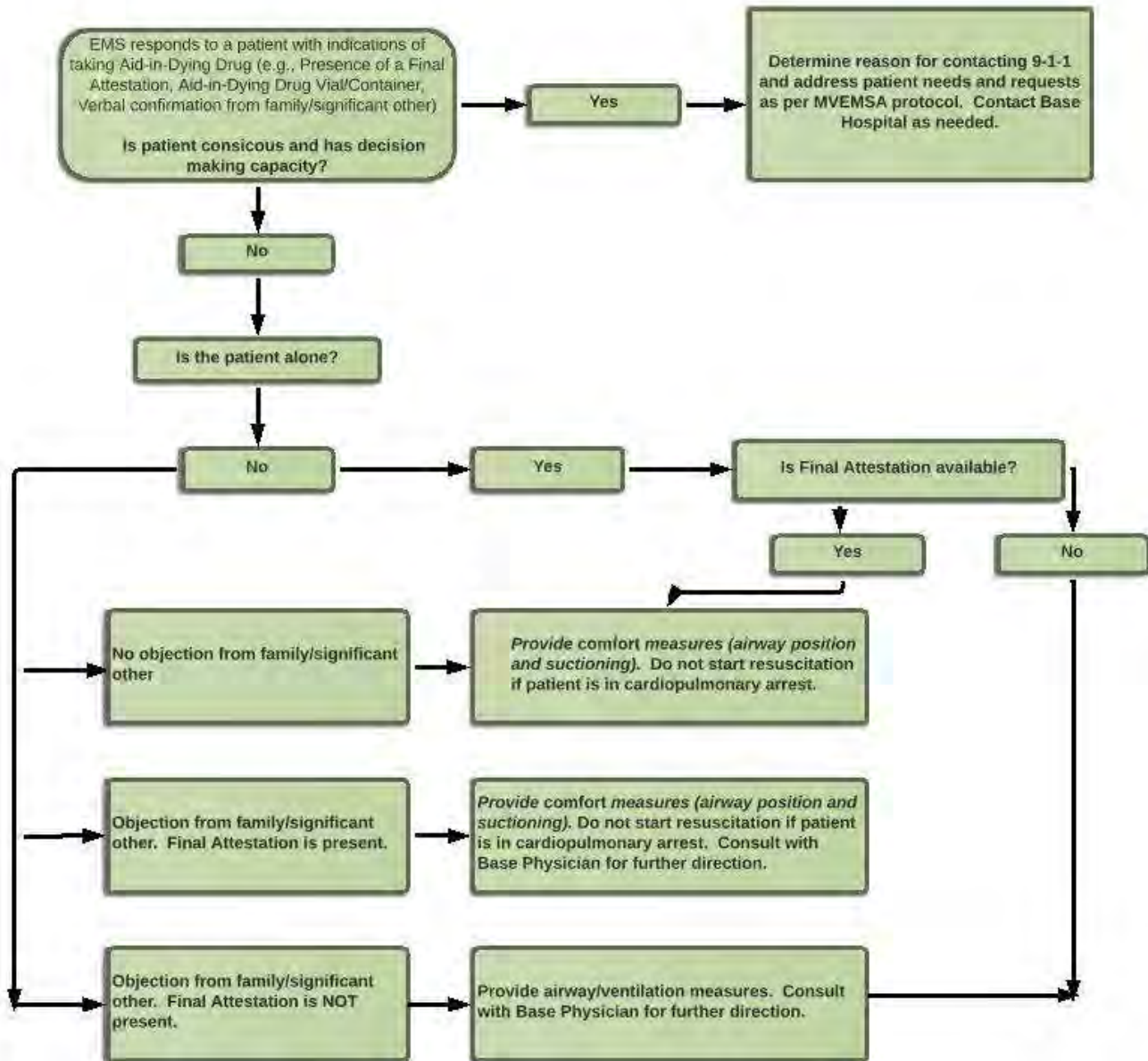
I make this decision to ingest the aid-in-dying drug to end my life in a humane and dignified manner. I understand I still may choose not to ingest the drug and by signing this form I am under no obligation to ingest the drug. I understand I may rescind this request at any time.

Signed: _____

Dated: _____

Time: _____

Exhibit C
End of Life Option Algorithm



APPROVED: SIGNATURE ON FILE IN EMS OFFICE
Executive Director

SIGNATURE ON FILE IN EMS OFFICE
Medical Director

EFFECTIVE DATE 4/13/2005
SUPERSEDES: _____
REVISED: 03/2005
REVIEW DATE: 04/2010
PAGE: 1 of 3

PHYSICIAN ON SCENE

I. AUTHORITY

Health and Safety Code, Section 1797.220, and Title 22, California Code of Regulations, Section 100169.

II. PURPOSE

To provide direction for prehospital personnel when a physician is present on the scene of an EMS call.

III. POLICY


Prehospital ALS personnel shall accept direction from a physician at the scene of an EMS call only under the circumstances described below.

IV. PROCEDURE

- A. If a physician wishes to direct the ALS care of a patient in the field and they are not recognized as a physician by EMS personnel, identification shall be requested. Identification should include a valid California Medical License and some form of identification that includes a picture (e.g. drivers license, hospital I.D.). Identification will not be required for calls originating at a physician's office, hospital or clinic.
- B. For calls originating at a private physician's office, clinic, emergency department, or when a patient's own private physician is on-scene, ALS personnel may follow the attending physician's written direction and will not be required to make base hospital contact unless: 1) the physician's orders do not comply with Regionally approved policies or treatment guidelines, or 2) the physician's orders do not comply with Regionally approved ALS/BLS scope of practice, or 3) there is an unexpected development in route which would require base hospital contact. Any written directions given by the physician shall accompany the patient and a copy shall be attached to the Patient Care Record.

- C. For calls originating at the scene of a medical emergency in which a physician is present who is not the patient's private physician, or if the attending physician's orders described in paragraph B, do not comply with approved treatment guidelines or scope of practice, the physician shall either be 1) advised that prehospital personnel function under the direction of a base hospital physician and place them in contact with the base physician; or 2) presented with a "Note to Physician on Involvement with EMT IIs and EMT-P (Paramedic)" card endorsed by the California Medical Association and the State EMS Authority (see page 3 of 3); or 3) informed that he/she may assume medical direction if they are also willing to accompany the patient in the ambulance to the receiving hospital.
- D. If the physician is not willing to accompany the patient and still wishes to direct the care, EMS personnel shall establish radio or telephone contact with the appropriate base hospital and explain the situation to the base hospital physician.
- E. If the base hospital physician so directs, the ALS personnel may take medical direction from the private physician as long as that direction is consistent with their scope of practice. In this situation, the base hospital physician shall assume medical control upon the initiation of transport.
- F. ALS personnel accepting appropriate direction from a private physician shall continue to follow Regional EMS policies, Treatment Guidelines, and Scope of Practice.
- G. The private physician may choose to offer assistance with another pair of eyes, hands, or suggestions; but allow the ALS personnel to operate under the direction of the base hospital, or the appropriate policies and procedures.
- H. At all times the private physician is to be treated with respect and courtesy. Utilize the base hospital physician to resolve any challenges that arise and file an Unusual Occurrence report with your employer liaison.

V. State of California - California Medical Association, Note To Physician on Involvement With EMT-IIs and EMT-Ps (Paramedic):

 <p>STATE OF CALIFORNIA EMSA &</p> <p>CALIFORNIA MEDICAL ASSOCIATION</p> <p>NOTE TO PHYSICIANS ON INVOLVEMENT WITH EMT-IIs AND PARAMEDICS</p> <p>A life support team (EMT-II or Paramedic) operates under standard policies and procedures developed by the local EMS agency and approved by their Medical Director under Authority of Division 2.5 of the California Health and Safety Code. The drugs they carry and procedures they can do are restricted by law and local policy. If you want to assist, this can only be done through one of the alternatives listed on the back of this card. These alternatives have been endorsed by CMA, State EMS Authority, CCLHO and BMQA.</p> <p>Assistance rendered in the endorsed fashion, without compensation, is covered by the protection of the Good Samaritan Code@ (see Business and Professional Code, Sections 2144, 2395-2298 and Health and Safety Code, Section 1799.104). (over)</p>	<p><u>ENDORSED ALTERNATIVES FOR PHYSICIAN INVOLVEMENT</u></p> <p>After identifying yourself by name as a physician licensed in the State of California, and, if requested, showing proof of identity, you may choose one of the following:</p> <ol style="list-style-type: none">1. Offer your assistance with another pair of eyes, hands or suggestions, but let the life support team remain under base hospital control; or,2. Request to talk to the base station physician and directly offer your medical advice and assistance; or,3. Take total responsibility for the care given by the life support team and physically accompany the patient until the patient arrives at a hospital and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedures. <p>(Whenever possible, remain in contact with the base station physician)</p> <p>(REV. 7/88) 88 49638 Provided by the Emergency Medical Services Authority</p>
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POLICY: 570.35
TITLE: Refusal of EMS Service

EFFECTIVE: 11/1/2021
REVIEW: 11/2026
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 4

REFUSAL OF EMS SERVICE

I. AUTHORITY

In accordance with Section 100147, Title 22 of the California Code of Regulations, H&S Code 1797.220 & Chapter 5 1798, the medical director of the local EMS Agency shall establish and maintain medical control.

II. DEFINITIONS

- A. **EMS Personnel**: All EMTs and Paramedics providing care within the Emergency Medical Services System.
- B. **Emancipated Minor** means a person who is under the age of 18 who is married or who is determined by a court of competent jurisdiction to be legally able to care for him or herself.
- C. **Person** means any individual encountered by EMS Personnel who does not manifest any overt evidence of illness or injury – AND – refuses any assessment by Emergency Medical Personnel.
- D. **Basic Life Support Ambulance** means an emergency ambulance staffed with a minimum of two (2) Emergency Medical Technicians (EMTs)
- E. **Patient** means any individual encountered by EMS Personnel who demonstrates any of the following.
 - 1. Suspected illness or injury
 - 2. Involved in an event with significant mechanism that could cause illness or injury
 - 3. Requests care or evaluation.
 - 4. An altered level of consciousness
- F. **Patient Relationship** exists because of EMS being summoned and EMS personnel coming into contact with a patient.
- G. **Refusal of Service** applies to those patients who are refusing any EMS services provided by EMS Personnel including assessment, treatment, or transportation.

- H. **5150** is defined in code as, “A patient who is held against their will for evaluation under the authority of Welfare and Institution Code, Section 5150, because the patient is a danger to themselves, a danger to others and/or gravely disabled (i.e., unable to care for self). This is a written order placed by a law enforcement officer, County Mental Health Worker, or a health worker certified by the County to place an individual on a 5150 hold.”
- I. **5170** is defined in code as, “A person who is a danger to others or to him/herself, or gravely disabled as a result of inebriation. A peace officer, member of the attending staff, as defined by regulation, of an evaluation facility designated by the County, or other person designated by the County may, upon reasonable cause, take or cause to be taken, the person into civil protective custody and place him in a facility designated by the County and approved by the State Department of Alcohol and Drug Abuse as a facility for 72-hour treatment and evaluation of inebriates.”

III PURPOSE

To provide direction and guidelines to EMS Personnel for patient-initiated refusal of service.

IV. POLICY

- A. Any patient may decline all or part of assessment, treatments, or transportation by EMS Personnel if the following factors are present:
 - 1. The patient has the ability to communicate a choice.
 - 2. The patient has the ability to understand the relevant information.
 - 3. The patient has the ability to appreciate the situation and its consequences.
 - 4. The patient has the ability to reason rationally.
 - 5. The patient is an emancipated minor or over the age of 18.
- B. When it is determined that a patient has refused assessment, treatment, or transport by ambulance, EMS personnel shall complete a refusal of EMS service form as developed by their respective employer.
- C. EMT’s conducting the Refusal of Service/AMA process must be operating in an Agency approved BLS Tiered Response system.
Example narrative: REFUSAL OF CARE AND TRANSPORT: The patient decided to refuse care which consisted of (Specify Care) and/or transport to the hospital of their choice. The patient was found alert and oriented to person, place, time, and situation at time of refusal. Further, we discussed several items that are consistent with someone who may demonstrate decisional capacity, such as; 1) Communicated a choice = The patient actively declined treatment and/or transport in their own words, 2) Understood relevant information = The patient expressed in their own words the medical crisis at hand and risks/benefits of medical treatment after discussion with Paramedic, 3) Appreciated the situation = The patient described their view of their medical condition and, 4) Reasoning about treatment/transport options = The patient’s criterion for making their decision appeared reasonable. The appropriate signature was obtained on SCEMSA refusal of service form for this patient.

V. PROCEDURE

- A. In the event a patient is refusing EMS services the EMS personnel with the highest medical authority on scene shall attempt the following:
1. Obtain a history of the event and prior medical history including medications.
 2. Perform a physical assessment to include a complete set of vital signs and ensure that there are no life or limb threatening injuries or illnesses that would place this patient's life in jeopardy if left untreated.
 3. You must give the patient enough information about the decision they are making so that there is informed consent. You must be satisfied that the patient has understood the risk and options concerning their decision.
 4. Explain in detail the Medical Miranda Card as defined below:

Patient Refusal Rights and Information

You are refusing medical treatment and/or transport. Your health and safety are our primary concern, please remember the following:

1. Our evaluation and/or treatment is not a substitute for medical evaluation and treatment by a doctor. We advise you to see a doctor or go to a hospital emergency department.
2. Your condition may not seem as bad to you as it is. Without treatment, your condition or problem could become worse.
3. If you change your mind or your condition becomes worse, please don't hesitate to call us back, by dialing 911. We will do our best to help you.
4. Don't wait! When medical treatment is needed, it's usually better to get it right away.

SPECIAL CONDITIONS:

5. Your condition has been discussed with a doctor at the hospital by radio or telephone and the advice given to you has been issued or approved by the doctor.
6. FOR MINORS: Instruct the patient's legal guardian that in this situation they are acting on behalf of the patient, and they understand the above information regarding refusal of treatment or transport and accept responsibility for the patient.

5. If a Basic Life Support Ambulance encounters a patient as defined in this policy and does not have a suspected ALS complaint, the EMTs shall complete the refusal of care process as outlined. If the patient is suspected to have an ALS complaint and refuses treatment and transport the EMT shall request an ALS ambulance, Paramedic supervisor or Paramedic QRV to complete the Refusal of Service process
- B. For patients that are refusing part or all the assessment, treatment, or transportation and who in the judgment of the EMS personnel, requires assessment, treatment, or transportation, consider the following.
1. Have your partner offer assessment, treatment, or transportation.

2. Contact a designated base hospital for assistance from the base hospital physician in further assessment of the patient. Communication with the base physician may require communication between the physician and patient.
 3. For a patient meeting “trauma criteria,” a designated Trauma Center will be contacted in all cases of patient refusal of assessment, treatment, or transportation.
 4. If the patient is a danger to themselves or others or meets the definition of a 5150 or 5170 patient, contact law enforcement officials.
- C. Complete and explain the refusal of EMS service form to the patient.
1. A signature should be obtained from the patient and a witness if possible.
 2. If patient is a minor or incompetent adult, assure that the legal guardian is refusing treatment prior to allowing the refusal.
- D. Each item described above shall be documented on the prehospital care report (PCR) and filed per individual EMS service provider policy.
- E. Provider Agencies will use the elements listed below on the EMS Service Patient Refusal Form:
1. Patient’s Name, Age, Date, Incident Number, and Incident Location
 2. Criteria for refusing care
 3. Acknowledgement of Information
 4. Release of Liability
 5. Location for patient’s signature and date
 6. Check box for “refused to sign”
 7. Witness signature line
 8. Form completed by, signature line, date, and ID number



Stanislaus County

Emergency Medical Services Agency

POLICIES AND PROCEDURES

POLICY: 954.20
TITLE: Stanislaus County BLS Tiered Response System

EFFECTIVE: 11/01/2021
REVIEW: 11/2026
SUPERCEDES:

APPROVAL SIGNATURES ON FILE IN EMS OFFICE

PAGE: 1 of 3

Stanislaus County BLS Tiered Response System

I. AUTHORITY

California Health and Safety Code, Division 2.5, Section 1797.200

II. DEFINITIONS

- A. “Emergency Medical Dispatch” means a dispatch center that provides Emergency Medical Dispatch, including pre-arrival instructions, utilizing a card system approved by the EMS Agency Medical Director.
- B. “Advanced Life Support Ambulance” means an emergency ambulance staffed with a minimum of one (1) Paramedic and one (1) Emergency Medical Technician (EMT)
- C. “Basic Life Support Ambulance” means an emergency ambulance staffed with a minimum of two (2) Emergency Medical Technicians (EMTs)

III. PURPOSE

To utilize Basic Life Support Ambulances in the 911 system for low acuity calls identified through the Emergency Medical Dispatch (EMD) process.

IV. POLICY

All Ambulance responses will be determined using the Medical Priority Dispatch System (MPDS) protocols and respond based on the level and mode of response approved by the Stanislaus County Emergency Medical Services Agency (SCEMSA) Medical Director.

V. PROCEDURE

- A. SCEMSA authorized Emergency Medical Services Dispatch Center shall ensure that each request for ambulance service is managed in a manner consistent with established Agency policies, procedures, and the Medical Priority Dispatch System (MPDS) protocols.
- B. A Basic Life Support Ambulance will be dispatched for service requests meeting the dispatch criteria using the MPDS and the Agency Medical Director approved level and mode of response.
- C. Emergency Medical Technicians shall use the Stanislaus County Emergency Medical Services Agency approved policies, procedures, and protocols within their Scope of Practice to assess and treat patients when dispatched to a request for service. This shall include, but not be limited to documentation standards and Receiving Facility Radio Report.

- D. If the patient assessment conducted by the Emergency Medical Technicians (Basic Life Support Ambulance) reveals a potentially unstable patient, the crew shall rendezvous with a paramedic resource (ALS Ambulance/ ALS Fire/Supervisor/QRV). If the time to rendezvous with a paramedic resource is greater than the estimated transport time to the closest receiving hospital, then the BLS crew shall transport to the closest receiving hospital. Transport mode, i.e., Code 2/3 is at the discretion of the transporting crew.

Potentially unstable adult patient:

- Cardiac Arrest
- Heart Rate < 50 or > 120
- Systolic Blood Pressure < 90mmHg
- Respiratory Rate > 24
- O₂ sat < 94% (88% for COPD patients)- if patient is on home oxygen, as measured on usual oxygen flow rate
- Any patient that meets trauma activation criteria per MVEMSA Policy 553.25 Trauma/Burn Triage and Patient Destination

Potentially unstable pediatric patient: Pediatric patients will be evaluated using the PAT - Pediatric Assessment Tool. This tool assesses the patient, under the age of 14, according to the following three components: appearance, work of breathing and circulation.

1. Appearance: Using the mnemonic TICLS. Patient is unstable if there is any abnormality of the following.
 - Tone
 - Interactiveness
 - Consolability
 - Look/gaze
 - Speech/cry
2. Work of Breathing: Presence of any of the following implies abnormal work of breath and therefore potential instability.
 - Stridor
 - Wheezing
 - Grunting
 - Tripod positioning
 - Retractions
 - Nasal flaring
 - Apnea/gasping
3. Circulation of the Skin: Presence of any of the following indicates abnormal circulation or poor perfusion.
 - Pale
 - Mottled
 - Cyanotic

Failing any one point within the three components of the PAT assessment will indicate a potentially unstable pediatric patient and therefore necessitate an ALS level of response

- E. If the patient refuses transport after assessment is completed, and/or any treatment provided, "Against Medical Advice" paperwork and process must be completed. Complete the process as outlined in SCEMSA policy 570.35 "Refusal of EMS Service." Generally, Stanislaus County fire departments will not respond to low acuity calls. ALS Fire shall NOT be requested specifically for the AMA process.

- F. All transports involving the use of Basic Life Support Ambulance in the 911 system must be reviewed through the Quality Improvement Process at the ambulance provider level. Any case that needs further attention and review according to SCEMSA Policy 620.00, Unusual Occurrence Reporting shall be forwarded to the Quality Improvement Coordinator at SCEMSA.
- G. The Emergency Medical Technician shall contact their immediate supervisor for any circumstances that may not be covered in this policy while responding to request for service, on scene of a request for service, and/or transporting to the receiving hospital.