



# Mountain-Valley

Emergency Medical Services Agency

## PLEASE POST

**REGIONAL ADVISORY COMMITTEE**  
Wednesday, March 17, 2010 at 1:00 P.M.

**Saddle Creek Resort**  
**1001 Saddle Creek Drive**  
**Copperopolis, California**  
**(Map Enclosed)**

**NOTICE: FOR MEMBERS ONLY**, LUNCH WILL BE SERVED AT 12:00 P.M.  
PLEASE RSVP TO TINA CASIAS AT (209)529-5085, OR, [tcasias@mvemsa.com](mailto:tcasias@mvemsa.com) BY  
MARCH 10, 2009

**(No Subcommittee Meetings)**

### AGENDA

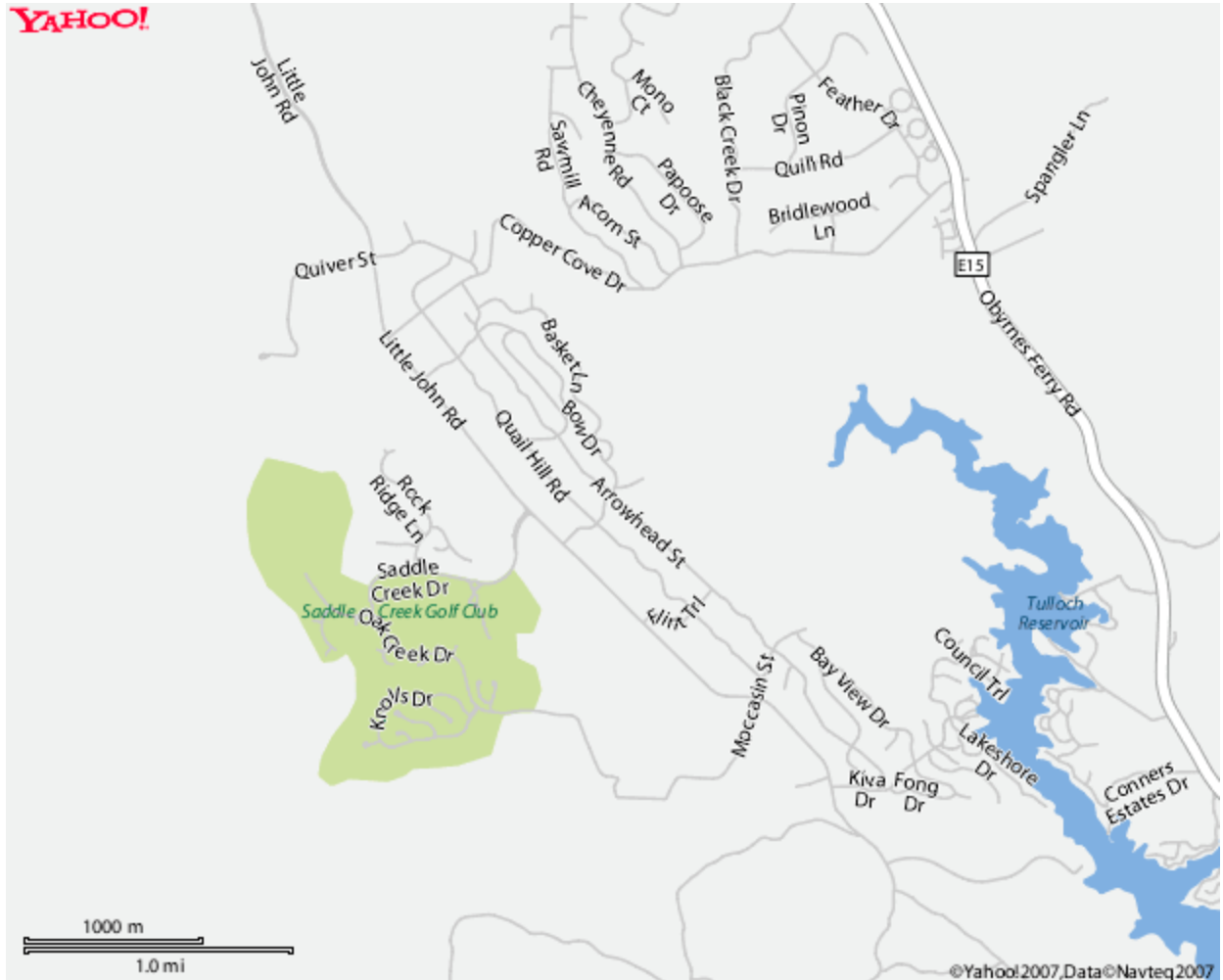
**Any member of the audience desiring to address the committee on a matter on the agenda:** Please raise your hand at the time the item is announced by the Committee Chairperson. In order that all interested parties have an opportunity to speak, any person addressing the Committee will be limited to a maximum of 5 minutes unless the Chairperson of the Committee grants a longer period of time.

**Public comment periods:** Matters under the jurisdiction of the Committee, and not on the posted agenda, may be addressed by the general public at the beginning of the regular agenda and any off-agenda matters before the Committee for consideration. However, California law prohibits the Committee from taking action on any matter which is not on the posted agenda unless it is determined to be an emergency by the Committee. Any member of the public wishing to address the Committee during the "Public Comment" period will be limited to a maximum of 5 minutes.

<b>ACTION</b>	<b>1.</b>	<b>Call to Order</b>
	<b>2.</b>	<b>Welcome and Introduction of Members and Guests</b>
<b>INFO</b>	<b>3.</b>	<b>Conflict of Interest Statements/Fair Political Practices:</b> <i>RAC members will be reminded that they should recuse themselves during any discussion concerning a topic of which they may have a conflict of interest.</i>
<b>INFO</b>	<b>4.</b>	<b>Public Comment</b>
<b>ACTION</b>	<b>5.</b>	<b>Acceptance/Additions/Deletions to Agenda</b>
<b>INFO</b>	<b>6.</b>	<b>Correspondence/Information</b> <i>No correspondence has been received this period.</i>

<b>ACTION</b>	<b>7.</b>	<b>Approval of November 18, 2009 Minutes</b> <span style="float: right;"><b>(Attachment #1)</b></span>
<b>INFO/ACTION</b>	<b>8.</b>	<b>Policy for Review:</b> <span style="float: right;"><b>(Attachment #2)</b></span> <ul style="list-style-type: none"> <li>a. 945.20 Significant Exposure Reporting for Mariposa</li> <li>b. 958.30 Chempack Request/Deployment for Amador</li> <li>c. 552.65 Paramedic Administration of H1N1 Vaccine</li> <li>d. 620.30 Communications/Ambulance Provider Data Requirements</li> <li>e. 853.00 Altered Standard of Care in Response to Disasters</li> <li>f. 545.00 Establishment of Service Areas for Trauma Centers</li> <li>g. 554.71 Childbirth</li> <li>h. 554.03 Asystole</li> <li>i. 554.21 Airway Obstruction – Stridor in Adult Patients)</li> <li>j. 554.23 Tension Pneumothorax</li> <li>k. 554.31 Altered Level of Consciousness</li> <li>l. 554.32 Acute CVA</li> <li>m. 554.33 Status Seizures</li> <li>n. 554.41 Non-Traumatic Shock</li> <li>o. 554.42 Blood Sugar Emergencies</li> <li>p. 554.43 Allergic Reaction</li> <li>q. 554.45 Abdominal Pain</li> <li>r. 554.44 Pain Management</li> <li>s. 554.52 Caustics – Corrosives – Petroleum Exposures</li> <li>t. 554.54 Dystonic Reaction</li> <li>u. 554.55 Narcotics Overdose</li> <li>v. 554.57 Petroleum Distillates</li> <li>w. 554.58 Amphetamine Intoxication</li> <li>x. 554.61 Envenomation</li> <li>y. 554.62 Hypothermia</li> <li>z. 554.63 Frostbite</li> <li>aa. 554.81 Burns</li> <li>bb. 554.82 Traumatic Shock</li> <li>cc. 554.84 Head-Neck-Facial Trauma</li> <li>dd. 554.85 Chest Trauma</li> <li>ee. 554.86 Abdominal Trauma</li> <li>ff. 554.87 Extremity Trauma</li> <li>gg. 958.20 Stanislaus Saturation Trial</li> </ul>
<b>INFO</b>	<b>9.</b>	<b>EMS Plan Update (EMS Plan due to State EMSA by Oct. 21, 2010)</b>
<b>INFO</b>	<b>10.</b>	<b>Agency/County Reports</b>
<b>INFO/ACTION</b>	<b>11.</b>	<b>Next Meeting Date /Time</b> <i>Wednesday, May 19, 2010</i>
<b>ACTION</b>	<b>12.</b>	<b>Adjournment</b>

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**REGIONAL ADVISORY COMMITTEE MEETING**  
**November 18, 2009**  
**Minutes**

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**Location:** Saddle Creek Resort  
Copperopolis, California

**Time:** 1:00 p.m.

**Committee Members Present** Cindy Woolston, Stanislaus County; Don Zyski, Calaveras County; Mildred Zyski, Calaveras County; Alan McNany, Amador County; Drew Hood, Amador County; Brian Kirk, Amador County; Jesse Figueroa, Mariposa County; Aaron King, Stanislaus County

**Committee Members Absent:** Mike Skinner, Stanislaus County; Suzanne Turpin, Mariposa County; William Schmiett, Calaveras County

**Guests:** None

**Staff:** Richard Murdock – Interim Deputy Director

**1. CALL TO ORDER**

Co-Chairman Alan McNany called the meeting to order at 12:35 p.m.

**2. WELCOME AND INTRODUCTION OF MEMBERS AND GUESTS**

Committee members and guests introduced themselves.

**3. CONFLICT OF INTEREST STATEMENTS/FAIR POLITICAL PRACTICES**

Co-Chairman McNany reminded Committee members to recuse themselves if they have a financial interest in matters before the Committee.

**4. PUBLIC COMMENT**

There were no comments from the public.

**5. ACCEPTANCE/ADDITIONS/DELETIONS TO AGENDA**

M/S/C (M. Hood/Woolston) to accept the agenda.

**Vote:** Unanimous

**6. CORRESPONDENCE/INFORMATION**

There was no correspondence to discuss.

**7. APPROVAL OF JULY 15, 2009 MINUTES**

M/S/C (M. M. Zyski/Hood) to accept the July 15, 2009 minutes as presented

**Vote:** Unanimous

## **8. EMERGENCY MEDICAL SERVICES SYSTEM PLAN FOR MVEMSA EXECUTIVE DIRECTOR**

The Committee was advised of the EMS Plan, which was approved by the Board of Directors and State EMSA.

## **9. POLICIES FOR REVIEW**

At the July 15, 2009 RAC meeting, the RAC members suggested changes to Policy 560.11 – Documentation of Patient Contacts to include an Interim PCR as Appendix A.

**Policy 560.11 – Documentation of Patient Contact:** This policy was extensively discussed and centered on having verbal orders signed by the physician and the requirement of providing completed medical record copy of the PCR prior to leaving the emergency department.

### **RAC Members suggested the following to the Medical Director:**

#### Section IV, B:

1. If prehospital personnel are dispatched to an emergency call or post assignment prior to completing required documentation, the completed medical record copy of the PCR shall be delivered to the nurse or physician managing the patient in the department which has received the patient no later than two (2) hours after the call or prior to their end of shift, whichever occurs first.
  
2. If the PCR is not submitted immediately upon delivery of a patient, the care provider completing the report must submit a completed “Interim PCR” (Appendix A) prior to the prehospital personnel's departure from the department receiving the patient.

Include an Appendix A.

Remove Section IV, B, 3 and 4.

Policy 560.11 was revised to reflect the changes recommended by the Regional Advisory Committee.

## **10. MVEMSA 12-LEAD PILOT PROPOSAL**

Richard Murdock advised the Committee of the inception of the 12-Lead EKG Pilot Study began in Amador and Calaveras Counties on November 1, 2009. AMR, Stanislaus County, has begun the process of training and completing equipment purchases. Patterson Ambulance, West Side Ambulance, and ProTransport, Stanislaus County, started utilizing 12-Lead EKGs in the field during the month of November 2009.

## **11. 12-LEAD EKG “TRAIN-THE-TRAINER FOR MVEMSA PROVIDERS**

Dr. Mackey has completed the “train-the-trainer” course for all counties within MVEMSA region. Dr. Mackey held 3 classes in the month of September 2009 for the trainers to attend (2 classes were held in Stanislaus Co. and 1 class was held in Calaveras Co.)

## **12. REVIEW ATTENDANCE RECORDS/CONSIDER ACTION**

The attendance record was reviewed for the time period 3/19/2006 – 7/15/2009. No action taken on attendance record by Committee.

## **13. AGENCY/COUNTY REPORTS**

### **Mountain-Valley EMS Agency**

Richard Murdock advised the committee that there were approximately 90 policies that will be out for review in 2010. The policies were not ready for the Jan. 2010 agenda but will be ready for review for the March 2010 meeting.

The newsletter will be sent out in December 2009.

### **Alpine County**

There was no report for Alpine County.

### **Calaveras County**

Calaveras Providers received the H1N1 vaccinations over a 3-night period. Approximately 110 Firefighters and EMS personnel received the vaccinations.

**Amador County**

CalFire is in the process of hiring an EMS director at the state level in order to for CalFire to have a Statewide EMT program.

**Mariposa County**

There was no report for Alpine County.

**Stanislaus County**

Ambulance Providers have started to receive H1N1 vaccinations  
Rural Providers have received their “go-books” for AVLs

**14. NEXT MEETING DATE/TIME**

The next meeting is scheduled for January 20, 2010 @ 1:00 pm.

**15. ADJOURNMENT**

**M/S/C (M.Zyski/Hood) to adjourn meeting**

**Vote:** Unanimous

The meeting was adjourned at 2:50 p.m.



# Mountain-Valley

Attachment #1

## Emergency Medical Services Agency

TO: Coordinators  
FROM: Richard Murdock, Interim Deputy Director  
DATE: February 17, 2010  
SUBJECT: 60-Day Review of Draft Policies

Policy	Comments	Staff Recommendations
945.20 (Significant Exposure Reporting for Mariposa)	No comments	
958.30 (Chempack Request/Deployment for Amador)	No comments	
552.65 (Paramedic Admin. Of H1N1 vaccine)	No comments (note, don't see this one on the website)	
620.30 (Communications/Amb. Provider Data Req.)	No comment	
853.00 (Altered Standard of Care in Response to disasters)	No comments	
545.00 (Establishment of service areas for trauma centers)	No comments	
554.71 (Childbirth)	See attached	Removed and added to next 60-day review
554.03 (Asystole)	See attached	
554.21 (Airway Obstruction – Stridor – Adult)	See attached	Pat Murphy - If available used and not used in different policies for the following sentence under Secure Airway: Continuous waveform capnography should be used in all intubated patients, if available. So in this one it is used...
554.23 (Tension Pneumothorax)	See attached	Pat Murphy - Under Secure Airway: "if available" striked through.
554.31 (ALOC)	See attached	
554.32 (Acute CVA)	See attached	
554.33 (Status Seizures)	See Attached	



# Mountain-Valley

## Emergency Medical Services Agency

TO: Coordinators

FROM: Richard Murdock, Interim Deputy Director

DATE: February 17, 2010

SUBJECT: 60-Day Review of Draft Policies

Policy	Comments	Staff Recommendations
554.41 (Non-Traumatic Shock)	No Comments	
554.42 (Blood Sugar Emergencies)	See attached	Pat Murphy - Under "Hyperglycemia" shouldn't Oxygen have "Oxygen delivery as appropriate" be used?
554.43 (Allergic Reaction)	See attached	
554.45 (Abdominal Pain)	Recommend removal of "pulsatile abdominal mass" under IV access; recommend morphine dosing be harmonized to other pain management profiles (5mg slow IVP/IO, then 2.5mg increments ...)	
554.44 (Pain Management)	No changes	
554.52 (Caustics)	Recommend combining with Petroleum Dist (policy 554.57)	Pat Murphy - Under Oxygen shouldn't it have "Oxygen delivery as appropriate" be used?
554.54 (Dystonic Reaction)	See attached	Pat Murphy - Under Oxygen shouldn't it have "Oxygen delivery as appropriate" be used?
554.55 (Narcotics OD)	See attached	Removed and added to next 60-day review period
554.57 (Petroleum Distillates)	Recommend combining with Caustics (policy 554.52)	Combined with Caustic Policy 554.53 Line out 554.57 to show deleted
554.58 (Amphetamine intoxication)	See attached	Removed and added to next 60-day review
554.61 (Envenomation)	See Attached	
554.62 (Hypothermia)	See attached	
554.63 (Frostbite)	See attached	





APPROVED: Signature On File In EMS Office  
Executive Director  
  
Signature On File In EMS Office  
Medical Director

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## SIGNIFICANT EXPOSURE REPORTING FOR MARIPOSA COUNTY

### I. AUTHORITY

Division 2.5, California Health and Safety Code, Sections 1797.186, 1797.188, 1797.189

### II. DEFINITION

- A. "Prehospital Emergency Medical Care Personnel" means those persons who have been certified as qualified to provide prehospital emergency medical care pursuant to Division 2.5, California Health and Safety Code.
- B. "Reportable disease or condition" or "a disease or condition listed as reportable" means those diseases prescribed by Subchapter 1 (commencing with Section 2500) of Chapter 4 of Title 17 of the California Administrative Code, as may be amended from time to time.
- C. "Health Care Facility" is any hospital authorized to receive patients from the EMS system.
- D. "Provider Agency" means an Agency that provides ~~p~~Prehospital Emergency ~~m~~Medical ~~c~~Care.
- E. "Significant Exposure" is defined as an unprotected exposure ~~to blood~~ or body fluid secretions or airborne ~~or droplet~~ contact.

1) Examples of exposure may include the following:

~~a) a healthcare provider without a protective mask or with a protective mask that DOES NOT meet OSHA Regulations that is in close proximity to a suspected tuberculosis patient without a OSHA regulated protective mask; or~~

~~a) Close proximity to a suspected tuberculosis without a protective mask, or~~  
b) ~~Close proximity to a~~ suspected meningitis patient without a OSHA regulated protective mask; or

c) ~~Blood or B~~body fluid entering the ~~healthcare providers~~ responder's body

by:

- 1) Needle stick,
- 2) Laceration by contaminated object,

- 3) Mucous membrane or eyes, or
- 4) Open wound or non-intact skin (e.g. rash from poison oak)

F. "Bystanders/Good Samaritans" is defined as someone who voluntarily helps someone else who is in distress.

### III. PURPOSE

To provide a procedure to be followed when individuals have received a potential significant exposure to blood, ~~or~~ body fluids, and/or a known reportable communicable disease.

### IV. POLICY

Pre-hospital emergency medical care personnel ~~individuals~~ shall have access to appropriate follow-up information after reporting a potential significant exposure. Employers of Prehospital Emergency Medical Care Personnel are advised to be familiar with and comply with OSHA CFR 1910.

~~reporting a potential significant exposure. Employers of Prehospital Emergency Medical Care Personnel are advised to be familiar with and comply with OSHA CFR 1910.~~

### V. PROCEDURE

A. ~~Prehospital emergency medical care personnel who suspect that they have had a significant exposure shall immediately notify the emergency department of the receiving health care facility for testing of the patient who exposed the EMS Worker(s) and the EMS Worker(s) being exposed. Prehospital emergency medical care personnel who suspect that they have had a significant exposure shall immediately notify their appropriate supervisor and the emergency department of the receiving health facility and shall complete and submit a "Significant Exposure Reporting Form" (See example of Form attached to this policy). A separate report form must be completed for each agency. This form should also be used for bystanders/good samaritans who have a possible significant exposure.~~

~~They shall also report to their appropriate supervisor and complete and submit a "Significant Exposure Reporting Form" (See Form attached to this policy) to the hospital. A separate report form must be completed for each person exposed. This form should also be used for bystanders/Good Samaritans who have a possible significant exposure.~~

B. The Significant Exposure Reporting Form shall be submitted to the health care facility receiving the source patient as soon as possible or to the Chief Medical Examiner/Coroner at the time of delivery of a deceased person. The completion of this form is the responsibility of the person/agency requesting notification. However completion of this form should not delay the collection of appropriate patient blood samples for testing.

- C. Timely delivery of this form to the Emergency Department receiving the source individual and the health facility treating the exposed individual may be accomplished in the following manner:
- 1) In person by the transporting ambulance personnel, or reporting party/agency,
  - 2) By faxing it to the receiving and treating facility (alert the receiving and treating facility ED prior to faxing) (J.C.Fremont Hospital ED Fax (209) 966-8233), or
- D. Once a Significant Exposure Reporting Form has been received by a health care facility (or the Chief Medical Examiner/Coroner in the event of a death), the health care facility will engage all appropriate internal policies and procedures dealing with significant exposures. The health care facility will follow-up with the reporting party/agency as soon as possible, ideally within 24 hours with the results of the tests and appropriate action(s) to be taken.
- E. Prehospital personnel should seek prophylactic medical treatment and/or advice per their agency/employer's policy. Reference can be made to J.C. Fremont's Policy #IC-3 "Management of Accident Exposure to Blood/Body Fluids". **Payment for any treatments/tests is the responsibility of the employing agency. Payment for medical expenses should be available through workers' compensation insurance.** Bystanders/Good Samaritans will be responsible for their own medical costs.
- F. Nothing in this policy shall be construed to authorize the disclosure of confidential medical information by the health facility or any of the prehospital emergency medical care personnel except as otherwise authorized by law.

**SIGNIFICANT EXPOSURE REPORTING FORM**

Submit to Emergency Department (with patient if possible) or Coroner if appropriate  
*ED: Please forward (fax) to Public Health Department Immediately (Fax (209) 966-4929)*  
*Coroner: Please forward (fax) to Public Health Department (Fax (209) 966-4929)*

Reporting Agency: \_\_\_\_\_ Unit #: \_\_\_\_\_

**Agency Contact Person (Designated Officer):** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_

Agency Address: \_\_\_\_\_

Form completed by: \_\_\_\_\_ Date submitted: \_\_\_\_\_

Date exposure took place: \_\_\_\_\_

**Individuals exposed:**  
**(separate for each)**

**Nature of Exposure: (airborne or droplet or body fluid  
contamination)**


Details of exposure:

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Source Patient name: \_\_\_\_\_ Transported \_\_\_\_\_

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**For Hospital Use Only**

No infectious disease documented as identified or suspected

Recommendations/Comments:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Follow-up with Public Health Department required: YES \_\_\_\_ NO \_\_\_\_

=====

**Initial follow-up with reporting agency**

Name of person notified: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Hospital Infection Control Practitioner (signature): \_\_\_\_\_ Date: \_\_\_\_\_

Deputy Coroner (signature): \_\_\_\_\_

MOUNTAIN-VALLEY EMS AGENCY  
POLICIES AND PROCEDURES

POLICY: 958.30

TITLE: CHEMPACK  
DEPLOYMENT -  
AMADOR COUNTY

APPROVED: SIGNATURE ON FILE IN EMS OFFICE  
Executive Director

EFFECTIVE DATE 5/2007DRAFT

SUPERSEDES:

REVISED:

SIGNATURE ON FILE IN EMS OFFICE  
Medical Director

REVIEW DATE: 5/2012DRAFT

PAGE: 1 of 4

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**CHEMPACK REQUEST & DEPLOYMENT FOR AMADOR COUNTY**

I. AUTHORITY

Sections 1797.152(c), 1797.153, and 1797.220 of Division 2.5 of the Health & Safety Code

II. DEFINITIONS

- A. "CHEMPACK" means a cache of nerve agent antidotes that is forward-placed in the community for availability to emergency health-care providers in the event of a release of nerve agents or organo~~ie~~-phosphates.
- B. "Deployment" means an outward movement of an asset from its initial location to an operational state.
- C. "Medical Health Operational Area Coordinator (MHOAC)" means an individual appointed by a county Department of Health Director/Local Health Officer who is responsible in the event of a disaster or major incident where mutual aid is requested, for obtaining and coordinating services and allocation of resources within the Operational Area (~~county~~).
- D. "Operational Area (OA)" means a county, including all political subdivisions (cities, districts, etc.).
- E. "RDMHS (Regional Disaster Medical Health Specialist)" means an individual selected by a local EMS agency, under contract with EMSA, as a staff function to coordinate preparedness activities, and to assist the RDMHC in coordinating services in the event of a disaster or in the event that medical mutual aid of some type is requested.
- F. "RDMHC" (Regional Disaster Medical Health Coordinator)" means a volunteer local health officer, EMS agency medical director or EMS agency administrator jointly appointed by the Directors of the California Department of Health Services (DHS) and the Emergency Medical Services Authority (EMSA) based upon the recommendation of the local health officer for a mutual aid region. The role of the RDMHC is to plan for and coordinate medical and health resources within one of California's six mutual aid regions during times of disaster or other major event requiring medical or health mutual aid.

III. PURPOSE

To establish a procedure for request and deployment of CHEMPACK assets maintained in Amador County.

IV. POLICY

- A. Qualifying Events to Deploy CHEMPACK
  - 1. Chempack material may be accessed, deployed or used only when it is determined that an accidental or intentional nerve agent or other organophosphate release has threatened the public health security of a community. A seal will be broken and

materiel used only when it is determined that other means to save human life will not be sufficient.

Authorization to deploy, break the seal on, or move a Chempack container from its specified location will be limited to any of the following events:

1. Release of a nerve agent or potent organophosphate with human effects or immediate threats too great to adequately manage with other pharmaceutical supplies available.
2. Large or unusual occurrence of patients presenting with signs and/or symptoms consistent with nerve agent or organophosphate exposure or intoxication.
3. A credible threat of an imminent event of a magnitude likely to require the assets of the Chempack.
4. An event with potential to create a nerve agent or organophosphate release with human exposure (e.g. a transportation accident with fire or loss of container integrity).
5. Any mutual aid request from another region or neighboring state in which Chempack assets are being deployed or staged.
6. Any event which, in the judgment of the County Health Officer, EMS Agency or Department Medical Director, or Medical & Health Operational Area Coordinator (MHOAC), justifies the deployment of Chempack supplies.
7. A physical threat to the Chempack at the fixed location (i.e. fire, theft, flood).

B. Intra-County Requests (Within Amador County Operational Area)

1. ~~Requests for assets from the CHEMPACK shall be made directly to the on-duty Base Hospital physician.~~
2. A “requestor” is considered to be one of the following at the scene of a suspected nerve agent or organophosphate release with known, suspected or potential contaminated, exposed or affected patients.
  - a) EMS pre-hospital personnel
  - b) Incident Commander (IC)
  - ~~(3)c) Medical Group Supervisor (MGS)~~
3. Requests for assets from the CHEMPACK shall be made directly to the on-duty Base Hospital physician

~~C. Inter-County Requests (Outside of Amador County Operational Area)~~

C. Inter-County Requests (Outside of Amador County Operational Area)

1. Request for CHEMPACK assets located outside of Amador County, or out-of-county requests for local CHEMPACK assets shall be made directly to the MHOAC.
2. A “requestor” is considered to be one of the following at the scene of a suspected nerve agent or organophosphate release with known, suspected or potential contaminated, exposed or affected patients.
  - a) EMS pre-hospital personnel
  - b) Incident Commander (IC)
  - ~~(3)c) Medical Group Supervisor (MGS)~~
  - d) Health Officer
3. Requests for assets from the CHEMPACK shall be made directly to the MOHAC through the 24 hour number (800-945-2273)

V. PROCEDURE

A. **Intra-County Requests (Within Amador County Operational Area)**

1. ~~A Requestor~~~~Hospital or EMS provider representatives~~ shall contact the on-duty Base Hospital physician at Sutter Amador Hospital via Med-Net or Recorded Line (223-0493) to request deployment of CHEMPACK assets and provide the following information:

- a) Name/Title of Requestor
- b) Contact number for Requestor
- c) Location of Event
- ~~a)d~~ Type of Exposure
- ~~b)e~~ Nature and Severity of Symptoms
- ~~e)f~~ Number of Potential Victims (Adult and Children)
- ~~d)g~~ Delivery Location

2. The on-duty Base Hospital physician makes determination to release CHEMPACK and notifies:
  - a) ~~Pharmacist~~ Hospital Pharmacist to release requested amount of medication. The Hospital Pharmacist will rendezvous with transport vehicle at the ER.
  - b) Sheriffs Dispatch of release and requests code 3-~~ambulance~~ transportation (Law, Fire, EMS, Helicopter) for deployment and transport to requested delivery location
  - ~~e~~ County Health Officer will be notified of incident (256-0598 (c) or 296-7374 (p)) AND:
    - (1) notify the on-call MVEMSA duty officer (800-945-2273)

~~3. The Amador County Health Officer (or designee) shall notify the on-call —MVEMSA duty officer~~

- 4.3. MVEMSA duty officer will make the following notifications:
  - a) MHOAC
  - b) RDMHC/S

B. **Inter-County Requests (Outside Amador County Operational Area)**

1. Request for CHEMPACK assets located outside of Amador County, or out-of-county requests for local CHEMPACK assets shall be made directly to the MHOAC through the 24-hour contact number (800-945-2273), pursuant to Policy 830.00 Medical/Health Mutual-Aid.
2. The agency requesting deployment of CHEMPACK assets will provide the following information:

- a) Name/Title of Requestor
- b) Contact number for Requestor
- c) Location of Event
- ~~a)d~~ Type of Exposure
- ~~b)e~~ Nature and Severity of Symptoms
- ~~e)f~~ Number of Potential Victims (Adult and Children)

d)g Delivery Location

3. The MOHOAC shall immediately contact the Amador County Health Officer (or designee) (256-0598 (c) or 296-7374 (p)) and request deployment of CHEMPACK assets, and provide the requestor's information listed above.
4. The requesting county will coordinate with Amador County Health Officer (or designee) for transport and delivery of CHEMPACK

**MOUNTAIN-VALLEY EMS AGENCY  
POLICIES AND PROCEDURES**

POLICY: **552.65**  
TITLE: **PARAMEDIC  
ADMINISTRATION OF  
H1N1 INFLUENZA  
VACCINE**

APPROVED: Signature On File In EMS Office  
Executive Director  
  
Signature On File In EMS Office  
Medical Director

EFFECTIVE DATE 11-1-09  
SUPERSEDES:  
REVISED:  
REVIEW DATE: 6-30-10  
PAGE: 1 of 2

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**PARAMEDIC ADMINISTRATION OF H1N1 INFLUENZA VACCINE  
TEMPORARY POLICY – EFFECTIVE NOVEMBER 1, 2009 – JUNE 30, 2010**

I. **AUTHORITY:**

Health and Safety Code, Division 2.5, Section 1797.172, 1797.220, 1797.214, California Code of Regulations, Title 22, Division 9, Chapter 4, Section 100145

II. **PURPOSE:**

To provide a mechanism for EMT-Ps to administer H1N1 Influenza Vaccine within the limitations of the timelines of this policy.

III. **POLICY:**

A. EMT-Ps may administer H1N1 Influenza Vaccine if they:

- 1 are associated with an Ambulance Provider Agency or ALS First Response Fire Department that has signed a Memorandum of Understanding to participate in the H1N1 Vaccination Program.
- 2 have successfully completed a training program approved by the Mountain-Valley EMS Agency Medical Director on H1N1 Influenza Vaccine Administration

B. Paramedics may administer the H1N1 Influenza Vaccine at an event scheduled by the Ambulance Provider Agency or ALS First Response Fire Department to which they are affiliated to:

- 1 Pre Hospital Employees of an Ambulance Provider Agency or ALS First Response Fire Department.
- 2 Fire Department First Response Personnel
- 3 Law Enforcement Personnel.

IV. PROCEDURE:

- A. A screening questionnaire, including consent for treatment, must be completed by each patient receiving a vaccination and reviewed prior to administration of the H1N1 Influenza Vaccine. Individual receiving H1N1 Influenza Vaccine must be given a Vaccine Information Statement.
- B. Paramedics must maintain aseptic technique when administering the H1N1 Influenza Vaccine.
- C. Equipment Required:
  - 1 H1N1 Influenza Vaccine
  - 2 Syringe
  - 3 22-25 Gauge needle that is 1" to 1 1/2" in length
  - 4 Alcohol prep swabs, allow to dry before administering vaccine
  - 5 Gloves
  - 6 Documentation Forms
- D. Wash hands and don gloves
- E. Check vial for proper drug, dose, and expiration date
- F. Shake syringe and vial before each withdrawal of vaccine
- G. Cleanse area of the deltoid muscle with alcohol prep
- H. Insert needle into vaccine and draw 0.5 mL into syringe
- I. Hold skin taut and insert needle at a 90 degree angle into the muscle with quick, darting motion
- J. Aspirate slightly on the syringe plunger to ensure proper needle placement
- K. Inject vaccine into tissue slowly in one continuous motion using steady pressure
- L. Monitor the patient, for 15 minutes, for any symptoms of an allergic reaction
- M. Document vaccination administration on the following forms:
  - 1 H1N1 Vaccination Administration Log
  - 2 H1N1 Influenza Vaccine Doses Administered Weekly Tally Sheet
  - 3 Individual Immunization Record Card, to be given to the individual receiving vaccination

APPROVED: SIGNATURE ON FILE IN EMS  
OFFICE

Executive Director

EFFECTIVE DATE 11/01/2010

SUPERSEDES:

REVISED:

SIGNATURE ON FILE IN EMS  
OFFICE

Medical Director

REVIEW DATE: 11/01/2015

PAGE: 1 of 2

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**EMD Provider Agency/Ambulance Provider Data Requirements**

**I. I. AUTHORITY:**

Health and Safety Code, Division 2.5, Section 1797.220

**II. H. PURPOSE:**

To establish the standard data specifications for Computer Aided Dispatch and patient care records maintained by ambulance providers and ambulance dispatch centers for submission to Mountain Valley EMS Agency

**III. DEFINITIONS:**

- A. "Agency" means Mountain Valley EMS Agency
- B. "CAD" means Computer Aided Dispatch
- C. "CEMSIS" means California Emergency Medical Services Information System as described in the California Emergency Medical Services Authority Policy #164 "CEMSIS Data System Standards with code values". CEMSIS Data Dictionary version 2.2.1 as posted on the California Emergency Medical Services Authority website
- D. "EMD Provider agency" means a dispatch center that provides
- E. Emergency Medical Dispatch, including pre-arrival instructions
- F. "ePCR" means Electronic Patient Care Report
- G. "XML" means Extensible Markup Language, a set of rules for encoding documents electronically

IV. POLICY:

A. EMD Provider agency shall submit CAD data to the Agency in an electronic format acceptable to the Agency on a daily basis, or as otherwise approved by the Agency. CAD data shall include records for all emergency and non-emergency ambulance requests received at the EMD Provider agency. Each computer dispatch record submitted to the Agency shall contain the following fields, as a minimum:

1. Call Date
2. Incident Number
3. Location
4. EMS Map Grid/Zone
- ~~5.4.~~ Call Type (e.g. scene, inter-facility transfer)
- ~~6.5.~~ Emergency Medical Dispatch (EMD) Determinate Code
- ~~7.6.~~ Ambulance Provider
- ~~8.7.~~ Vehicle ID Number
- ~~9.8.~~ Time Call Received
- ~~10.9.~~ Time Call Entered
- ~~11.10.~~ Time Call in Dispatcher Queue
- ~~12.11.~~ Time Dispatched
- ~~13.12.~~ Time En Route
- ~~14.13.~~ Time Arrived Scene
- ~~15.14.~~ Time Patient Contact, if applicable
- ~~16.15.~~ Time Departed Scene.
- ~~17.16.~~ Time Arrived Destination.
- ~~18.17.~~ Time canceled (if applicable)
- ~~19.18.~~ Code of Response
- ~~20.19.~~ Updated Code of Response, if applicable
- ~~21.20.~~ Code of Transport
- ~~22.21.~~ Updated Code of Transport, if applicable
- ~~23.22.~~ Call Disposition, final result of the call for this vehicle or transport  
—status

B. Ambulance Providers shall submit ePCR data to the Agency in an electronic format acceptable to the Agency on a daily basis, or as otherwise approved by the Agency. The ePCR shall include all fields listed in CEMISIS

~~C.~~ Ambulance Providers shall comply with patient care record documentation Requirements as specified in Agency Documentation Policy # 560.11

~~D.~~ Ambulance Providers shall use XML format as the approved data format by the Agency with respect to data structures, code sets (i.e. pick list values), and data export capabilities

~~E.~~ —Agency reserves the right to add additional mandatory data elements as needed

**MOUNTAIN-VALLEY EMS AGENCY  
POLICIES AND PROCEDURES**

POLICY: **853.00**  
TITLE: **ALTERED STANDARD  
OF CARE IN  
RESPONSE TO  
DISASTER**

APPROVED: Signature On File In EMS Office  
Executive Director  
  
Signature On File In EMS Office  
Medical Director

EFFECTIVE DATE  
SUPERSEDES:  
REVISED:  
REVIEW DATE:  
PAGE: 1 OF 13

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**ALTERED STANDARD OF CARE IN RESPONSE TO DISASTER**

I. **AUTHORITY**

California Health and Safety Code, Division 2.5, Section 1797, et seq. California Code of Regulations, Title 22, Division 9, Chapters 4 through 9

II. **DEFINITIONS**

- A. **“Altered Standard of Care”** means a level of medical care delivered to individuals under conditions of duress, such as after a disaster or when medical supplies are insufficient for demand for emergency care. ~~Examples would include an earthquake with major infrastructure damage, biological events with depletion of health care resources, or a severe shortage of medical supplies and personnel due to physical factors such as a vessel isolated at sea.~~
- B. **“Medical/Health Operational Area Coordinator (MHOAC)”** means the Public Health Officer and local EMS Agency Administrator or designee who is responsible, in the event of a disaster or major incident where mutual aid is requested, for obtaining and coordinating services and allocation of resources within the Operational Area (county) border.
- C. **“OA EOC”** means the Operational Area Emergency Operations Center ~~for of any of the member counties within the of Mountain-Valley EMS Agency Region.~~

III. **PURPOSE**

The purpose of the Altered Standard of Care policy is to provide a standard level of care to ~~every~~ individuals when a local emergency has been declared, and; mutual-aid resources are scarce or unavailable

a local emergency has been declared, and  
~~mutual-aid resources are scarce or unavailable~~

IV. **POLICY**

- A. The Altered Standard of Care policy shall be implemented when a local emergency has been declared, and mutual-aid resources are scarce or unavailable. only be rendered in the setting of disaster or isolation and requires activation as described in this policy.
- B. ~~The Altered Standard of Care shall not be used in settings when comprehensive emergency care is available.~~

- B. The Altered Standard of Care policy shall be ~~rendered implemented by the EMS Agency~~ upon authorization of the Public Health Officer, the EMS Agency Medical Director, or his or her designee, in cooperation with the OA EOC. ~~Communication of the decision to use the Altered Standard of Care will be sent through the Incident Command System chain of authority.~~
- ~~D. Medical units will render care as described in the following protocols. If warranted, standard emergency medical care protocols can be utilized at the discretion of the Medical Group Supervisor depending on local conditions and resources available. The Altered Standard of Care is designed to be a “floor” level of medical care, which may be superseded or augmented as conditions permit.~~
- C. Wherever possible, palliative care (i.e. pain control and reassurance) should be given to all patients who are in need of it. ~~In natural disasters such as earthquakes and severe climactic conditions, environmental injury (heat, cold) and trauma (wound and burn) care will be in the highest demand. This protocol provides recommendations for patient care that is less extensive in most areas, with the exception of wounds, than standard treatment protocols.~~ Communication with the Base Hospital for physician consultation is encouraged only for special circumstances, as communication channels are likely to be busy with other traffic.

## V. PROCEDURE

### A. ~~System Access~~ SYSTEM ACCESS

#### ~~1. Multi Agency Coordination~~

1. The EMS Agency shall work with the MHOAC-OA EOC to establish priorities for 911 medical-aid response based upon available system resources. ~~Consideration shall be given to establishing a Multi Agency Coordination (MAC) group for developing altered triage/response criteria. Consider inclusion of medical directors from Public Health, Hospitals, Medical Society, Ambulance Providers, etc. in MAC group.~~
2. The MHOAC-EMS Agency shall complete the Standard Dispatch Order (Appendix A) to ensure the stability of the EMS system, and inform all Public Safety Answering Points (PSAPs), ~~private~~ ambulance dispatch centers, Disaster Control Facilities, hospitals, and EMS providers field units of these orders.
3. Public Access Number  
~~In cooperation with the MHOAC, The EMS Agency shall ensure notification of all provider agencies in the event that~~ reate a Public Access telephone number (e.g. 2-1-1) ~~and or~~ web-based information for the public seeking minor medical care, social services, and other non-urgent needs has been established by the OA EOC.
4. Field Treatment Sites  
The EMS Agency shall consider establishing Field Treatment Sites for rapid triage, treatment, and referral, in cooperation with the OA EOC.
5. 911 Medical-Aid Requests  
The EMS Agency shall ~~issue revised~~ authorize altered triage and response protocols for all persons seeking medical aid through the 911 system. Triage Criteria and Resource Response shall be categorized as Immediate, Delayed, Minor, and Deceased. The EMS Agency shall consider:
  - a. Suspension of Pre-Arrival Instructions
  - b. Implementation of Altered Triage
6. Scheduled Transport Center  
In cooperation with the OA EOC, the The EMS Agency shall consider establishing a Scheduled Transport Center for all medical transport requests from all System Access Points

(i.e. hospitals, health facilities, Public Access Number, 911, and field). The Scheduled Transport Center shall consider:

- a. Augmenting medical transportation with alternative vehicles: buses, taxis, etc.
- b. Developing and implementing a medical transportation scheduling process
- c. Working with Disaster Control Facilities to direct destinations of transport resources, including possible Alternate Care Sites, clinics, etc.

**EXAMPLE OF ALTERED 911 TRIAGE**

<b>Access Point</b>	<b>Immediate</b>	<b>Delayed</b>	<b>Minor</b>	<b>Deceased</b>
Public Access #	Refer to 911	Refer to Scheduled Transport Center	TBD	TBD
911 / Ambulance Dispatch	ALS Response	Refer to Scheduled Transport Center	Refer to Public Access #	Refer to Public Access #
Scheduled Transport Center (Ambl. Dispatch)	ALS Response	Schedule Transport	Refer to Public Access #	Refer to Public Access #
Field EMS	Treat and Transport	Treat, Release or Refer	Refer to Public Access #	Witnessed = shock X3, unwitnessed = refer to Public Access #

~~B. Response Resource~~

- ~~1. Public Access Number~~
- ~~2. Consider establishing medical call center for field patient support/referral~~
- ~~3. Consider establishing internet-based medical support pages~~
- ~~4. Emergency Medical Dispatch~~
  - ~~a. Consider suspending Pre-Arrival Instructions.~~
  - ~~b. Consider implementing Altered EMD Triage Process (Appendix B).~~
- ~~5. Scheduled Transport Center~~
  - ~~a. Consider augmenting medical transportation with alternative vehicles: buses, taxis, etc.~~
  - ~~b. Develop and implement medical transportation scheduling process~~
  - ~~e. Work with Control Facility to direct destinations of transport resources, including possible Alternate Care Sites, clinics, etc.~~

**B. ALS-FIELD RESPONSE**

1. In cooperation with the OA EOC, the EMS Agency shall consider:
  - a. Establishing EMS staging area to consolidate personnel, equipment, supplies, and emergency response vehicles.
  - b. Convert all ALS ambulances to BLS transport units
  - c. Implement Quick Response Vehicles (QRVs)
  - d. Secure vehicles for QRVs (consider shared resources from other emergency response agencies, company cars, rental cars, private cars, etc.)
  - e. Equip QRVs with ALS equipment/supplies, communications, etc.
  - f. Develop additional Disaster Cache, as needed, to augment ALS supplies (e.g. Flu Cache of: powdered Gatorade, compazine suppositories, ibuprofen, pepcid, etc.)

2. EMS Agency shall work with the OA EOC to develop a Family/Patient brochure to be distributed by EMS personnel to include:
  - Explanation of current healthcare situation and altered standards currently being implemented.
  - Preventative measures to avoid exposure to health threat.
  - Available community resources (e.g. Public Access Number, website, etc.)

C. JUST-IN-TIME TRAINING

~~A. EMS Agency to work with Public Health and the Joint Information Center to develop Family/Patient brochure for EMS personnel to include:~~

- ~~1. Ad hoc family/patient brochure explaining current healthcare situation and explanation of altered standards protocol currently being implemented.~~
- ~~2. Preventative measures to avoid exposure to health threat.~~
- ~~3. Available community resources (e.g. Public Access Number, website, etc.)~~

~~EMS AGENCY TO DEVELOP JUST IN TIME TRAINING FOR DISPATCH AND FIELD PERSONNEL, TO INCLUDE: In cooperation with the OA EOC, the EMS Agency shall develop Just-in-Time Training for ambulance dispatch and field personnel to include:~~

- A. Altered Standard Orders (Appendix A)
- B. Altered 911/EMD Triage/Treatment Algorithm (Appendix B)
- ~~A.C.~~ Altered Treatment Orders (Appendix C)
- ~~B.D.~~ Family/Patient Brochure
- ~~C.E.~~ Consider just-in-time training for Grief Support

**Altered Standard Orders**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Effective Period:  UFN \_\_\_\_\_  UFN \_\_\_\_\_

**NOTICE**

The following actions shall be implemented immediately in order to ensure the stability of the Emergency Medical Services system. All ~~Public Safety Answering Points~~ EMS providers, ambulance dispatch centers, and EMS field units shall be informed of these orders. If it is not possible to electronically transmit a copy of this form, these orders may be relayed verbally to all affected agencies.

Authority: Division 2.5, Health and Safety Code, Sections 1797.170, 1797.220, 1798.101; California Code of Regulations, Title 22, Division 9, Chapters 4 through 9

**EMERGENCY ORDERS**

Operating as an agent of the Medical Health Operational Area Coordinator, I hereby authorize the following emergency dispatch orders.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date / Time: \_\_\_\_\_

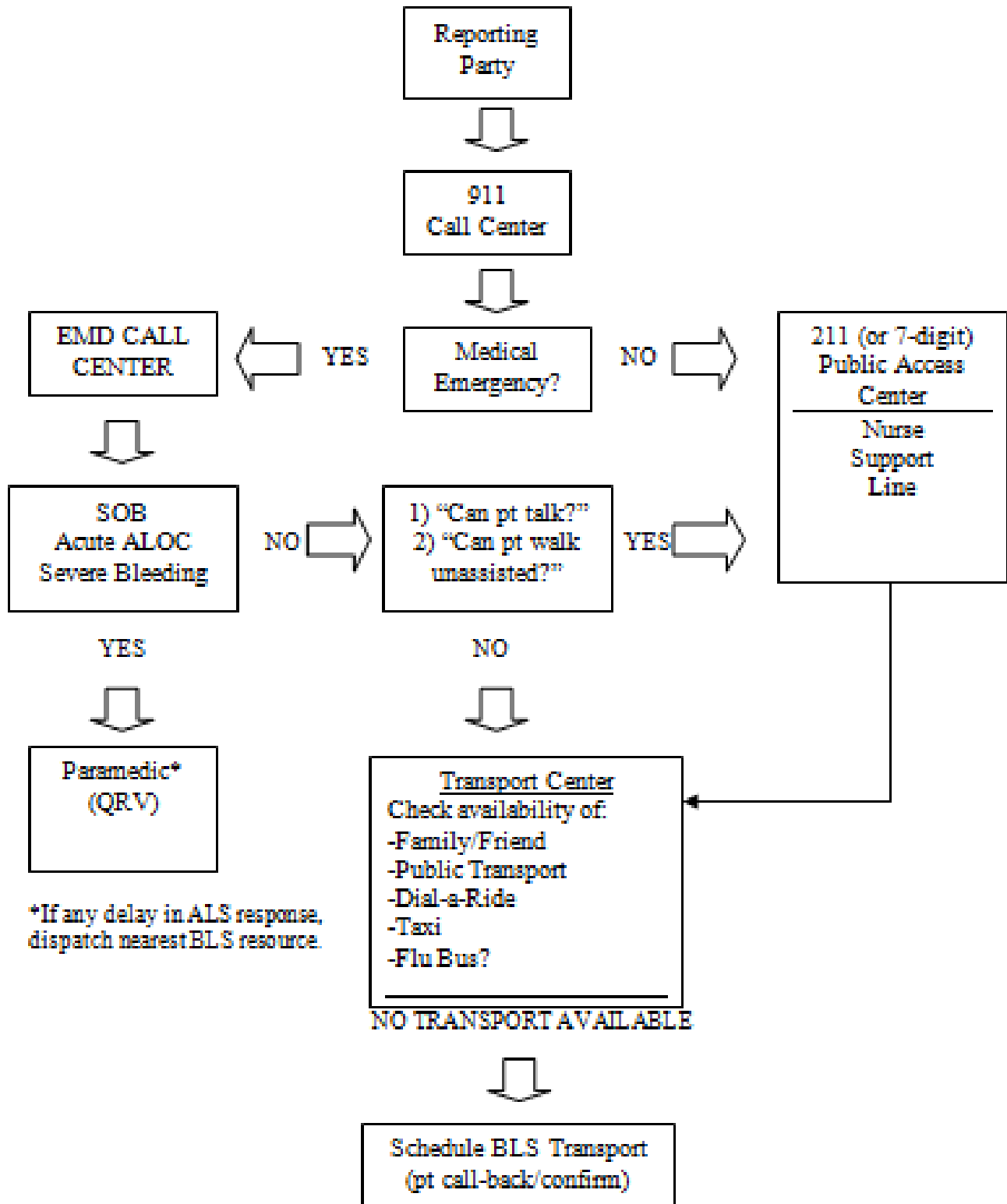
**ACTIONS**

	Order Number	Check to Execute	Description
DISPATCH	ASO-1		<b>Notify All Dispatch Center personnel of ASOs</b>
	ASO-2		<b>Notify All EMS Field Units and personnel of ASOs</b>
	ASO-3		<b>Place All Available Ambulances in Service</b> Place all available ambulances in service. Once attached to an event, a BLS unit shall not be canceled because of ALS availability.
	ASO-4		<b>Dispatch BLS to Alpha, Bravo, and Code 2 EMS Events</b> Once attached to an event, the BLS ambulance shall remain on the event even if the call is upgraded. If ALS is required, the first responder agency shall provide this service (if available) and follow up to the hospital if needed.
	ASO-5		<b>Automatic Ambulance Dispatches are Suspended Until Verified by First Responder</b> Ambulances shall only be sent to calls for services when a patient has been identified and is in need of EMERGENCY transportation by ambulance. <u>Patients not in immediate need will not be transported.</u>
	ASO-6		<b>Ambulance Dispatches to Alpha, Bravo, and Code 2 EMS Calls are Suspended</b>
	ASO-7		<b>Discontinue Use of Emergency Medical Dispatching (EMD) Procedures</b> Implement Altered Triage Algorithm
	ASO-8		<b>Discontinue Use of Pre-Arrival Instructions (PAI)</b>
	ASO-9		<b>Shelter-in-Place</b> Implement Shelter-in-Place protocols in response to external threat.
DCF	ASO-10		<b>Notify All DCF personnel and Hospitals of ASOs</b>
	ASO-11		<b>Suspend VHF HEAR System Communications</b> Notify all hospitals that use of HEAR (VHF 155.385, Tone 88.5) is suspended and allocated for EMS Command Net communications.
	ASO-12		<b>Directed all Ambulance Patient Destinations</b>
	ASO-13		<b>All Hospitals Ordered Open</b> Notify hospitals that diversion and trauma bypass statuses are suspended.

EMS PROVIDERS	ASO-14	<b>Ambulance High System Volume Actions</b> Implement or continue high system volume management plans.								
	ASO-15	<b>All Ambulances are Handled Code 3</b> To increase ambulance availability, all ambulance transports to the hospital to be handled Code 3, regardless of patient severity.								
	ASO-16	<b>Alert EMS Command Staff</b> Alert all EMS Command Staff (managers, supervisors) and advise to monitor EMS Command Net communications on frequency: _____.								
	ASO-17	<b>Activity Suspension</b> Announce to field units that the following activities have been suspended until further notice: <input type="checkbox"/> off-duty times (e.g. vacations, PTO, etc), <input type="checkbox"/> meal breaks, <input type="checkbox"/> inter-facility transports.								
	ASO-18	<b>Ambulances Shall Transport to the Closest Open Emergency Department</b>								
		<b>Replace PCRs with Triage Tags</b> Discontinue all Patient Care Reports (PCRs) and replace with Triage Tags. Only basic patient information and triage status is collected.								
	ASO-19	<b>Emergency Staging Areas</b> Resources shall be staged at the following Staging Areas: <table style="margin-left: 40px; border: none;"> <thead> <tr> <th style="text-align: center;"><u>RESOURCE</u></th> <th style="text-align: center;"><u>LOCATION</u></th> </tr> </thead> <tbody> <tr> <td>#1 _____</td> <td>_____</td> </tr> <tr> <td>#2 _____</td> <td>_____</td> </tr> <tr> <td>#3 _____</td> <td>_____</td> </tr> </tbody> </table>	<u>RESOURCE</u>	<u>LOCATION</u>	#1 _____	_____	#2 _____	_____	#3 _____	_____
	<u>RESOURCE</u>	<u>LOCATION</u>								
	#1 _____	_____								
	#2 _____	_____								
#3 _____	_____									
ASO-20										
ASO-21										
ASO-22										
ASO-23										
ASO-24										
<b>Additions/Notes</b>										
<b>Discontinue the Following Orders</b>										

Total Number of Actions to Execute \_\_\_\_\_ Total Number of Actions to Discontinue \_\_\_\_\_

Appendix B: Altered 911/EMD Triage



Appendix:C

### Altered Treatment Orders

Data: \_\_\_\_\_ Time: \_\_\_\_\_ Effective Period:  UFN \_\_\_\_\_  UFN \_\_\_\_\_

## NOTICE

The following orders shall be implemented immediately in order to ensure the stability of the Emergency Medical Services system. All ALS-EMS providers shall be informed of these orders. If it is not possible to electronically transmit a copy of this form, these orders may be relayed verbally to all affected agencies.

Authority: Division 2.5, Health and Safety Code, Sections 1797.170, 1797.220, 1798.101; California Code of Regulations, Title 22, Division 9, Chapters 4 through 9

## EMERGENCY ORDERS

Operating as an agent of the Medical Health Operational Area Coordinator, I hereby authorize the following altered treatment orders.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date / Time: \_\_\_\_\_

## ACTIONS

Check to Execute	ALS Guideline	Altered Treatment	Altered Disposition
<b>ADULTS</b>			
	Implement Changes to accommodate BLS Transport:		
	<ul style="list-style-type: none"> <li>- No cardiac monitoring / pacing</li> <li>- No continuous drug therapy (during transport)</li> <li>- No ALS airway</li> </ul>		
	554.01 - V-Fib PVT	No treatment	Refer to Public Access #
	554.02 - PEA	No treatment	Refer to Public Access #
	554.03 - Asystole	No treatment	Refer to Public Access #
<input checked="" type="checkbox"/>	554.04 - Bradycardia	<b>No change</b>	<b>Schedule BLS Transport</b>
<input checked="" type="checkbox"/>	554.05 - V-Tach with Pulses	<b>No change</b>	<b>Schedule BLS Transport</b>
<input checked="" type="checkbox"/>	554.06 - PSVT	<b>No change</b>	<b>Schedule BLS Transport</b>
<input checked="" type="checkbox"/>	554.07 - Wide Complex Tach	<b>No change</b>	<b>Schedule BLS Transport</b>
<input checked="" type="checkbox"/>	554.08 - Atrial Fib - Flutter	<b>No change</b>	<b>Schedule BLS Transport</b>
<input checked="" type="checkbox"/>	554.09 - Coronary Ischemic Chest Discomfort	<b>No change</b>	<b>Schedule BLS Transport</b>
<input checked="" type="checkbox"/>	554.10 - Acute CHF	<b>No change</b>	<b>Schedule BLS Transport</b>
<input checked="" type="checkbox"/>	554.21 - Airway Obstruction - Stridor	<b>No change</b>	<b>Schedule BLS Transport</b>
<input checked="" type="checkbox"/>	554.22 - COPD - Asthma - Bronchospasm	<b>No change</b>	<b>Schedule BLS Transport</b>
<input checked="" type="checkbox"/>	554.23 - Tension Pneumothorax	<b>No change</b>	<b>Schedule BLS Transport</b>

✓	554.31 - ALOC	No change	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.
	554.32 - Acute CVA	Aspirin	<b>Schedule BLS Transport</b>
✓	554.33 - Status Seizures	No change	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.
	554.41 - Non-Traumatic Shock	Oral rehydration solutions (Gatorade, sports juices, water, etc.)	<b>Schedule BLS Transport</b>
✓	554.42 - Blood Sugar Emergencies	No change	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.
✓	554.43 - Allergic Reaction	No change	<b>Schedule BLS Transport</b>
	554.44 - Pain Management	Consider over-the-counter pain control as necessary: Aspirin: 325mg orally or rectally, (contraindications: pregnancy, child, ALOC, allergy. OTC Tylenol/Motrin (follow instructions on label)	<b>Schedule BLS Transport</b>
	554.45 - Abdominal Pain	Treat for shock if indicated. Trial of p.o. fluids. Trial of over-the-counter antacid, if available (follow label instructions).	<b>Schedule BLS Transport</b>
✓	554.51 - Beta Blocker and Calcium Channel Blocker OD	No change	<b>Schedule BLS Transport</b>
	554.52 - Caustics - Corrosives	Irrigate	<b>Schedule BLS Transport</b>
✓	554.53 - Cyclic Antidepressants	No change	<b>Schedule BLS Transport</b>
✓	554.54 - Dystonic Reactions to Phenothiazines	No change	<b>Schedule BLS Transport</b>
✓	554.55 - Narcotics - Sedatives	No change	<b>Schedule BLS Transport</b>
✓	554.56 - Organophosphates	No change	<b>Schedule BLS Transport</b>
✓	554.57 - Petroleum Distillates	No change	<b>Schedule BLS Transport</b>
✓	554.58 - Amphetamine or Cocaine OD or Psychosis	No change	<b>Schedule BLS Transport</b>
✓	554.61 - Envenomation	No change	<b>Schedule BLS Transport</b>
✓	554.62 - Hypothermia	No change	<b>Schedule BLS Transport</b>
✓	554.63 - Frostbite	No change	<b>Schedule BLS Transport</b>
✓	554.64 - Heat Illness	No change	<b>Schedule BLS Transport</b>
	554.71 - Childbirth	Oxygen and IV fluid. Deliver baby.	<b>Schedule BLS Transport</b>
✓	554.81 - Burns	No change	<b>Schedule BLS Transport</b>
✓	554.82 - Traumatic Shock	No change	<b>Schedule BLS Transport</b>
	554.83 - Traumatic Cardiac Arrest	No Treatment	<b>Coroner</b>

	554.84 - Head Neck Face Trauma	If shock develops, and does not respond to initial IV infusion of 2 liters, provide palliative care only. Provide immobilization, ice pack, and pain control (morphine or over-the-county pain meds).  Clean wounds with soap and water. Remove foreign bodies and debris. Irrigate with normal saline or clean water as available. Apply dressings. Signs of infection require higher level care.	<b>Schedule BLS Transport</b>
	554.85 - Chest Trauma		<b>Schedule BLS Transport</b>
	554.86 - Abdominal Trauma		<b>Schedule BLS Transport</b>
	554.87 - Extremity Trauma		<b>Schedule BLS Transport</b>
<b>PEDIATRICS</b>			
	555.10 - Newborn Resuscitation	No Treatment	Refer to Public Access #
	555.11 - V-Fib - Pulseless V-Tach	No Treatment	Refer to Public Access #
	555.12 - PEA	No Treatment	Refer to Public Access #
	555.13 - Asystole	No Treatment	Refer to Public Access #
✓	555.14 - Bradycardia	<b>No change</b>	Schedule BLS Transport
✓	555.15 - Tachycardia	<b>No change</b>	Schedule BLS Transport
	555.21 - Airway Obstruction	BLS care	Schedule BLS Transport
	555.22 - Respiratory Arrest	Attempt to open airway Establish BLS Airway	Refer to Public Access # for deceased Schedule BLS Transport all others
✓	555.23 - Respiratory Distress	<b>No change</b>	Schedule BLS Transport
✓	555.31 - ALOC	<b>No change</b>	Schedule BLS Transport
✓	555.32 - Status Seizure	<b>No change</b>	Schedule BLS Transport
	555.41 - Non-traumatic Shock	Oral hydration	Schedule BLS Transport
✓	555.42 - Allergic Reaction	<b>No change</b>	Schedule BLS Transport
	555.43 - Pain Management	Tylenol (15mg/kg, max.650mg)	Schedule BLS Transport
	555.51 - Caustic - Corrosives	Irrigate	Schedule BLS Transport
✓	555.52 - Cyclic Antidepressants	<b>No change</b>	Schedule BLS Transport
✓	555.53 - Dystonic Reactions to Phenothiazines	<b>No change</b>	Schedule BLS Transport
	555.54 - Narcotics - Sedatives	Contact Poison Control	Schedule BLS Transport
	555.55 - Organophosphates	Contact Poison Control	Schedule BLS Transport



TITLE: Establishment of Service Areas for Trauma Centers

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

EFFECTIVE DATE: 01/01/2004  
SUPERSEDES: \_\_\_\_\_  
REVISED: \_\_\_\_\_  
REVIEW DATE: 01/01/2009  
PAGE 1 OF 2-1

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**ESTABLISHMENT OF SERVICE AREAS FOR TRAUMA CENTERS**

I. AUTHORITY

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

II. DEFINITIONS

- A. "Service area" means that geographic area defined by the local EMS agency in its trauma care system plan as the area served by a designated trauma center.
- B. "Trauma Center" or "designated trauma center" means a licensed hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV trauma center and/or Level I or II pediatric trauma center by the local EMS agency, in accordance with California Trauma Care System Regulations.

III. PURPOSE

To establish service areas for trauma centers serving the Mountain Valley EMS system.

IV. POLICY

- A. To provide optimal care for major trauma patients, care will be regionalized through the designation ~~of Level of Level~~ Level II trauma centers and preferential triage of major trauma patients to those centers. In addition ~~at~~, Level III and Level IV trauma centers will be designated, when identified, for care of patients who are distant from the Level II trauma centers, ~~or whose clinical condition does not require the higher level of care.~~
- B. Pediatric patients (less than<14 y.o.) meeting pediatric trauma triage criteria (~~Policy 553.25) who are within 45 minutes by ground or air to a pediatric trauma center (e.g., UC Davis, Children's Hospital of Oakland, or Children's Hospital of Central California)~~) will be transported directly to the pediatric trauma ~~center~~center (e.g., UC Davis, Children's Hospital of Oakland), in accordance with Policy #553.25. ~~Children in extremis or without a stable airway will be transported to the closest hospital.~~
- C. Patients meeting trauma triage criteria (~~Policy 553.25) who are within forty five (45)~~

~~minutes (by ground ambulance) of a Level II trauma center or who are closer to a Level II trauma center than to a Level III or Level IV center, shall be transported directly to the Level II trauma center, in accordance with Policy #553.25(F).~~

~~D. Patients meeting triage criteria (Policy 553.25) who are transported by air ambulance shall be transported to the appropriate Level II trauma center. In accordance with Policy #553.25(F).~~

~~E. Patients meeting triage criteria (Policy 553.25) who are greater than forty five (45) minutes (by ground ambulance) of a Level II trauma center, shall be transported to the closest accessible Level III or Level IV trauma center.~~

FD. While ~~the closest Level II trauma center (for ground ambulances) and~~ the rotational schedule ~~(for air ambulances)~~ is the preferred procedure for determining the appropriate receiving facility trauma center, efforts should be made to avoid overwhelming an single facility. ~~In the event of simultaneous multiple patients or other factors resulting in potential diversion, p~~atient flow shall be conducted in accordance with Policy #~~571.00~~553.25(F).

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**ASYSTOLE**

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

II. PURPOSE: To serve as a patient ~~the~~ treatment standard for EMT-Is and EMT-Ps ~~in treating patients within their scope of practice.~~

III. PROTOCOL:

Asystole represents the total absence of electrical activity in the ventricle. There is no rhythm, although an occasional P wave or agonal QRS may be seen. Heart rate is less than five beats per minute. Note: Asystole should be confirmed by at least two leads, since low-amplitude ventricular fibrillation can mimic asystole.

~~For the majority of adults, asystole represents death, not a treatable arrhythmia. Look for the few patients with treatable causes.~~

~~Consider Code 2 transport of all patients in cardiac arrest, unless special circumstances which might favor survival are suspected.~~

**STANDING ORDERS**

**ABCs**

**CPR**

~~Minimize interruptions in compression as much as possible. Do Not interrupt chest compressions to perform airway management or to administer medications.~~

**SECURE AIRWAY/  
INTUBATE**

Using the simplest effective method. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Consider intubation/perilaryngeal airway. Confirm placement. Consider intubation while en route. Confirm placement, if intubated, with end tidal CO<sub>2</sub> detector and esophageal detector device. Continuous waveform capnography should be used in all intubated patients with advanced airways.

**IV/IO ACCESS**

**TKO**

**~~CONSIDER TREATABLE  
CAUSES~~**

~~Hypoxia (oxygenate)~~

~~Hypothermia (rewarm) Refer to Hypothermia Protocol 554.62~~

~~Hyperkalemia (sodium bicarbonate, calcium chloride)~~

**EPINEPHRINE**

1 mg of 1:10,000 IV/IO push ~~(or 2 mg of 1:1,000 ET Flush with 5 ml NS).~~ Repeat every 3 minutes ~~(Do not delay epinephrine due to difficult IV/IO starts — give via ET).~~

**ATROPINE**

1 mg IV/IO push ~~(or 2 mg ET Flush with 5 ml NS).~~ Repeat every 3 minutes up to a total of 3 doses.

**SODIUM BICARBONATE**

1 mEq/kg IV/IO for suspected hyperkalemia (hemorenal dialysis or peritoneal dialysis patient) or cyclic antidepressant overdose or cocaine/amphetamine overdose in cardiac

~~arrest. Repeat every 5 minutes.~~

CALCIUM CHLORIDE

1000 mg (10ml) IV for suspected hyperkalemia. ~~Repeat once in 5 minutes.~~

**BASE PHYSICIANS ORDERS**

~~DECLARATION OF  
DEATH DETERMINATION OF  
DEATH~~

Refer to ~~Declaration of Death~~ Determination of Death Policy 570.20

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**AIRWAY OBSTRUCTION – STRIDOR**

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 EMT-Is and EMT-Ps in treating patients.~~ To serve as a patient treatment standard for EMT-Is and EMT-Ps 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.

III. PROTOCOL: Consider the cause of the airway partial or complete obstruction, support ABC's.

**STANDING ORDERS**

ABC's

OXYGEN

MONITOR

Oxygen delivery as appropriate  
Treat rhythm as appropriate.

IV/IO ACCESS

TKO

~~ABC's~~

**SEVERE OBSTRUCTION — (unable to cough or speak)**

**CONSIDER CAUSE and SEVERITY:**

**PARTIAL OBSTRUCTION:**

- Foreign body: ~~Abdominal thrusts, finger sweep, laryngoscopy and removal with Magill Forceps~~ Observe patient; supportive care
- Croup/Epiglottitis: Position of comfort. Consider ~~humidified or~~ nebulized oxygen-saline with the highest flow rate tolerated. Avoid visualization of throat/airway unless tracheal intubation required.
- Trauma: ~~Intubate and suction~~ Suction; supportive care.
- Anaphylaxis: Refer to Allergic Reaction Policy 554.43

**COMPLETE OBSTRUCTION:**

~~Foreign body:~~ **DIRECT AIRWAY VISUALIZATION:**

Abdominal thrusts (chest thrusts for pregnant patients), laryngoscopy and removal with Magill Forceps.  
With laryngoscope and oral intubation, if patient unable to maintain airway. Confirm placement with end-tidal CO<sub>2</sub> detector and esophageal detector device. ~~Continuous waveform capnography should be used in all intubated patients, if available.~~

~~NEEDLE CRICOTHYROTOMY:~~

~~Catheter-over-needle system with maximum gauge of 10, followed by 50 psi~~

<b>IV ACCESS:</b>	<u>transtracheal oxygen ventilation if unable to manage airway by other methods.</u>
	<u>TKO</u>
• <u>Croup/Epiglottitis:</u>	<u>Position of comfort. Consider nebulized saline with the highest flow rate tolerated. Avoid visualization of throat/airway unless endotracheal intubation required.</u>
• <u>Trauma:</u>	<u>Aggressive suctioning, supportive care, secure airway as appropriate.</u>
• <u>Anaphylaxis:</u>	<u>Refer to Allergic Reaction Policy 554.43</u>
<b><u>UNCONSCIOUS PATIENT:</u></b>	<u>CPR</u>
<b><u>SECURE AIRWAY</u></b>	<u>Using the simplest effective method. Refer to General Protocol Policy 554.00</u>
<b><u>NEEDLE CRICOTHYROTOMY:</u></b>	<u>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.</u>
	<b><u>CONTRAINDICATED IN KNOWN COMPLETE OBSTRUCTION</u></b>

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### TENSION PNEUMOTHORAX

- 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 EMT-Is and EMT-Ps in treating patients.
- III. PROTOCOL:

Physical signs may include: Systolic BP less than ~~89~~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

#### **STANDING ORDERS**

**ABC's  
OXYGEN**

Oxygen delivery as appropriate

**NEEDLE THORACOSTOMY**

10 or 12 gauge catheter-over-needle, minimum 2 inch length, inserted into ~~On~~ affected side in second intercostal space, in mid-clavicular line. Perform on other side if no response to ~~treatment~~ treatment and the tension pneumothorax physiology persists. Secure catheter to chest.

**Required Equipment**

~~10 or 12 gauge catheter over needle, with minimum 2 inch length.~~

**SECURE AIRWAY:**

~~As appropriate. Confirm tube placement, if intubated, with end-tidal CO<sub>2</sub> detector and esophageal detector device. Monitor intubated patients with continuous waveform capnography if available.~~

Refer to General Protocol 554.00

**MONITOR:**

Treat rhythm as appropriate

**IV ACCESS:**

Two 14-16 gauge IVs. If systolic BP is less than 90, give 250 ml boluses to systolic BP 90-100. Reassess the patient after each bolus.

**OBSERVE**

Continue to monitor for signs of recurrence of a tension pneumothorax and for obstruction or dislodgement of thoracostomy catheter.

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**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 EMT-Is and EMT-Ps in treating patients.~~ To serve as a patient treatment standard for EMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

Characterized by a Glasgow coma score less than 15, confusion or unconsciousness.

<b>STANDING ORDERS</b>	
<b>ABC's</b>	
<b>OXYGEN</b>	Oxygen delivery as appropriate
<b>MONITOR</b>	Treat rhythm as appropriate.
<b>IV/IO ACCESS</b>	TKO. If systolic BP less than 90, give 250 ml fluid boluses to systolic BP 90-100. Reassess the patient after each bolus.
<b><u>TEST FOR GLUCOSE</u></b>	<b><u>DRAW BLOOD SAMPLE: Test for glucose Finger Stick.</u></b>
<b>DEXTROSE</b>	25 gms IV/IO push – if blood glucose less than <del>75</del> <u>60</u> mg/dl. May repeat once. Recheck blood glucose <del>in</del> <u>5 minutes after each dose.</u> <u>Give oral glucose solutions to patients who are awake and have an intact gag reflex.</u>
<b>GLUCAGON</b>	<u>If no IV/IO access immediately available with a blood glucose less than 60 mg/dl, give 1 unit IM. May repeat once.</u> <del>1 unit IM if no IV access immediately available and blood glucose less than 75 mg/dl. May repeat once.</del> Recheck blood glucose in 5 minutes.
<b>NALOXONE</b>	2 mg <u>IN (SQ/IM/IV/ET)</u> only if respiratory rate <del>less than 10/minute</del> or systolic BP <u>less than &lt;90</u> AND narcotic overdose is suspected: <del>(e.g. pinpoint pupils, track marks, drug paraphernalia, history of narcotic use, etc.). May repeat twice in 3 minute intervals SQ/IM/IV/ET if respiratory rate less than 10/minute persists or reoccurs.</del>
	<b><u>Narcan must be administered before intubating a symptomatic narcotic overdose</u></b>
<b>BASE PHYSICIAN ORDERS</b>	
<b>RELEASE-AT-SCENE</b>	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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**ACUTE CEREBROVASCULAR ACCIDENT (CVA)**

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 EMT-Is and EMT-Ps in treating patients~~ as a patient treatment standard for EMTs and Paramedics within their scope of practice.

III. PROTOCOL:

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

**STANDING ORDERS**

**ABC's**

~~OXYGEN:~~ Oxygen delivery as appropriate

~~MONITOR:~~ Treat rhythm as appropriate.

~~IV/IO ACCESS~~ Normal Saline-TKO

~~DRAW BLOOD SAMPLE- TEST FOR GLUCOSE~~ Test for glucose-Finger Stick

~~DEXTROSE:~~ 25 gms IV push – if blood glucose less than ~~75~~ 60 mg/dl. May repeat once. Recheck blood glucose in 5 minutes after each dose.

~~GLUCAGON:~~ 1 unit IM—if no IV access immediately available ~~and~~ with blood glucose less than ~~75-60~~ mg/dl, give 1 unit IM. May repeat once. Recheck blood glucose in 5 minutes after each dose.

~~ASSESS & DOCUMENT:~~ Los Angeles Prehospital Stroke Screen (LAPSS):

- ~~A.~~ Age greater than 45
- ~~B.~~ No history of seizures or epilepsy
- ~~C.~~ Symptom duration less than 25 hours
- ~~D.~~ At baseline, patient not wheelchair-bound or bedridden
- ~~E.~~ Blood glucose between 75 and 400
- ~~F.~~ Unilateral weakness only on exam
  - 1. Facial smile or grimace
  - 2. Hand grip
  - 3. Arm strength (pronator drift)

Notify Base Hospital if all LAPSS criteria are met.

<u>CINCINNATI PREHOSPITAL STROKE SCALE</u>			
<u>Sign/Symptom</u>	<u>How Tested</u>	<u>Normal</u>	<u>Abnormal</u>
<u>Facial Droop</u>	<u>Have the patient show their teeth, or smile.</u>	<u>Both sides of the face move equally.</u>	<u>One side of the face does not move as well as the other.</u>
<u>Arm Drift</u>	<u>The patient closes their eyes and extends both arms straight out for 10 seconds</u>	<u>Both arms move about the same, or both do not move at all.</u>	<u>One arm either does not move, or one arm drifts downward compared to the other.</u>
<u>Speech</u>	<u>The patient repeats "The sky is blue in Cincinnati."</u>	<u>The patient says the correct words with no slurring of words</u>	<u>The patient slurs words, says the wrong words, or is unable to speak.</u>
<u>Time of Onset</u>	<u>Must be observed within 2.5 hours, observed by a reliable historian</u>		
<u>Transport</u>	<u>The patient is considered a possible CVA patient if any of the tested signs/symptoms are abnormal.</u>		

**Document Total Stroke Scale Score** (0-3 total points possible, 1 point for each category scored "Abnormal").

**Document the last time patient was seen normal and calculate duration of symptoms.**

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**STATUS 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 EMT-Is and EMT-Ps in treating patients.
- III. PROTOCOL:

An actively seizing patient who has been seizing for more than ~~ten~~10 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.

<b>STANDING ORDERS</b>	
<p><b>ABC's</b></p> <p><del>OXYGEN:</del></p> <p><del>MONITOR:</del></p> <p><b>IV ACCESS</b></p> <p><del>MIDAZOLAM</del></p> <p><b>POSITION:</b></p> <p><del>TRANSPORT:</del></p> <p><del>DRAW BLOOD SAMPLE: TEST FOR GLUCOSE</del></p>	<p><u>Oxygen delivery as appropriate</u></p> <p>Treat rhythm as appropriate.</p> <p>TKO</p> <p><u>2.0 mg initial dose IV push. Titrate in 1 mg. increments for seizure control (maximum dose: 6 mg). If unable to establish IV after one attempt, give 5 mg IM. May repeat once in 10 minutes if seizures continue.</u></p> <p>Place on left side.</p> <p><u>Transport Code 2 unless in shock or unmanageable airway.</u></p> <p><u>Test for glucose. Finger Stick</u></p>
<u>DEXTROSE</u>	<u>25 gms IV push – if blood glucose less than 60 mg/dl. May repeat once. Recheck blood glucose in 5 minutes after each dose.</u>
<u>GLUCAGON</u>	<u>if no IV access immediately available with blood glucose less than 60 mg/dl, give 1 unit IM. May repeat once. Recheck blood glucose in 5 minutes after each dose.</u>
<u>NALOXONE</u>	<u>2 mg IN (SQ/IM/IV if IN not available), only if respiratory rate less than 10/minute or systolic BP less than 90 AND narcotic overdose is suspected: pinpoint pupils, track marks, drug paraphernalia, history of narcotic use.</u>
<u><b>Narcan must be administered before intubating a symptomatic narcotic overdose</b></u>	
<del>DEXTROSE:</del>	<del>25 gms IV push – if blood glucose less than 75 mg/dl. May repeat once. Recheck blood glucose in 5 minutes.</del>
<u>MIDAZOLAM</u>	<u>If suspected Status Epilepticus, then give 2.0 mg initial dose IV/IO push. Titrate in 1 mg increments for seizure control (max. dose: 6 mg). If unable to establish IV/IO access, may give 5 mg IM. May repeat IM injection ONE TIME, if after 10 minutes seizure continues.</u>

<b>GLUCAGON:</b>	<del>1 unit IM— if no IV access immediately available and blood glucose less than 75 mg/dl. May repeat once. Recheck blood glucose in 5 minutes.</del>
<b>NALOXONE:</b>	<del>2 mg SQ/IM/IV/ET, only if respiratory rate less than 10/minute or systolic BP less than 90 AND narcotic overdose is suspected, (e.g. pinpoint pupils, track marks, drug paraphernalia, history of narcotic use, etc.). May repeat twice in 3 minute intervals SQ/IM/IV/ET, if respiratory rate less than 10/minute persists or reoccurs.</del>

**BASE PHYSICIAN ORDERS**

<b>RELEASE-AT-SCENE</b>	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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**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 EMT-Is and EMT-Ps in treating patients.
- 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.

**STANDING ORDERS**

**ABC's**

- OXYGEN:** Oxygen delivery as appropriate
- POSITION:** Place patient on left side.
- MONITOR:** Treat rhythm as appropriate.
- IV ACCESS:** Two 14-16 gauge. If systolic BP is less than 90, give 250 ml boluses to systolic BP 90-100. Reassess the patient after each bolus.
- CONSIDER CAUSE:**
  - Cardiogenic – IV fluid boluses
  - Hypovolemia – IV fluid boluses
  - Hypoxia – Oxygenate
  - Anaphylaxis – refer to Allergic Reaction Policy 554.43
  - Overdose – refer to Policies 554.51 – 554.58

**BASE PHYSICIAN ORDERS**

- DOPAMINE:** Drip at 10 mcg/kg/minute for systolic BP less than 90 unresponsive to fluids. Titrate to systolic BP 90-100.

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**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 the treatment standard for EMT-Is and EMT-Ps in treating patients.

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 less than ~~75~~ 60 mg/dl. Characterized by: ALOC, seizures, combativeness, disorientation, diaphoresis, shaking.

| ~~High Blood Sugar~~ 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.

**STANDING ORDERS**

**HYPOGLYCEMIA**

ABC's

~~OXYGEN~~: Oxygen delivery as appropriate

~~MONITOR~~: Treat rhythm as appropriate.

~~DRAW BLOOD SAMPLE: TEST FOR GLUCOSE~~: Test for glucose: Finger Stick

IV ACCESS TKO

~~DEXTROSE~~: 25 gms IV push – if blood glucose less than ~~75~~ 60 mg/dl. May repeat once. Recheck blood glucose ~~in~~ 5 minutes after each dose. Give oral glucose solutions to patients who are awake and have an intact gag reflex.

~~GLUCAGON~~: 1 unit IM – if no IV access immediately available and blood glucose less than 75 mg/dl. May repeat once. Recheck blood glucose in 5 minutes.

**HYPERGLYCEMIA**

ABC's

~~OXYGEN~~: Oxygen delivery as appropriate

~~MONITOR~~: Treat rhythm as appropriate.

~~DRAW BLOOD SAMPLE: TEST FOR GLUCOSE~~: Test for glucose: Finger Stick

IV ACCESS If systolic BP is less than 90, give 250 ml boluses to systolic BP 90-100. Reassess the patient after each bolus.

**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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**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 the treatment standard for EMT-Is and EMT-Ps in treating patients.
- 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 ~~deteriorate~~ escalate into anaphylaxis - reassess often and be prepared to treat for anaphylaxis.

**ABCs**

- REMOVE ALLERGEN:** If possible (e.g. bee stinger) and apply ice to site.
- OXYGEN:** Oxygen delivery as appropriate
- MONITOR:** Treat rhythm as appropriate.
- IV ACCESS** TKO
- DIPHENHYDRAMINE:** 50-25 mg IV push, ~~or~~ May administer 25 mg IM if IV 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 involvement of the upper or lower respiratory systems~~ ~~OR any~~ derangement of deterioration of vital signs.

**ABCs**

- 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-~~SQ~~, IM. May repeat every 15 minutes
- IV/IO ACCESS** Two 14-16 gauge IVs. If systolic BP is less than 90, give 250 ml boluses to systolic BP 90-100. Reassess the patient after each bolus.
- DIPHENHYDRAMINE:** 50 mg IV/IO push, ~~or~~ May administer 50 mg IM if IV access not promptly available.
- ALBUTEROL** If wheezing or stridor: 3.0ml of 0.5% solution in 15ml saline (or 6 unit dose vials) ~~via nebulizer~~ 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 holding chamber. Repeat as needed.

**BASE PHYSICIAN ORDERS**

- EPINEPHRINE** 0.1 mg (1.0 ml) of 1:10,000 slow IV push if systolic BP less than 90 and severe respiratory distress. May repeat every 1 – 2 minutes to systolic BP 90 – 100 or improved ventilation.

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**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 the treatment standard for EMT-Is and EMT-Ps in treating patients.
- III. PROTOCOL:

**STANDING ORDERS**

**See Policy 554.86 for Abdominal Trauma**

ABC's

**OXYGEN:**

Oxygen delivery as appropriate

**MONITOR:**

Treat rhythm as appropriate.

**IV ACCESS**

**Establish an IV ~~with NS~~, titrate to a systolic BP of 90 – 100 mmHg if the assessment indicates any of the following:**

- a. Hemodynamic instability
- b. Concurrent respiratory compromise
- c. Glasgow Coma Score of less than or equal to 13
- d. Significant hemorrhage

e. Pulsatile abdominal mass

f. Suspected Ectopic Pregnancy

g. May establish an IV for pain management

— OR —

Of the pulse rate is less than or equal to 120 BPM AND there are signs of hypoperfusion such as decreased sensorium, diaphoresis, capillary refill greater than two seconds, cool extremities, or cyanosis.

May establish an IV for pain management

**MORPHINE:**

2 mg IVP/IM. May repeat once. Medical abdominal pain patients may only receive 4 mg Morphine without Base Physician Order. Refer to Pain Management Protocol 554.44

**BASE PHYSICIAN ORDER**

**MORPHINE:**

Additional Morphine per Base Physician order.

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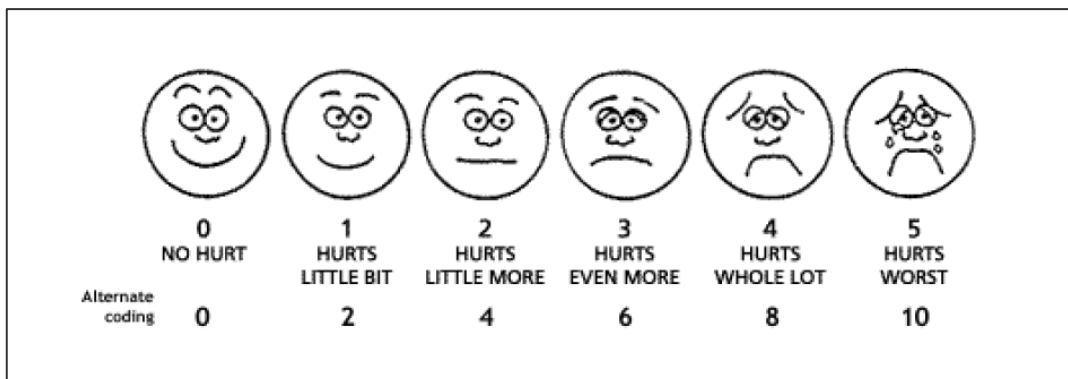
**PAIN MANAGEMENT**

- 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 EMT-Is and EMT-Ps in treating patients.
- III. PROTOCOL:

Every patient deserves to have their pain managed, but not necessarily treated with morphine. Consider reassurance, position of comfort, ice or heat, and gentle transport. Maintain eye contact and be truthful about painful procedures. Acknowledge the patient's fears and allow crying. Privacy and separation from parents may benefit adolescents. Maintain modesty for all. Do not attempt to completely relieve the patient's pain, but treat aggressively enough to make it bearable.

<b>STANDING ORDERS</b>	
<b>ABCs</b>	
<b>OXYGEN:</b>	<u>Oxygen delivery as appropriate</u>
<b>MONITOR:</b>	Treat rhythm as appropriate.
<b>IV ACCESS:</b>	TKO
<b>MORPHINE:</b>	Up to 5 mg slow IV push. <u>May repeat every 5-10 minutes then in</u> 2.5 mg increments slow IV (if systolic <del>BP greater</del> <u>BP greater</u> than 100) to relieve pain. <del>May repeat as needed.</del> May give 5 – 10 mg IM if no IV access <u>ONCE</u> .  Maximum dose of Morphine for patients without Base Physician Contact is 20 mg.  <del>For patients with ETOH intoxication, head injuries, chest, or abdomen trauma, Base Physician contact is required before Morphine may be administered</del>
<b>BASE PHYSICIAN ORDERS</b>	
<b>MORPHINE</b>	Additional Morphine per Base Physician order.

This is the official pain scale to be used in patient assessment and documented on the PCR. Using the pain scale below, pain must be documented for the initial assessment with vital signs, after medications, and after all procedures.



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**CAUSTICS – CORROSIVES – PETROLEUM EXPOSURE**

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 EMT-Is and EMT-Ps in treating patients.

III. PROTOCOL:

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.

**STANDING ORDERS**

**ABC's**

**REMOVE AGENT:**

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

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

**OXYGEN:**

**MONITOR:**

Treat rhythm as appropriate.

**IV ACCESS**

TKO

**PAIN MANAGEMENT**

Refer to Pain Management Protocol 554.44

**NOTE**

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

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### 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 EMT-Is and EMT-Ps in treating patients.
- III. PROTOCOL:

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

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

History of ingestion of phenothiazine with Symptoms might include restlessness (akathisia), muscle restlessness; muscle spasms of the neck; jaw and back; movement of eyeballs (oculogyric crisis); frightened; small pupils; facial grimace; protruding tongue, back arching (opisthotonus) (back arching).

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

Other medications that can cause dystonic reactions include: droperidol (Inapsine) and haloperidol (Haldol).

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

#### STANDING ORDERS

ABC's

**OXYGEN:** Oxygen administration as appropriate

**MONITOR:** Treat rhythm as appropriate.

**IV/IO ACCESS:** TKO

**DIPHENHYDRAMINE:** 50-25 mg IV push. May repeat 25 mg once (x1) if needed. ~~or~~ May administer 25 mg IM if IV access not promptly available. ~~IM if IV access not promptly available. May repeat if needed.~~

#### 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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**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 EMT-Is and EMT-Ps in treating patients.
- III. PROTOCOL:

**STANDING ORDERS**

**ABCs**

**OXYGEN:** Oxygen delivery as appropriate

**MONITOR:** Treat rhythm as appropriate.

**IV ACCESS** Normal Saline TKO

**IDENTIFY CAUSE**

**Bee/Wasp/Yellow Jacket/Fire Ant sting**

Remove stinger. Refer to Allergic Reaction Policy 554.43

**Spider bite - Scorpion sting - Centipede sting**

No specific treatment.

**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!**

**MORPHINE PAIN MANAGEMENT:**

Up to 5 mg slow IV push, then 2.5 mg increments slow IV (if systolic BP greater than 100), to relieve pain. May repeat as needed.

Maximum morphine dose without Base Physician contact is 20 mg.

Refer to Pain Management Protocol 554.44

**BASE PHYSICIAN ORDERS**

**MORPHINE:** Additional Morphine per Base Physician Order

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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 the treatment standard for EMT-Is and EMT-Ps in treating patients.
- 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**

ABC's

**Mild Hypothermia (Verbally responsive or GCS greater than or equal to 12)**

~~W~~ARMING MEASURES:

Remove wet clothing and cover patient with warm dry blankets.

~~O~~XYGEN:

~~Warmed humidified oxygen, if available. Oxygen delivery as appropriate~~

~~M~~ONITOR:

Treat rhythm as appropriate.

~~I~~V ACCESS

Warm IV fluid, rate as indicated.

**CONSIDER**

~~DRAW BLOOD SAMPLE: TEST FOR GLUCOSE~~

~~Test for glucose: Finger Stick~~

~~D~~EXTROSE:

25 gms IV push – if blood glucose less than 75-60 mg/dl. May repeat once. ~~Recheck blood glucose in 5 minutes~~ Recheck Blood Sugar 5 minutes after each dose. Give oral glucose solution to patients who are awake and have an intact gag reflex.

~~G~~LUCAGON:

1 unit IM – if no IV access immediately available and blood glucose less than 75-60 mg/dl. May repeat once. Recheck blood glucose in 5 minutes.

~~N~~ALOXONE:

2 mg IN (SQ/IM/IV if IN not available), ~~ET~~ only if respiratory rate less than 10/minute or systolic BP less than 90 AND narcotic overdose is suspected: pinpoint pupils, track marks, drug paraphernalia, and history of narcotic use; (e.g.: ~~pin-point pupils, track marks, drug paraphernalia, history of narcotic use, etc.~~)

Narcan must be administered before intubating a symptomatic narcotic overdose

~~May repeat once in 3 minutes SQ/IM/IV/ET if respiratory rate less than 10/minute persists or reoccurs.~~

**STANDING ORDERS CONTINUED NEXT PAGE**

**STANDING ORDERS CONTINUED**

**Severe Hypothermia (Non-verbal or GCS less than or equal to 12)**

**WARMING MEASURES:**

Remove wet clothing and cover patient with warm dry blankets.

**\*Sudden movement to patient may cause life-threatening arrhythmia**

**SECURE AIRWAY:**

~~As appropriate.~~ 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. Consider intubation/perilaryngeal airway. Confirm placement. Continuous Waveform Capnography should be used in all patients with advanced airways. Confirm tube placement, if intubated, with end-tidal CO<sub>2</sub> device and esophageal detector device. Monitor intubated patients with continuous waveform capnography if available.

**OXYGEN:**

~~Warmed humidified 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**

**~~DRAW BLOOD SAMPLE: TEST FOR GLUCOSE~~**

~~Test for glucose. Finger Stick~~

**DEXTROSE:**

25 gms IV/IO push – if blood glucose less than 75-60 mg/dl. May repeat once. Recheck ~~B~~lood ~~glucose~~ 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 access immediately available and blood ~~glucose~~ less glucose less than 75-60 mg/dl. May repeat once. Recheck blood glucose in 5 minutes.

**NALOXONE:**

2 ~~mg~~ mg IN (SQ/IM/IV if IN not available), ~~ET~~ only if respiratory rate less than 10/minute or systolic ~~BP~~ less BP less than 90 AND narcotic overdose is suspected; pinpoint pupils, track marks, drug paraphernalia, and history of narcotic use. (e.g. pinpoint pupils, track marks, drug paraphernalia, history of narcotic use, etc.). May repeat once in 3 minutes SQ/IM/IV/ET if respiratory ~~than less than 10/minute persists or reoccurs.~~

Narcan must be administered before intubating a symptomatic narcotic overdose.

**CARDIAC ARREST:**

~~Severe bradycardia with pulses requires no antiarrhythmic therapy.~~ 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 the treatment standard for EMT-Is and EMT-Ps in treating patients.
- III. PROTOCOL:

**STANDING ORDERS**

~~ABC's~~

~~OXYGEN~~

Oxygen delivery as appropriate

~~EVALUATE WARMING MEASURES:~~

~~Of Evaluate~~ all exposed at-risk body parts. Move patient to warm environment and wrap affected extremity with thick, unwarmed blankets or clothing. **Do not rub affected extremity. Avoid chemical heat packs, radiant heat, or forced-air heating.**

~~IV ACCESS~~

TKO

~~MORPHINE:PAIN MANAGEMENT~~

Refer to Pain Management Protocol 554.44 Up to 5 mg slow IV push, then 2.5 mg increments slow IV (if systolic BP greater than 100), to relieve pain. May repeat as needed.

~~Maximum dose of Morphine for patients without Base Physician contact is 20 mg.~~

**BASE PHYSICIAN ORDERS**

~~MORPHINE:~~

Additional morphine per Base Physician order.

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**BURNS**

- 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 EMT-Is and EMT-Ps in treating patients.
- III. PROTOCOL:

**STANDING ORDERS**

<b>MOVE PATIENT</b>	To a safe environment
<b>ABCs</b>	
<b><u>COOLING</u> PROCESS</b>	<del>For decontamination instructions and transport with patient.</del>  Tar Burns: Cool with water and transport. Do not attempt to remove tar.  Thermal Burns: Cool with water for up to 5 minutes to stop the burning process.
<b>OXYGEN</b>	<u>Oxygen delivery as appropriate</u>
<b>SECURE AIRWAY/ INTUBATE</b>	<u>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.</u>  <u>Refer to General Protocol 554.00</u>  <del>If facial or oral swelling and respiratory depression are present, especially if the patient has a history of smoke exposure in a confined space. Ventilate with bag-valve or approved ventilator with 100% oxygen. Confirm placement, if intubated with end tidal CO<sub>2</sub> detector &amp; esophageal detector device. Continuous waveform capnography should be used in all intubated patients, if available.</del>
<b>IV/IO ACCESS</b>	<b>Superficial Burns:</b> <del>Consider Normal Saline</del> <u>TKOTKO</u>  <b>Partial and full-thickness burns:</b> 0.5 ml x patient weight in kg x % of burn = IV fluid per hour. If systolic BP less than 90, give 250 ml boluses until systolic BP 90-100. Reassess patient after each bolus.  <b>Major Burns:</b> Two 14-16 gauge in patients with major burns (greater than 9%) <del>with Normal Saline at</del> TKO. If systolic BP less than 90, give 250 ml boluses to systolic BP 90-100. Reassess the patient after each bolus.  IV site in order of preference: 1. unburned upper extremity, or external jugular 2. unburned lower extremity 3. burned upper extremity 4. burned lower extremity
<b>MONITOR</b>	Treat rhythm as appropriate.
<b>DRESS BURNS</b>	Cover with dry dressing and keep patient warm.
<b>MORPHINE</b>	<del>Up to 5 mg slow IVP, then 2.5 mg increments IVP (if systolic BP &gt; 100) to relieve pain. May repeat to maximum dose of 20 mg without Base Physician order. Refer to Pain Management Protocol 554.44</del>

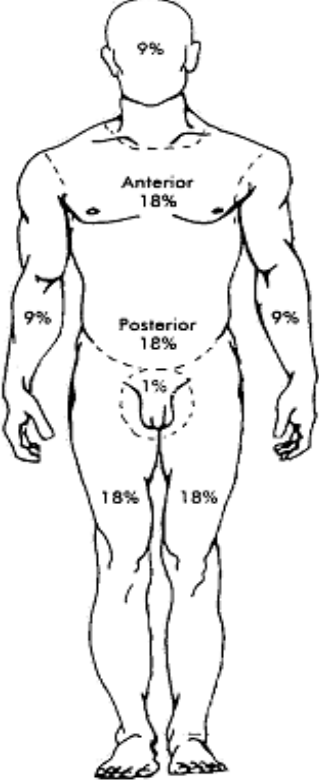
**TRANSPORT**

To nearest facility if patient is unstable (airway difficulty, hypotension) or according to Trauma Triage and Patient Destination Policy 553.25 if stable.

**BASE PHYSICIAN ORDERS**

~~MORPHINE~~

~~Additional Morphine per Base Physician Order~~



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

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

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**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 EMT-Is and EMT-Ps in treating patients~~ To serve as a patient treatment standard for EMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

**STANDING ORDERS**

**ABCs**

**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. Consider ~~intubating while en route~~ intubation/perilaryngeal airway. Confirm placement, ~~if intubated, with end-tidal CO<sub>2</sub> detector and esophageal detector device~~. **Continuous waveform capnography should be used in all ~~intubated~~ patients with advanced airways, if available.**

**OXYGEN** Oxygen delivery as appropriate

**SPINE IMMOBILIZATION** If indicated, refer to ~~ALS Introduction Policy~~ General Protocols 554.00

**CONTROL OBVIOUS BLEEDING** Consider tourniquet for uncontrolled extremity hemorrhage

**POSITION** Do not use Trendelenberg (feet elevated) position. If patient is pregnant place patient on left side, or if in spinal immobilization, tilt spine board 30° to left.

**IV/IO ACCESS** Two 14-16 gauge, wide-open until systolic BP 90-100 or 2L infused, then TKO. If systolic BP remains less than 90, give 250 ml boluses until systolic BP 90-100. Reassess the patient after each bolus.

**DRESS & SPLINT** As needed

**CONSIDER**

**NEEDLE THORACOSTOMY/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. Refer to Tension Pneumothorax Protocol 554.23~~

**BASE PHYSICIAN ORDERS**

**MORPHINE** ~~Per Base Physician Orders only~~

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**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 the treatment standard for EMT-Is and EMT-Ps in treating patients.
- III. PROTOCOL:

**STANDING ORDERS**

<b>ABC's</b>	
<b>SECURE AIRWAY/<del>INTUBATE</del></b>	Use simplest effective method while maintaining c-spine. <del>Avoid nasotracheal intubation in patients with midface injuries that distort nasopharyngeal anatomy. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. Confirm tube placement, if intubated, with end-tidal CO<sub>2</sub> detector and esophageal detector device. Continuous waveform capnography should be used in all intubated patients, if available. Consider intubation/perilaryngeal airway. Refer to General Protocol 554.00</del>
	<b>NOTE: Medicate brain injury patients with Lidocaine 1.5 mg/kg IV prior to intubating, when time allows.</b>
<b>SPINE IMMOBILIZATION:</b>	If indicated refer to <del>ALS Introduction Policy</del> <u>General Protocols 554.00</u>
<b>OXYGEN:</b>	<del>Hyperventilate only if neurologic status is deteriorating. Oxygen delivery as appropriate.</del>
<b>POSITION:</b>	Elevate the heads of brain injured patients, if patient exhibits no signs of shock. If patient is pregnant, place patient on left side, or if in spinal immobilization, tilt spine board 30 <u>degrees</u> to left.
<b>IV ACCESS</b>	TKO
<b>MORPHINE:</b>	<del>Up to 5 mg slow IV push, then 2.5 mg increments slow IV (if systolic BP greater than 100), to relieve pain. May give up to 20 mg morphine without Base Physician order. Refer to Pain Management Protocol 554.44.</del>
<b>DRESS &amp; SPLINT:</b>	As needed.
<b>CONSIDERATIONS:</b>	<ul style="list-style-type: none"> <li>● <b>Avulsed Tooth</b> - Place tooth in milk, normal saline, saline soaked gauze or a commercial "tooth saver."</li> <li>● <b>Eye Injuries</b> - 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.</li> <li>● <b>Impaled Object</b> - immobilize and leave in place. Remove object if it interferes with CPR, extrication, or ventilation.</li> </ul>

**BASE PHYSICIAN ORDERS**

**MORPHINE** Additional Morphine per Base Physician Order



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**CHEST TRAUMA**

- 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 EMT-Ps in treating patients~~ To serve as a patient treatment standard for EMTs and Paramedics within their scope of practice.
- III. PROTOCOL:

**STANDING ORDERS**

**ABCs**

**SECURE AIRWAY**

Use simplest effective method while maintaining c-spine. A BLS airway with objective evidence of good ventilation and oxygenation is adequate and acceptable. ~~Consider intubation while enroute. Confirm tube placement, if intubated, with end-tidal CO<sub>2</sub> detector and esophageal detector device. Continuous waveform capnography should be used in all intubated patients, if available.~~ Refer to General Protocol 554.00

**SPINE IMMOBILIZATION**

If indicated Refer to ~~ALS Introduction Policy~~ General Protocol 554.00

**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**

~~Normal Saline~~ TKO

**DRESS WOUNDS**

**CONSIDERATIONS**

**Impaled Object** - Immobilize and leave in place. Remove object if it interferes with CPR, ventilation or extrication.  
**Flail Chest** - Stabilize ~~chest~~ flail segment. Observe for tension pneumothorax. Consider assisted ventilation.  
**Open Chest Wound** - Cover wound. Dress wound loosely (do not seal). Continuously re-evaluate patient for the development of a tension pneumothorax.  
**Tension Pneumothorax** - Perform needle thoracostomy or remove any occlusive dressing covering an open chest wound. Refer to the Tension Pneumothorax Policy 554.23.  
**Cardiac Tamponade** - If systolic BP less than 90, administer 250 cc fluid boluses until systolic BP 90-100. Reassess the patient after each bolus. Refer to the Traumatic Shock Policy 554.82  
**Cardiac Contusion** - Monitor for dysrhythmias. Refer to Cardiac Protocols.

**BASE PHYSICIAN ORDERS**

**MORPHINE PAIN MANAGEMENT**

~~Up to 5 mg slow IV push, then 2.5 mg increments slow IV (if systolic BP greater than 100), to relieve pain. May repeat as needed.~~ Refer to Pain Management Protocol 544.44

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### 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 EMTs and Paramedics within their scope of practice.  
~~To serve as the treatment standard for EMT-Is and EMT-Ps in treating patients.~~

III. PROTOCOL:

#### STANDING ORDERS

##### ABCs

**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. ~~Consider intubation while enroute. Confirm tube placement, if intubated, with end-tidal CO<sub>2</sub> detector and esophageal detector device. Continuous waveform capnography should be used in all intubated patients, if available.~~ Refer to General Protocol 554.00

##### SPINE IMMOBILIZATION

If indicated, Refer to ~~ALS Introduction Policy~~ General Protocol 554.00

##### 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. If systolic BP less than 90, give 250 ml fluid boluses until systolic BP 90-100. Reassess the patient after each bolus.

##### DRESS WOUNDS

##### CONSIDERATIONS

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

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

**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

#### BASE PHYSICIAN ORDERS

##### MORPHINE PAIN MANAGEMENT

Up to 5 mg slow IV push, then 2.5 mg increments slow IV (if systolic BP greater than 100), to relieve pain. Refer to Pain Management Protocol 544.44

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**EXTREMITY TRAUMA**

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

II. PURPOSE: To To serve as a patient treatment standard for EMTs and Paramedics within their scope of practice.  
~~serve as the treatment standard for EMT-Is and EMT- Ps in treating patients.~~

III. PROTOCOL:

**STANDING ORDERS**

**ABCS**

**SECURE AIRWAY**

~~As appropriate. Confirm tube placement, if intubated, with end-tidal CO<sub>2</sub> detector and esophageal detector device. Monitor intubated patients with continuous waveform capnography if available.~~ 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 General Protocol 554.00

**SPINE IMMOBILIZATION**

If indicated Refer to ~~ALS Introduction~~ General Protocol Policy 554.00

**OXYGEN**

Oxygen delivery as appropriate

**HEMORRHAGE CONTROL**

- Control bleeding with direct pressure
- Consider tourniquet if bleeding uncontrolled or systolic BP less than 90 mmHg
- Elevate and splint injured extremity in position of comfort

**DRESS & SPLINT**

- ~~Open or closed femur fractures may be splinted with Hare, Sager, or Cardboard splints after gentle realignment with manual traction. (Morphine should be administered to facilitate muscle relaxation.)~~ Cover open wounds with sterile dressing
- Remove rings or other possible constricting items.
- ~~Minimum traction should be utilized for Hare and Sager to minimize reversal nerve injury.~~
- ~~Splint dislocations in position found.~~
- ~~Check neuro-vascular 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 extremity.~~

**IV/IO ACCESS**

~~Rate as indicated~~ TKO. If systolic BP is less than 90, give 250 boluses to SPB 90-100. Reassess patient after each bolus

**MORPHINE PAIN MANAGEMENT**

~~Up to 5 mg slow IV push, then 2.5 mg increments slow IV (if systolic BP greater than 100), to relieve pain. May give up to 20 mg MS without Base Physician order. May give 5-10 mg IM.~~

~~Maximum dose of Morphine for patients without Base Physician contact is 20 mg~~ Refer to Pain Management Protocol 554.44

**CONSIDERATIONS**

Fracture/Dislocation – Open or closed femur fractures may be splinted with traction or cardboard splints after gentle realignment with manual traction (Morphine 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.

**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 ~~in~~on ice, if possible.

**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 have been identified.~~

~~MORPHINE PAIN MANAGEMENT~~

~~Additional morphine per Base Physician order. Refer to Pain Management Protocol 554.44~~

APPROVED: DRAFT  
Executive Director  
  
DRAFT  
Medical Director

EFFECTIVE DATE DRAFT  
SUPERSEDES:  
REVISED: DRAFT  
REVIEW DATE:  
PAGE: Page 1 of 8

## STANISLAUS COUNTY EMS/HOSPITAL SYSTEM SATURATION

### I AUTHORITY

California Health and Safety Code, Division 2.5, Section 1797, et seq. California Code of Regulations, Title 22, Division 9, Chapters 4 through 9

### II DEFINITIONS

- A. **“Altered Standard of Care Protocols”**: means temporary protocols issued by the EMS Agency Medical Director that direct field personnel to implement a revised set of treatment procedures due to scarce equipment, supplies, or personnel in order to save the largest number of lives in contrast to the traditional focus on saving individuals.
- B. **“Disaster Control Facility (DCF)”** is the facility designated by the EMS Agency to monitor capacity and capability and to assume primary responsibility for directing patient destinations by ambulance during a Multiple Casualty Incident or EMS/Hospital System Saturation.
- C. **“Healthcare Surge Event”** means a proclamation by the local health officer or designee, using professional judgment determines, subsequent to a significant event or circumstances, that the healthcare delivery system has been impacted, resulting in an excess in demand over capacity and/or capability in hospitals, community care clinics, public health departments, other primary and secondary care providers, resources, and/or emergency medical services.
- D. **“Joint Information Center (JIC)”** is the location established by local government to coordinate the release of information to the press, media, and general public.
- E. **“Surge”** means a sudden and excessive rise in number of patients presenting to local emergency rooms.

### III PURPOSE

- A. To prevent the escalation of EMS/hospital system saturation and mitigate its impact on the EMS community by developing a system for appropriate distribution of available resources during a system overload or disaster.

- B. To provide EMS/hospital system managers and local government representatives with timely and accurate information that allows them to mitigate current or pending healthcare resource or capacity deficiencies.
- C. To augment standard EMS System MCI Policies and Procedures.

#### IV POLICY

##### A. PLANNING AND PREVENTION

1. Hospital and EMS provider agencies shall ensure that emergency operations plans, phone numbers, and staff call back trees are current, including local and state government agency contacts. Key contacts include the Stanislaus County Health Department, Mountain Valley EMS Agency, Stanislaus County Office of Emergency Services, the Disaster Control Facility, and California Department of Public Health, Licensing and Certification.
2. Hospitals and EMS provider agencies shall implement recurring training in disaster and emergency operations, to include ICS, SEMS, NIMS, Haz-Mat/Decontamination, and relevant emergency operations plans.
3. Hospital and EMS provider agencies shall develop and maintain equipment and supply caches necessary to sustain operations during a system saturation event. Hospital and EMS provider agencies shall coordinate planning for public education and information messages with county OES and Public Health.
4. Hospitals shall work with their corporate organization to develop pre-incident inter-facility staffing reciprocity agreements and post-incident expedited credentialing capacity among their corporate facilities.
5. Hospitals shall develop, maintain, and periodically exercise internal Surge policies, that integrate with the policies and procedures contained herein.
6. Hospitals shall update facility status in EMS system each morning at 8 a.m., noting the Level of internal surge, and update the status as often as the internal surge level changes or as requested by the DCF.

#### V PROCEDURE

##### A. Saturation Avoidance:

1. A hospital will implement its internal Saturation-Avoidance activities and Surge Protocols when its internal surge protocol triggers have been met.

2. When the DCF becomes aware of a hospital with multiple critical patients impacting the ED, the DCF will:
  - a. Implement MVEMSA Policy 820.00, activating the MCI Plan Assess all Hospital EDs capabilities and direct ambulance traffic to prevent significant impact on any one facility.

ab The DCF will discontinue the direction of ambulance traffic once the critical threat has been resolved.

B. System Saturation:

1. Criteria:

Criteria for System Saturation include:

- a. All hospital within the county have met internal hospital surge triggers of Level 1 (Appendix A), or
- b. Two or more hospitals within the county have met internal hospital surge triggers of Level 2 (Appendix A).

2. Impacted Hospital(s):

- a. Initiate or continue with internal hospital surge policies.

ab. Update facility status in EMSsystem to Advisory (including Level of internal surge and surge triggers) and provide additional updates as needed, or as requested by Control Facility.

3. Non-impacted Hospitals

- a. Participate in Saturation Conference Call as requested.

ab Update Facility Status in EMSsystem as needed or as requested by the DCF.

4. DCF

- a. Monitor hospital statuses in EMSsystem.
- b. Immediately notify the EMS Agency Duty Officer when System Saturation criteria are met. If EMS Agency Duty Officer determines that the system does **NOT** meet the criteria, the DCF will notify impacted facilities.
- c. Consider augmenting DCF staff and project staffing needs for future operational periods.

5. Mountain-Valley EMS Agency

a. Respond to the DCF request within 5 minutes.

a.b. Review the Hospital Status information with the DCF to determine if criteria are met to schedule a System Saturation Conference call.

c. If criteria are met, schedule and conduct initial System Saturation Conference call within 15 minutes ( see “C” below).

d. Consider site visits of hospitals to verify Saturation avoidance activities, as necessary.

e. Attempt to forecast impact and duration of event.

C. System Saturation Conference Calls

When System Saturation criteria have been met, the EMS Agency Duty Officer shall schedule and conduct a System Saturation Conference Call within the hour.

1. The EMS Agency Duty Officer shall notify the DCF and provide the Conference Call date/time and call-in number and PIN.
2. The EMS Agency Duty Officer or DCF will notify all hospitals and ambulance providers of conference call by sending a message via the EMS system (or telephone) with date/time, call in phone number and PIN.
3. The EMS Agency Duty Officer shall conduct the conference call, including:
  - a. Updates from each facility to provide current status and Saturation-prevention activities.
  - b. Consideration for implementation of Patient Rotation through the DCF.
  - c. Date/time of next Conference Call to assess current status of System Saturation, to continue/discontinue Patient Rotation.

D. Patient Rotation

1. The DCF shall implement Patient Rotation among hospital EDs, as authorized by the EMS Agency Duty Officer.
2. Patient Rotation shall be reevaluated after a predetermined time established by the initial conference call, unless otherwise authorized by the EMS Agency Duty Officer.

E. Re-Evaluation of the System

1. For any of the following criteria, the EMS Agency Duty Officer shall contact the Public Health Officer (or designee) to consider initiating the County Surge Plan:
  - a Patient Rotation continues for more than eight (8) hours
  - ab** More than two hospitals have met Level 2 hospital surge triggers (appendix A)
  - c Any hospital has met Level 3 hospital surge triggers (appendix A)

F. Surge Matrix

The matrix below indicates the “trigger” points to initiate appropriate notifications (see item H. Medical-Health Notification Process below)

# OF HOSPITALS	HOSPITAL ACTIVATION LEVELS			
	0	1	2	3
1				*DCF/**TAG
2			*DCF	**TAG/**STanMAC
3			**TAG	**TAG/**STanMAC
4			**TAG	***STanMAC
5		*DCF	**TAG	***STanMAC

\* DCF- Disaster Control Facility

\*\* TAG – Threat Assessment Group

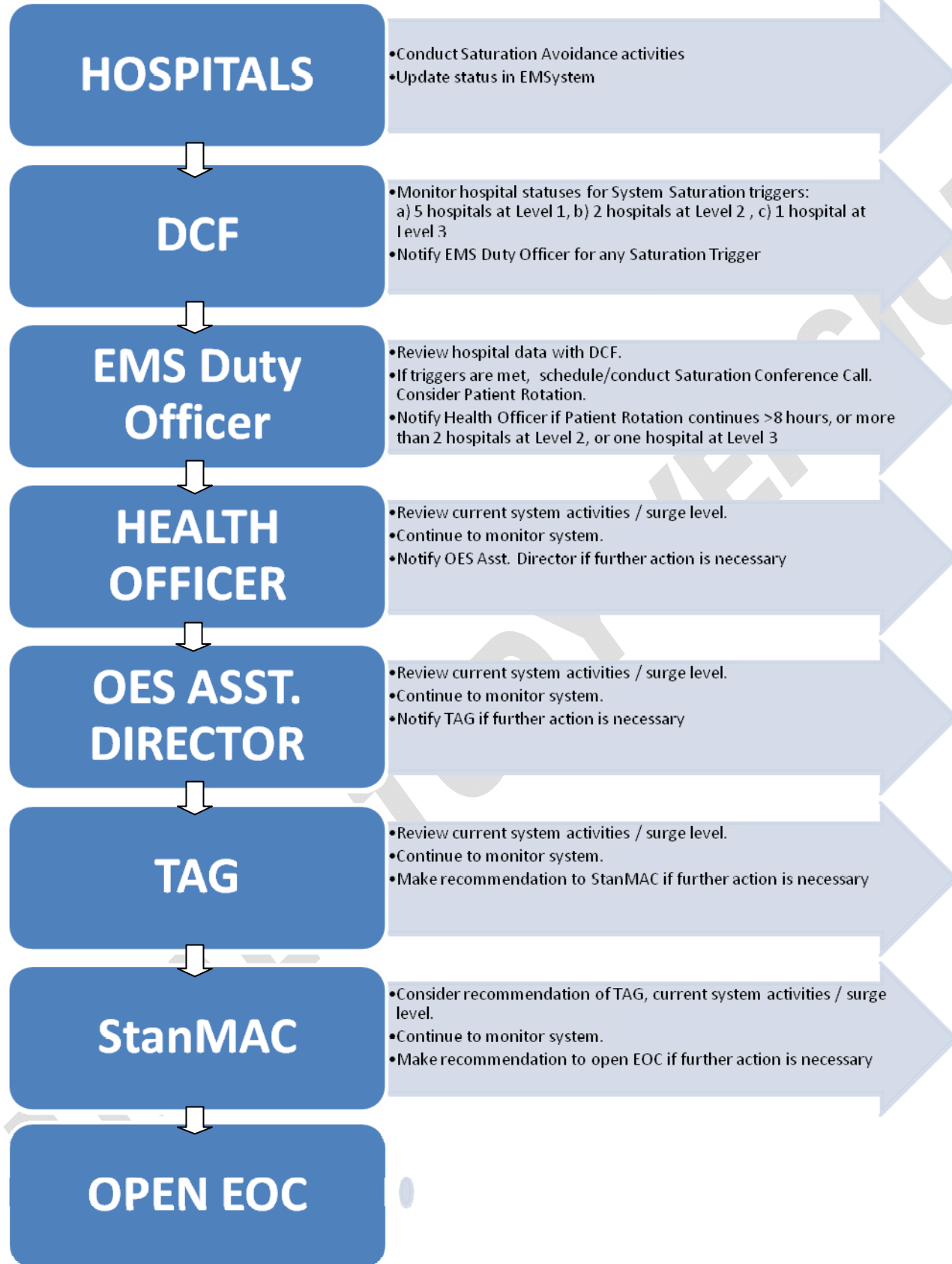
\*\*\* STanMAC – Stanislaus Multi-Agency Coordination Group

G. Transition to Operational Area Disaster Operations

In the event that it becomes necessary to declare a Healthcare Surge Event, medical/health disaster operations will be transitioned to the authority of the Public Health Officer and the Operational Area Emergency Operations Center (EOC) **and the Stanislaus County Medical Health Surge Plan may be activated.**

H. Medical-Health Surge Plan Notification Process

TRIAL STUDY VERSION



Hospital Internal Surge Levels

Hospitals within Stanislaus County will be considered as having met the following Hospital Internal Surge Level when two or more of the respective triggers have been met. (Need to explain this in simpler/clearer terms)

Level	Trigger	DMC	MMC	KPM	EMC	OVHD
<b>1</b>	# of simultaneous ED patients or (trauma) within 60 minutes	10 or (3)	10 or (2)	4 or (1)	4 or (1)	3 or (1)
	Hours of ED wait time	>4	>4	>2	>2	>2
	# of ED patients within 4 hours	30	30	20	20	10
	# of admissions, greater than hospital licensed bed capacity	10	10	8	4	1
	Estimated hours before exhaustion of Critical hospital supplies	48	72	48	48	48
	% of facility staffing shortage	15	15	10	10	5
	Horizontal Evacuation within facility	Yes	Yes	Yes	Yes	Yes
<b>2</b>	# of simultaneous ED patients or (trauma) within 60 minutes	20 or (5)	20 or (4)	6 or (2)	6 or (1)	5 or (1)
	Hours of ED wait time	6	6	4	4	4
	# of ED patients within 4 hours	45	45	30	25	7
	# of admissions, greater than hospital licensed bed capacity	20	20	10	7	2
	Estimated hours before exhaustion of Critical hospital supplies	48	48	48	48	48
	% of facility staffing shortage	25	25	15	15	10
	# hours of Level 1 internal surge	>6	>6	>6	>6	>6
<b>3</b>	# of simultaneous ED patients or (trauma) within 60 minutes	30 or (6)	30 or (6)	10 or (3)	7	7
	Hours of ED wait time	8	8	6	6	8
	# of ED patients within 4 hours	50	50	40	30	15
	# of admissions, greater than hospital licensed bed capacity	20	20	15	10	5
	Estimated hours before exhaustion of Critical hospital supplies	--	--	--	--	--
	% of facility staffing shortage	40	Labor pool	16	16	20
	# hours of Level 2 internal surge	24	24	24	24	24