San Joaquin County
Emergency Medical Services Agency

A DIVISION OF
HEALTH CARE SERVICES
AGENCY

Thursday, February 8, 2024
0900 – 1100
San Joaquin County General Hospital
Conference Room #2
French Camp, CA 95231

SJC EMS ADVISORY COMMITTEE

AGENDA

I. CALL TO ORDER/INTRODUCTIONS

II. APPROVAL OF PAST EMS ADVISORY COMMITTEE MEETING MINUTES:

a. Review and approval of November 9, 2023, EMS Advisory Committee meeting minutes

III. OLD BUSINESS:

a. 2023 APOT/APOD — Presentation / Update
b. Paramedic Training Program — Update
c. EMS System Assessment, and Emergency Ambulance RFP — Update
d. BHS Mobile Crisis Response — Update

IV. NEW BUSINESS:

a. Project Advisory Group
b. Policy review
    i. 2610, MICN Authorization
    ii. 3415, Trauma Center Notification and Transfer of Care Process
    iii. 4101, EMS Vehicle Medication and Equipment
    iv. 4448, EMS Aircraft Utilization
    v. 4981, Receiving Hospital Status
    vi. 5201, Medical Patient Destination
    vii. 6640, STEMI Quality Improvement Committee
    viii. 6650, Stroke Quality Improvement Committee
    ix. 5700, Trauma Protocol ATRA 1 and ATRA 2
c. EMS Week – EMS Award of Excellence Nominations
    i. Efforts and dedication to improving the EMS system
    ii. Providing mentorship support of other EMS system participants

iii. Providing valuable education and feedback to the EMS system
iv. Commitment to helping others in our community

V. EMS SYSTEM PROGRAMS/REPORTS:

a. Specialty Care Reports
   i. STEMI Program — Update
   ii. Stroke Program — Update
   iii. Trauma Program — Update
   iv. CQI — Update

VI. ANNOUNCEMENTS/GOOD OF THE ORDER:
   a. New EMS Agency Staff

VII. NEXT MEETING:

   a. The next regularly scheduled EMS Advisory Committee meeting is scheduled for May 9, 2024.

VIII. ADJOURNMENT

Attachments:

Draft November 9, 2023, EMS Advisory Committee meeting minutes
San Joaquin County EMS Agency APOD Report 2023
EMS Policy Drafts

San Joaquin County
Emergency Medical Services Agency

A DIVISION OF HEALTH CARE SERVICES AGENCY

EMS Advisory Committee

Thursday, November 9th, 2023 at 0900

MINUTES

Members	Membership Representing	Present	Absent
Jared Bagwell (Co-Chair)	SJCEMSA	**X**	
Dr. Katherine Shafer (Co-Chair)	SJCEMSA	**X**	
Nasir Khan	ED RN – Base Hospital - SJGH	**X**	
Cheryl Heaney-Ordez	ED RN – Receiving Hospital – St. Joseph's Medical Center	**X**	
Brian Hajik	EOA emergency ambulance provider – American Medical Response	**X**	
Erica Lowry	ED Director – Receiving Hospital – Sutter Tracy Community Hospital	**X**	
John Andrews	EOA emergency ambulance provider – Manteca District Ambulance	**x**	
Bryan Carr	Representative of an ALS fire dept./district – Stockton Fire Department	**X**	
Ken Johnson	BLS fire departments or districts – Lodi Fire Department	**X**	
Vince Stroup	Paramedic Non fire-based ALS emergency ambulance providers – Manteca District Ambulance	**X**	
Lucas Mejia	EMT Non Fire-based ALS emergency ambulance		**x**

	providers – Manteca District Ambulance		
Vanessa Herrero	SJC accredited paramedic member representing a non fire-based ALS provider		**X**
Pat Burns	EOA emergency ambulance provider – Ripon Fire		**x**
Dennis Bitters	Fire-based emergency ambulance provider – Ripon Fire	**X**	
Anna Josephson	Emergency Medical Dispatcher – SFD ECD	**x**	
Nicholas Taiariol	Law Enforcement – San Joaquin County Sheriff		**X**
Alternate members			
Mary Barnes	San Joaquin General Hospital		**X**
James Trinchera	American Medical Response		**X**
George McKelvie	Manteca District Ambulance		**x**
Jeremy Abundiz	Ripon Fire Department		**X**
Jeremy Bishop	Stockton Fire Department		**X**
Jennifer Fowler	Sutter Tracy Community Hosp.		**X**
EMS Agency Staff	**Title**	**Present**	**Absent**
Christine Tualla	EMS Analyst	**X**	
Matthew Esposito	EMS Coordinator	**X**	
Amanda Petroske	EMS Trauma Coordinator	**X**	
Jeffrey Costa	EMS STEMI/Stroke Coordinator		**X**
Anita Canarios	EMS Office Technician Coordinator	**x**	

Sophany Bodine	EMS Specialist	**x**	
Guests			
Michelle Garibaldi	Chief Mental Health Clinician, Behavioral Health Services	**X**	
Betsey Pettis	Deputy Director, BHS Clinical, Behavioral Health Services	**X**	

Meeting called to order by at 0905 hours by Co-Chair EMS Director Jared Bagwell.

I. INTRODUCTIONS:

Committee member introductions.

II. APPROVAL OF PAST EMS ADVISORY COMMITTEE MEETING MINUTES:

a. M/S – Brian Hajik/Ken Johnson - Minutes approved as amended with corrected typo for pain management.

III. OLD BUSINESS:

a. APOT/APOD**:** EMSA has been behind on publishing APOD data. SJCEMSA is seeing major discrepancies with EMSA and internal data and working on resolving. SJCEMSA intends to publish once data issues are resolved. APOD should be caught up after the first of the year.
b. EMS System Staffing Updates: Committee members discussed ongoing staffing challenges in their respective sectors of EMS.
c. Paramedic Training: Committee members updated on progress to the NCTI/SJCEMSA paramedic class scheduled for March of 2024. Class will be 100 percent provider sponsorship and will contain at least 4 open spots for non-AMR students. Screening dates and details to come as the program gets approved. SJCMESA recruiting for a paramedic instructor and reserving space at Ag Center for didactic schedule through Oct 2024. Adjunct instructors from local EMS system will be needed.
d. EMS Response subcommittee: Michelle Garibaldi gave a presentation on State required expansion of local Behavioral Health Mobile Crisis Response Team

(MCRT), that will respond to mental/behavioral health crisis calls that do not require medical response or law enforcement. MCRT will be available 24/7 to anyone in San Joaquin County. The plan for expansion includes MCRT to respond to calls that meet their specific criteria Monday through Friday 7am to 7pm, AMR will be supporting staffing and responding with BHS staff to after-hours calls. AMR EMT's will be trained and provide support from BHS as needed and perform non-medical duties outside of the EMS System. Ms. Garibaldi stated that this is a first phase roll out and is open to suggestions as they continue to work through agreement and details.

IV. NEW BUSINESS:

a. SJCEMSA Internal Promotion and Vacant Positions: SJCEMSA has new internal promotions; Matt Esposito has been promoted to the EMS Coordinator; Christine Tualla has been promoted to the EMS Training Programs Analyst. SJCEMSA is currently recruiting for four positions: EMS Pre-Hospital Care Coordinator, EMS Specialist, EMS Analyst, and an EMS Paramedic Principal Instructor.
b. EMS Symposium 2024: J. Bagwell asked the Committee if there was interest and suggestions on topics for a 2024 EMS Symposium 2024. Topics that were suggested were: human trafficking, Trauma, EKGs, and EMS week.
c. EMS Assessment: Senior consultant Lou Myer from Healthcare Strategist introduced their team and plan to assist SJCEMSA thorough a comprehensive EMS assessment in part by collecting data and conducting interviews with stakeholders. SJCEMSA will develop RFP in part based on internal and external findings.

V. EMS SYSTEM REPORTS:

a. Specialty Care Oral Reports:

    i. STEMI Program: A. Petroske discussed that they are working on a streamlined process for non-STEMI receiving hospitals to transfer to San Joaquin County STEMI hospitals.
    ii. Stroke Program: All Stroke center agreements are renewed and in place.
    iii. Trauma Program: San Joaquin General Hospital is the designated trauma center in San Joaquin County and the next ACS trauma survey will be in August of 2024. SJCEMSA will be facilitating with the survey.
    iv. CQI: M. Esposito discussed SJCEMSA BLS response and documentation CQI since July.

VI. ANNOUNCEMENTS/GOOD OF THE ORDER:

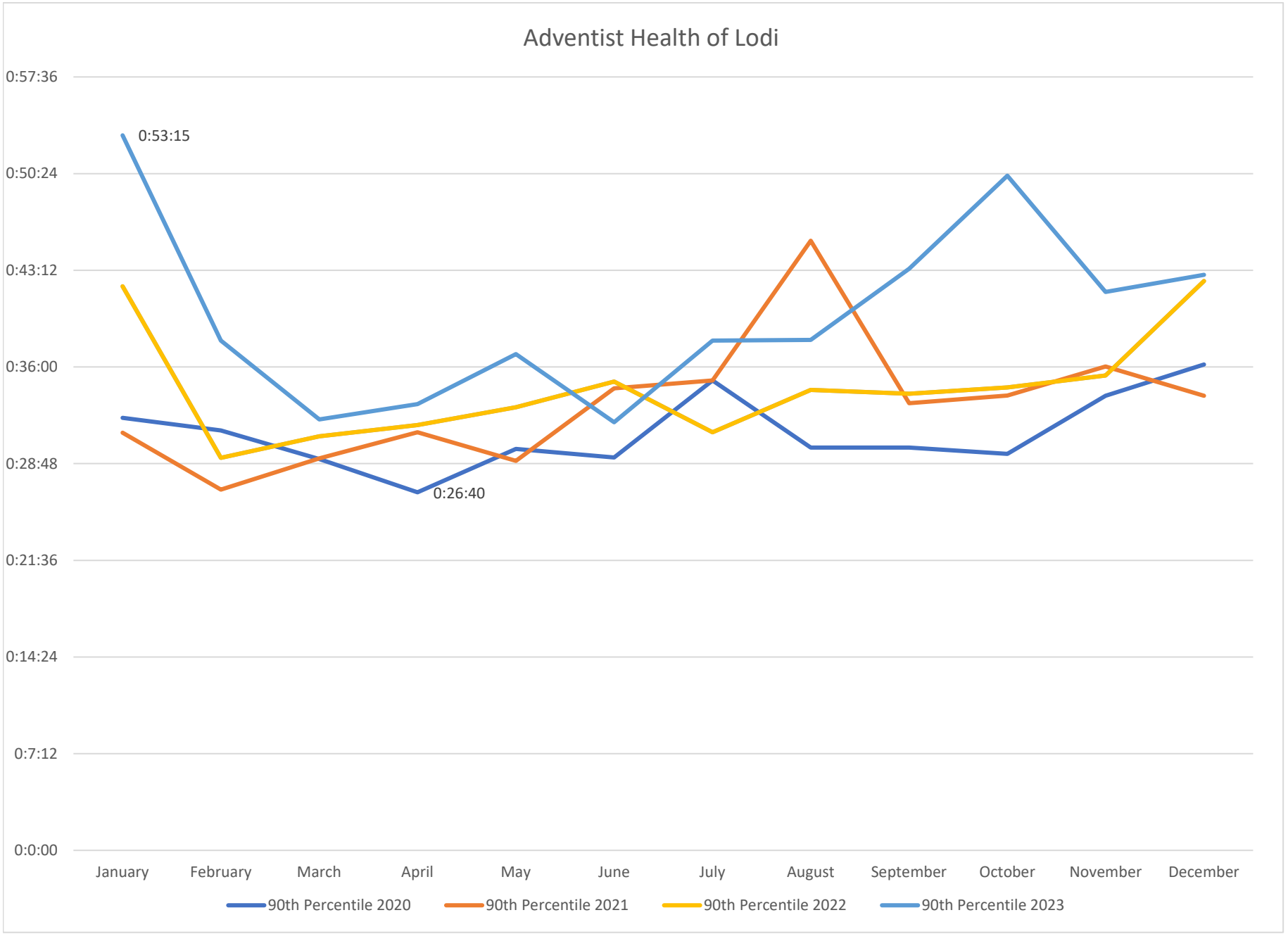
a. Lodi FD had four members complete the paramedic program.
b. Stockton FD has four members in the Merced paramedic program.
c. SJMC had MCI drill the day before, all RN positions are filled.
d. AMR is updating their water response resources in CAD.
e. SJGH is currently in the process of staffing updates.
f. Manteca FD has their strike team conference next week.

VII. NEXT MEETING:

a. The next regularly scheduled meeting is scheduled for February 08, 2024.

VIII. ADJOURNMENT:

Meeting adjourned 1100.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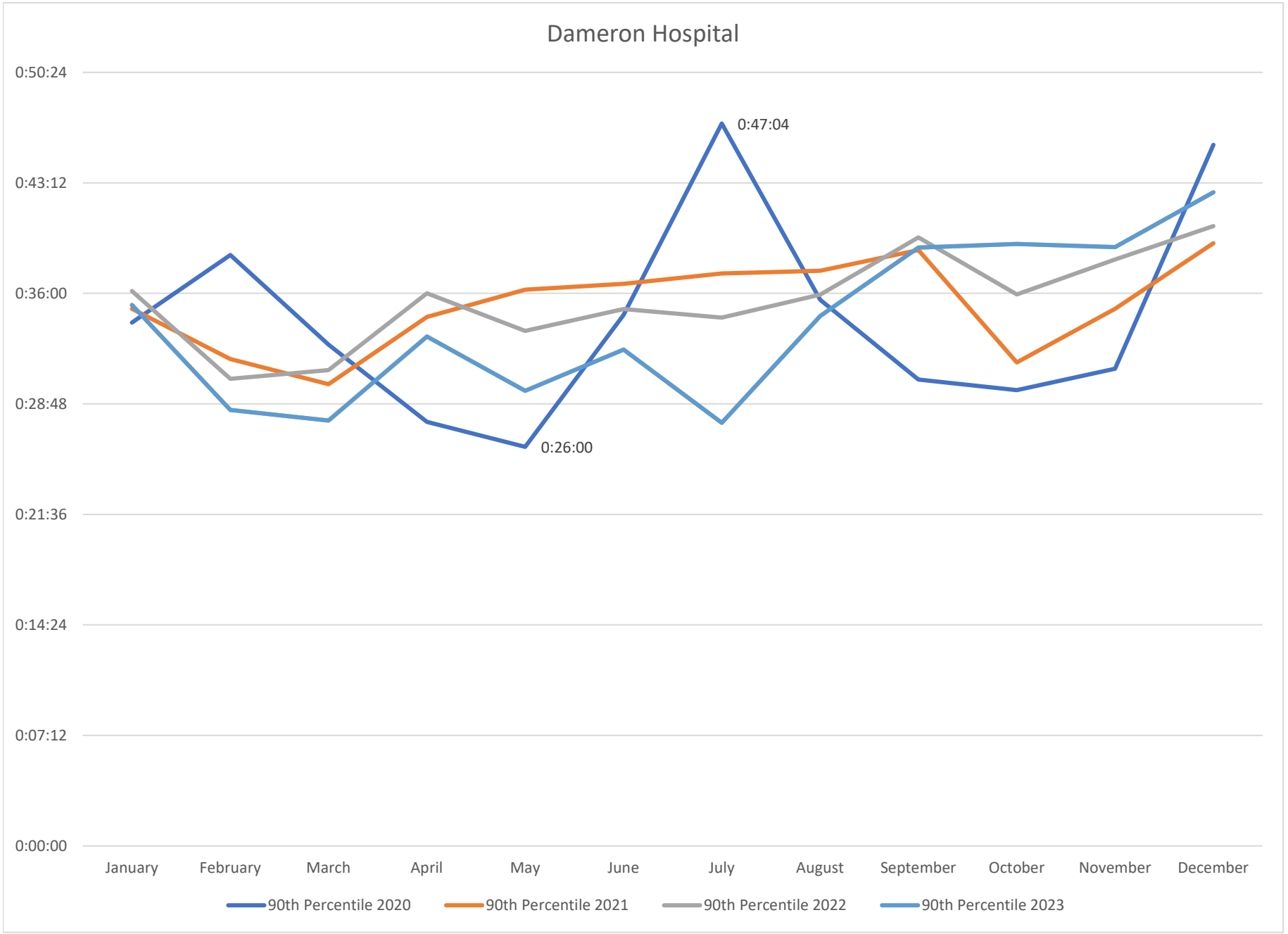
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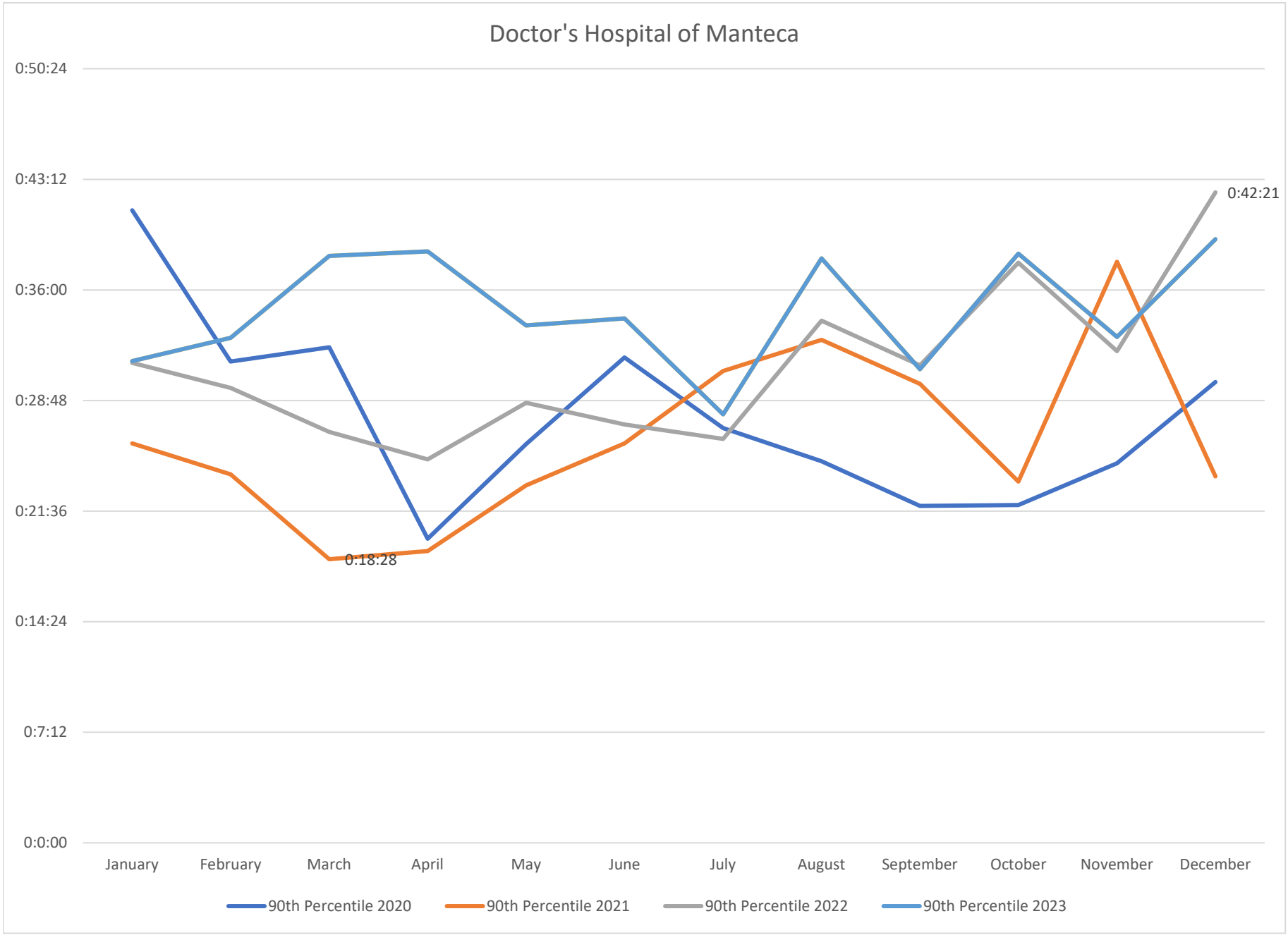
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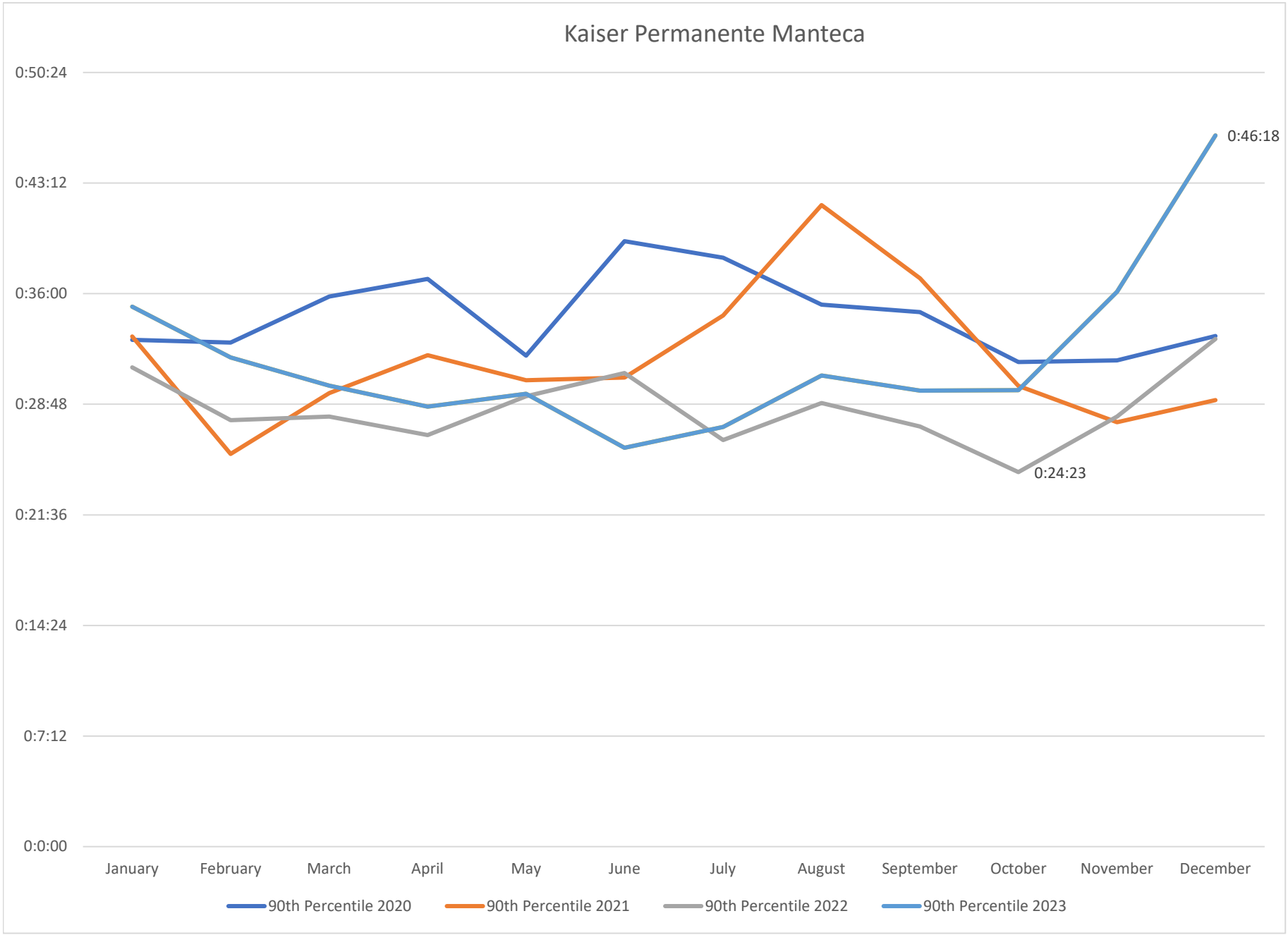
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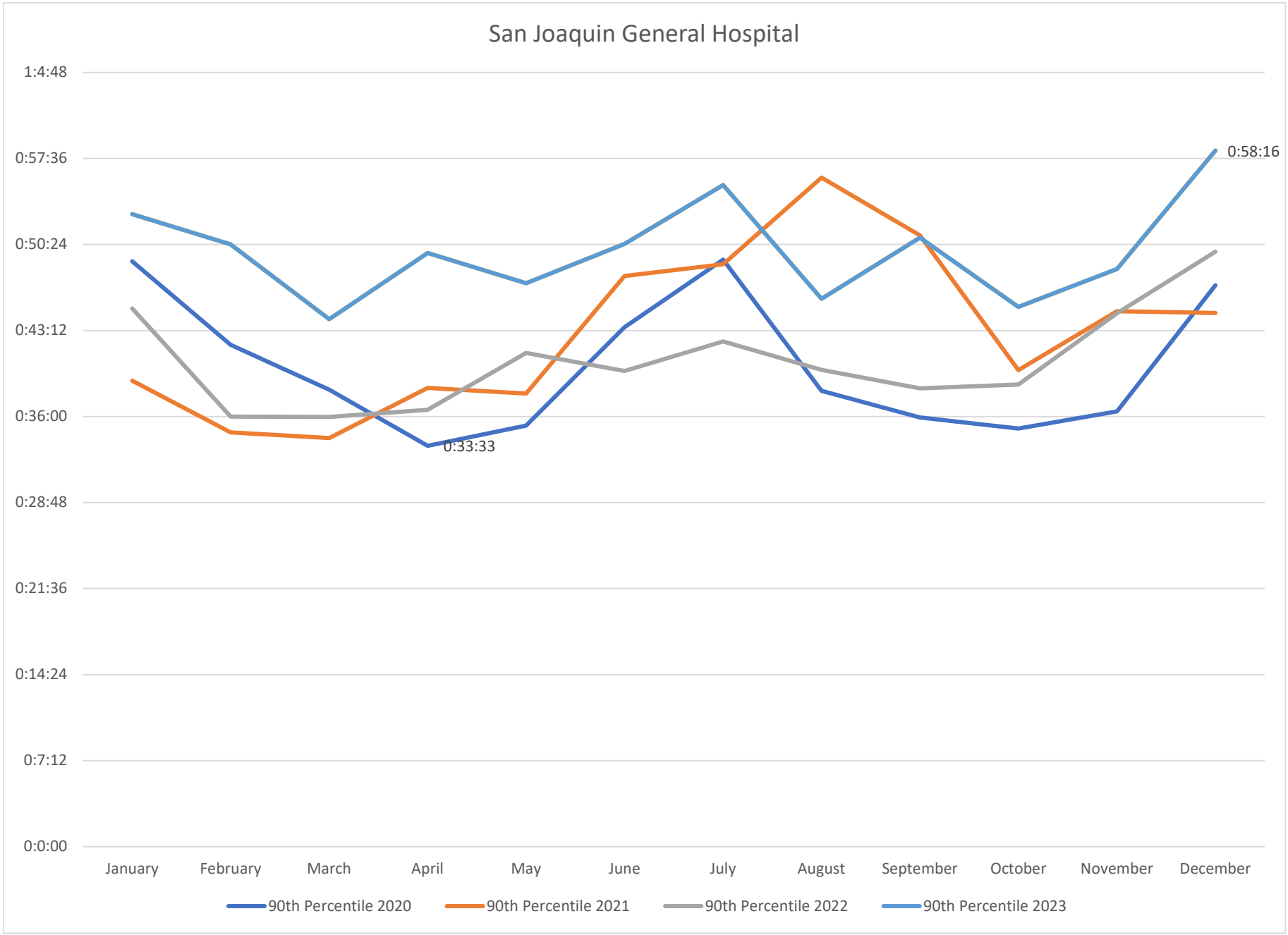
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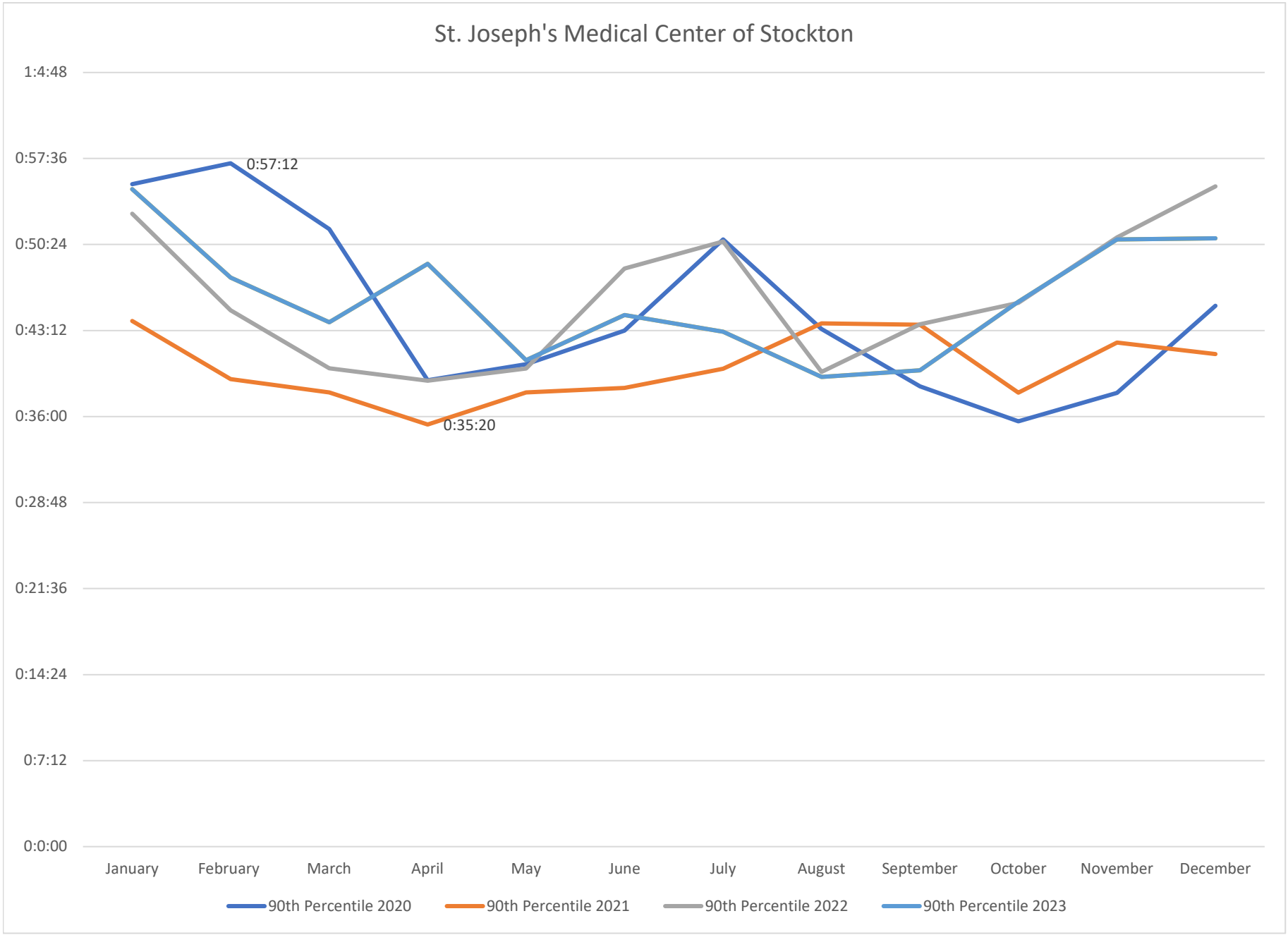
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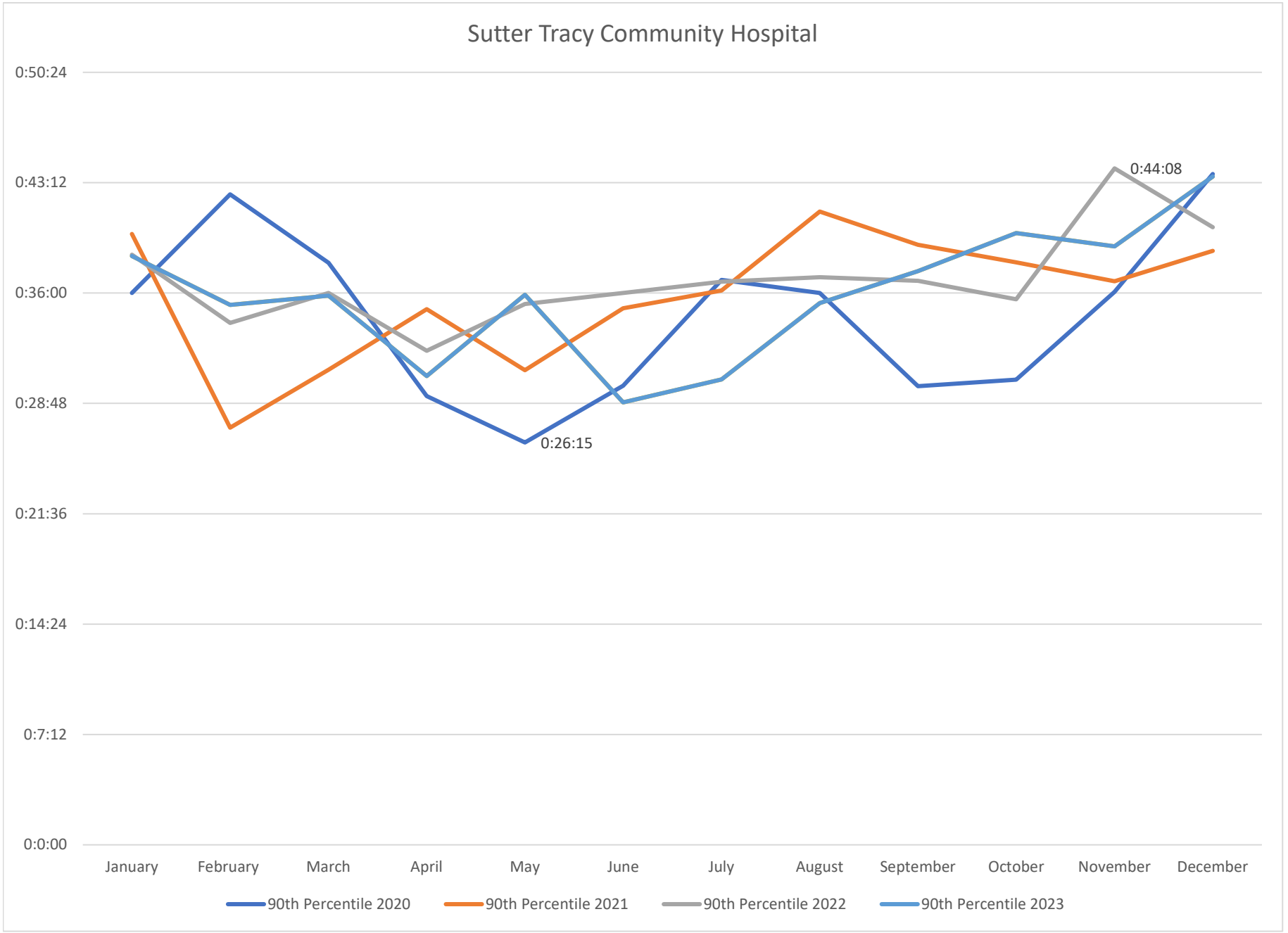
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San Joaquin County
Emergency Medical Services Agency

A DIVISION OF HEALTH CARE SERVICES AGENCY

Memorandum

DATE: January 19, 2024

TO: All Prehospital Personnel and Providers
Base Hospital Personnel
Emergency Department Physicians and Nurse Liaisons

FROM: Katherine Shafer, M.D., EMS Medical Director
Jared Bagwell, EMS Director

SUBJ.: EMS Policy Revisions 45-day Stakeholder Comment

The purpose of this memorandum is to advise EMS system stakeholders that the following policies are out for 45-day stakeholder comment period starting on January 19, 2024. All comments must be received by the close of business Monday, March 4, 2024.

EMS Policy No. 2610, MICN Authorization:
1. Minor Administrative changes.
2. Removed requirement for MICR training for MICN.
3. Added a minimum of eight (8) hours ambulance ride-a-long.

EMS Policy No. 2610C, MICN Field Observation Form C.
1. New form.

EMS Policy No. 3415, Trauma Center Notification and Transfer of Care Process.
1. Added M.I.V.T. report format to policy.

EMS Policy 4101, EMS Vehicle Medication and Equipment.
1. Added Tranexamic acid (TXA).

EMS Policy No. 4981, Receiving Hospital Status.
1. Updated definitions.
2. Multiple clerical and administrative changes throughout.
3. Added EMS Duty Officer override of hospitals status.
4. Removed 08:00 update in EMResource.
5. Added the requirement to have the EMResource mobile app.
6. Removed reference to diversion.
7. Added the requirement to have the Administrator on Call (AOC) involved should a facility go on internal disaster.

EMS Policy No. 5201, Medical Patient Destination.

1. Removed “Sustained” to transport ROSC patients to a STEMI Center.
2. Multiple clerical and administrative changes throughout.
3. Removed Doctors Hospital of Manteca from the OB receiving facility list.

Ems Policy No. 5700, ATRA 1 Trauma Protocol ATRA 1 AND 2.

1. Added TXA.
2. Multiple clerical and administrative changes throughout.
3. Updated Traumatic Arrest algorithm to remove working on scene for ten (10) minutes if greater than 20 minutes to trauma center.
4. Added an EKG rhythm check for V-fib or V-tach in the decision tree to transport or cease efforts.

EMS Policy No. 6640, STEMI Quality Improvement Committee.

1. Changed meeting frequency from quarterly to biannual.

EMS Policy No. 6650, Stroke Quality Improvement Committee.

1. Changed meeting frequency from quarterly to biannual.

EMS Policy No. 4980, Receiving Hospital Diversion.

1. Policy RESCINDED – Irrelevant

TITLE: **MOBILE INTENSIVE CARE NURSE AUTHORIZATION** EMS Policy No. **2610**

PURPOSE: The purpose of this policy is to establish procedures for issuing and maintaining Mobile Intensive Care Nurse (MICN) authorization by the San Joaquin County EMS Agency (SJCEMSA).

AUTHORITY: Health and Safety Code, Division 2.5, Section 1797.5, 1797.210, 1797.220, and 1798.207. California Code of Regulations, Title 22, Division 9, Chapter 4 Section 100169(b).

POLICY:

I. Initial Authorization

A. ~~In order to~~To be authorized as an MICN in San Joaquin County, the candidate shall:

1. Submit a completed MICN application.
2. Be a currently licensed registered nurse, in good standing (without any current disciplinary action), in the State of California.
3. Have at least six (6) months of experience as a full-time RN in a critical care area such as ED, ICU, or CCU in the past two (2) years. This experience needs to be verified by the prehospital liaison nurse (PLN) at the base hospital, who shall complete the verification section of the MICN Application.
4. Apply for authorization within thirty (30) days of MICN course completion, unless previously authorized as an MICN.
5. Submit copies of the following:
   a. Copy of current and valid State of California Registered Nurse License verification printout from https://www.rn.ca.gov/online/verify.shtml.
   b. Current and valid state identification card (i.e., driver's license) or current valid federal identification (i.e., military identification).
   c. Current and valid Advanced Cardiac Life Support (ACLS) certification.
   d. Current and valid certification in cardiopulmonary resuscitation (CPR) for the Professional Rescuer or Healthcare Provider, issued from the American Heart Association, American Red Cross, or programs approved by the SJCEMSA.
   e. Copy of a current and valid Trauma Nursing Core Course (TNCC).

Approved: Signature on file
Medical Director

Signature on file
EMS Administrator

f. MICN Course completion certificate issued by an approved SJCEMSA MICN training provider.
g. ICS-100 Introduction to Incident Command System.
h. ICS-200 ICS for Single Resource and Initial Action Incidents.
~~i. SJCEMSA Minimally Interrupted Cardiac Resuscitation (MICR) Video and Post Test.~~
~~j.~~i. Pay the application fee established by the San Joaquin County Board of Supervisors.

6. Successful completion of the SJCEMSA MICN Course shall be comprised of:
   a. ~~Minimum~~A minimum of twenty-four (24) hours of didactic instruction.
   b. Eight (8) hours of ambulance field observation with an SJCEMSA approved emergency ambulance service provider.
   c. Successfully pass, with a score of 80% or higher, a closed book examination of SJCEMSA policies.
   d. Pass with a score of 75% or higher, a proctored radio exam.

B. An MICN who has completed the requirements of I. A. 1 – 6 will be issued and MICN interim authorization for a maximum of ninety (90) days. The interim MICN shall work under the direct supervision of an SJCEMSA authorized MICN. The following components of the authorization process shall be completed by the interim MICN under the direct supervision:
   1. Ten (10) actual or simulated ALS base contacts.
   2. Demonstrate knowledge of skills and medications which are part of the San Joaquin County paramedic scope of practice.
   3. The PLN shall document the orientation/training on the MICN Interim Verification Form (2610A) and submit it to SJCEMSA.

C. Interim status may be maintained for a maximum of ninety (90) days. If the interim MICN does not complete the authorization process within ninety (90) days, the individual shall re-start the authorization process. At the discretion of the SJCEMSA, this time frame may be extended following a written request from the applicant and an explanation as to why the authorization process was not completed during the initial ninety (90) day time period.

D. Individuals applying for authorization shall receive notification of the SJCEMSA's decision to approve or deny authorization within thirty (30) days of submission of a complete application packet and receipt of the MICN Interim Verification Form (2610A).

E. The SJCEMSA Medical Director shall evaluate any candidate who fails to

successfully complete the authorization process. The Medical Director may recommend further evaluation or training or deny authorization.

II. Maintenance of Authorization

A. To maintain authorization in San Joaquin County an individual shall:

1. Submit a completed MICN re-authorization form thirty (30) days prior to the expiration date of their current MICN authorization.
2. Submit copies of the following
   a. C~~opy of c~~urrent and valid State of California Registered Nurse License verification printout from https://www.rn.ca.gov/online/verify.shtml.
   b. Current and valid state identification card (i.e., driver's license) or current and valid federal identification (i.e., military identification.
   c. Current and valid ACLS certification.
   d. Current and valid certification in cardiopulmonary resuscitation (CPR) for the Professional Rescuer or Healthcare Provider issued from the American Heart Association, American Red Cross, or programs approved by the SJCEMSA.
   e. C~~After July 31, 2021, a copy of a c~~urrent and valid Trauma Nursing Core Course (TNCC).
3. Complete the following requirements every two (2) years and document on the MICN Continuing Education Form (2610C~~B~~):
   a. Fourteen~~Twelve~~ (14~~2~~) hours of approved EMS continuing education that shall at a minimum include:
      i. Completion of six (6) field care audits held by San Joaquin General Hospital or SJCEMSA.
      ~~i.~~b. A minimum of eight (8) hours of ambulance field observation with an SJCEMSA approved emergency ambulance service provider.
4. Successfully complete mandatory training sessions as may be required by SJCEMSA. These sessions may include training and testing on new or revised local EMS policies and procedures, or other topics pertinent to prehospital care in the San Joaquin County EMS system.

III. Lapsed Authorization

Approved: Signature on file
Medical Director

Signature on file
EMS Administrator

A. ~~In order for~~For an individual whose authorization has lapsed to be eligible for renewal, the following applies:
   1. For a lapse of less than twenty-four (24) months, requirements listed in Section II. A. 1 – 4 must be completed within the last 24 months. The application fee will include the late fee established by the San Joaquin County Board of Supervisors.
   2. For a lapse of more than twenty-four (24) months, all requirements listed in Section I. must be completed.

IV. Authorization Dates:

A. The effective date of MICN authorization shall be the date the authorization is issued after the individual satisfactorily completes all certification requirements and has applied for authorization. The authorization expiration date will be the final day of the final month of the two-year period, except in the following instances:
   1. For applicants meeting the requirements for maintaining authorization greater than six months prior to expiration, the effective date of the authorization shall be the date the applicant satisfactorily completes all requirements and has applied for authorization and the new authorization expiration shall be the final day of the final month of the two-year period.

V. MICN's shall be responsible for notifying the SJCEMSA of their proper and current mailing address and shall notify the SJCEMSA in writing within thirty (30) calendar days.

VI. Falsification of any of the authorization documents may result in denial of authorization and referral to the appropriate state licensing body for disciplinary action.

VII. CQI Process

A. If through the CQI process, the employer or SJCEMSA Medical Director determines that an MICN needs additional training, observation or testing, the employer or the SJCEMSA Medical Director may create a specific and targeted program of remediation based upon the identified need of the MICN. If there is disagreement between the employer and the Medical Director, the decision of the Medical Director shall prevail.

VIII. Testing:

A. An applicant is allowed to take the MICN course examination a maximum of three (3) times per year.
   1. First Attempt: Proceeding the MICN course.
   2. Second Attempt: May be scheduled after a one (1) week waiting period from the initial examination.
   3. Third Attempt: May be scheduled following completion of four (4) hours of remedial training pertaining to the SJCEMSA policies.
   4. After three (3) failed attempts, the SJCEMSA Medical Director may suspend or revoke the applicant's authorization until such time that the applicant passes the examination.

B. It is a misdemeanor for any person to knowingly and willfully engage in conduct that subverts or attempts to subvert any certification or licensing examination or the administration of an examination, conducted pursuant to the Health and Safety Code, Division 2.5, including any authorization examination process. Unlawful conduct includes:
   1. Conduct that violates the security of the examination material.
   2. Removing from the examination room any examination materials without authorization.
   3. ~~The unauthorized~~Unauthorized reproduction by any means of any portion of the actual licensing or certification examination.
   4. Aiding by any means the unauthorized reproduction of any portion of the actual licensing or certification examination.
   5. Paying or using professional or paid examination-takers, for the purpose of reconstructing any portion of the licensing or certification examination.
   6. Obtaining or attempting to obtain examination questions or other examination material from examinees or by any other method, except by specific authorization before, during, or after an examination.
   7. Using or purporting to use any examination questions or materials that were improperly removed or taken from any examination for the purpose of instructing or preparing any applicant for examination.
   8. Selling, distributing, buying, receiving, or having unauthorized possession of any portion of a future, current, or previously administered licensing or certification examination.
   9. Communicating with any other examinee during the administration of a licensing or certification examination.

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Medical Director

Signature on file
EMS Administrator

10. Copying answers from another examinee or permitting one's answers to be copied by another examinee.
11. Having in one's possession during the administration of the licensing or certification examination any books, equipment, notes written or printed materials, or data of any kind, other than the examination materials distributed, or otherwise authorized to be in one's possession during the examination.
12. Impersonating any examinee or having an impersonator take the licensing or certification examination on one's behalf.

C. The penalties provided for in Health and Safety Code Section 1798.207 are not exclusive remedies and shall not preclude remedies provided pursuant to any other provision of law.

D. In addition to any other penalties, a person found guilty of violating Health and Safety Code Section 1798.207 shall be liable for the actual damages sustained by the agency administering the examination not to exceed ten thousand dollars ($10,000) and the costs of litigation.

Approved: Signature on file
Medical Director

Signature on file
EMS Administrator

San Joaquin County

Emergency Medical Services Agency

MICN FIELD OBSERVATION FORM C

DATE:	START TIME: END TIME:
RN NAME:	BASE HOSPITAL:
MEDIC NAME:	PROVIDER AGENCY: MEDIC UNIT #:

ORIENTED TO:

- Ambulance Equipment
- Communication Methods
- Safety Considerations while on scene

Describe Patient contact: Treatment Protocol used: Skills Observed:	Comments
Describe Patient contact: Treatment Protocol used: Skills Observed:	Comments
Describe Patient contact: Treatment Protocol used: Skills Observed:	Comments

REVIEW COMPONENTS OF ALS RESPONSE:

- ☐ Dispatch
- ☐ Patient Assessment
- ☐ Field Management and Reassessment
- ☐ Base Hospital Contact
- ☐ Transport

Describe the importance of developing effective communication and a professional relationship with the Base Hospital, MICN and EMS personnel:

List 3 things you have learned from your ambulance ride-along experience:

1.

2.

3.

Paramedic Signature: _____ RN Signature: _____

Print Name: _____ Print Name: _____

Date: _____ Date: _____

TITLE: **TRAUMA CENTER NOTIFICATION** EMS Policy No. **3415**

PURPOSE:

The purpose of this policy is to establish requirements for prehospital personnel to notify the trauma center of a major trauma patient.

AUTHORITY:

Health and Safety Code, Division 2.5, Sections 1797.220, 1798, 1798.162, 1798.163, 1798.164, 1798.165, 1798.168, 1798.170, and 1798.172. California Code of Regulations, Title 22, Division 9, Chapter 7.

DEFINITIONS:

A. "Disaster Control Facility" or "DCF" means San Joaquin General Hospital which is assigned responsibility by the SJCEMSA for determining the destination of patients transported by ambulance from a multi-casualty incident in accordance with the policies and procedures of the SJCEMSA.
B. "SJCEMSA" means San Joaquin County Emergency Medical Services Agency.

POLICY:

Prehospital personnel shall provide early notification for patients meeting major trauma criteria using med-net communication.

PROCEDURE:

I. Prehospital personnel using available med-net communications shall notify the intended trauma center as early as possible of the intended transport of a patient meeting major trauma triage criteria to their facility. Early notification is necessary to ensure the availability and prompt activation of appropriate trauma team personnel.

II. When notifying the trauma center prehospital personnel shall provide the trauma center with a concise patient report indicating the criteria met in EMS Policy No. 5210, Major Trauma Triage Criteria.

III. Prehospital personnel using available med-net communications shall contact the DCF for the coordination of multi-casualty incidents or ~~to~~ receive on-line medical control as required by SJCEMSA policies and procedures.

IV. Early trauma center notification by prehospital personnel shall be monitored and evaluated through the CQI process.

V. Transfer of Care Process

In most cases the attending paramedic will be allowed approximately 40 seconds prior to patient transfer from ambulance stretcher to trauma center gurney to deliver an MIVT report. If the major trauma patient is requiring life saving measures such as ~~under~~ chest compressions or requires immediate airway management ~~control~~ the MIVT report will be delayed until after patient transfer to the trauma center gurney with the MIVT report being given at the direction of the attending trauma surgeon.

MIVT Format:

M = Mechanism of injury. Include all mechanisms of injury, including a description of all blunt mechanisms as well as penetrating injuries.

I = Injuries identified or injuries suspected. Paramedics usually describe, in addition to obviously identified injuries, areas where the patient has complained of pain or soreness.

V = Vital signs including level of consciousness. It is very important for the paramedic to state level of consciousness and Glasgow Coma Scale. If the level of consciousness has waxed and waned, or decreased in any way, it is important to make note of this. It is also at this point that the paramedic should note pupil assessment (unequal, fixed, dilated, pinpoint, reactive or nonreactive).

T = Treatment or therapies and response to therapies. If the patient had low blood pressure and received a fluid challenge of crystalloid to which his blood pressure responded, it should be noted here. If the patient had lack of a distal pulse prior to hare traction splint application which did not reappear or did reappear after application of the splint, it should be noted here.

The following is an example of an MIVT report: “Pedestrian in cross walk struck by pickup truck and thrown approximately 40 feet; Chest trauma with paradoxical breathing, blood in nose, ears, and airway; obvious femur fractures, and unstable symphysis on palpation; Initial GSC of eight now a GSC of three; systolic BP of 60; right pupil fixed and dilated; I-gel airway established, bilateral needle decompression with positive air release, assisted ventilations, fourteen gauge IV with normal saline.”

Approved: Signature on file
Medical Director

Signature on file
EMS Administrator

VI. Transport Directly to Operation Suite

In certain circumstances ambulance personnel may be directed by the attending trauma surgeon to transport a major trauma patient on the ambulance stretcher directly to an operating suite. In such instances ambulance personnel are required to fully cooperate and follow the instructions of the trauma surgeon and trauma team.

~~IV.~~

TITLE: **EMS RESPONSE VEHICLE MEDICATION AND EQUIPMENT** EMS Policy No. **4101**

PURPOSE:

The purpose of this policy is to standardize and establish par levels for the medication and equipment available on EMS response vehicles in San Joaquin County.

AUTHORITY:

Health and Safety Code, Division 2.5, Sections 1797.197, 1797.197a, 1797.206, 1797.220, 1798; California Code of Regulations, Title 22, Division 9, Chapter 2 Section 100063, 100063.1, 100064, and Chapter 4 Sections 100145, 100146, 100168, 100170.

DEFINITIONS:

A. "Advanced Life Support" or "ALS" means special services designed to provide definitive prehospital emergency medical care, including, but not limited to, cardiopulmonary resuscitation, cardiac monitoring, cardiac defibrillation, advanced airway management, intravenous therapy, administration of specified drugs and other medicinal preparations, and other specified techniques and procedures administered by authorized personnel under the direct supervision of a base hospital as part of the organized EMS system at the scene of an emergency, during transport to an acute care hospital, during inter-facility transfer, and while in the emergency department of an acute care hospital until responsibility is assumed by the emergency or other medical staff of that hospital.
B. "AMB" means ambulance.
C. "Basic life support" or "BLS" means emergency first aid and cardiopulmonary resuscitation procedures which, as a minimum, include recognizing respiratory and cardiac arrest and starting the proper application of cardiopulmonary resuscitation to maintain life without invasive techniques until the patient may be transported or until advanced life support is available.
D. "EMS Service Providers" means those ambulance services, fire departments, fire districts or other entities operating within the organized EMS system.
E. "EMS Response Vehicle" means all ambulances and any fire apparatus or other motor vehicle used to respond to EMS requests for service.
F. "EMT Enhanced Skills" means those items specified in EMS Policy No. 2360, EMT Scope of Practice as EMT Enhanced Skills.
G. "NA" means not authorized.
H. "NR" means not required.
I. "NT" means a non-transport EMS response vehicle.
J. "Par Level" means the minimum quantity of an item stocked at the beginning of a shift and replenished during the shift if below the par level.
K. "Organized EMS System" means those entities included in the San Joaquin

County EMS Agency's EMS Plan as submitted to the Emergency Medical Services Authority pursuant to Health and Safety Code § 1797.254.

L. "SJCEMSA" means the San Joaquin County Emergency Medical Services (EMS) Agency, which is the designated local emergency medical services agency for San Joaquin County.

POLICY:

It is the policy of SJCEMSA to standardize and require minimum levels of medical equipment and medications for EMS response vehicles working in the San Joaquin County EMS system.

PROCEDURE:

I. EMS Service Providers are required to develop a vehicle inspection procedure to ensure compliance with this policy at the start of each shift including a written record of each daily inspection for each EMS vehicle maintained in an auditable format. Records shall be maintained for a minimum of six months. EMS service providers shall require each attending paramedic or EMT to conduct an inspection of their assigned EMS response vehicle at the beginning of their shift.

II. The attending paramedic or EMT on each EMS response vehicle is responsible for ensuring that all medications and equipment are present at the beginning of each shift, that all equipment is functioning properly, and that all battery-powered devices are charged.

III. Medications, supplies, and equipment shall be stored in accordance with the manufacturer's recommendation unless otherwise specified in this policy. The use of expired medications and supplies is prohibited.

IV. The quantities specified are minimum quantities except for controlled substances which are maximum quantities.

V. EMS service providers shall have and maintain appropriate state and federal approvals for point of care testing including a waiver form the from the Centers for Medicare and Medicaid Services, pursuant to the Clinical Laboratory Improvement Amendments (CLIA), for laboratory devices including testing to measure lab values in the prehospital setting as follows:
   A. BLS NT and BLS AMB for finger stick glucose.
   B. ALS NT and ALS AMB for finger stick glucose, capnometry, capnography, and carbon monoxide.

VI. EMS service providers that are unable to maintain medication or equipment par levels required in this policy due to ongoing or imminent national medication and equipment shortages shall complete and submit Form 4101A Medication Shortage Mitigation and Response Strategies.

VII. EMS service providers that request a waiver from medication or equipment par levels of this policy shall complete and submit Form 4101B, Request for Waiver of Requirements.

VIII. Any substitutions or modifications of this list must be approved by the EMS Medical Director.

Table 1: ALS and BLS Common Equipment and Supplies	**Par Level**			
	BLS		**ALS**	
	NT	**AMB**	**NT**	**AMB**
Airway Management				
In ambulance oxygen source, minimum of 500 PSI with a wall mounted regulator	NR	1	NR	1
Portable oxygen - D or E size cylinders, minimum of 200 PSI, with regulator	1	1	1	1
Spare Portable oxygen - D or E size cylinders, minimum of 1800 PSI	1	1	1	1
Wall mount suction device	NR	1	NR	1
Battery powered suction unit	1	1	1	1
Suction catheters with control for each size Fr 6, 8, 10, 12, 14, 18	1	1	1	1
Connecting tubing for suction units	2	2	2	2
Yankauer Tonsil Tip Suction Catheter	2	2	2	2
Disposable bag valve device - adult, with appropriate connector masks	2	2	2	2
Disposable bag valve device – pediatric, with appropriate connector masks for child and infant	1	1	1	1
Tube of water soluble lubricating jelly (or multiple single use packets)	1	1	1	1
Oropharyngeal Airway Kit (adult, child, infant) each size 0 – 9	1	1	1	1
Tongue blade for use in inserting child and infant OPA	1	1	1	1
Nasopharyngeal Airways, each size Fr 20, 24, 28, 32, 36	1	1	1	1
Nasal Cannula, pediatric	1	1	1	2
Nasal Cannula, adult	2	2	3	3
Adult Non-rebreather oxygen mask	2	2	2	3
Pediatric Non-rebreather oxygen mask	2	1	1	2

Table 1: ALS and BLS Common Equipment and Supplies	**Par Level**			
	BLS		**ALS**	
	NT	**AMB**	**NT**	**AMB**
Adult laryngoscope handle with alkaline batteries or 2 disposable handles	NA	NA	1	1
Pediatric laryngoscope handle with alkaline batteries or 2 disposable handles	NA	NA	1	1
Spare alkaline batteries for laryngoscope handle	NA	NA	2	2
Disposable Macintosh laryngeal blades each size: #1, #2, #3, #4	NA	NA	1	1
Disposal Miller laryngeal blades each size: #0, #1, #2, #3, #4	NA	NA	1	1
Magill Forceps – Adult and Pediatric	NA	NA	1	1
Endotracheal tubes each size: 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5	NA	NA	1	2
ET tube holder	NA	NA	1	2
Disposable endotracheal tube introducers	NA	NA	2	2
Endotracheal tube stylet	NA	NA	1	2
End tidal CO2 device, adult	NA	NA	1	2
End tidal CO2 device, pediatric	NA	NA	1	2
Nebulizer mask	0	0	1	1
Saline humidifier	1	1	1	1
Breath actuated nebulizer	NA	NA	1	2
Needle and catheter for pleural decompression: 10 or 14 gauge 3.25 inch needle (with Betadine swab, tape, and 10 ml syringe)	NA	NA	4	4
Percutaneous Needle Cricothyroidotomy insertion kit, which includes: 10 ml syringe, Translaryngeal jet ventilator device with push-button and high-pressure tubing with locking device (Adult), 10 or 12 gauge needle for adult, and Betadine swab, or Enk Oxygen Flow Modulator set, (Adult), and Betadine swab or kit approved by EMS Medical Director.	NA	NA	1	1
iGel Airway each size 3.0, 4.0, 5.0	NA	NA	2	2
iGel Airway each size 1.0,1.5, 2.0, 2.5	NA	NA	2	2
Pneumatic Continuous Positive Airway Pressure (CPAP) device	NA	NA	1	NA
Zoll Z series™ ventilator with CPAP and/or BiPAP *Optional for Non- Emergent ALS interfacility transfer ambulance	NA	NA	NA	1
Adult Ventilator Circuits *Optional for Non- Emergent ALS interfacility transfer ambulance	NA	NA	NA	3

Table 1: ALS and BLS Common Equipment and Supplies	**Par Level**			
	BLS		**ALS**	
	NT	**AMB**	**NT**	**AMB**
CPAP mask compatible with Zoll Z series™ ventilator each size large and extra large *Optional for Non- Emergent ALS interfacility transfer ambulance	NA	NA	NA	3
Inline Hepa Filter *Optional for Non- Emergent ALS interfacility transfer ambulance	NA	NA	1	2
Assessment and Treatment				
Stethoscope	1	1	1	2
Penlight	1	1	1	1
Blood pressure cuff: thigh, adult, child, infant	1 ea	1 ea	1 ea	1 ea
Patient thermometer (temporal or noncontact)	1	1	1	1
Pulse oximetry device approved by the Food and Drug Administration (FDA);	1	1	1	1
Blood glucose measuring device approved by the FDA with multiple test strips	NA	NA	1	1
Length based pediatric resuscitation tape	NR	NR	1	1
Cardiac monitor with defibrillation/pacing/12 lead capable	NA	NA	1	1
Pediatric defibrillation equipment	NA	NA	1	1
ECG electrodes all patient sizes	NA	NA	6	9
Automated External Defibrillator – Compliant with the current AHA Guidelines and capable of delivering both adult and pediatric shocks	1	1	NR	NR
AED cables and pads for sizes adult and pediatric	1	1	NR	NR
Piston style mechanical compression device	1	0	1	0
Bandage shears (heavy duty)	1	1	1	2
Rolls of tape, size 1” or 2” or 3” Hypoallergenic (Transpore/paper)	2	2	2	2
Emesis basins	NR	2	NR	2
Bed pan/fracture pan	NR	1	NR	1
Urinal	NR	1	NR	1
OB Kit, which includes: (1) pair of sterile gloves, (1) drape sheet, (2) umbilical clamps, (4) disposal towels, (2) O.B. towelettes, (1) bulb syringe, (2) alcohol preps, (1) O.B. sterile pad (1) plastic bag	1	1	1	1

Table 1: ALS and BLS Common Equipment and Supplies	**Par Level**			
	BLS		**ALS**	
	NT	**AMB**	**NT**	**AMB**
for placenta, (2) twist ties, (1) receiving blanket, (3) gauze sponges, (pk/2)				
Ring Cutter	1	1	1	1
Soft ankle/wrist restraints	0	4	0	4
Trauma				
Board for use in extrication	1	1	1	1
One or more of the following for use in patient movement on scene: collapsible litter, pole-less litter, soft or tarp litter, or stokes litter	1	1	1	1
Scoop stretcher	0	1	0	1
Kendrick Immobilization Device (KED) or similar device approved by the EMS Agency	1	1	1	1
Pediatric immobilization device	0	0	0	1
X-Collars™	4	4	4	4
Soft cervical collars – small pediatric	2	2	2	2
Adult traction splint for femur	1	1	1	1
Pediatric traction splint for femur or adult traction splint that adjusts to pediatric size	1	1	1	1
Rigid splints for splinting each extremity	1	2	1	2
Sterile burn sheets	2	2	2	4
Occlusive dressings	2	2	2	4
2 x 2 gauze pads Sterile	0	0	4	8
4 x 4 gauze pads Sterile	10	10	10	10
Hemostatic dressings: Quick Clot Combat Gauze LE; or Quick Clot, EMS Rolled Gauze, 4x4 Dressing, Trauma Pad; or Celox Gauze, Z-Fold Hemostatic Gauze; or Celox Rapid, Hemostatic Z-Fold Gauze	2	2	2	2
Trauma dressings	2	2	2	4
Gauze roll type bandages, size 2 or 4 or 6	2	2	2	4
Triangular bandages	1	1	1	2
Instant ice packs	2	2	2	8
Trauma Tourniquets: SOF Tactical Tourniquet or the Combat Application Tourniquet (CAT)	4	4	4	4
General Equipment				
San Joaquin County Map Book (current within 2 years) or GPS Equivalent	1	1	1	1

Table 1: ALS and BLS Common Equipment and Supplies	**Par Level**			
	BLS		**ALS**	
	NT	**AMB**	**NT**	**AMB**
Map book for assigned response zones or district (current within 1 year) or GPS Equivalent	1	1	1	1
Battery operated flashlight	1	1	1	1
Functional environmental controls for heat and air conditioning for the patient compartment.	NR	1	NR	1
Patient compartment door latches operable from inside and outside.	NR	1	NR	1
Patient sheets (disposable)	0	2	0	4
Patient blankets (disposable)	1	2	1	2
Patient pillows	0	2	0	2
Ambulance gurney with mattress, capable of elevating the head, feet, and adjustable to several levels.	0	1	0	1
VHF and UHF mobile radio with minimum of 45-watt power located in the driver's compartment programmed to communicate with dispatch, hospitals, and other responding units to include the following frequencies: SJC Med Net channels 1 through 8, SJC HEAR, and Cal Cord.	NR	1	1	1
UHF control head, microphone and speaker installed in each ambulance's patient compartment to communicate with the base and receiving hospitals.	NR	1	NR	1
San Joaquin County EMS Agency BLS Protocols	1	1	1	1
San Joaquin County EMS Agency ALS Protocols	NR	NR	1	1
Field Operations Guide ICS 420-1 *(FOG Manual),* current edition	1	1	1	1
START triage tags	50	20	50	50
MCI Vests - Medical Group Supervisor, Triage Unit Leader (minimum)	0	0	1	1
Infection Control				
Bottle of instant hand sanitizer (alcohol based) or box of disinfectant wipes for human use.	1	2	1	2
Biohazard bags (various sizes recommended)	2	3	3	5
Commercial Biohazard spill kit or equivalent	1	1	1	1
Covered waste container	0	1	0	1
Needle disposal system, which is OSHA compliant	1	1	1	1
Antibacterial disinfectant solution	1	1	1	1
Latex free gloves in sizes small, medium, large, extra-large.	1 box	1 box	1box	1 box
Isolation Kit including: (2) Gowns, (2) N95 or N100 respirators, (2) eye/face splash guards. Must have sizes sufficient for all staff	3	2	3	2

Table 1: ALS and BLS Common Equipment and Supplies	**Par Level**			
	BLS		**ALS**	
	NT	**AMB**	**NT**	**AMB**
necessary to meet OSHA requirements.				

Table 2: BLS Specific Medications, Supplies, and Equipment	**Par Level**	
	BLS NT	**BLS AMB**
Epinephrine auto-injector (adult) 0.3mg	1	1
Epinephrine auto-injector (pediatric) 0.15mg	1	1
Naloxone preload syringe	2	1
Mucosal Atomizer Device	2	1
Glucose for oral administration (tube)	1	1
Saline/Sterile Water Irrigating	2000 ml	2000 ml
Glucometer with spare batteries	1	1
Glucometer test strips and lancets	25 each	25 each
Aspirin chewable 81 mg tablets	1 bottle	1 bottle
Dial-a-Flow or equivalent	NA	1

Table 3: ALS Specific Medications, Supplies, and Equipment	**Par Level**	
	ALS NT	**ALS AMB**
Acetaminophen – liquid for oral administration	2,600 mg	2,600 mg
Adenosine for injection	30 mg	30 mg
Albuterol Aerosolized Solution 2.5 mg each	4	8
Aspirin, chewable 81 mg tablets	1 bottle	1 bottle
Atropine for injection	3 mg	6 mg
Atrovent (Ipratropium bromide HFA) 0.5 mg packets	2	3
Diphenhydramine for injection	50 mg	100 mg
Diphenhydramine – liquid for oral administration	50 mg	100 mg
Calcium Chloride for injection	0	1 gm
Dextrose 50% for injection or; Dextrose 10% solution in 250 ml bags for injection	50 gm or (3) 250 ml bags of 10% solution or combination	75 gm or (2) 250 ml bags of 10% solution or combination
Dopamine for injection	0	400 mg
Epinephrine 1:1,000 for injection	2 mg	4 mg
Epinephrine 1:10,000 for injection	4 mg	8 mg
Fentanyl for injection	300 mcg	500 mcg

Table 3: ALS Specific Medications, Supplies, and Equipment	**Par Level**	
	ALS NT	**ALS AMB**
Glucose for oral administration (tube)	2	2
Ibuprofen – liquid for oral administration	1,600 mg	1,600 mg
Lidocaine for injection	400 mg	400 mg
Magnesium Sulfate for injection	4 gm	8 gm
Midazolam for injection	10 mg	20 mg
Morphine Sulfate for injection	20 mg	40 mg
Naloxone for injection	2 mg	4 mg
Nitroglycerin spray (minimum of 60 metered doses) or Tablet 1/150 gr	1 bottle	2 bottles
IV Normal Saline 250ml (maintained at manufacturer's recommended temperature range)	4	4
IV Normal Saline 1000ml bags (maintained at a range of 2 degrees within normal body temperature	2	2
IV warming system capable of maintaining two 1000ml bags at a range of 2 degrees within normal body temperature	1	1
IV Normal Saline 500ml or 1000ml bags (maintained at manufacturer's recommended temperature range)	4000 ml	8000 ml
Normal saline for injection 10ml or 20 ml vials or preloads	4	4
Saline/Sterile Water 1000ml Irrigating	2	5
Ondansetron – Packet of 2 x 4mg oral disintegrating tablets	8 mg	16 mg
Ondansetron for injection	0	16 mg
Sodium Bicarbonate for injection	50 mEq	100mEq
Tranexamic acid (TXA)	2gm	4gm
IV start kit, which contains: – (2) Alcohol or Chlorhexidine wipes, (1) Roll tape, 3/4", (2) – 2" x 2" gauze sponge, (1) ID label, (1) Providone iodine prep, (1) Adhesive bandage, (1) Latex Free Tourniquet, (1) OpSite Dressing (or equivalent)	3	8
Disposable razors	2	2
IV catheters each size: 16ga, 18ga, 20ga, 22ga	2	5
IV catheters each size: 14ga, 24ga	2	2
Hypodermic needles each size: 20ga, 21ga, 22ga, 23ga, 25ga	2	5
Disposable syringes each size: 1ml sub-q, 3ml, 5ml/6ml, 10ml/12ml	2	3
Disposable syringes each size: 20ml/30ml	1	2
EZ-IO drill	0	1
EZ-IO Needles each size: 15mm, 25mm	0	1
Betadine solution or swabs	2	4
Solution administration set, Macrodrip	2	4
Solution administration set, Microdrip	1	2

Table 3: ALS Specific Medications, Supplies, and Equipment	**Par Level**	
	ALS NT	**ALS AMB**
IV extension tubing	2	4
Secondary IV infusion kit	2	4
Medication added labels	2	4
Saline locks	2	4
Dial-a-Flow or equivalent	1	1
1000ml Pressure infusion bag or equivalent	1	1
Mucosal Atomizer Device	2	2

Table 4 Optional Equipment	**Par Level**	
	ALS NT	**ALS AMB**
Non C Channel Video Laryngoscope with photo or video recording ability *Must be approved by medical director prior to being put into service.	1	1

TITLE: **EMS AIRCRAFT UTILIZATION** EMS Policy No. **4448**

PURPOSE: The purpose of this policy is to specify the patient type and time criteria for utilization of an EMS Aircraft during an EMS system response.

AUTHORITY: Title 22, California Code of Regulations, Division 9, Chapter 8

DEFINITIONS:

A. "Inappropriate" means when the incident or patient's condition does not meet the utilization criteria as outlined in this policy.

B. "~~LIFECOM~~ SJCEMSA authorized dispatch center" means the authorized point of contact for all EMS aircraft requests in San Joaquin County.

C. "Total Transport Time" means the ground transport time, air transport time (including response time if the helicopter is not on-scene), weather, traffic considerations (closures/detours), or other similar factors, which may affect ***total*** transport time.

POLICY:

I. EMS Aircraft should only be used when it is in the best interest of the patient. In general, consideration should be given to requesting an EMS Aircraft whenever the patient's condition appears life or permanent disability threatening after field assessment. It is expected that the patient's condition, available ground resources, incident location in relation to the closest, most appropriate receiving facility and call circumstances will be evaluated and balanced when making the determination of transport modality.

II. All EMS aircraft requests will be routed through the SJCEMSA authorized dispatch center~~LIFECOM~~. Request from any other source, other than the SJCEMSA authorized dispatch center~~LIFECOM~~ will not be honored by EMS aircraft providers. The requesting agency shall be redirected to the SJCEMSA authorized dispatch center~~LIFECOM~~ by the EMS Aircraft dispatch center.

~~II.~~III. SJCEMSA authorized dispatch centers shall simultaneously dispatch air ambulance resources to MPDS determinants 3D, 4D, 7C/D/E, 14D, 15D/E, 17D, 22D, 27D, 29D, 30D and where ground transport time to a County-approved trauma center is equal to or greater than 30-minutes, and presenting conditions are not in conflict with Section VII.

~~III.~~IV. EMS Responders ~~The responding paramedic~~ may request an air ambulance while enroute to the call, if the responding crew suspects that an air ambulance will be needed based on previous knowledge of the area.

Approved: ~~Signature on File~~ ~~Signature on File~~
Medical Director EMS Administrator

~~IV.~~V. The senior medical person on scene shall be responsible for assessing EMS Aircraft utilization criteria and shall advise the IC or designee to cancel the EMS Aircraft when indicated.

~~V.~~VI. Prehospital personnel shall consider the request of an EMS Aircraft only after a risk/benefit analysis has been performed and when the ***clinical and time criteria*** are met.

~~VI.~~VII. When these criteria are not met, the EMS Aircraft shall **not be requested** or **shall be cancelled** by the IC, if already dispatched. EMS Aircraft has the authority and responsibility to turn over patient care to ground ambulance if patient does not meet EMS aircraft utilization criteria.

~~VII.~~VIII. Do Not Utilize Ems Aircraft Transport For The Following Patients:

A. Cardiac arrest (in hypothermic arrest consider air transport).
B. Stable patient(s); i.e., fracture ankle, dislocated shoulder, etc. (consideration for air transport may be given when the ground transport unit is greater than 30 minutes from a receiving facility).
C. Patient(s) contaminated by hazardous materials that cannot be completely decontaminated prior to transport (e.g., possible nausea/vomiting of Hazardous Materials; eye wash or wound care necessary which has Hazardous Materials contaminant, etc).
D. Patient(s) who are agitated or combative and a potential threat to the crew.
E. Patient(s) located within any city limits. The only exception to this shall be Mass casualty incidents.~~if the patient must be transported to a specialty care facility (i.e., trauma center, burn center, etc.) outside the city limits.~~
F.

~~VIII.~~IX. **Patient Transport Criteria:** Prior to requesting an EMS Aircraft a risk/benefit assessment shall be performed, see Appendix A, **EMS Aircraft Request Form** for an overview of this criteria.

A. Risk/benefit analysis:
   1. Does this patient meet the clinical criteria to be transported by air?
   2. Does air transport save at least 10 minutes over ground to the closest, ***MOST*** appropriate receiving facility?
   3. Is air transport in the best interest of the patient?
   4. Is air transport the safest way to transport the patient from the scene?
   5. Is air transport the most appropriate mode of transportation?
B. Clinical Criteria: EMS Aircraft transport shall only be used when the patient(s) meet the following clinical criteria.
   1. Unusual circumstances

a. Inaccessibility to the scene by ground personnel or equipment.
b. Extended extrication.
c. A multi-casualty incident.

2. Patient Condition (s)
   a. Multi-casualty incidents (red or yellow priority patients).
   b. Critical trauma patients
   c. Spinal injury with neurological deficit.
   d. Unstable burn patient.
   e. Unstable patient from environmental injuries.
   f. Vascular compromise in a limb or amputation.
   g. Prolonged seizure refractory to medication or seizures involving pregnancy.
   h. Cardiovascular instability.
   i. Respiratory arrest or severe respiratory comprise.
   j. Complications of childbirth (e.g., abnormal presentations, massive blood loss, etc.)
   k. Pediatric Trauma (Refer to Pediatric Trauma Policy).
   l. Any other conditions subject to approval of the ***Base Hospital Physician.***

C. Time Criteria: EMS Aircraft transport shall only be used when it will provide benefit in ***total transport time*** to the closest, most appropriate facility when compared to ground transport time, specifically:
   1. Long response times to scene, i.e., greater than twenty (20) minutes by ground.
   2. Patient transport to the closest, most appropriate facility is twenty (20) or more minutes by ground.
   3. Air transport may be considered for a stable patient, if the transport time is greater than thirty (30) minutes by ground.
   4. Air transport for approved patients as identified in this policy will be significantly more rapid (at least ten (10) minutes faster).

SAN JOAQUIN COUNTY
EMERGENCY MEDICAL SERVICES AGENCY

TITLE: **RECEIVING HOSPITAL STATUS** EMS Policy No. **4981**

PURPOSE:

The purpose of this policy is to establish requirements for receiving hospitals to maintain and communicate emergency department status.

AUTHORITY: Health and Safety Code, Division 2.5, Section 1797.220; & 1798 et seq.

DEFINITIONS:

A. "EMResource~~Diversion~~" means the web based ~~-~~emergency resource management system designed for receiving hospitals and emergency dispatch centers to~~healthcare providers and first responders to~~ track availability and facility operations status for patient distribution during Multi-Casualty Incidents and daily operations. ~~giving comprehensive views of local, state and regional resources.~~~~closure of a hospital's emergency department from receiving ambulance patients including all specialty services.~~

~~B. "HAvBED" means the national Hospital Available Beds for Emergencies and Disasters system developed by the U.S. Department of Health and Human Services.~~

~~C.~~B. "Receiving Hospital" means a ~~-~~licensed acute care hospital, with a comprehensive or basic emergency permit from the California Department of Public Health, ~~that~~and is approved by the San Joaquin County EMS Agency (SJCEMSA) to participate in the EMS system.

~~D.~~C. "~~SJCEMSA~~ EMS Duty Officer" means an on call 24/7 employee of the San Joaquin County Emergency Medical Services ~~MS~~ Agency (SJCEMSA) designated to serve as the alternate San Joaquin County Medical Health Operational Area Coordinator (MHOAC) ~~, the alternate OES Region IV Regional Disaster Medical Health Coordinator,~~ and empowered to act on behalf of the SJCEMSA.

~~E.~~D. "WebEOC" means a secure online emergency management and information sharing platform for use by authorized agencies and organizations within the San Joaquin County Operational Area.

POLICY:

I. The EMS Duty Officer may override a receiving hospital's status if the determined that such a change is necessary to ensure the integrity of the EMS system.

~~I.~~II. All receiving hospitals and emergency ~~ambulance~~dispatch centers ~~providers~~ in San Joaquin County shall ensure appropriate ~~proper~~staff training and familiarity with ~~with this policy to personnel to on a daily basis utilize the~~ EM~~S~~Resource™ related to hospital operational ~~to communicate regional communication system and continually maintain the receiving hospital's current emergency department~~ status ~~real time~~ using the following categories:

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A. Open: Open and fully functional to all patients.
~~—~~Advisory: Open with limited functionality that may require~~s~~ prehospital personnel to contact the SJCEMSA designated Base Hospital ~~Control Facility~~ for proper destination ~~Full hospital services not available~~ based on one or more of the following:

B.

1. Stroke services limited ~~limited oo~~r ~~unavailable;~~unavailable;
~~2. Major~~ Trauma services limited or unavailable~~Contact Control Facility (CF) for major trauma patient destination~~;
~~3.~~2. ~~Main power outage using auxiliary power;~~
~~4.~~ STEMI services limited or ~~limited or~~ unavailable~~;~~;
3.
4. Other limited or unavailable services in the emergency department that potentially affect adequate care of patients from the EMS system.
~~C. Diversion: Closed to ambulance traffic including all specialty services (not for use by San Joaquin County hospitals).~~

C. Internal Disaster: Closed to all patients based on an internal hospital event(s) that directly involves the facility and is a threat to staff and/or patients as determined by hospital and/or SJCEMSA. Examples include but are not limited to~~one or more of the following~~:

~~D.~~

1. On Campus fire or explosion;
2. On Campus security threat, i.e. assailant, active shooter, bomb threat;
3. Damaged infrastructure, i.e. building collapse or network/internet failure~~potential building collapse~~;
4. Hazardous material incident~~ – sheltering in place~~;
5. Loss of main and auxiliary power;
6. Loss of water supply;
7. Other event requiring hospital evacuation or sheltering in place.
~~7.~~ Other event not listed and in coordination with the EMSA Duty Officer. ~~;~~
8. ~~Other event requiring sheltering in place.~~

III. Maintaining status on EMResource™:

~~II.~~

A. Receiving hospitals shall actively monitor EMResource™ in the emergency department with a visual display and audible ~~alerting~~alert capability.
~~B.~~ Receiving hospitals shall update their facility status immediately:

~~1. Each morning at 0800 hours;~~
~~2.~~1. When necessary to communicate changes in their status to the EMS system;

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~~3.~~2. When requested to provide a status update and report on bed availability during an active multi-casualty incident (MCI) or exercise;

~~4. When requested to provide a status update and report on bed availability during an active HAvBED poll or exercise.~~

Receiving hospitals shall maintain access to the EMResource mobile app, at all times, to ensure continuity of operations during a network/internet failure.

~~III. Diversion:~~

~~A.~~B. ~~Receiving hospitals in San Joaquin County are prohibited from placing themselves on diversion or re-routing or attempting to re-route incoming ambulances to another receiving hospital.~~

IV. Internal Disaster:

~~IV.~~

A. Receiving hospitals that declare ~~post~~ a facility status of Internal Disaster are required to submit an updated Hospital Status Report in WebEOC and notify the EMS~~SJCEMSA~~ Duty Officer within 30 minutes.

~~A.~~B. The Administrator on-call (AOC) of each hospital declaring a facility status of Internal Disaster must immediately communicate directly with the EMS Duty Officer to verify a change in hospital status.

~~B.~~ The EMS~~SJCEMSA~~ Duty Officer shall ~~forward the Hospital Status Report~~submit a California ~~Public~~ Medical~~Health~~ and Health~~Medical Health~~ Situation Report, for all internal disaster occurrences, to the California Department of Public Health Services, ~~and~~ the California EMS Authority, and the Regional Disaster Medical Health Coordinator/Specialist.

~~Accountability:~~

~~V.~~

~~A. SJCEMSA personnel may perform unannounced site visits to receiving hospitals to ensure compliance with this policy.~~

~~B.~~C. ~~The EMSSJCEMSA Duty Officer may override a receiving hospital's status if the EMSSJCEMSA Duty Officer determines that such a change is necessary to ensure the integrity and operation of the EMS system.~~

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TITLE: **MEDICAL PAITENT DESTINATION** EMS Policy No. **5201**

PURPOSE:

The purpose of this policy is to provide direction to EMS personnel on determining the appropriate destination for medical patients.

AUTHORITY:

Health and Safety Code, Division 2.5, Section 1797.220, 1798, and 1798.170

DEFINITIONS:

A. "Base Hospital" and "Disaster Control Facility (DCF)" means San Joaquin General Hospital which is responsible for directing the prehospital care system in accordance with the policies and procedures of the SJCEMSA.
B. "Non-traumatic Life-Threatening Condition" means a medical patient with an unmanageable airway compromised by swelling or obstruction, or uncontrolled bleeding, or rapidly deteriorating vital signs.
C. "Primary Stroke Center" or "PSC" means a receiving hospital designated as a PSC by the SJCEMSA or designated as a PSC by another local EMS agency and recognized by the SJCEMSA.
D. "Receiving Hospital" means a licensed general acute care hospital with a permit for basic or comprehensive emergency services.
E. "ROSC" means the return of spontaneous circulation following cardiac arrest.
F. "SJCEMSA" means the San Joaquin County Emergency Medical Services (EMS) Agency, which is the designated local emergency medical services agency for San Joaquin County.
G. "STEMI Receiving Center" or "SRC" means a licensed acute care hospital with the capability to perform PCI which has satisfied the requirements for designation as set forth by the SJCEMSA or designated by another local EMS agency and recognized by SJCEMSA.

POLICY:

I. Prehospital personnel shall assess all patients and offer ambulance transportation to any patient needing medical care and provide ambulance transportation to any patient requesting transport to a receiving hospital with implicit or implied consent.

II. Medical patients shall be transported to a receiving hospital based on the following priorities:
    A. Multi-casualty incident – destination as coordinated with DCF.

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B. Cardiac arrest – closest receiving hospital.
C. Acute STEMI ~~and~~ or ~~sustained~~ ROSC – closest STEMI receiving center.
D. Sustained ventricular tachycardia with a pulse – closest STEMI receiving center.
E. Acute stroke:
   1. Patients with last known well time of less than 4 hours or RACE Score greater than or equal to 5 transport to closest PSC.
   2. All other patients transport to PSC of their choice or if no choice transport to closest PSC.
F. Non-traumatic life-threatening condition – closest receiving hospital or base hospital direction.
G. Active labor with complications – closest hospital with labor and delivery (L&D) service.
H. Active labor without complications – patient choice of receiving hospital with labor and delivery services.
I. Non-emergent condition – patient choice.
J. No preference specified – closest receiving hospital.

III. Parameters affecting transport destinations for medical patients:

A. Acute ST Elevated Myocardial Infarction (STEMI) Patient Considerations:
   1. Patients with an acute STEMI shall be transported to a designated STEMI Receiving Center (SRC) by-passing all other receiving hospitals.
   2. The following receiving hospitals are designated or recognized as SRCs for the San Joaquin County EMS System:
      a. Dameron Hospital.
      b. St. Joseph's Medical Center.
      c. Doctors Medical Center
      d. Memorial Medical Center.
   3. ~~The travel distance between Dameron Hospital and St. Joseph's Medical Center is determined to be inconsequential.~~ If a STEMI patient does not expresses a preference the patient ~~may~~ should be transported to ~~either~~ the closet SRC in Stockton. ~~-~~The same patient preference applies to the choice between Doctors Medical Center and Memorial Medical Center.

B. The following receiving hospitals are designated or recognized as a Primary Stroke Center (PSC) by the SJCEMSA:
   1. Adventist Lodi Memorial Hospital.
   2. Dameron Hospital.

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3. Doctors Hospital of Manteca.
4. Kaiser Hospital Manteca.
5. San Joaquin General Hospital.
6. St. Joseph's Medical Center.
7. Sutter-Tracy Community Hospital.
8. Doctors Medical Center, Modesto.
9. Kaiser Medical Center, Modesto.
10. Memorial Medical Center, Modesto.

C. Active Labor Considerations:

1. Active labor without complications is deemed to be a non-emergent condition. These patients may be taken to the receiving hospital with labor and delivery services (L&D) of their choice, as listed in subparagraph C. 3.
2. Active labor with complications (prolapsed cord, breech presentation) shall be transported to the closest receiving hospital with L&D services.
3. The following is a list of receiving hospitals with L&D services in San Joaquin County and in areas immediately adjacent to San Joaquin County:
   ~~a. Doctors Hospital of Manteca.~~
   ~~b.~~a. Adventist Lodi Memorial Hospital.
   ~~c.~~b. San Joaquin General Hospital.
   ~~d.~~c. St. Joseph's Medical Center.
   ~~e.~~d. Sutter-Tracy Community Hospital.
   ~~f.~~e. Kaiser Medical Center, Modesto.
   ~~g.~~f. Doctors Medical Center, Modesto.
   ~~h.~~g. Memorial Medical Center, Modesto.
   ~~i.~~h. Kaiser Medical Center, South Sacramento.

D. Non-Emergent Medical Patient Destination Considerations:

1. In a non-emergent situation, as determined by prehospital care personnel on scene or following base hospital consultation, the patient may be transported to the receiving hospital of their choice in San Joaquin County, Stanislaus County, or Sacramento County.
2. If the patient is unable or unwilling to express a choice, defer to the wishes of the patient's private physician and/or family. In the absence of such direction, patients should be transported to the closest receiving hospital.
3. Whenever possible ambulance personnel should determine where

the patient normally receives medical care and encourage the patient to return to that hospital.

4. Prehospital care personnel should only provide the patient and/or family with the available destination options and should not endorse a receiving facility or otherwise provide their ~~personal~~ opinion on the quality or merits of any receiving hospital.
5. If the patient is a member of a health plan with a preferred hospital, an attempt should be made to transport the patient to a participating or preferred receiving hospital.
6. If the countywide system status management ambulance availability is less than seven (7) ambulances, non-emergent medical destinations may be limited to receiving hospitals in San Joaquin County.
7. Ambulance personnel are not required to contact and should not contact the base hospital for permission to transport a non-emergent patient to a receiving hospital in San Joaquin County, Stanislaus County, or Sacramento County.

IV. Medical Multi-Casualty Incidents:

A. During an MCI the DCF may expand patient destinations to any receiving hospital within OES Region IV with initial preference being hospitals located in San Joaquin County, Stanislaus County, and Sacramento County.

V. Receiving Hospital Facility Status:

~~A. Patients shall not be transported to a receiving hospital with a facility status of diversion.~~

A. Patients shall not be transported to a receiving hospital with a facility status of internal disaster/closed.

~~B.~~

B. If a receiving hospital's facility status advises that a specialty care service is unavailable or limited, patients requiring such specialty care services should be advised and given the option of transport to similar receiving hospital with specialty care services.

~~C.~~ Specialty Care Services:

~~If a receiving hospital posts a facility status advising that a specialty service is unavailable, patients requiring such specialty service should be transported to another receiving hospital offering that specialty service.~~

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C.

~~1. Specialty care services include:~~

~~a.~~ Trauma Center ~~Computerized tomography (CT);~~

1. Primary.

~~2. y~~ Stroke Center ~~services~~.

2.

~~3.~~ STEMI Receiving Center ~~services~~.

3. Labor and delivery services.

~~If a receiving hospital's facility status advises that a specialty service is unavailable or limited, patients requiring such specialty services should be advised and given the option of transport to similar receiving hospital with specialty services.~~

~~If a receiving hospital posts a facility status advising that a specialty service is unavailable, patients requiring such specialty service should be transported to another receiving hospital offering that specialty service.~~

~~a.~~

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Adult Trauma

Trauma

Trauma can either be blunt or penetrating, open or closed, or any combination of all.

Definitions:

1. **Blunt Trauma**- Traumatic injury caused by a blunt object or surface.
2. **Penetrating**- Traumatic injury caused when an object enters the body.
3. **Open**- Traumatic injury with a break in the skin.
4. **Closed**- Traumatic injury without a break in the skin.
5. **TBSA**- Total Burn Surface Area.

Documentation Standards:

1. Every 5 minutes for unstable patients, every 15 minutes for stable patients:
   A. BP.
   B. Respirations.
   C. Pulse.
   D. SpO2.
2. If performed, before and after intervention or if condition changes:
   A. 12 lead ECG.
   B. Blood glucose ~~level, if~~level if diabetic.
   C. Pain scale PRN.
   D. Medications such as blood thinners.
   E. Baseline GCS and GCS after treatment.
   F. Physical assessment including skin signs and capillary refill
   G. Lung sounds.
   H. Complete/Head to toe exam.

Objective Findings:

1. Mechanism of injury.
2. Medical history e.g. cardiovascular problems, diabetes, or seizure disorder
3. Check for DCAP-BTLS (Deformity, Contusion/Crepitus, Abrasion, Puncture, Bleeding, Tenderness, Laceration, Swelling).
4. Glasgow coma ~~score .~~score.
5. Neurological impairment or focal deficit e.g. paralysis, weakness.
6. Eyes/vision e.g. pupil inequality and reactivity, eye tracking, impaired vision/double vision, stars.
7. Check for paradoxical chest wall movement (flail chest), rib cage, and sternal instability.
8. Check for pelvic instability, abdominal rigidity and guarding. Check for range of motion, distal pulses, sensation, skin color, and associated injuries.

Trauma

1. Place in spinal motion restricting if indicated.
2. See injury specific guidelines.
3. If bleeding, see injury specific guidelines.

Treatment #1- Symptomatic:
1. Monitor SpO2, if <94%, 1-15 LPM via NC or NRB, titrate to 94%.
2. Consider treating for pain. See protocol AGEN-03, p. 126.

If loss of consciousness:
3. Obtain blood glucose level. If <70 mg/dL, see protocol ANRO-03, p. 66.
4. Consider stroke screen. If positive, see protocol ANRO-01, p, 62.

If chest pain:
5. Cardiac monitor.
6. Consider 12 lead ECG. Obtain if concern for medical emergency caused traumatic event or blunt trauma to chest.

Treatment #2- Grossly symptomatic or signs or shock:
1. Cardiac monitor.
2. Monitor SpO2, if <94%, O2 1-15 LPM via NC or NRB, titrate to 94%.
3. Consider treating for pain. See protocol AGEN-03, p. 126.

If loss of consciousness or ALOC:
4. Obtain blood glucose level. If <70 mg/dL, see protocol ANRO-03, p. 66.
5. Consider stroke screen. If positive, see protocol ANRO-01, p. 62.

If chest injury:
6. Consider 12 lead ECG. Obtain if concern for medical emergency caused traumatic event or blunt trauma to chest.
7. Large bore IV x2, NS, TKO.
8. If SBP <90, NS 500ml rapid IVF bolus. Titrate to SBP >90, max of 1~~4~~L and,
9. Administer 2 gm TXA ~~in 100ml NS over 10 min for~~slow IV/IO push over two minutes for all penetrating or blunt trauma to the torso.

Considerations:
1. Continually assess for signs of shock.
2. If brain injury is suspected, elevate the head of the patient as long as no signs of shock are present.
3. Head injured patients that require intubation (No gag reflex and cannot protect own airway AAIR-01, p. 24) if time allows, pre-medicate head injured patients with fentanyl 2 mcg/kg IVP/IO prior to intubation.
4. Traumatic brain patients are especially sensitive to hypotension and hypoxia.
5. Significant internal thoracic and abdominal trauma may occur without any signs of injury.
6. Transport patient in position of comfort if not in spinal precautions. Place pregnant patients in left lateral recumbent position.
7. If concern for spinal cord injury, patient should be laid flat. If patient is without thoracic or lumbar tenderness, may be placed in semi-fowler position no greater than 30 degrees.
8. All patients with a period of unconsciousness should be transported to an emergency department for evaluation.
9. If patient meets Trauma Triage Criteria, transport to approved trauma center.
10. Scene time should be **LESS THAN 10 MINUTES** for any serious trauma patient and all treatment should be done enroute to hospital.
11. TBI is not contraindicated in TBI patients.
12. TXA may result in hypotension.

Base Hospital Orders
1. Consult Base Hospital if additional orders are needed or patient has atypical presentation.

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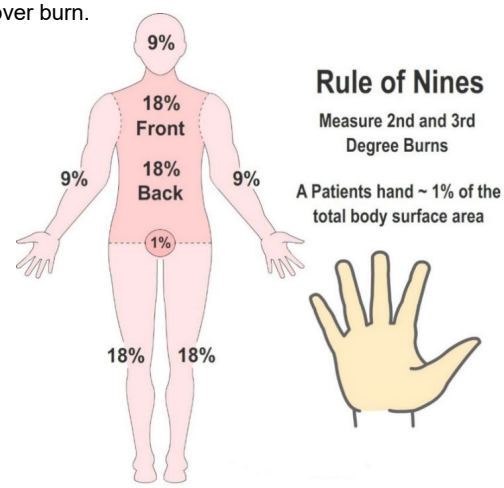
Injury Specific Guidelines

TRAUMA: Injury Specific Treatments

Treatment for Bleeding Control	Treatment Considerations
1. Direct pressure. 2. If unable to control with direct pressure alone, use hemostatic dressing on wound and pack wound if applicable. 3. Elevate extremity 4. If bleeding is still not controlled, apply tourniquet.	1. Secure tourniquets as high on arm or leg as possible. 2. Note time of placement. 3. Do not apply bulky dressing to wounds as they can hide bleeding.
Treatment for Eye Injury	**Treatment Considerations**
1. Apply dressing as appropriate. 2. Loosely cover affected and unaffected eye.	1. **DO NOT** attempt to re-insert eye.
Treatment for Tooth Injury	**Treatment Considerations**
1. Keep avulsed teeth in ~~saline soaked~~saline-soaked gauze. **OR** 2. Commercial tooth saver kit. 3. Transport tooth with patient.	1. **DO NOT** attempt to re-insert teeth. 2. **DO NOT** attempt to remove partially avulsed teeth.
Treatment for Mandible Fracture	**Treatment Considerations**
1. Splint with cravat or bandage.	1. Monitor airway for compromise or difficulty breathing.
Treatment for Impaled Object	**Treatment Considerations**
1. Stabilize with large bulky dressings. 2. Leave in place.	1. Removal of impaled objects should only be considered if object interferes with CPR or airway cannot be managed. 2. Consider base contact for consult.
Treatment for Flail Chest	**Treatment Considerations**
1. Stabilize chest with large bulky dressing.	1. Observe for tension pneumothorax.
Treatment for Open Chest Wound	**Treatment Considerations**
1. Cover wound with loose dressing, **DO NOT** seal. Sucking chest wounds: 2. Immediately cover with gloved hand. 3. Cover with occlusive dressing taped on three sides **OR** 4. Use commercially available chest seal.	1. Continuously monitor patient for tension pneumothorax. 2. Attempt to "burp" the wound by removing occlusive dressing, allowing air to escape and then recovering the wound, prior to needle decompression.
Treatment for Tension Pneumothorax	**Treatment Considerations**
1. Perform needle decompression: A. 2nd or 3rd Intercostal space at midclavicular line.	1. Tension pneumothorax occurs when a patient has: A. Absent or decreased lung sounds. B. Difficulty breathing. C. Hypotension.

TRAUMA: Injury Specific Treatments	
Treatment for Cardiac Tamponade	Treatment Considerations
1. Cardiac monitor. 2. 12 Lead ECG. 3. If SBP <90, NS 500ml rapid IVF bolus. Titrate to SBP >90, max of 12L.	
Treatment for Cardiac Contusion	Treatment Considerations
1. Cardiac monitor for dysrhythmias. A. V-Tach- see protocol ACAR-09, p. 50. 2. Obtain 12 lead ECG.	1. Consider 12 lead with blunt chest trauma.
Treatment for Evisceration of Organs	Treatment Considerations
1. Cover eviscerated organs with saline soaked gauze.	1. Frequently assess gauze for dryness and add additional saline if needed. 2. **DO NOT** attempt to reinsert organs.
Treatment for Genital Injuries	Treatment Considerations
1. Cover genitalia with saline soaked gauze.	1. If necessary, apply direct pressure to control bleeding. 2. Treat amputation as extremity amputation.
Treatment for extremity Injuries	Treatment Considerations
1. Check for range of motion, distal pulses, sensation, skin color, and associated injuries. 2. Elevate extremity. 3. Apply cold packs to reduce pain and decrease soft tissue swelling. 4. Splint injured extremity in position found unless precluded by extrication consideration, no palpable pulses, or patient discomfort.	1. Pad all splinted extremities and recheck distal pulses and neurological function every 5 minutes. 2. Do not apply traction or attempt to reduce an open extremity fracture.
Treatment for Mid Shaft Femur Fracture	Treatment Considerations
1. Apply traction splint.	1. Closed Mid shaft only.
Treatment for Extremity Amputation	Treatment Considerations
1. Place or cover amputated part with dry sterile dressing. 2. Place in sealed plastic bag or wrap with plastic. 3. Place dressed and wrapped part on top of ice or cold pack.	1. If patient condition allows transport amputated part with patient.
Treatment for Soft Tissue Injuries without serious bleeding	Treatment Considerations
1. Cover open wounds with sterile dressings.	

TRAUMA: Injury Specific Treatments

Treatment for Burns	Treatment Considerations
1. Remove clothing from burned area if ~~possible~~possible, without removing skin. 2. Calculate TBSA using rule of nines. 3. Patients with respiratory distress see protocol ARSP-01 to 03, pp. 54-58. 4. Consider treating for pain. See protocol AGEN-03, p. 126. If <20% TBSA: 5. Estimate depth of burn (full thickness, partial thickness, surface burn). 6. Cover with sterile dressing soaked with sterile water. If >20% TBSA: 7. Cover with dry sterile burn sheet or cleanest dry sheet. 8. Place patient on dry sterile burn sheet for transport. 9. IV x2, NS, WO, titrate to Parkland Formula. **Chemical:** 1. Follow appropriate decontamination or hazmat procedures. 2. Brush off dry powders. 3. Remove contaminated clothing. 4. Irrigate with copious amounts of water. **Thermal and electrical:** 1. Stop the burning process. 2. Cool with water for up to thirty (30) minutes, **DO NOT DELAY** transport to approved trauma center. 3. Remove jewelry and non-adhered clothing. 4. Cover burn.  	1. Always attempt to identify type and source of burn: A. Chemical. B. Electrical. C. Steam. D. Smoke. E. Open flame. **Parkland Formula** 4 ml x %TBSA x body weight (kg) = Total for 24 hours. 50% given in first eight hours; 50% given in next 16 hours. **Chemical:** 1. **DO NOT** attempt to remove tar or other adhered material. 2. If possible, bring chemical Safety Data Sheet (S DS) with patient to hospital. **Thermal and electrical:** 1. Avoid prolonged cool water usage due to risk for hypothermia and local cold injury. 2. **DO NOT** use ice water or apply ice or ice packs to patient. 3. **DO NOT** break blisters.

TRAUMATIC Arrest

Loss of Cardiac and pulmonary function due to traumatic event.

Definitions:

1. High quality CPR - Use TEAM approach:
   A. 100 to 120 compressions per minute.
   B. **30:2** ratio compression to ventilation ratio.
   C. Compress at least 2 inches.
   D. Allow complete recoil.
   E. Minimize interruptions.
   F. Rotate compressors every 2 minutes.
   G. Pre-charge monitor for defibrillation while CPR is in progress.

Documentation Standards:

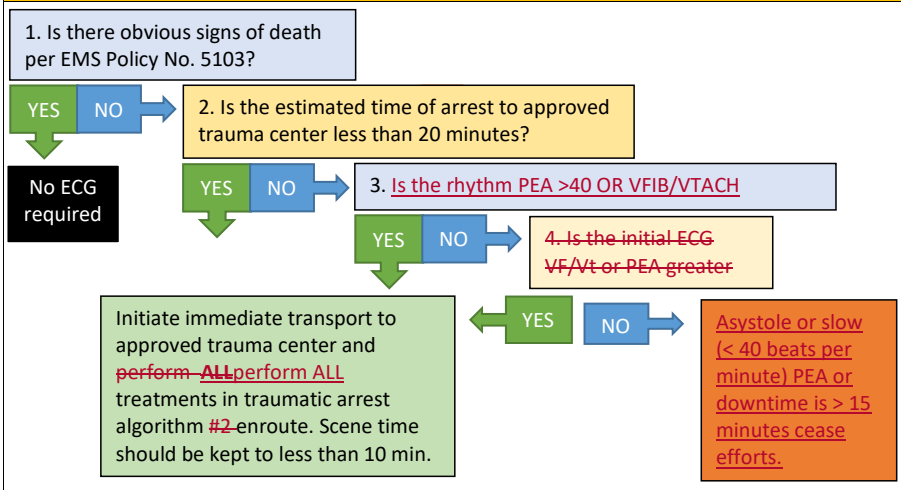
1. Every 5 minutes:
   A. BP.
   B. Respirations.
   C. Pulse.
   D. SpO2.
2. If performed, before and after intervention or if condition changes:
   1. Capnography.
   2. Blood glucose.
   3. Physical assessment.

Objective Findings:

Obtain patient history and document the following:

1. Estimated down time.
2. Quickly assess for obvious signs of death:
   A. Decapitation.
   B. Decomposition.
   C. Burnt beyond recognition.
   D. Lividity.
   E. Rigor mortis.
3. Circumstances surrounding the arrest:
   A. Onset (witnessed or unwitnessed).
   B. Preceding symptoms.
   C. Bystander CPR.
   D. Medications.
   E. Environmental factors (hypothermia, inhalation, and asphyxiation).

TRAUMATIC Arrest



Treatment- Treat reversible causes upon identification

Reversible Causes:

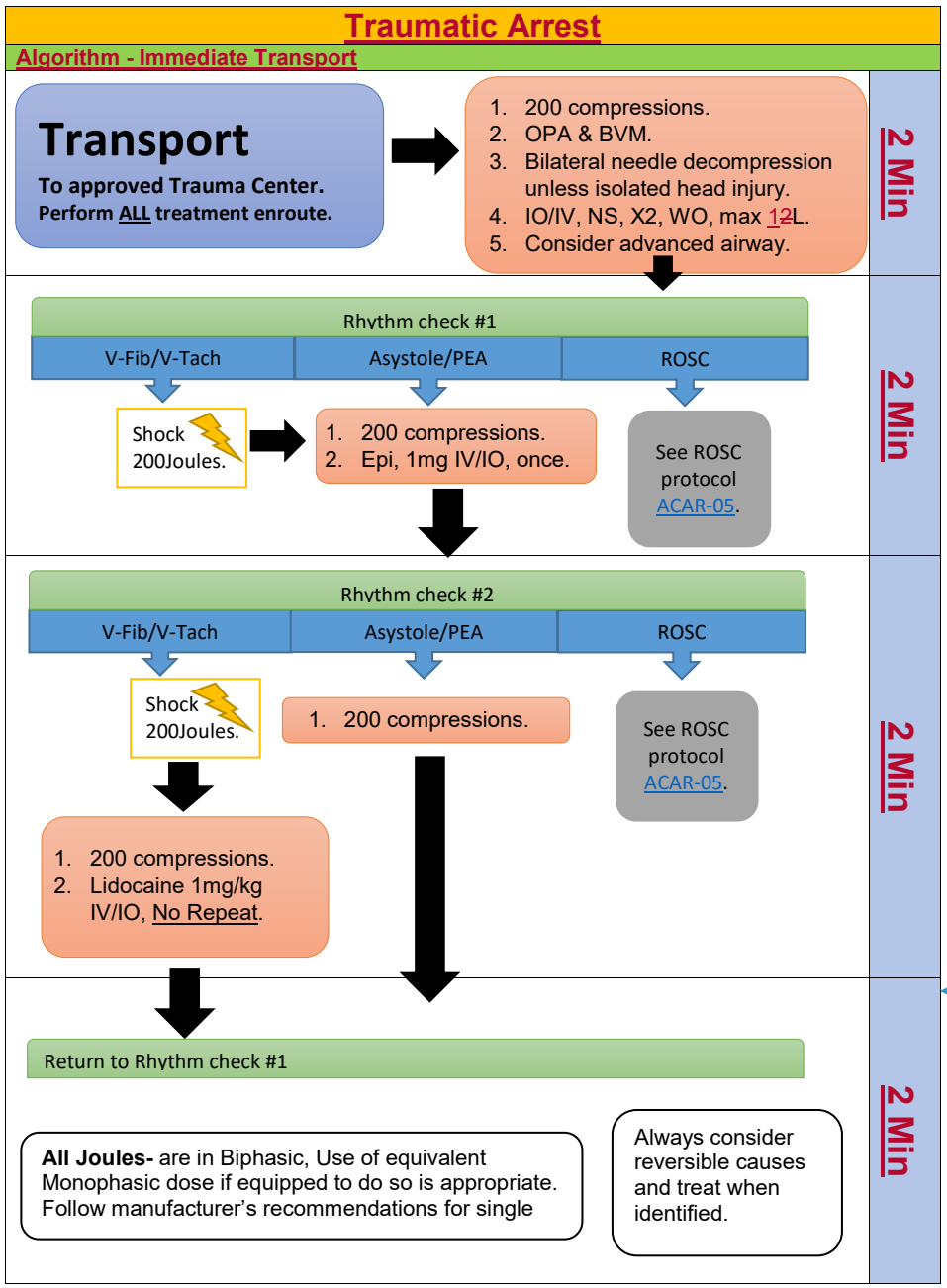
1. **Hypovolemia-** (History suggesting volume depletion) NS 2L IVF bolus, start 2nd IV.
2. **Hypoxia-** (SpO2 <94%) Maintain ventilations at 8-10/min, with 100% O2, BVM & OPA. Intubate if CL of 1 or 2, supraglottic airway if CL >3.
3. **Hydrogen Ion-** (Acidosis, crush patient, long down time, dialysis patient) Sodium Bicarbonate 1mEq/~~kg IV~~kg IV/IO.
4. **Hypoglycemia-** (Blood glucose level <70 mg/dL) Dextrose 10% 10ml/kg IV/IO or Dextrose 50% 25g IV/IO.
5. **Hypocalcemia-** (Long down time, crush injury, dialysis patient) Calcium Chloride 500mg 10% IV/IO.
6. **Hyperkalemia-** (Long down time, crush injury, dialysis patient) Sodium Bicarbonate 1mEq/kg IV/IO.
7. **Hypothermia-** (Body temp below 34°C) Active rewarming with warm IV/IO fluids, start IV if ~~possible, hot~~possible, hot packs to neck and groin.
8. **Tension Pneumothorax-** (Absent lung sounds on affected side) Needle decompression.
9. **Tamponade, Cardiac-** If SBP <90, lung sounds are clear and no fluid restrictions exist: NS 2L IVF Bolus, start 2nd IV.
10. **Toxins-** See protocol AODP-01 to 07, 105-118.
11. **Thrombosis, Pulmonary & Coronary-** Needle decompression.
12. **Torsade's De Pointes-** Magnesium Sulfate 2g- IV/IO.

Considerations:

1. The goal is high quality CPR.
2. **DO NOT** delay vascular access with IV attempts. Go directly to IO if IV is not established after first attempt.
3. Monitor capnography with BVM & OPA.
4. Oral tracheal intubation should be used as the definitive airway for CL scores of 1 & 2.

Base Hospital Orders

1. Consult Base Hospital if additional orders are needed **or** patient has atypical presentation.



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SAN JOAQUIN COUNTY
EMERGENCY MEDICAL SERVICES AGENCY

TITLE: STEMI Quality Improvement Committee (STEMI QIC) EMS Policy No. 6640

PURPOSE:

The purpose of this policy is to establish membership, role, responsibilities, process, and structure of the STEMI Quality Improvement Committee (STEMI QIC).

AUTHORITY:

Health and Safety Code, Division 2.5, Section 1797.220, 1798, 1798.170, and 1798.172. Evidence Code Section 1040. California Code of Regulations, Title 22, Division 9, Chapter 7.1.

POLICY:

I. The STEMI Quality Improvement Committee (STEMI QIC) is an EMS System level multi-disciplinary peer committee established to monitor, review, evaluate, and improve the provision of care to STEMI patients in the EMS System and advise the EMS Medical Director on STEMI related education, training, quality improvement, and data collection.

II. STEMI QIC Roles and Responsibilities:

A. Monitor the delivery of STEMI services, analyze STEMI data to identify opportunities for improving STEMI care, and offer advice to the EMS Medical Director on the design of the STEMI system.
B. Conduct mortality and morbidity review of STEMI-related deaths, major complications, and transfers.
C. Review others cases identified through the Continuous Quality Improvement Council (CQI) process that may involve prehospital care, system design, or an exceptional educational or scientific benefit.
D. For each case reviewed by STEMI QIC, provide a finding of the appropriateness of care rendered and when applicable make recommendations for improving care.
E. Present and review STEMI center specific issues with the goal of improving processes.

III. STEMI QIC Membership:

A. The STEMI QIC membership shall be comprised of fifteen (15) designated members, properly affiliated, with one (1) member representing each of the following:
1. EMS Administrator - permanent member.

2. EMS Medical Director – permanent member.
3. A STEMI program medical director from SJCEMSA designated SRCs;
   a. Dameron Hospital Association.
   b. St. Joseph's Medical Center.
4. An emergency medical physician from each SJCEMSA designated SRC;
   a. Dameron Hospital Association.
   b. St. Joseph's Medical Center.
5. SJCEMSA Trauma Coordinator / Critical Care Coordinator.
6. STEMI Program Nurse Director from each SJCEMSA designated SRC;
   a. Dameron Hospital Association.
   b. St. Joseph's Medical Center.
7. A representative from each of the authorized advanced life support (ALS) emergency ambulance transport providers;
   a. American Medical Response.
   b. Manteca District Ambulance.
   c. Ripon Consolidated Fire Protection District.
   d. Escalon Community Ambulance.
8. A Base Hospital Liaison Nurse.
9. A representative from non-transport ALS providers.

IV. STEMI QIC Term Limits and Filling Vacancies:

A. There are no term limits to membership.
B. Affiliated organizations with membership represented in the STEMI QIC shall ensure that the SJCEMSA is notified of resigning members and their respective replacements.

V. The EMS Medical Director or SJCEMSA Trauma Coordinator / Critical Care Coordinator may approve the attendance of guests during regular or ad hoc meetings of the STEMI QIC.

VI. STEMI QIC Schedule and Attendance:

A. STEMI QIC shall meet no less than ~~quarterly~~ biannually on a schedule to be determined by majority of STEMI QIC members.
B. Members shall notify the SJCEMSA in advance of any meeting they will be unable to attend.
C. Members serve with the approval of the EMS Medical Director and may be

removed from the STEMI QIC for absenteeism or other misconduct.

D. The EMS Medical Director or designee will serve as the chairperson for each meeting.

VII. Confidentiality:

A. All proceedings, documents, and discussions of the STEMI QIC are confidential and are covered under Sections 1040 and 1157.7 of the California State Evidence Code. The prohibition relating to discovery of testimony provided to the STEMI QIC shall be applicable to all proceedings and records of this Committee, which is one established by a local government agency to monitor, evaluate, and report on the necessity, quality, and level of specialty health services, including but not limited to, STEMI care services.

TITLE: Stroke Quality Improvement Committee (STROKE QIC) | EMS Policy No. 6650

PURPOSE:

The purpose of this policy is to establish membership, role, responsibilities, process, and structure of the Stroke Quality Improvement Committee (STROKE QIC).

AUTHORITY:

Health and Safety Code, Division 2.5, Section 1797.220, 1798, 1798.170, and 1798.172. Evidence Code Sections 1040. California Code of Regulations, Title 22, Division 9, Chapter 7.2.

POLICY:

I. The Stroke Quality Improvement Committee (STROKE QIC) is an EMS System level multi-disciplinary peer committee established to monitor, review, evaluate, and improve the provision of care to Stroke patients in the EMS System and advise the EMS Medical Director on Stroke related education, training, quality improvement, and data collection.

II. STROKE QIC Roles and Responsibilities:
   A. Monitor the delivery of Stroke services, analyze Stroke data to identify opportunities for improving Stroke care, and offer advice to the EMS Medical Director on the design of the Stroke system.
   B. Conduct mortality and morbidity review of Stroke-related deaths, major complications, and transfers.
   C. Review others cases identified through the Continuous Quality Improvement Council (CQI) process that may involve prehospital care, system design, or an exceptional educational or scientific benefit.
   D. For each case reviewed by STROKE QIC provide a finding of the appropriateness of care rendered and when applicable make recommendations for improving care.
   E. Present and review Stroke center specific issues with the goal of improving processes.

III. Membership:
   A. STROKE QIC membership shall be comprised of sixteen (16) designated members properly affiliated, representing one (1) member for each of the following:
      1. EMS Administrator - permanent member.
      2. EMS Medical Director – permanent member.
      3. EMS Agency Trauma Coordinator / Critical Care Coordinator.

4. A Stroke Program Nurse Director from each EMS Agency designated SRC;
   a. Adventist Health Lodi Memorial Hospital.
   b. Dameron Hospital Association.
   c. Doctors Hospital Manteca.
   d. Kaiser Permanente Hospital Manteca.
   e. San Joaquin General Hospital.
   f. St. Joseph's Medical Center.
   g. Sutter Tracy Community Hospital.
5. A representative from each of the authorized advanced life support (ALS) emergency ambulance transport providers;
   a. American Medical Response.
   b. Manteca District Ambulance.
   c. Ripon Consolidated Fire Protection District.
   d. Escalon Community Ambulance.
6. A Base Hospital Liaison Nurse.
7. A representative for non-transport ALS providers.

IV. Term Limits and Filling Vacancies:
   A. There are no term limits to membership.
   B. Affiliated organizations with membership represented in the STROKE QIC shall ensure that the SJCEMSA is notified of resigning members and their respective replacements.

V. The EMS Medical Director or EMS Agency Trauma Coordinator / Critical Care Coordinator may approve the attendance of guests during regular or ad hoc meetings of the STROKE QIC.

VI. Attendance:
   A. STROKE QIC shall meet no less than ~~quarterly~~ biannually on a schedule to be determined by majority of members.
   B. Members shall notify the SJCEMSA in advance of any meeting they will be unable to attend.
   C. Members serve with the approval of the EMS Medical Director and may be removed from the STROKE QIC for absenteeism or other misconduct.
   D. The EMS Medical Director, or designee, will serve as the chairperson for each meeting.

VII. Confidentiality:
   A. All proceedings, documents, and discussions of the STROKE QIC are confidential and are covered under Sections 1040 and 1157.7 of the

California State Evidence Code. The prohibition relating to discovery of testimony provided to the STROKE QIC shall be applicable to all proceedings and records of this Committee, which is one established by a local government agency to monitor, evaluate, and report on the necessity, quality, and level of specialty health services, including but not limited to, Stroke care services.