



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

**EMERGENCY MEDICAL SERVICES
BASE HOSPITAL ADVISORY COMMITTEE
MEETING NOTICE**

Date: June 12, 2013
Time: 1:00 P.M.
Location: EMS Headquarters
EMS Commission Hearing Room 1st Floor
10100 Pioneer Blvd.
Santa Fe Springs, CA 90670

The Base Hospital Advisory Committee meetings are open to the public. You may address the Committee on any agenda item before or during consideration of that item, and on other items of interest that are not on the agenda, but are within the subject matter jurisdiction of the Committee.

AGENDA

1. **CALL TO ORDER**
2. **APPROVAL OF MINUTES- April 10, 2013**
Review of Minutes – February 13, 2013
3. **INTRODUCTIONS/ANNOUNCEMENTS**
4. **REPORTS & UPDATES**
 - 4.1 Sidewalk CPR
 - 4.2 Prehospital Patient Care Operational Analysis
5. **UNFINISHED BUSINESS**
 - 5.1 Reference No. 606, Documentation of Prehospital Care
6. **NEW BUSINESS**
 - 6.1 Los Angeles County Prehospital Code of Ethics
 - 6.2 Reference No. 524, Requirements for Approval of a 9-1-1 Receiving Hospital
 - 6.3 Reference No. 1200, General Instructions for Treatment Protocols
7. **OPEN DISCUSSION**
8. **NEXT MEETING: August 14, 2013**
9. **ADJOURNMENT**



**EMERGENCY MEDICAL
SERVICES AGENCY**
LOS ANGELES COUNTY

**EMERGENCY MEDICAL SERVICES COMMISSION
BASE HOSPITAL ADVISORY COMMITTEE
MINUTES
April 10, 2013**

REPRESENTATIVES		EMS AGENCY STAFF	
<input type="checkbox"/> Gerald Clute, Chair	EMSC Commission	William Koenig, MD	Susan Mori
<input checked="" type="checkbox"/> Robert Flashman, M.D. Vice Chair	EMSC Commission	Richard Tadeo	Carolyn Naylor
<input type="checkbox"/> Frank Binch, Commissioner	EMSC Commission	Lucy Hickey	Christy Preston
<input checked="" type="checkbox"/> Gloria Tolle	County Hospital Region	Deidre Gorospe	Paula Rashi
<input checked="" type="checkbox"/> Paula Park	County Hospital Region	Michele Hanley	Erika Reich
<input type="checkbox"/> Shantel Luciano	Alternate, County Region	Nichole Bosson, MD	David Wells
<input checked="" type="checkbox"/> Michael Martini	Northern Region	Christine Clare	Michelle Williams
<input checked="" type="checkbox"/> Judy Grimaldi	Northern Region	Dianna Glass	
<input checked="" type="checkbox"/> Terri Halverson	Alternate, Northern Region		
<input checked="" type="checkbox"/> Kristina Crews	Southern Region		
<input checked="" type="checkbox"/> Kristine Cash	Southern Region		
<input type="checkbox"/> Samantha Verga-Gates	Southern Region		
<input checked="" type="checkbox"/> JoAnn Birdsong	Alternate, Southern Region		
<input checked="" type="checkbox"/> Alina Candal	Eastern Region		
<input checked="" type="checkbox"/> Laurie Sepke	Eastern Region		
<input checked="" type="checkbox"/> Suzette Otley	Alternate, Eastern Region		
<input checked="" type="checkbox"/> Paula Rosenfield	Western Region		
<input checked="" type="checkbox"/> Ann Munnely	Western Region		
<input checked="" type="checkbox"/> Rosie Romero	Alternate, Western Region		
<input type="checkbox"/> Mary Thompson	MICN Representative		
<input type="checkbox"/> VACANT	Alternate, MICN Representative		
<input checked="" type="checkbox"/> Brian Hudson	Provider Agency Advisory Committee		
<input type="checkbox"/> Isaac Yang	Alternate, PAAC		
<input type="checkbox"/> Robin Goodman	Pediatric Advisory Committee		
<input checked="" type="checkbox"/> Kerry Gold-Tsakonas	Alternate PedAC Representative		
PREHOSPITAL CARE COORDINATORS		GUESTS	
Joanne Dolan	Charrise Powell	Rex Pritchard, LBFD	
Lila Mier	Jenny Van Slyke	Nicole Steeneken, LACoFD	
Jennifer Pickard		Dee Fontana, GWT	

e-Excused

1. CALL TO ORDER: The meeting was called to order at 1:07 P.M. by Dr. Robert Flashman, Vice Chair

2. APPROVAL OF MINUTES – February 13, 2013

(Candal/Van Slyke) Approve the February 13, 2013 minutes with an amendment to item #4.2, Reference No. 407, ALS Unit Alternate Staffing Pilot Program.

3. INTRODUCTIONS AND ANNOUNCEMENTS:

Dee Fontana, RN was introduced as the Emergency Department Manager at Glendale Adventist Medical Center.

4. REPORTS AND UPDATES:

4.1 Sidewalk CPR

Just a reminder, Sidewalk CPR is scheduled for June 4, 2013. Posters advertising the event are available to disseminate to the EMS community.

4.2 2013 Annual EMSAAC Conference

Flyers for the upcoming EMSAAC Conference scheduled for May 29 & 30 are available for distribution.

4.3 Trauma and Emergency Medicine Information System

The contract with Lancet Technology will expire next year. Prior to contract negotiations, there are a few items that should be discussed with the hospitals. The vendor is recommending the migration of the database to a web-based system. Currently, the hospitals maintain a local copy of the data. In a web-based system, data would still be accessible; however, not in the current format. The security of the data would be maintained.

Another issue could be the hosting of the database by the vendor, which may create expansion and performance issues when multiple users are logged on. Currently this problem is managed by having data imports and exports done during off-hours.

In anticipation of the negotiation process, it is recommended that the PCCs consult with their facility IT personnel to create a list of questions and concerns for the vendor and the EMS Agency. Additional information will be forthcoming.

The State provided feedback to the EMS Agency related to submitted trauma data, which was excellent overall. The outstanding deficient data elements were injury zip codes, and alcohol levels, which were facility specific. This feedback has been provided to the trauma centers.

The base hospitals began using the revised Base Hospital Form (BHF) effective April 1, 2013. The revised BHF dictionary can be found on the EMS website. Base hospitals must notify the EMS Agency once they are ready to begin entering the new forms so that they may receive their software upgrade. The upgrade should take less than one hour.

The Agency is developing quarterly data reports for the base hospitals to provide ongoing feedback related to data accuracy. Base hospital data will also be used for development of potential systemwide QI reports – the first reports will focus on patients documented as “AMA” (against medical advice), and the new passenger space intrusion criteria.

The first integration of Stroke data into TEMIS was successful in a test environment. This will allow the Agency to develop reports utilizing the TEMIS report generator and evaluate stroke care on a systemwide basis. This same process is planned for the STEMI database.

4.4 Reference No. 506, Trauma Triage

Ref. No. 505 was revised at the request of the EMS community to clarify the passenger space intrusion 12 versus 18 inches triage criteria.

4.5 Ambulance Guidelines for Response to Radiation Events

Ambulance Guidelines for Response to Radiation Events are a set of guidelines for provider agencies and facilities to prepare for, respond to, and recover from radiological incidents. Comments and feedback should be forwarded to Terry Crammer at tcrammer@dhs.lacounty.gov.

4.6 Reference 606, Documentation of Prehospital Care

Ref. No. 606 - Documentation of Prehospital Care received contradicting comments from the different committees regarding providers using electronic patient care records providing a paper copy of documentation. Therefore a multi-disciplinary work group has been formed to find a mutually acceptable process of providing documentation to the facility from prehospital care personnel. They will review and revised this policy and return it to the committees once these issues have been reviewed.

4.7 Glucose Administration

At the request of this committee, Medical Council discussed the revised American Diabetic Association's recommended guidelines to treat for hypoglycemia with glucose readings of 70 and below. Based on the field treatment of patients with stroke symptoms, the Medical Council decided not to change the prehospital care treatment guidelines at this time.

4.8 Drug Shortage

There continues to be a shortage of Atropine 1 mg/10 ml preloaded syringes. Dopamine 400mg in 250 ml premixed are currently available, however the shortage of Dopamine 400 mg vials remains. There are still isolated occurrences of Midazolam shortages. Sodium Chloride one liter bags have a recall on certain lots due to possible brass particulates. An email will be distributed with detailed information and lot numbers regarding this recall. There is still a severe shortage of Dextrose 50%. The agency has been unable to secure any stock. Odansatron is on back-order, but is projected to be available later on this year.

4.9 Hospital Closures

A notice was distributed to the EMS community regarding the closure of Los Angeles Metropolitan Hospital and Bellflower Medical Center. The Department of Public Health Services has authorized these hospital closures, and a public hearing will not be required. The surrounding hospitals are reporting an expected impact to obstetrical and psychiatric patients.

5. UNFINISHED BUSINESS:

5.1 Reference No. 607, Electronic Submission of Prehospital Data

Reference No. 607, Electronic Submission of Prehospital Data has recurring issues regarding leaving a copy of the prehospital care record at the hospital. The transfer of info between providers is also an issue.

(Grimaldi/Van Slyke) Table Reference No. 607, Electronic Submission of Prehospital Data.

6. NEW BUSINESS:

6.1 Reporting of MICN Certification Exam Pass Rates

For informational purposes, the MICN Certification program pass rates will be distributed to APCC.

APCC requested information on scheduling the next EMS Agency MICN Development course.

6.2 Reference No. 304, Role of the Base Hospital

Reference No. 304, Role of the Base Hospital revisions are based on recent system changes.

(Grimaldi/Tolle) Approve Reference No. 304, Role of the Base Hospital

6.3 Reference No. 308, Base Hospital Medical Director

Reference No. 308, Base Hospital Medical Director defines the qualification, role, and responsibilities of the Base Hospital Medical Director.

(Candal/Grimaldi) Approve Reference No. 308, Base Hospital Medical Director

6.4 Reference No. 407, Advanced Life Support (ALS) Unit Alternate Staffing Pilot Program Requirements

Reference No. 407, Advanced Life Support (ALS) Unit Alternate Staffing Pilot Program Requirements defines the requirements to implement a pilot program. This policy was reviewed in its entirety with lengthy discussion and comments

Principles:

A previous version of the policy included Board of Supervisor (BOS) approval for alternate staffing models which has been removed.

This clause was removed as pilot programs do not require BOS approval.

Definitions:

During a recent LA Area Fire Chiefs meeting, it was discussed that the definition of One-and-One Staffing be removed from this policy.

The definition of One-and-One Staffing is included based on recommendation from Governance. The inclusion of this definition is to eliminate any confusion between the two models.

Education and Training

Members of Association of Prehospital Care Coordinators (APCC) expressed concern regarding the paramedic training. The training is insufficient preparation for a newly certified paramedic to single-handedly care for patients with complex medical problems. It is recommended the paramedic have at minimum one year of training to participate in the alternate staffing pilot program.

EMT Roles and Requirements

A question was raised regarding EMT operation of paramedic communications equipment. The EMT will need to have knowledge of operation of the paramedic communications equipment for situations requiring the paramedic to focus on patient care. In these cases the EMT may find it necessary to relay changes in the patient's condition to the receiving hospital, but will not receive paramedic orders.

Additional Comments

APCC members verbalized compelling concerns regarding approval of this policy. They feel that the motive for the alternative staffing is based on budget deficits and not patient care considerations. There are concerns of how moving forward with an alternative staffing program may affect the quality of patient care.

They expressed the opinion that while budgetary issues are real, alternative measures must be considered to maintain the quality of the EMS system.

If alternative staffing pilots are approved, there should be consideration of expanding the role of the EMT to improve the probability of a successful program.

They felt that the one-plus-one staffing model specifically would have a direct effect on how medical care is delivered, and result in an increased time to ALS interventions. They feel that the current call volume is too high for this staffing model and will lead to paramedic burnout.

Public Comment

Mr. Rex Pritchard, Long Beach Firefighters Association, offered comments. The Long Beach pilot program should not be allowed to move forward. Mr. Pritchard expressed concerns that this pilot project stems from budgetary deficits of the city of Long Beach. Care providers are concerned for patient safety with only one paramedic on the ambulance unit. There are concerns that this model of staffing will lead to poor patient outcomes and increase the likelihood of medication errors. If this pilot program does move forward, there is a strong recommendation that the paramedics should be required to have at least one year of experience. A recommendation to review comparative data with other systems that use alternate models was offered.

(Candal/Crews) Do Not Approve Reference No. 407, Advanced Life Support (ALS) Unit Alternate Staffing Pilot Program Requirements.

(Candal/Crews) Rescind previous motion Do No Approve Reference No. 407, Advanced Life Support (ALS) Unit Alternate Staffing Pilot Program Requirements.

Recommended changes:

Page 1, Principles: The Board of Supervisors shall approve any proposed pilot project and continuation of the pilot project beyond the maximum two year pilot program.

Page 3, Policy, F. Education and Training: One year experience functioning as a paramedic must be a minimum requirement in order for a paramedic to participate in an ALS Unit Alternate Staffing Program, similar to the current SFTP requirements.

Page 5, Policy, III, Paramedic Role and Requirements: A one year experience functioning as a paramedic must be a minimum requirement in order for a paramedic to participate in an ALS Unit Alternate Staffing Program, similar to the current SFTP requirements.

(Van Slyke/Grimaldi) Approve the recommended changes.

(Van Slyke/Otlewis) Do Not Approve Reference No. 407, Advanced Life Support (ALS) Unit Alternate Staffing Pilot Program Requirements. The members would like to know the recommendations from the Provider Agency Advisory Committee before they can take action on the entire policy.

6.5 Reference No. 816, Physician at the Scene

Reference No. 816, Physician At the Scene revisions includes the role of an EMS Fellow at scene.

(Candal/Grimaldi) Approve Reference No. 816, Physician at the Scene

6.6 Reference No. 838, Application of Patient Restraints

Reference No. 838, Application of Patient Restraints provides guidelines for the use of restraints during patient transports.

(Candal/Grimaldi) Approve Reference No. 838, Application of Patient Restraints

6.7 Reference No. 1011, Mobile Intensive Care Nurse Field Observation

Reference No. 1011, Mobile Intensive Care Nurse Field Observation establishes the function of the MICN/MICN candidate participating in field observation.

(Candal/Grimaldi) Approve Reference No. 1011, Mobile Intensive Care Nurse Field Observation

7 OPEN DISCUSSION:

BHAC
April 10, 2013

Pediatric Medical Center (PMC) Transports

The LA County Pediatric Liaison Nurses (PdLN) are requesting a change in guidelines for PMC transports to include children with a glucose reading greater than 400.

EMS Continuing Education

The EMS Certification section reminded field educators to submit continuing education calendars prior to the education dates, as required.

Data Advisory Committee

APCC members commented on the discussion at the Data Advisory Committee meeting about whether to discontinue the committee. APCC would like to see this committee continue based on the benefit to the EMS system.

- 8 **NEXT MEETING:** June 12, 2013 P.M.
- 9 **ADJOURNMENT:** The meeting was adjourned at 3:16 P.M.



**EMERGENCY MEDICAL SERVICES COMMISSION
BASE HOSPITAL ADVISORY COMMITTEE
MINUTES
February 13, 2013**



REPRESENTATIVES		EMS AGENCY STAFF	
<input type="checkbox"/>	Jerry Clute, Chair	EMS Commission	Christine Bender
<input checked="" type="checkbox"/>	Robert Flashman, M.D., Vice Chair	EMS Commission	Nicole Bosson, MD
<input type="checkbox"/>	Frank Binch, Commissioner	EMS Commission	Christine Clare
<input checked="" type="checkbox"/>	Gloria Tolle	County Hospital Region	Dianna Glass
<input type="checkbox"/>	Paula Park	County Hospital Region, Alternate	Deidre Gorospe
<input type="checkbox"/>	Shantel Luciano	County Hospital Region, Alternate	Michele Hanley
<input checked="" type="checkbox"/>	Michael Martini	Northern Region	Carl Hernandez
<input checked="" type="checkbox"/>	Judy Grimaldi	Northern Region	Cathlyn Jennings
<input checked="" type="checkbox"/>	Melanie Ridgley	Northern Region, Alternate	Susan Mori
<input checked="" type="checkbox"/>	Kristina Crews	Southern Region	Carolyn Naylor
<input checked="" type="checkbox"/>	Kristine Cash	Southern Region	John Opalski
<input type="checkbox"/>	Samantha Verga-Gates	Southern Region	Christy Preston
<input checked="" type="checkbox"/>	Jo Ann Birdsong	Southern Region, Alternate	Paula Rashi
<input type="checkbox"/>	Natalie Burciago	Southern Region, Alternate	Erika Reich
<input checked="" type="checkbox"/>	Paula Rosenfield	Western Region	Dana Scala
<input checked="" type="checkbox"/>	Ann Munnely	Western Region	Robin Smilor
<input checked="" type="checkbox"/>	Rosie Romero	Western Region, Alternate	Richard Tadeo
<input checked="" type="checkbox"/>	Laurie Sepke	Eastern Region	John Telmos
<input checked="" type="checkbox"/>	Alina Candal	Eastern Region	Gary Watson
<input checked="" type="checkbox"/>	Adrienne Roel	Eastern Region, Alternate	David Wells
<input checked="" type="checkbox"/>	Brian Hudson	Provider Agency Advisory Committee	Michelle Williams
<input type="checkbox"/>	Isaac Yang	Provider Agency Advisory Committee, Alt.	
<input type="checkbox"/>	Mary Thompson	MICN Representative	
<input type="checkbox"/>	VACANT	MICN Representative, Alt.	
<input checked="" type="checkbox"/>	Robin Goodman	Pediatric Advisory Committee	
<input type="checkbox"/>	Kerry Gold-Tsakonas	Pediatric Advisory Committee, Alt.	
PREHOSPITAL CARE COORDINATORS		GUESTS	
<input checked="" type="checkbox"/>	Juliette Garrett (AVH)	E. Jean Kirby, LACoFD	
<input checked="" type="checkbox"/>	Rachel Caffey (NRH)		
<input checked="" type="checkbox"/>	Joanne Dolan (SMM)		
<input checked="" type="checkbox"/>	Gloria Guerra (QVH)		
<input checked="" type="checkbox"/>	Leonila Mier (HMN)		
<input checked="" type="checkbox"/>	Jennifer Pickard (SMM)		
<input checked="" type="checkbox"/>	Charrise Powell (SFM)		
<input checked="" type="checkbox"/>	Jenny Van Slyke (HMH)		

1. CALL TO ORDER

The meeting was called to order at 1:04 P.M. by Dr. Robert Flashman, Vice Chair, EMS Commission.

2. APPROVAL OF MINUTES-

(M/S/C Candal/Cash) Approve the minutes for October 10, 2012 as written.

(M/S/C Candal/Cash) Approve the minutes for December 12, 2012 as written.

3. INTRODUCTIONS/ANNOUNCEMENTS

3.1 The 2013 Annual EMSAAC Conference is being held May 29 and 30, 2013 at the Hilton San Diego Resort & Spa. Additional information can be found at www.EMSAAC.org.

3.2 EMS Update 2013 Train the Trainer classes will be held at the EMS Agency on:

- Wednesday, February 27, 2013 – 1 to 4 P.M.
- Wednesday, March 6, 2013 – 8 to 11 A.M.
- Wednesday, March 6, 2013 – 1 to 4 P.M.

3.3 SideWalk CPR is scheduled for June 4, 2013. The EMS Agency is encouraging hospitals and provider agency participation. The goal is to train as many bystanders as possible statewide during this event.

4. REPORTS & UPDATES

4.1 Base Hospital Form Instruction Manual

The revisions to the Base Hospital Form Instruction Manual will be ready by March 1, 2013 and will be available on the EMS website.

The Association of Prehospital Care Coordinators (APCC) shared experiences and challenges with training of documentation using the revised Base Hospital Form (BHF) without the instruction manual.

4.2 Reference No. 407, ALS Unit Alternate Staffing Pilot Program:

The Governance Committee convened on February 12, 2013 to review Reference No. 407, ALS Unit Alternate Staffing Pilot Program. The policy has been revised to reflect the recommendations of the Governance Committee. This policy will be presented at the February 20th Provider Agency Advisory Committee. This committee will have the opportunity to review the policy during the April 2013 meeting.

The policy defines the guidelines for pilot program approval for alternate staffing. A one-plus-one pilot will not be approved as it deviates from the BOS definition of a paramedic unit.

The One-and-One staffing model maintains two paramedics on scene to provide patient care although they may arrive to the scene by different apparatuses. The transport of the patient would be done by one EMT as the ambulance driver and one paramedic as the direct patient provider.

Committee members voiced the following concerns:

The Board of Supervisor (BOS) approval was removed from the policy. The committee proposes this remains in the policy as the BOS initially defined the paramedic unit.

There is concern regarding the paramedic experience/training. Participants in the pilot program should have at least one year of experience to ensure patient safety is maintained. Additionally, the qualifications of the educator overseeing a pilot program are not specified.

The training program should include competencies to ensure that paramedics are able to provide the level of care necessary for an alternate staffing program.

4.3 Drug Shortage:

There is a critical nationwide shortage of Atropine 1 mg/10 ml preloaded syringes and limited availability of the 1 mg/1 ml ampules/vials. If a provider agency is unable to obtain preloaded syringes they may use ampules by mixing with nine milliliters of normal saline solution. Reconstitution of Atropine in prehospital care requires approval by the Medical Director of the EMS Agency. Approval will be granted on a case by case basis. The alternative field treatment if Atropine is unavailable is percutaneous pacing or Dopamine infusion.

5. **UNFINISHED BUSINESS (None)**

6. **NEW BUSINESS**

6.1 Reference No. 222, Downgrade or Closure of 9-1-1 Receiving Hospitals or Emergency Departments

Reference No. 222, Downgrade or Closure of 9-1-1 Receiving Hospitals of Emergency Departments defines the procedure to downgrade or eliminate emergency services or close the hospital completely.

(M/S/C) Approve Reference No. 222, Downgrade or Closure of 9-1-1 Receiving Hospitals or Emergency Departments..

6.2 Reference No. 606, Documentation of Prehospital Care

Reference No. 606, Documentation of Prehospital Care identifies the base hospital and EMS provider procedures for documentation of prehospital care.

Recommended change: Move G, Field Transfer of Care, from Page 4, to Page 2, D as follows:

D. Multiple Providers

1. If the provider agency transferring patient care utilizes electronic documentation, a mechanism to provide immediate transfer of patient information to the transporting agency and receiving hospital must be available.

Recommended change: Revise Policy, Page 4, G as follows:

G. Field Transfer of Care

BHAC
February 13, 2013

4. It is the responsibility of the EMS provider to ensure that a printed copy of the EMS Report Form is provided to the Receiving facility upon transfer of care.

(M/S/C Candal/Grimaldi) Approve Reference No. 606, Documentation of Prehospital Care with recommended changes.

7. OPEN DISCUSSION

Glucose Value

The Prehospital Care Coordinators are requesting the EMS Agency review the guidelines for treatment of hypoglycemia due to the changes by the American Diabetes Association defining hypoglycemia as blood glucose less than 70.

8. NEXT MEETING: April 10, 2013

9. ADJOURNMENT: The meeting was adjourned at 2:05 P.M.



LOS ANGELES COUNTY PREHOSPITAL CODE OF ETHICS



The Emergency Medical Services (EMS) System consists of health care professionals that include EMT's, paramedics, nurses, physicians, educators, and administrators. This Code defines our ethical responsibilities and beliefs in the following principles for guiding practice...

RESPECT

- Recognize, acknowledge, listen, and encourage all members of the health care team
- Uphold and maintain patient confidentiality and privacy
- Honor the patient's rights and autonomy to make decisions about their medical care

CARING

- Provide professional, compassionate, and competent care to all patients
- Advocate for the patient's care needs
- Participate and support the advancement of the EMS system through education, training, and continuous quality improvement
- Support prehospital care research to validate, improve and promote evidence-based practice

FAIRNESS

- Provide competent medical care to all persons with compassion and respect for human dignity regardless of nationality, race, creed, religion, sex, status, or financial considerations
- Ensure justice by treating all individuals equally and fairly
- Encourage and support impartiality in the delivery of patient care. Decisions should be absent of bias, prejudice or benefit one person over another for improper reasons and based on objective criteria

INTEGRITY

- Promote honesty, truthfulness, and consistency in action and practice from all members of the health care team
- Demonstrate responsibility and accountability by maintaining licensure, operating within scope of practice, and utilizing thorough documentation
- Inspire fidelity by adhering to professional code(s) of ethics, by following policies and procedures, ensuring team members are respectful, competent and capable of performing duties, and honoring agreements made with patients and colleagues
- Maintain trustworthiness and excellence in the delivery of patient care and medical practice

SUBJECT: **REQUIREMENTS FOR APPROVAL AS A
9-1-1 RECEIVING HOSPITAL**

(HOSPITAL)
REFERENCE NO. 524

PURPOSE: To outline the guidelines to be approved as a 9-1-1 receiving hospital.

AUTHORITY: Health & Safety Code 1797.88, 1798.175(a)(1)(2)

DEFINITIONS:

9-1-1 Receiving Hospital: A licensed, general acute care hospital with a permit for basic or comprehensive emergency medicine service that receives patients with emergency medical conditions from the 9-1-1 system.

PRINCIPLES:

1. Patients who call 9-1-1 receive optimal care when transported to a facility that is staffed, equipped and prepared to administer emergency medical care appropriate to their needs.
2. Emergency departments equipped with the communications required of 9-1-1 receiving facilities drill regularly with other system participants and can communicate effectively during multi-casualty incidents and disasters.

POLICY:

- I. Procedure for Approval to be a 9-1-1 Receiving Hospital
 - A. Submit a written request to the Director of the Emergency Medical Services (EMS) Agency to include:
 1. The rationale for the request to be a 9-1-1 receiving hospital.
 2. A document verifying the hospital has a permit for basic or comprehensive emergency medical service.
 3. The proposed date the emergency department (ED) would open to 9-1-1 traffic.
 - B. Communications
 1. All 9-1-1 EDs in Los Angeles County are required to:
 - a. Have an operational dedicated ReddiNet terminal with redundant connectivity via satellite and internet packet radio.
 - b. Provide and maintain a printer capable of printing electronic records received from prehospital care providers.

EFFECTIVE: 2-15-10
REVISED: XX-XX-13
SUPERSEDES: 2-15-10

PAGE 1 OF 3

APPROVED: _____
Director, EMS Agency Medical Director, EMS Agency

- ~~2. The ReddiNet microwave terminal must be operational prior to approval.~~
- ~~2. The ReddiNet internet connection may be utilized temporarily if the Hospital Association of Southern California assures the EMS Agency that the facility has met all contractual requirements for the packet radio.~~
23. It is strongly suggested that the hospital install VMED28 for communication with paramedic providers and the Medical Alert Center during multiple casualty incidents.
34. It is recommended that the facility install a dedicated telephone line to facilitate direct communication with the paramedic base hospital, 9-1-1 personnel, and the Medical Alert Center.

C. Site Visit

1. Once all required communication systems are installed and hospital staff training on the equipment is complete, the EMS Agency will coordinate a site visit.
2. Administrative and field personnel from local EMS provider agencies will be invited to exchange contact information, participate in the VMED28 and the ReddiNet system tests, and become familiar with the physical layout of the facility.
3. Representatives from the nearest base hospital (Administrative, Medical Director and/or Prehospital Care Coordinator) will provide contact information, explain the role and function of the paramedic base, and discuss how patient information is communicated to the surrounding 9-1-1 receiving hospitals.
4. 9-1-1 receiving hospitals:
 - a. Are encouraged to attend the Regional Meetings to stay current with EMS practice, policy and equipment.
 - b. Should provide updated contact information to the base hospital and the EMS Agency whenever key personnel change to ensure a mechanism for issue resolution.
 - c. Should maintain an accurate list of hospital services and contact information in the ReddiNet for disaster and MCI purposes.
5. EMS Agency role at the site visit:
 - a. Conduct ReddiNet drills and VMED28 tests
 - b. Explain the role of the MAC and provide contact information
 - c. Discuss disaster preparedness activities drills and exercises
 - d. Review the Prehospital Care Policy Manual, Medical Control Guidelines, and Standing Field Treatment Protocols and other relevant materials:
 - (1) Ref. No. 502, Patient Destination

- (2) Ref. No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients
- (3) Ref. No. 620.1, Notification of Personnel Change
- (4) EMS Agency staff contacts
- (5) Base hospital/receiving hospital contacts
- (6) EMS Agency meeting calendar
- (7) EMS Regional Meeting calendar and information
- (8) Situation Report/Problem resolution
- (9) EmergiPress Newsletter

CROSS REFERENCES:

Prehospital Care Manual:

Reference No. 304, **Role of the Base Hospital**

SUBJECT: **DOCUMENTATION OF PREHOSPITAL CARE**

(EMT, PARAMEDIC, MICN)
REFERENCE NO. 606

PURPOSE: To identify the base hospital and Emergency Medical Services (EMS) provider procedures for documentation of prehospital care.

AUTHORITY: California Code of Regulations, Title 22, Chapter 4, Sections 100169, 100170

DEFINITIONS:

Patient: A person who seeks or appears to require medical assessment and/or medical treatment.

Patient Contact: An EMS response that results in an actual patient or patients.

EMS Response: The physical response of an EMS provider due to activation of the EMS system with a request for medical evaluation.

Patient Response: An EMS Response that results in an actual patient or patients.

Multiple Casualty Incident (MCI): The combination of numbers of ill/injured patients and the type of injuries going beyond the capability of an entity's normal first response.

PRINCIPLES:

1. The EMS Report Form and the Base Hospital Form are:
 - a. Patient care records
 - b. Legal documents
 - c. Quality improvement instruments
 - d. Billing resources
 - e. Records of canceled calls, false alarms, and no patient found (EMS Report Form only)
2. Any assessment or treatment provided to, and medical history obtained from, the patient shall be accurately and thoroughly documented on the EMS Report Form.
3. Any person who alters or modifies the medical record of any person, with fraudulent intent, or who, with fraudulent intent, creates any false medical record, is guilty of a misdemeanor (section 471.5 of the California Penal Code).
4. An EMS Report Form must be completed for every EMS response if a provider agency is unable to submit an annual volume report to the EMS Agency for the following types of calls:
 - a. Canceled calls
 - b. No patient(s) found
 - c. False alarms

EFFECTIVE: 6-25-1974
REVISED: XX-XX-13
SUPERSEDES: 4-1-10

PAGE 1 OF 6

APPROVED: _____
Director, EMS Agency

Medical Director, EMS Agency

POLICY:

- I. EMS Report Form Completion – Paramedic/EMT Personnel
 - A. EMS providers shall document prehospital care according to procedures identified in the EMS Report Form Training Manual.
 - B. Manual EMS Report Form Completion
 1. Paramedic/EMT personnel from the first responding agency shall complete one local EMS Agency approved EMS Report Form (one for each patient) for every 9-1-1 patient contact which includes the following:
 - a. Regular runs
 - b. DOA (dead on arrival; patients determined or pronounced dead per Reference No. 814, Determination/Pronouncement of Death in the Field)
 - c. ALS interfacility transfer patients

~~**Note: In the event of an automatic or mutual aid incident when two first responding providers have responded and have each completed an EMS Report Form, each provider agency shall legibly handwrite the Sequence Number from the other provider's form in the space designated for Second Sequence Number. DO NOT cross out or line through the imprinted Sequence Number.**~~

~~**If patient care is transferred from one ALS provider agency to another, each provider agency shall complete an EMS Report Form and legibly handwrite the Sequence Number from the other provider's in the space designated for Second Sequence Number. Do not cross out or line through the imprinted Sequence Number.**~~

- C. Electronic EMS Report Form Completion
 1. Paramedic/EMT personnel may document and submit prehospital care data electronically in lieu of the standard EMS Report Form if their department has received prior authorization from the EMS Agency.
 2. Paramedic/EMT personnel shall complete one EMS Agency approved electronic EMS Report Form (one for each patient) for every patient contact and one for each ALS interfacility transferred patient.
- D. Multiple Providers
 1. In the event of an automatic or mutual aid incident when two first responding providers have each completed an EMS Report Form, or patient care is transferred from one ALS provider agency to another, each provider agency shall document the Sequence Number from the other provider's patient care record in the space designated for Second Sequence Number. DO NOT cross out or line through the imprinted Sequence Number if utilizing a paper EMS Report Form.

2. If the provider agency transferring patient care utilizes electronic documentation, a mechanism to provide immediate transfer of patient information to the transporting agency must be available.

DE. Multiple Casualty Incidents (MCI)

1. One standard EMS Report Form must be initiated for each patient transported in an MCI. Provider agencies may use alternate means of documenting MCIs if the EMS Agency is notified prior to implementation and agrees with the proposed process.
2. Documentation should include the following, at minimum:
 - a. Name
 - b. Chief Complaint
 - c. Mechanism of Injury
 - d. Age and units of age
 - e. Gender
 - f. Brief patient assessment
 - g. Brief description of treatment provided
 - h. Transporting provider (provider code and unit number) and level of service (ALS, BLS or Helicopter)
 - i. Receiving facility
3. Non-transported patients should be documented on a standard EMS Report Form, an EMS Agency-approved MCI Report Form, or a patient log.
4. Each provider agency should submit copies of all records and logs pertaining to an MCI of greater than 5 victims to the EMS Agency within 10 business days of the incident. MCI documents should be hand carried or delivered to the EMS Agency in an envelope clearly marked with the incident date and location.

EF. Completion of the EMS Report Form Prior to Distribution

1. EMTs and paramedics responsible for documenting prehospital care shall ensure that EMS Report Forms are completed in their entirety prior to dissemination of copies. In most instances, this means that the form is completed at the scene or upon arrival at the receiving facility.
2. An exception to this is when a first responding agency is giving the receiving hospital (red/~~pink~~) copy to a transporting agency. In the interest of expediting the transfer of care, it is recognized that information such as the unit times may not be documented on the receiving hospital (red/~~pink~~) copy of the EMS Report Form.

FG. Field Transfer of Care

1. When patient care has been transferred from the first responding ALS or BLS provider agency to a BLS provider agency for transport to a receiving facility, the provider agency receiving the patient should **NOT** complete a

standard EMS Report Form with an imprinted Sequence Number (will result in the same patient being entered into TEMIS with two different numbers).

2. The provider agency that receives the BLS patient for transport to a receiving facility should complete their agency's PCR/invoice and document the Sequence Number imprinted on the first responding agency's PCR on their PCR.
3. The receiving hospital (red/pink) copy of the EMS Report Form, as well as the PCR from the BLS transport provider (red/pink copy), must accompany the patient to the receiving facility where it becomes part of the patient's medical record.
4. It is the responsibility of the EMS Provider to ensure that a completed printed copy of the EMS Report form is provided to the receiving facility upon transfer of care when an electronic health care record (ePCR) is not immediately available.

GH. Completion of Advanced Life Support Continuation Form

1. Required for each patient on whom airway management is necessary or cardiopulmonary resuscitation is attempted or patient is pronounced dead following resuscitative efforts if the information is not documented elsewhere on the EMS Report Form.
2. Paramedics completing this form must ensure that the demographic information (patient name, date, provider code/unit) and Sequence Number are legibly and accurately transcribed from the EMS Report Form.

II. Base Hospital Form - MICN and/or Physicians

A. Base hospital personnel (MICNs and physicians) shall document prehospital care according to procedures identified in the Base Hospital Form Training Manual.

B. Base Hospital Form Completion

1. MICNs and/or physicians shall complete at least one EMS Agency approved Base Hospital Form (one for each patient in which medical direction is given) for every base hospital paramedic radio/telephone contact.
2. MICNs and/or physicians shall **NOT** complete a Base Hospital Form when another base hospital calls with notification of an incoming paramedic call.
3. MICNs and/or physicians may document and submit base hospital data electronically in lieu of the standard Base Hospital Form if the base hospital has received prior authorization from the EMS Agency.

C. Base Hospital Directed Multiple Casualty Incidents (MCI)

1. EMS Agency-approved **MCI Base Hospital** Forms may be utilized for incidents involving three or more patients.

2. Physicians and MICNs should limit requested information to **only** that which is essential to determine destination or medical management. Additional information and Sequence Numbers should be obtained after the MCI has cleared.
3. The following should be documented for MCIs involving three or more patients:
 - a. Date
 - b. Time
 - c. Sequence Number
 - d. Provider and unit
 - e. Chief complaint
 - f. Mechanism of injury
 - g. Age
 - h. Gender
 - i. Brief patient assessment (primary injuries and MOI)
 - j. Transporting provider, method of transport (ALS, BLS or Helicopter)
 - k. Destination
4. ~~Upon request of the EMS Agency the~~ **Each** base hospital should submit all records pertaining to an MCI of >5 victims to the EMS Agency within 10 business days of the incident. ~~MCI documents should be hand-carried or delivered to the EMS Agency in an envelope clearly marked with the incident data and location.~~
5. Provider agencies may use alternate means of reporting MCIs. Base Hospitals will be notified by the EMS Agency when alternate reporting methods will be implemented by various provider agencies.
6. MCIs involving **ONLY** BLS patients: BLS patients who are transported to a receiving facility should be documented on one form (provided no medical direction is given).
7. MCIs involving ALS **and** BLS Patients:
 - a. One standard Base Hospital Form or one EMS Agency-approved MCI Base Hospital Form must be completed for each ALS patient.
 - b. One standard Base Hospital Form must be completed for each SFTP patient when the base hospital provides destination and/or medical direction.
 - c. BLS patients on whom no medical direction has been given do not require a Base Hospital Form. The number and disposition of the BLS patients may be documented on the Base Hospital Form of an ALS patient in the Comments Section.
8. Alternate methods of documenting MCIs may be initiated by Base Hospitals with the approval of the EMS Agency.

III. Modification of the EMS Report Form

- A. Modifying the EMS Report Form (additions, deletions or changes) after the form has been completed or disseminated:
1. Make corrections by drawing a single line through the incorrect item or narrative (the writing underneath the single line must remain readable).
 2. Make the changes on the original, noting the date and time the changes were made, with the signature of the individual making the changes adjacent to the correction. Ideally, changes should be made by the individual who initially completed the form. Under no circumstances should changes to either patient assessment or patient treatment documentation be made by an individual who did not participate in the response.
- B. Making substantive changes (documentation of additional medications, defibrillation attempts, pertinent comments, complaints, etc.) to the EMS Report Form:
1. Photocopy the EMS Report Form with the changes and send the copy, along with a cover letter, to all entities that received the original form (EMS Agency, receiving facility, ~~base hospital~~). The cover letter should explain the modifications and request that the modified copy be attached to the original copy.
 2. Do not re-write the incident on a new EMS Report Form because this would result in a mismatch in Sequence Number. If the form requiring corrections has been mutilated or soiled and cannot be photocopied, then a new form may be used to re-write the incident provided the Sequence Number of the new form has been replaced with the Sequence Number from the original form.
 3. For electronic documentation systems, corrections are to be made as per provider agency policy. Notification of the updated record will be made to all entities who received the original form (receiving hospital, EMS Agency). If the receiving hospital receives a printed copy of the record, a printed copy of the revised record will be provided directly to them.

CROSS REFERENCES:Prehospital Care Manual:Ref. No. 608, **Disposition of Copies of the EMS Report Form**Ref. No. 607, **Electronic Submission of Prehospital Data**Ref. No. 519, **Management of Multiple Casualty Incidents**

GENERAL INSTRUCTIONS FOR TREATMENT PROTOCOLS

The Treatment Protocols were developed by combining the Base Hospital Treatment Guidelines (BHTG) and the Standing Field Treatment Protocols (SFTP). The foundations for the revised guidelines are the paramedic scope of practice, medical research, and community standards in medical practice. A sign/symptom orientation to treating the prehospital care patient has been retained.

GENERAL INFORMATION

1. Patients with the same disease may have differing complaints and presentations, and conversely, patients with similar signs and symptoms may have very different diagnoses.
2. The Treatment Protocols guide treatment of “classic” presentations based on evidence-based practice. Base hospital physicians, mobile intensive care nurses (MICNs) and paramedics must utilize their medical knowledge, expertise and critical thinking to determine appropriate treatments for each patient.
3. The protocols were not developed with the intent that all therapies be done on scene. Transport of patients with treatment en route is left to the discretion of the base hospital and the field unit.

PROTOCOL FORMAT

1. Pharmacologic agents are in **bold** typeface.
2. Pediatric treatments are preceded by the Los Angeles County Emergency Department Approved for Pediatrics (EDAP) teddy bear symbol. 
3. Paramedics must measure all pediatric patients using a pediatric resuscitation tape and report the identified color code. The color is documented on the EMS Report Form in the patient weight section. Medication dosages are then determined by correlating the pediatric resuscitation tape color with the appropriate range on the Color Code Drug Doses/L.A. County Kids chart or the pediatric doses in the Drug Administration section.
4. The **Special Considerations** section has additional helpful information specific to the chief complaint and/or specific patient population.

USING THE TREATMENT PROTOCOLS

Determine the patient’s chief complaint or problem and then identify the protocol that best meets their needs.

1. Follow each treatment protocol in sequence as written.

2. If more than one treatment protocol applies, begin by using the one most closely associated with the patient's primary complaint. Utilize Reference No. 806.1, Procedures Prior to Base Contact, as indicated and refer to other treatment protocols as needed.
3. If the patient's status changes, a different treatment protocol might be needed. Select the new treatment protocol by taking into account the treatments already performed.
4. Not all the treatment protocols have an SFTP component. Some have only procedures that can be done under Ref. No. 806.1 and then base contact is required. Report the treatment protocol number or name when making base contact such as, "we have a crush injury and are utilizing Ref. No. 1277" or "we are using the crush injury treatment protocol".
5. All treatment protocols will be located in Section 1200 of the Prehospital Care Manual; therefore, each protocol will be identified by a four-digit number starting with "12". The 4-digit protocol number should be documented if the Base Hospital Report Form or EMS Report Form has adequate space. If the form does not allow for four digits, document the last three digits of the protocol.
6. The treatment protocols replace the former SFTPs; therefore, all protocols that have designations with an alpha character and a number (M4, T2, P1, etc.) have been deleted.
7. The SFTP portion of the treatment protocols can only be used by approved SFTP provider agencies.

CONTACT THE BASE HOSPITAL WHEN:

1. Indicated by the protocol
2. ALS intervention is performed and the provider agency is not an authorized SFTP provider
3. Additional or unlisted treatments are required
4. Consultation with the base hospital would be helpful
5. ST Elevation Myocardial Infarction (STEMI) notification and destination are required
6. Stroke notification, last known well date and time, and destination are required

Once base contact is made for medical control, all subsequent treatments listed in the protocol require a base hospital order.

Airway/Pulse Oximetry/Oxygen Therapy

Providing oxygen to emergency medical services (EMS) patients is frequently may be a lifesaving procedure. In particular, patients in acute respiratory distress should receive aggressive oxygenation, including patients who have a history of chronic lung disease.

Oxygen should be treated like any other drug and administered only when indicated for signs and/or symptoms of hypoxia such as: oxygen saturation (SpO₂) less than 94% with respiratory distress, altered mental status or changes in skin signs.

Basic airway maneuvers: establishing and maintaining an open airway with positioning, obstructed airway maneuvers, airway adjuncts and suctioning should be performed prior to advanced airway maneuvers: direct laryngoscopy for foreign body removal, endotracheal intubation or King LTs-D (Disposable Supraglottic Airway device).

1. If pulse oximetry is not available (BLS Unit) and the patient is in mild or moderate respiratory distress, provide oxygen (O₂) with nasal cannula at 2-6 liters per minute.
2. When available, use pulse oximetry to guide oxygen therapy. Document the oxygen saturation (SpO₂) reading. The desired SpO₂ for most non-critical patients is 94 – 98%.
 3. Initiate oxygen O₂ therapy and titrate as follows:
 - a. Stable patients with mild hypoxia (SpO₂ less than 94%) – start O₂ with nasal cannula at 2-6 liters per minute or basic mask at 8-10 liters per minute
 - b. Patients unable to tolerate nasal cannula or basic mask – use blow-by technique using the following:
 - Adult – 10-15 liters per minute
 - Infant/Child – 6-10 liters per minute
 - Neonate – 5 liters per minute
 - c. Critical patients (those with impending or actual respiratory or cardiopulmonary arrest) – **O₂ should not be withheld in any critical patient**, start O₂ using the appropriate O₂ delivery system based on the patient's condition:
 - Non-rebreather mask – 12-15 liters per minute
 - BVM with reservoir – 15 liters per minute
 - Endotracheal tube – 15 liters per minute
 - King LTS-D airway – 15 liters per minute
 - CPAP – Refer to Ref. No. 1312
 - d. Special Considerations:
 - Chronic Obstructive Pulmonary Disease (COPD) – goal SpO₂ is 88 – 92%
 - Carbon Monoxide Poisoning – goal SpO₂ is 100%
 - Neonates in need of positive-pressure ventilation – ventilate for 90 seconds with room air, if heart rate remains less than 100 beats per minute, start O₂ at 15 liters per minute
 - Traumatic Brain Injury - goal SpO₂ is 100%



4. Continue oxygen therapy until transfer of patient care.

5. Monitor and document the SpO₂, oxygen delivery system used and the liters per minute administered.

6. If suctioning is required, pre-oxygenate prior to suctioning. Maintain sterile procedures and do not suction longer than 10 seconds per occurrence.

7. Considerations for oropharyngeal airway:

- Unconscious
- Absent gag reflex

8. Considerations for nasopharyngeal airway:

- Oropharyngeal airway cannot be inserted
- Spontaneously breathing patients who require assistance in maintaining a patent airway

9. Considerations for bag-valve-mask (BVM) ventilation:

- Apnea or agonal respirations
- Compromised ventilatory effort

10. Considerations for endotracheal intubation



Adults or Pediatrics 12yrs of age or older **or** height greater than the length of the pediatric resuscitation tape with:

- Ineffective ventilation with BVM
- Prolonged transport time
- Unprotected airway

11. Considerations for rescue airway (King LTS-D)

- Unsuccessful attempts (maximum three attempts) at endotracheal intubation
- Suspected difficult airway based on assessment and anatomical features

Small adult: Size 3 for 12yrs of age or older **and** height between 4'-5'

Adult: Size 4 for 12yrs of age or older **and** height between 5'-6'

Large adult: Size 5 for 12yrs of age or older **and** height greater or equal to 6'

12. Verify endotracheal tube or rescue airway placement. Document the methods used for placement verification which should include a combination of:

- Capnography
- End-tidal CO₂ detector
- Bilateral lung sounds
- Bilateral chest rise
- Absent gastric sounds
- Esophageal detector device (EDD)

13. Continuously assess ventilation status and monitor waveform capnography of all patients requiring bag-valve-mask ventilation or advanced airway placement. Report capnography reading to the base hospital and document capnography reading as follows:

- Every five minutes during transport
- After any patient movement
- Upon transfer of care
- Change in patient condition

BASIC AIRWAY MANEUVERS

Establish and maintain an open airway with positioning, obstructed airway maneuvers, airway adjuncts and suctioning.

1. ~~Preferred: mask at 10-15L/min for patients who are short of breath and/or in respiratory distress~~
2. ~~Alternative: cannula at 6L/min, adequate for most "stable" patients~~
3. ~~History of COPD without distress: cannula at 2L/min~~
4. ~~To assist respirations: bag-valve device at 15L/min~~

ADVANCED AIRWAY MANEUVERS

Adults:

1. ~~Direct laryngoscopy~~
2. ~~Endotracheal intubation (ET):~~



~~Pediatrics: 12yrs of age or older or height greater than the length of the pediatric resuscitation tape~~

3. ~~King LTs-D (Disposable Supraglottic Airway device):
Small adult: Size 3 for 12yrs of age or older and height between 4'-5'
Adult: Size 4 for 12yrs of age or older and height between 5'-6'
Large adult: Size 5 for 12yrs of age or older and height greater or equal to 6'~~



14. ~~Pediatrics: If 12yrs of age or younger or height fits within the pediatric resuscitation tape: direct laryngoscopy with Magill pediatric forceps for foreign body removal.~~

Perfusion Status

Perfusion status is determined by a **combination** of parameters that includes heart rate, blood pressure, tissue color and mentation.

1. **Adequate Perfusion:** adequate circulation of blood through organs and tissues, manifested by normal pulse, tissue color, level of consciousness and blood pressure.
2. **Poor Perfusion:** Bradycardia, tachycardia, and/or altered mental status (includes anxiety, restlessness, lethargy, altered level of consciousness) associated with other symptoms of poor perfusion (hypotension, shortness of breath, chest pain and/or poor tissue color).

3. Base hospital contact should be initiated on hypotensive patients or if perfusion status is borderline.

GUIDELINES FOR DETERMINATION OF POOR PERFUSION:

Adults:

1. Systolic blood pressure (SBP) less than 100mmHg, many medications are not administered if the SBP is less than 100mmHg.
2. Bradycardia, tachycardia, and/or altered mental status (includes anxiety, restlessness, lethargy, altered level of consciousness) associated with other symptoms of poor perfusion (hypotension, shortness of breath, chest pain and/or poor tissue color).
3. Poor pulse quality (weak/thready)
4. Increased respiratory effort and/or rate greater than 24 per minute in conjunction with other parameters
5. Delayed capillary refill time (greater than 2 seconds)
6. History of current chief complaint with potential for rapid deterioration



Pediatrics:

1. SBP less than 60mmHg in conjunction with other parameters
2. Heart rate less than 60bpm or greater than 180bpm in conjunction with other parameters
3. Labored respirations (retractions, grunting, nasal flaring) in conjunction with other parameters
4. Tissue color (i.e., pallor, cyanosis, mottling) is considered a sign of poor perfusion
5. Altered mental status (includes anxiety, restlessness, lethargy, or altered level of consciousness)
6. Delayed capillary refill time (greater than 2 seconds) in conjunction with other parameters
7. History of current chief complaint with potential for rapid deterioration

Venous Access

Venous access is a catheter inserted into a vein and attached to either an intravenous (IV) line of normal saline or a saline lock.

1. Saline lock: intermittent IV device used for patients with stable vital signs or

patients who do not require volume replacement but may need limited IV medications

2. To keep open (TKO): slowest drip rate (approx. 30gtts/min); used for patients who might need fluid replacement or multiple intravenous medications
3. Fluid challenge: 10ml/kg rapid IV fluid administration with reassessment at 250ml increments



Pediatrics: 20ml/kg, reassess after initial fluid challenge

4. Fluid resuscitate: wide open intravenous fluid administration through large lumen tubing, preferably using two sites



Pediatrics: 20ml/kg, may repeat two times, reassess after each fluid challenge

5. Pre-existing vascular access device: paramedics may access external venous access devices for patients who are in extremis or if directed by the base hospital

ECG Documentation

Complete and accurate ECG documentation is essential for patient care and quality improvement purposes.

1. Document the ECG interpretation on the front of the EMS Report Form in the ECG Section. If a dysrhythmia is identified, a six-second strip must accompany the following:
 - a. Receiving Hospital copy for continuation of patient care.
 - b. Provider Agency copy as the official medical record.
2. The patient's name and/or sequence number should be written on the ECG strip. If only one segment of the ECG is available (i.e., run of V-tach), attach to the Receiving Hospital copy and, if possible, photocopy and attach to the Provider Agency copy.
2. 12-Lead ECG documentation: document the computer ECG interpretation of STEMI on the EMS Report Form with the time noted. Write the sequence number on the 12-lead tracing and distribute the copies as follows:
 - a. Hand the original directly to the nursing staff at the ST Elevation Myocardial Infarction Receiving Center (SRC).
 - b. Retain a copy per the provider agency's departmental policy.



Pediatric Patients

Separate pediatric guidelines were not developed for every sign and symptom. For guidelines not developed expressly for pediatrics, treatments specific to pediatrics are referenced under Drug Administration and/or Special Considerations and are preceded by a teddy bear symbol

for easy identification.

Medication Orders and Administration

Base hospitals must provide complete medication orders to include:

1. Name of the medication
2. Dose
3. Route of administration
 - a. Intravenous (IV)
 - b. Intravenous Piggy-Back (IVPB)
 - c. Intramuscular (IM)
 - d. Intranasal (IN)
 - e. Intraosseous (IO)
 - f. Per Os (PO)
 - g. Sublingual (SL)
4. Frequency of administration, if applicable

Paramedics are to repeat complete orders back to the base hospital.

*Standing Field Treatment Protocol (SFTP) Providers

Additional treatments that can be performed by an approved SFTP provider prior to base contact are identified by “**Continue SFTP or Base Contact**”. All subsequent treatments may be performed until the paramedic reaches the notation “**Establish Base Contact**”. Once “**Establish Base Contact All**” appears, all ensuing treatments require an order from the base hospital.

The following dysrhythmias require establishing base hospital contact:

- Symptomatic Bradycardia
- Supraventricular Tachycardia (SVT)
- Ventricular Tachycardia (contact not required if utilizing Cardiac Arrest protocol and no pulse is present)
- Ventricular Fibrillation
- Second and Third Degree Heart Blocks
- Symptomatic Atrial Fibrillation/Atrial Flutter

If base hospital contact is made to obtain patient care orders, a full patient report will be given. If the patient meets trauma guidelines but is being transported to a non-trauma hospital, a full patient report must be given.

When giving a receiving hospital report for patient notification only, the following minimal patient information will be provided:

Medical Complaint

Provider Code/Unit #
Sequence Number
Location (if 9-1-1 transfer)
Chief complaint
Age/ and units Gender
Gender
Pediatric Weight (in kg from weight-based tape) and Color Code (if applicable)
Level of distress
Name of the protocol (number optional)
Glasgow Coma Scale (GCS), if altered
Airway adjuncts utilized, if applicable
Destination/ETA
Report "STEMI" patient if the 12-lead ECG indicates this
Report modified Los Angeles Prehospital Stroke Screen (mLAPSS) positive if exam indicates this and the last known well date and time

If Trauma Complaint

Provider Code/Unit #
Sequence Number
Age/Gender
Level of distress
Mechanism of injury/Chief Complaint
Chief Complaint
Location of injuries/pertinent information (flail segment, rigid abdomen, evisceration, etc.)
Complete vital signs and GCS
Destination/ETA

If patient meets trauma criteria/guidelines/judgment:

Regions of the body affected
Complete vital signs/GCS
Airway adjuncts utilized
Pertinent information (flail segment, rigid abdomen, evisceration)

If 12-Lead ECG Performed:

ECG rhythm/interpretation
If the 12-lead ECG indicates STEMI, include quality of tracing

If mLAPSS (modified Los Angeles Stroke Screen) performed:

If positive/met
Last known well date and time