EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

10100 Pioneer Blvd, Suite 200
Santa Fe Springs, CA 90670

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To ensure timely, compassionate and quality emergency and disaster medical services.

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES

PROVIDER AGENCY ADVISORY COMMITTEE

10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670
(562) 347-1500 FAX (562) 941-5835
http://dhs.lacounty.gov/wps/portal/dhs/ems/

DATE: **October 21, 2015**

TIME: **1:00 pm**

LOCATION: **Los Angeles County EMS Agency**
10100 Pioneer Boulevard
EMS Commission Hearing Room – 1st Floor
Santa Fe Springs, California 90670

The Provider Agency 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

CALL TO ORDER

1. **APPROVAL OF MINUTES – August 19, 2015**

2. **INTRODUCTIONS / ANNOUNCEMENT**

   2.1 Posting of Policy Updates

3. **REPORTS & UPDATES**

   3.1 EMS Update 2016
   3.2 Reference No. 814, Determination/Pronouncement of Death in the Field *(Info Only)*

4. **UNFINISHED BUSINESS**

   4.1 Reference No. 1244, Treatment Protocol: Chest Pain
   4.2 Reference No. 453.1, Ambulance Licensing Enforcement Officers *(Previously Distributed)*

5. **NEW BUSINESS**

   5.1 Reference No. 521, Stroke Patient Destination
   5.2 Reference No. 620, EMS Quality Improvement Program
   5.3 Reference No. 832, Treatment/Transport of Minors

6. **OPEN DISCUSSION**

7. **NEXT MEETING: December 16, 2015**

8. **ADJOURNMENT**

County of Los Angeles
Department of Health Services

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

EMERGENCY MEDICAL SERVICES COMMISSION

PROVIDER AGENCY ADVISORY COMMITTEE

MINUTES
(Updated October 8, 2015)

Wednesday, August 19, 2015

MEMBERSHIP / ATTENDANCE

MEMBERS	ORGANIZATION
☑ David Austin, Chair	EMSC, Commissioner
☐ Robert Barnes, Vice-Chair	EMSC, Commissioner
☐ Jon Thompson, Commissioner	EMSC, Commissioner
☑ Clayton Kazan, MD, Commissioner	EMSC, Commissioner
☑ Jodi Nevandro	Area A
☐ Sean Stokes	Area A Alt (Rep to Med Council, Alt)
☐ Jon O'Brien	Area B
☑ Kevin Klar	Area B, Alt.
☑ Victoria Hernandez	Area B Alt. (Rep to Med Council)
☑ Ken Leasure	Area C
☐ Susan Hayward	Area C, Alt
☐ Bob Yellen	Area E
☑ Richard Roman	Area E, Alt.
☑ Dwayne Preston	Area F
☐ Joanne Dolan	Area F, Alt.
☑ Brian Hudson	Area G (Rep to BHAC)
☐ Michael Murrey	Area G, Alt. (Rep to BHAC, Alt.)
☑ Jeffrey Elder	Area H (Rep to DAC)
☑ Douglas Zabilski	Area H, Alt.
☐ Brandon Greene	Employed EMT-P Coordinator (LACAA)
☐ Matthew Chelette	Employed EMT-P Coordinator, Alt. (LACAA)
☐ Ryan Burgess	Prehospital Care Coordinator (BHAC)
☑ Alina Chandal	Prehospital Care Coordinator, Alt. (BHAC)
☐ Todd Tucker	Public Sector Paramedic (LAAFCA)
☐ James Michael	Public Sector Paramedic, Alt. (LAAFCA)
☑ Maurice Guillen	Private Sector EMT-P (LACAA)
☐ Ernie Foster	Private Sector EMT-P, Alt. (LACAA)
☐ Marc Eckstein, MD	Provider Agency Medical Director (Med Council)
☐ Stephen Shea, MD	Provider Agency Medical Director, Alt. (Med Council)
☑ Diane Baker	Private Sector Nurse Staffed Ambulance Program (LACAA)
☐ Vacant	Private Sector Nurse Staffed Ambulance Program, Alt (LACAA)

EMS AGENCY STAFF PRESENT	
Nichole Bosson, MD	Roel Amara
Christy Preston	Stephanie Raby
April Ramelli, MD	Paula Rashi
Ericka Reich	Karen Rodgers
Phillip Santos	Michelle Williams
Carolyn Naylor	Christine Zaiser
Mark Ferguson	Gary Watson

OTHER ATTENDEES	
Scott Martinez	El Segundo FD
Evie Anguian	LACo FD
Nicole Steeneken	LACo FD
Terry Millsaps	LACo FD
Mike Barilla	Pasadena FD
Chad Richardson	La Habra Heights
Michael Beeghly	Santa Fe Springs FD
Matt Hill	Santa Monica FD
Trevor Stonum	MedCoast Amb
Carter Wystrach	UCLA
Jesse Cardoza	AMR Ambulance
Gary Cevello	AMR Ambulance
Chad Brewster	Gentle Ride Amb
Ian Wilson	PRN Ambulance
David Konieczny	McCormick Amb
Dennis Smith	Royalty Amb
Tisha Hamilton	Bowers Amb
Caroline Jack	Care Amb
Sean Allen	Liberty Amb
Rocky Allen	Mercy Air Amb
Robert Ower	LACAA

LACAA – *Los Angeles County Ambulance Association* * LAAFCA – *Los Angeles Area Fire Chiefs Association* * BHAC – *Base Hospital Advisory Committee* * DAC – *Data Advisory Committee*

CALL TO ORDER: Chair, Commissioner David Austin called meeting to order at 1:05 p.m.

1. **APPROVAL OF MINUTES (Hernandez/Baker)** June 17, 2015 minutes were approved.

2. INTRODUCTIONS / ANNOUNCEMENTS

2.1 New Medical Director, EMS Agency *(John Telmos)*

Effective July 1, 2015, Marianne Gausche-Hill, M.D., became the Los Angeles County EMS Agency's Medical Director.

2.2 Martin Luther King, Jr. Community Hospital (MLK) 9-1-1 Receiving Designation *(John Telmos)*

- On August 11, 2015, MLK began receiving ambulance patients. Since opening, MLK has been receiving approximately10-15 BLS and ALS patients per day. There have been approximately 80 walk-in patients per day.
- The EMS Agency's plan is to monitor the number of patients MLK receives and possibly to expand MLK's Transitional Transport Guideline boundaries to allow more ambulance transports into the emergency department.

2.3 Middle Eastern Respiratory Syndrome (MERS) – Transportation Guidelines *(Roel Amara)*

- The following two Guideline charts were distributed and reviewed:
  - LAX Suspect Middle Eastern Respiratory Syndrome – Corona Virus (MERS-CoV): Patient Assessment and Transport Guidelines.
  - Suspect Middle Eastern Respiratory Syndrome – Corona Virus (MERS-CoV): Patient Assessment and Transportation Guidelines.
- Providers were advised, when contacting patients with suspected MERS, to utilize their body substance isolation equipment and to contact Public Health Department for MERS confirmation and patient destination. Phone numbers for Public Health varies, depending on day of the week and time of the week. See Guideline charts listed above for details.
- There is no need to utilize the specially prepared "communicable disease" ambulances for transport.
- Questions or concerns may be directed to Roel Amara at ramara@dhs.lacounty.gov.

3. REPORTS & UPDATES

There were no Reports & Updates.

4. UNFINISHED BUSINESS

4.1 Reference No. 1244, Treatment Protocol: Chest Pain

Policy remains tabled. There was no discussion.

Tabled Reference No. 1244, Treatment Protocol: Chest Pain

5. NEW BUSINESS

5.1 Reference No. 420, Private Ambulance Operator Medical DIrector *(Stephanie Raby)*

Policy reviewed and approved as written.

M/S/C (Guillen/Nevandro): Approve Reference No. 420, Private Ambulance Operator Medical Director

5.2 Reference No. 451.1a, Ambulance Vehicle Essential Medical and Personal Protective Equipment *(Stephanie Raby)*

Policy reviewed and approved with the following recommendations:

- SUBJECT and throughout policy: Add word "Private" to specify that this policy is intended for private ambulance companies
- PURPOSE: Rephrase the description to be more clear
- Page 2: Add "head immobilizers" to inventory
- Page 3: Change quantity of Adenosine to "18 mg"
- Page 4: Change quantity of Epinephrine 1:1000 to "5 mg"
- Page 4: Add "Benadryl" and quantity
- Page 4: Add "Odansetron" and quantity
- Page 6: Change the Needle Thoracostomy size to "3.0 – 3.5 inch"
- Page 7: Remove "Sodium bicarbonate"

M/S/C (Klar/Kazan): Approve Reference No. 451.1a, **Ambulance Vehicle Essential Medical and Personal Protective Equipment, with the above recommendations**

5.3 Reference No. 453, Ambulance Licensing Investigations *(Stephanie Raby)*

Policy reviewed and approved with the following recommendation:

- SUBJECT and throughout policy: Add word "Private" to specify that this policy is intended for private ambulance companies

M/S/C (Hudson/Preston): Approve Reference No. 453, Ambulance Licensing Investigations, with the above recommendation.

5.4 Reference No. 453.1, Ambulance Licensing Enforcement Officers *(Stephanie Raby)*

Policy tabled until reviewed by County Council.

Tabled Reference No. 453.1, Ambulance Licensing Enforcement Officers.

5.5 Reference No. 454, Ambulance Vehicle Color Scheme and Insignia Guidelines *(Stephanie Raby)*

Policy reviewed and approved with the following recommendation:

- SUBJECT and throughout policy: Add word "Private" to specify that this policy is intended for private ambulance companies

M/S/C (Hudson/Hernandez): Approve Reference No. 454, Ambulance Vehicle Color Scheme and Insignia Guidelines, with the above recommendation.

5.6 Reference No. 455, Ambulance Vehicle Age Limit Requirements and Exemptions *(Stephanie Raby)*

Policy reviewed and approved with the following recommendation:

- SUBJECT and throughout policy: Add word "Private" to specify that this policy is intended for private ambulance companies

M/S/C (Baker/Hudson): Approve Reference No. 455, Ambulance Vehicle Age Limit Requirements and Exemptions, with the above recommendation.

5.7 Reference No. 712, Nurse Staffed Critical Care Transport (CCT) Unit Inventory *(John Telmos)*

Policy presented as "Information Only".

6. OPEN DISCUSSION

There were no further discussion topics.

7. NEXT MEETING: October 21, 2015

8. ADJOURNMENT: Meeting adjourned at 1:40 p.m.

(EMT, PARAMEDIC, MICN)

SUBJECT: **STROKE PATIENT DESTINATION** REFERENCE NO. 521

PURPOSE: To provide guidelines for transporting suspected stroke patients to the most accessible facility appropriate to their needs.

AUTHORITY: Health & Safety Code, Division 2.5, Section 1798

DEFINITIONS:

Approved Stroke Center (ASC): A 9-1-1 receiving hospital that has met the standards of a Center for Medicaid & Medicare Services (CMS) approved accreditation body as a Primary Stroke Center and has been approved as a Stroke Center by the Los Angeles (LA) County Emergency Medical Services (EMS) Agency.

Modified Los Angeles Prehospital Stroke Screen (mLAPSS): A screening tool utilized by prehospital care providers to assist in identifying patients who may be having a stroke.

Modified LAPSS criteria:

1. Symptom duration less than ~~2~~6 hours
2. No history of seizures or epilepsy
3. Age ≥ 40
4. At baseline, patient is not wheelchair bound or bedridden
5. Blood glucose between 60 and 400 mg/dL
6. Motor Exam: Examine for obvious asymmetry-unilateral weakness (exam is positive if one or more of the following are present)
    a. Facial Smile/Grimace
    b. Grip
    c. Arm Strength

Local Neurological Signs: Signs that may indicate an irritation in the nervous system such as a stroke or lesion. These signs include: speech disturbances, altered level of consciousness, paresthesias, new onset seizures, dizziness, unilateral weakness, and visual disturbances.

PRINCIPLES:

1. Patients experiencing a stroke should be transported to the most accessible facility appropriate to their needs. This determination will be made by the base hospital physician or Mobile Intensive Care Nurse after consideration of the guidelines established in this policy. Final authority for patient destination rests with the base hospital handling the call or SFTP provider functioning under protocols.

2. Basic Life Support units shall call an Advanced Life Support unit for suspected stroke patients as outlined in Reference No. 808, Base Hospital Contact and Transport Criteria-Section I.

APPROVED:

Director, EMS Agency

Medical Director, EMS Agency

3. In all cases, the health and well being of the patient is the overriding consideration in determining patient destination. Factors to be considered include: severity and stability of the patient's condition; anticipation of transport time; available transport resources; and request by the patient, family, guardian or physician.

POLICY:

I. Responsibility of the Provider Agency

A. Perform a mLAPSS for patients exhibiting local neurological signs or symptoms of a possible stroke.

B. Transport the patient to the nearest ASC if mLAPSS screening criteria are met.

Note: SFTP providers are responsible for assuring the ASC is notified of the patient's pending arrival and contacting the base hospital to provide minimal patient information, including the results of the mLAPSS, last known well date and time, and patient destination. Base contact may be performed after the transfer of care if the receiving ASC is not the base hospital.

C. Document the results of mLAPSS and last known well time in designated area on the EMS Report Form or electronic patient care report (ePCR).

D. In order to ensure that proper consent for treatment can be obtained by hospital personnel, if possible, document the name and contact information of the family member, caregiver, or witness who can help verify the patient's last known well time in the Comments area of the EMS Report Form or ePCR. When practical, transport the witness with the patient.

II. Responsibility of the Base Hospital

A. Provide medical direction and destination for all patients who meet mLAPSS criteria or have symptoms strongly suggestive of a stroke.

B. Determine patient destination via the ReddiNet® system.

C. Notify the receiving ASC if the base hospital is not the patient's destination.

D. Document the results of mLAPSS and last known well time in designated area on the Base Hospital Form.

E. Prompt prehospital care personnel to obtain and document witness contact information on the EMS Report Form or ePCR.

III. Responsibility of the ASC

A. Provide services 24 hours a day/7 days a week for stroke patients as required for Primary Stroke Center certification.

B. Diversion of stroke patients is allowed only for internal disaster.

IV. Transportation of Stroke Patients to an ASC

A. All suspected stroke patients shall be transported to the most accessible ASC if ground transport is 30 minutes or less regardless of service area rules and/or considerations.

B. If ground transport time to an ASC is greater than the maximum allowable time of 30 minutes, the patient shall be transported to the most accessible receiving facility.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 501, **Hospital Directory**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Units**
Ref. No. 808, **Base Hospital Contact and Transport Criteria**
Ref. No. 1200, **Treatment Protocols**
Ref. No. 1251, **Stroke/Acute Neurological Deficits**

Centers for Medicare & Medicaid Services, www.cms.gov

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMS QUALITY IMPROVEMENT PROGRAM** REFERENCE NO. 620

PURPOSE: To establish a process for the Los Angeles County Emergency Medical Services (EMS) Agency and system participants to evaluate the EMS system to ensure safety and continued improvement in prehospital patient care delivery.

AUTHORITY: California Code of Regulations, Title 22, Chapter 12
Health and Safety Code Division 2.5
California Evidence Code, Section 1157.7
California Civil Code Part 2.6, Section 56

DEFINITIONS:

Indicator: A well-defined, objective, measurable, and important aspect of care.

Important Aspects of Care: Patient care activities that are of greatest significance to the quality of patient care. These include activities that are high in volume, high risk, and/or problem prone for patients and/or healthcare providers.

Periodic Review: A re-evaluation of a discontinued indicator within a predetermined time frame after achievement of threshold to ensure ongoing compliance.

Quality Improvement (QI): The analysis of performance and systematic effort to improve it.

System Participant: For the purposes of this policy, a system participant is any prehospital care provider or entity required by law, regulation, agreement, or policy to develop and maintain a QI program consistent with state and local requirements.

Threshold: A pre-established level of performance related to a specific indicator.

Technical Advisory Group (TAG): A group of EMS system participants (stakeholders) that assist in the implementation of the QI process.

Unusual Occurrence: An unexpected event that has impacted or could potentially impact the routine safe delivery of care.

PRINCIPLES:

1. An EMS QI program is an essential component of an effective EMS system capable of providing quality patient care and achieving system performance goals. ~~Each system participant shall develop and maintain a QI program consistent with state and local requirements.~~

2. Key components of an EMS QI program include:
   a. Personnel

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Director, EMS Agency Medical Director, EMS Agency

b. Equipment and Supplies
c. Documentation
d. Clinical Care/Patient Outcome
e. Skills Maintenance/Competency
f. Transportation/Facilities
g. Risk Management
h. Public Education/Prevention

3. EMS organizations become valuable stakeholders in the State QI program by participating in the local EMS Agency QI program.

4. Randomized data sampling may be utilized to measure an indicator or monitor performance. However, to obtain meaningful data that is representative of the study population, factors such as the population affected, the frequency of the activity, and the severity of consequence when thresholds are not met, must all be considered when determining the size and population of data samples.

POLICY:

I. EMS Agency Responsibilities**:**

A. Implement a state-approved EMS QI plan consistent with all regulatory requirements.

B. Review QI programs and approve QI plans of local EMS system participants.

C. Maintain a systemwide QI program.

II. ~~EMS Provider Agency and Base Hospital~~ System Participant Responsibilities

A. Implement and maintain a QI program approved by the EMS Agency that reflects the organization's current QI process(es).

B. Demonstrate how EMS QI is integrated within the organization.

C. Designate a representative to attend the relevant EMS Agency QI Committee meeting(s).

D. Participate in systemwide QI studies, to include timely submission of requested data to the EMS Agency.

E. Provide education, training, or other methods utilized to disseminate information (i.e., newsletters or posters) specific to findings identified in the QI process.

F. Establish and maintain relationships with stakeholders (e.g., Technical Advisory Group) and, as needed, convene meetings to facilitate the QI process.

G. Review the QI plan annually and update as needed. If there are no revisions, a signed copy of the QI plan signature page or written statement to that effect, along with a copy of the current QI indicators, may be submitted in lieu of the entire plan.

III. Other Specified Specialty Care Center Responsibilities:

A. Participate in the EMS QI Program, to include collection and submission of data to the EMS Agency.

IV. QI Plan Requirements

Each QI plan shall include a description, at minimum, of the following components:

A. Organizational Structure

1. Mission statement and/or philosophy of the organization.

2. Goals and objectives.

3. Organizational chart or narrative description of how the QI program is integrated within the organization (include local stakeholder participation), EMS Agency QI Program, and State EMS QI Program.

4. Organizational chart or narrative description of how the organization's QI program is integrated with local and State QI programs

B. Methodology, processes and tools used to facilitate the QI Process (i.e., FOCUS-PDSA)

F Find a process to improve
O Organize an effort to work on improvement
C Clarify current knowledge of the process
U Understand process variation and capability
S Select a strategy for further improvement

P Plan a change or test aimed at improvement
D Do – carry out the change or the test
S Study the results, what was learned, what went wrong
A Act – adopt the change, or abandon it, or run through the cycle again

C. Data Collection and Reporting

1. All reliable sources of information utilized in the QI process; including EMS databases, prehospital care records, checklists, customer input, direct observations, and skills simulation.

2. Flow of information.

3. Methods used to document QI findings.

4. Process used to submit data to the EMS Agency.

D. Training, education or methods that will be used to communicate relevant information among stakeholders.

V. QI Program Requirements

Each QI Program shall include, at minimum, the following:

A. An approved QI Plan

B. Develop a minimum of two QI indicators that relate to important aspects of care, to include the following:

1. Well-defined description of the important aspect of care being measured.

2. Threshold for compliance.

3. Timeline for tracking indicator once the threshold has been achieved.

4. Data source.

C. Methods for tracking compliance and identifying trends.

D. Written analysis that summarizes the QI findings.

E. Corrective actions that may be taken to improve processes.

F. Written trending report that includes effectiveness of performance improvement action plans.

G. Education and training specific to findings identified in the QI process.

H. Methods utilized for dissemination of the QI findings to stakeholders.

I. Recognition and acknowledgment of performance improvement.

J. Periodic review or a re-evaluation of a discontinued indicator within a predetermined time frame after achievement of threshold to ensure ongoing compliance.

K. Methods for identifying, tracking, documenting and addressing non-indicator issues and unusual occurrences.

L. Record Keeping

1. All QI records shall be maintained in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations.

2. The following records shall be maintained and available for review until the EMS Agency Program Review is concluded:

a. QI meeting minutes and attendance rosters/sign-in sheets.

b. Attendance rosters/sign-in sheets for activities where QI findings and/or actions are discussed.

c. QI indicator(s) data collection tools.

d. Written summaries of the trending/analysis.

e. Documentation of dissemination of QI findings to stakeholders.

f. Dates and times of continuing education and skill training based on QI findings.

g. Dates and times of remedial education or skills training, when provided.

h. Non-indicator tracking tool for monitoring performance excellence, unusual occurrences or issues regarding non-compliance with current policies and procedures outside of QI activities.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 618, **EMS Quality Improvement Program Committees**

California EMS Authority, Quality Improvement Program Model Guidelines, 2005
Los Angeles County EMS Agency Quality Improvement Plan: ems.dhs.lacounty.gov/QI/QI

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DETERMINATION/PRONOUNCEMENT OF DEATH IN THE FIELD** (EMT/ PARAMEDIC/MICN) REFERENCE NO. 814

PURPOSE: This policy is intended to provide EMS personnel with parameters to determine whether or not to withhold resuscitative efforts in accordance with the patient's wishes, and to provide guidelines for base hospital physicians to discontinue resuscitative efforts and pronounce death.

AUTHORITY: California Health and Safety Code, Division 2.5
California Probate Code, Division 4.7
California Family Code, Section 297-297.5

DEFINITIONS:

Advance Health Care Directive (AHCD): A written document that allows patients who are unable to speak for themselves to provide health care instructions and/or appoint a Power-of-Attorney for Health Care. There is no one standard format for an AHCD. Examples of AHCDs include:

- Durable power of attorney (DPAHC)
- Healthcare proxies
- Living wills (valid in California if dated prior to 7-1-2000; advisory but not legally binding after that date)

Agent: An individual, eighteen years of age or older, designated in a power of attorney for health care to make health care decisions for the patient, also known as "attorney-in-fact".

Conservator: Court-appointed authority to make health care decisions for a patient.

Determination of Death: To conclude that a patient has died by conducting an assessment to confirm the absence of respiratory, cardiac, and neurologic function.

Immediate Family: The spouse, domestic partner, adult children or adult sibling(s) of the patient.

Organized ECG Activity: A narrow complex supraventricular rhythm.

Pronouncement of Death: A formal declaration by a base hospital physician that life has ceased.

Standardized Patient-Designated Directives: Forms or medallions that recognize and accommodate a patient's wish to limit prehospital treatment at home, in long term care facilities or during transport between facilities. Examples include:

- Statewide Emergency Medical Services Authority (EMSA)/California Medical Association

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Director, EMS Agency Medical Director, EMS Agency

(CMA) Prehospital DNR Form (Ref. No. 815.1)
- Physician Orders for Life-Sustaining Treatment (POLST, Ref. No. 815.2)
- State EMS Authority-approved DNR Medallion

PRINCIPLES:

1. Resuscitative efforts are of no benefit to patients whose physical condition precludes any possibility of successful resuscitation.

2. EMTs and paramedics may **determine** death based on specific criteria set forth in this policy.

3. Base hospital physicians may **pronounce** death based on information provided by the paramedics in the field and guidelines set forth in this policy.

4. If there is any objection or disagreement by family members or EMS personnel regarding terminating or withholding resuscitation, basic life support (BLS) resuscitation, including defibrillation, may continue or begin immediately and paramedics should contact the base hospital for further directions.

5. Aggressive resuscitation in the field to obtain the return of spontaneous circulation (ROSC) is encouraged. Transporting patients without ROSC is discouraged.

6. EMS personnel should honor valid do-not-resuscitate (DNR) orders and other patient designated end-of-life directives in the field and act in accordance with the patient's wishes when death appears imminent.

POLICY:

I. EMS personnel may determine death in the following circumstances:

A. In addition to the absence of respiration, cardiac activity, and neurologic reflexes, one or more of the following physical or circumstantial conditions exist:

1. Decapitation

2. Massive crush injury

3. Penetrating or blunt injury with evisceration of the heart, lung or brain

4. Decomposition

5. Incineration

6. Pulseless, non-breathing victims with extrication time greater than fifteen minutes, where no resuscitative measures can be performed prior to extrication.

7. Penetrating trauma patients who, based on the paramedic's thorough assessment, are found apneic, pulseless, asystolic, and without pupillary

reflexes upon the arrival of EMS personnel at the scene.

8. Blunt trauma patients who, based on a paramedic's thorough patient assessment, are found apneic, pulseless, and without organized ECG activity (narrow complex supraventricular rhythm) upon the arrival of EMS personnel at the scene.

9. Pulseless, non-breathing victims of a multiple victim incident where insufficient medical resources preclude initiating resuscitative measures.

10. Drowning victims, when it is reasonably determined that submersion has been greater than one hour.

11. Rigor mortis (requires assessment as described in Section I, B.)

12. Post-mortem lividity (requires assessment as described in Section I, B.)

B. If the initial assessment reveals rigor mortis and/or post-mortem lividity only, EMTs and/or paramedics shall perform the following assessments (may be performed concurrently) to confirm the absence of respiratory, cardiac, and neurologic function for determination of death in the field:

1. Assessment of respiratory status:

a. Assure that the patient has an open airway.

b. Look, listen and feel for respirations. Auscultate the lungs for a minimum of 30 seconds to confirm apnea.

2. Assessment of cardiac status:

a. Auscultate the apical pulse for a minimum of 60 seconds to confirm the absence of heart sounds.

b. Adults and children: Palpate the carotid pulse for a minimum of 60 seconds to confirm the absence of a pulse.

c. Infants: Palpate the brachial pulse for a minimum of 60 seconds to confirm the absence of a pulse.

3. Assessment of neurological reflexes:

a. Check for pupillary response with a penlight or flashlight to determine if pupils are fixed and dilated.

b. Check and confirm unresponsive to pain stimuli.

C. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I. A. require immediate BLS measures to be initiated. If one or more of the following conditions is met, resuscitation may be discontinued and the patient is determined to be dead:

1. A valid standardized patient-designated directive indicating DNR.

2. A valid AHCD with written DNR instructions or the agent identified in the AHCD requesting no resuscitation.

3. Immediate family member present at scene:

   a. With a patient-designated directive on scene requesting no resuscitation

   b. Without said documents at scene with full agreement of others, if present, requesting no resuscitation

4. Parent or legal guardian is required and must be present at scene to withhold or terminate resuscitation for patients less than 18 years of age.

II. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I require immediate cardiopulmonary resuscitation in accordance with Ref. No. 1210, Treatment Protocol: Non-Traumatic Cardiac Arrest (Adult). Base contact for medical direction shall be established when indicated by Ref. No. 1210.

A. ~~EMS~~ Paramedics~~Personnel~~ may determine death if a patient in **asystole** after 20 minutes of ~~quality~~ cardiopulmonary resuscitation by EMS personnel on scene meets ALL of the following criteria:

1. Patient 18 years or greater

2. Arrest not witnessed by EMS personnel

3. No shockable rhythm identified at any time during the resuscitation

4. No ROSC at any time during the resuscitation

5. No hypothermia

B. Base Physician consultation for pronouncement is not required if Section A is met.

C. Base Physician contact shall be established for all patients in cardiopulmonary arrest who do not meet the conditions described in Section I or IIA of this policy.

III. Physician guidelines for transport versus termination.

A. Resuscitation should be continued on-scene until one of the following:

1. ROSC is confirmed with a corresponding rise in EtCO2

2. Base physician determines further resuscitative efforts are futile

3. Decision to transport after 20 minutes of ~~quality~~ resuscitation on-scene and

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ROSC is not achieved

B. Patients who have not achieved ROSC after 20 minutes of ~~quality~~ on-scene resuscitation **should** be considered for transport if:

1. Arrest witnessed by EMS personnel

2. Persistent VF/VT rhythm after three (3) shocks delivered

C. Additional considerations for transport of pulseless non-breathing patients **may** include:

1. Suspected reversible non-cardiac etiologies, including hypothermia

2. Paramedic judgment (i.e., unsafe environment, public location)

3. Shock delivered at any time during the resuscitation

IV. Crime Scene Responsibility, Including Presumed Accidental Deaths and Suspected Suicides:

A. Responsibility for medical management rests with the most medically qualified person on scene.

B. Authority for crime scene management shall be vested in law enforcement. To access the patient it may be necessary to ask law enforcement officers for assistance to create a “safe path” that minimizes scene contamination.

C. If law enforcement is not on scene, EMS personnel should attempt to create a "safe path" and secure the scene until law enforcement arrives.

V. Procedures Following Pronouncement of Death:

A. The deceased should not be moved without the coroner’s authorization. Any invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient should be left in place.

NOTE: If it is necessary to move the deceased because the scene is unsafe or the body is creating a hazard, EMS personnel may relocate the deceased to a safer location or transport to the most accessible receiving facility.

B. If law enforcement or the coroner confirms that the deceased will not be a coroner’s case and the personal physician is going to sign the death certificate, any invasive equipment used during the resuscitation may be removed.

C. EMS personnel should remain on scene until law enforcement arrives. During this time, when appropriate, the provider should provide grief support to family members.

VI. Required Documentation for Patients Determined Dead/Pronounced in the Field:

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A. The time and criteria utilized to determine death; the condition, location and position of the body, and any care provided.

B. The location and the rationale if the deceased was moved. If the coroner authorized movement of the deceased, document the coroner's case number (if available) and the coroner's representative who authorized the movement.

C. Time of pronouncement and name of the pronouncing physician if base hospital contact was initiated

D. The name of the agent identified in the AHCD or patient-designated directive or the name of the immediate family member who made the decision to withhold or withdraw resuscitative measures. Obtain their signature on the EMS Report Form.

E. If the deceased is **not** a coroner's case and their personal physician is going to sign the death certificate:

1. Document the name of the coroner's representative who authorized release of the patient, and

2. The name of the patient's personal physician signing the death certificate, and

3. Any invasive equipment removed

CROSS REFERENCE:

Prehospital Care Manual:
Reference No. 518, **Decompression Emergencies/Patient Destination**
Reference No. 519, **Management of Multiple Casualty Incidents**
Reference No. 606, **Documentation of Prehospital Care**
Reference No. 806, **Procedures Prior to Base Contact**
Reference No. 808, **Base Hospital Contact and Transport Criteria**
Reference No. 815, **Honoring Prehospital Do Not Resuscitate Orders**
Reference No. 815.1 **EMSA/CMA Prehospital Do Not Resuscitate (DNR) Form**
Reference No. 819, **Organ Donor Identification**
Reference No. 815.2 **Physician Orders for Life-Sustaining Treatment (POLST) Form**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT-I/EMT-P/MICN)

SUBJECT: **TREATMENT/TRANSPORT OF MINORS** REFERENCE NO. 832

PURPOSE: To describe the guidelines for treatment and/or transport of a patient under the age of eighteen.

AUTHORITY: Health and Safety Code Section 124260
California Family Code 6922, 6925, 6926, 6927, 6929(~~4)~~b, 7002~~(a)(b)(c)~~, 7050, 7122, 7140
Business and Professions Code 2397

DEFINITIONS:

Emergency Medical Condition: ~~Condition or s~~Situation in which an individual has a need for immediate medical attention or where the potential for need is perceived by EMS personnel or a public safety agency.

~~**Involuntary** **Implied** **Consent:** In the absence of a parent or legal representative, emergency treatment and/or transport of a minor may be initiated without consent.

Legal Representative: A person who is granted custody or conservatorship of another person by a court of law.

Minor: A person less than eighteen years of age.

Minor not requiring parental consent is a person who is:

1. Not married and ~~H~~has an emergency medical condition and parent is not available.
2. ~~Is m~~Married or was previously married.
3. ~~Is o~~On active duty ~~in the military~~with the Armed Forces.
4. ~~Is~~ Self-sufficient15 years of age or older, living separate and apart from his/her parents, and managing his/her own financial affairs.
5. ~~Is a~~An emancipated minor ~~(decreed by court, identification card by DMV)~~ with a declaration by the court or an identification card from the Department of Motor Vehicles.
6. ~~Is~~ Not married ~~pregnant~~ and requires care related to the treatment or prevention of pregnancy.
7. ~~Is i~~In need of care for sexual assault or rape.
8. Not married and seeking care related to an abortion.
9. ~~Is 12 years or older and in need of care for rape~~

APPROVED:

Director, EMS Agency

Medical Director, EMS Agency

~~10.~~9. ~~Is~~ 12 years of age or older and in need of care for ~~contagious~~ communicable reportable disease ~~or condition~~, prevention of a sexually transmitted disease (STD), alcohol or ~~for~~ substance abuse, or outpatient mental health.

Voluntary Consent: Treatment or transport of a minor child shall be with the verbal or written consent of the parents or legal representative.

PROCEDURES:

I. Treatment/Transport of Minors

A. In the absence of a parent or legal representative, minors with an emergency medical condition shall be treated and transported to the ~~health facility most~~ appropriate ~~to the needs of the patient~~ receiving facility or a specialty care center (e.g. EDAP, PMC, PTC, SART Center, Trauma Center, etc.).

B. Hospital or provider agency personnel shall make every effort to inform a parent or legal representative where their child has been transported.

C. If prehospital care personnel believe a parent or other legal representative of a minor is making a decision which appears to be endangering the health and welfare of the minor by refusing indicated immediate care or transport, law enforcement authorities should be involved.

D. Infants ≤ 12 months of age shall be transported, regardless of chief complaint and /or mechanism of injury, in accordance with Reference No. 808.

II. Minors **Not** Requiring Transport

A. A minor child (excluding children ≤ twelve (12) months of age) who is evaluated by EMS personnel and determined not to be injured, to have sustained only minor injuries, or to have illnesses or injuries not requiring immediate treatment or transportation, may be released to:

1. Self (consideration should be given to age, maturity, environment and other factors that may be pertinent to the situation)

2. Parent or legal representative

3. A responsible adult at the scene

4. Designated care giver

5. Law enforcement

B. Children ~~<~~13 - 36 months of age require base hospital contact and/or transport, except isolated minor extremity injury, in accordance with Reference No. 808.

C Prehospital care personnel shall document on the EMS Report Form to whom the patient was released.

CROSS REFERENCE:

Prehospital Care Manual
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 508.1, **SART Center Roster**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 808, **Base Contact and Transport Criteria**
Ref. No. 822, **Suspected Child Abuse Reporting Guidelines**
Ref. No. 834, **Patient Refusal of Treatment or Transport**

~~California Association of Hospitals and Health Systems Consent Manual~~