# COUNTY OF LOS ANGELES
# EMERGENCY MEDICAL SERVICES COMMISSION

**10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670**
**(562) 347-1604 FAX (562) 941-5835**
**http://.ems.dhs.lacounty.gov/**

**DATE:** **March 16, 2016**

**TIME:** **1:00 – 3:00 PM**

**LOCATION:** **Los Angeles County EMS Agency**
10100 Pioneer Blvd., EMSC Hearing Room – 1st Fl
Santa Fe Springs, CA 90670

***The Commission meetings are open to the public. You may address the Commission on any agenda item before or during consideration of that item, and on other items of interest which are not on the agenda, but which are within the subject matter jurisdiction of the Commission. Public comment is limited to three (3) minutes and may be extended by Commission Chair as time permits.***
**NOTE: Please SIGN IN if you would like to address the Commission.**

## AGENDA

**CALL TO ORDER –** Clayton Kazan, M.D., Chairman

**INTRODUCTIONS/ANNOUNCEMENTS/PRESENTATIONS**
- "California Department of Public Health Executive Toolkit Video"

**CONSENT CALENDAR** (Commissioners/Public may request that an item be held for discussion.)

**1 MINUTES**
- January 20, 2016

**2 CORRESPONDENCE**
2.1 (2-25-2016) Distribution: College Medical Center Perinatal Status
2.2 (2-23-2016) Bocki Park, CEO, Encino Hospital Medical Center: Encino Hospital Medical Center's designation as an Approved Stroke Center (ASC)
2.3 (2-22-2016) Fire Chief, Each Fire Department, CEO/President, Each Ambulance Company: ALS Unit, Assessment Unit and ALS EMS Aircraft Unit Medical Supply Inventories
2.4 (2-22-2016) Fire Chief/CEO, Each EMS Provider Agency: New State EMS Data System Requirements
2.5 (2-8-2016) Distribution: Countywide Sidewalk Cardiac Resuscitation Day – Thursday, June 2, 2016
2.6 (2-7-2016) FAX/E-Mail Distribution: Los Angeles (LA) Marathon 2016
2.7 (1-27-2016) Mario Rueda, Fire Chief, San Gabriel Fire Department: Newly Appointed Medical Director – Grace Ting, M.D.
2.8 (1-25-2016) Roger E. Seaver, President & Chief Executive Officer, Henry Mayo Newhall Hospital: Henry Mayo Newhall Hospital SRC Medical Director
2.9 (1-19-2016) Martin Serna, Fire Chief, Torrance Fire Department: Newly Appointed Medical Director – Marc Cohen, M.D.

**3. COMMITTEE REPORTS**

3.1 Base Hospital Advisory Committee
3.2 Data Advisory Committee
3.3 Education Advisory Committee
3.4 Provider Agency Advisory Committee

**4. POLICIES**

4.1 Reference No. 506, Trauma Triage
4.2 Reference No. 511, Perinatal Patient Destination
4.3 Reference No. 521, Stroke Patient Destination
4.4 Reference No. 703, ALS Unit Inventory
4.5 Reference No. 704, Assessment Unit Inventory
4.6 Reference No. 706, ALS EMS Aircraft Inventory
4.7 Reference No. 806.1, Procedures Prior to Base Contact
4.8 Reference No. 808, Base Hospital Contact and Transport Criteria

(For Information Only)
4.9 Reference No. 1202, Treatment Protocol: General ALS*
4.10 Reference No. 1251, Treatment Protocol: Stroke/Acute Neurological Deficits*
4.11 Reference No. 1261, Treatment Protocol: Emergency Childbirth (Mother)*
4.12 Reference No. 1275, Treatment Protocol: General Trauma*
4.13 Reference No. 1277, Treatment Protocol: Traumatic Arrest*
4.14 Reference No. 1320, Medical Control Guideline: Needle Thoracostomy

**5. BUSINESS**

Old:
5.1 Community Paramedicine *(July 18, 2012)*
5.2 EMSC Ad Hoc Committee *(May 20, 2015)*

New:
5.3 EMS Update 2016

**6. COMMISSIONERS COMMENTS/REQUESTS**

**7. LEGISLATION**

**8. EMS DIRECTOR'S REPORT**

**9. ADJOURNMENT**

(To the meeting of May 18, 2016)

**Lobbyist Registration**: Any person or entity who seeks support or endorsement from the EMS Commission on official action must certify that they are familiar with the requirements of Ordinance No. 93-0031. Persons not in compliance with the requirements of the Ordinance shall be denied the right to address the Commission for such period of time as the noncompliance exists.

# CONSENT CALENDAR
## March 16, 2016

**MINUTES**

- January 20, 2016

**2. CORRESPONDENCE**

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# COUNTY OF LOS ANGELES
# EMERGENCY MEDICAL SERVICES COMMISSION

**10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, CA 90670**
**(562) 347-1604 FAX (562) 941-5835**
**http://.ems.dhs.lacounty.gov/**

## January 20, 2016

| | COMMISSIONERS | ORGANIZATION | EMS AGENCY STAFF | POSITION |
|---|---|---|---|---|
| ☑ | Robert Ower | LAC Ambulance Assn | Cathy Chidester | Director, EMS Agency |
| * | Robert Barnes | LAC Police Chiefs Assn | Kay Fruhwirth | Asst. Dir, EMS Agency |
| * | Frank Binch | Public Member, 4th District | Richard Tadeo | Asst. Dir, EMS Agency |
| ☑ | Erick H. Cheung, M.D. | So. CA Psychiatric Society | M. Gausche-Hill | Medical Director, EMS |
| ☑ | Robert Flashman, M.D. | L.A. County Medical Assn | Marilyn Rideaux | EMS Staff |
| ☑ | John Hisserich | Public Member, 3rd District | Lucy Hickey | " |
| ☑ | James Lott | Public Member, 2nd District | | |
| ☑ | Clayton Kazan, M.D. | CAL/ACEP | | |
| ☑ | Ray Mosack | CA State Firefighters' Assn. | | |
| * | Colin Tudor | League of California Cities | | |
| ☑ | Margaret Peterson, PhD | HASC | | |
| * | Andres Ramirez | Peace Officers Assn. of LAC | | |
| ☑ | Nerses Sanossian, M.D. | American Heart Assn. | | |
| ☑ | Carole Snyder | Emergency Nurses Assn. | | |
| ☑ | David White | *LA Chapter-Fire Chiefs Association* | | |
| * | Gary Washburn | Public Member, 5th District | | |
| | Bernard Weintraub (Ab) | S. CA Public Health Assn. | | |

### GUESTS

| | | | |
|---|---|---|---|
| Al Flores | LAFD | Rex Pritchard | Local 372 |
| Dwayne Preston | LBFD | Tim Ernst | LAFD |
| Richard Roman | Compton Fire | Laurie Mejia | Long Beach Mem. |
| Victoria Hernandez | LACoFD | Michael Shrout | Long Beach Fire |
| Nicole Steeneken | LACoFD | Ken Millikan | Torrance FD |
| Eddris Aubry III | PRN Ambulance | | |

(Ab) = Absent; (*) = Excused Absence

## CALL TO ORDER:

The Emergency Medical Services Commission (EMSC) meeting was held in the EMS Commission Hearing Room, 10100 Pioneer Blvd, Santa Fe Springs, 90670. The meeting was called to order at 1:13 PM by Chairman, Clayton Kazan. A quorum was present with 11 Commissioners in attendance.

## ANNOUNCEMENTS/PRESENTATIONS:

Commissioner Mosack was recognized for many years of service to the EMS Commission (1999 – 2015) by the EMS Agency and by the California State Firefighters Association.

Commissioner Mosack introduced his replacement on the EMSC, Paul Rodriguez, who brings 14 years of paramedic experience. Chairman Kazan acknowledged new Commissioners Robert Ower representing the Los Angeles County Ambulance Association and Dave White representing Los Angeles Area Fire Chiefs Association.

Ms. Cathy Chidester, Director of the EMS Agency shared a PowerPoint presentation on EMS personnel working in Los Angeles County who were honored by the State EMS Authority at the 2015 EMS Award Ceremony held in San Francisco in December.

**CONSENT CALENDAR:**

Ms. Chidester commented on correspondence items included in the Consent Calendar.

***M/S/C: Commissioner White/Hisserich to approve the Consent Calendar.***

**5. OLD BUSINESS**

**5.1 Report by the Nominating Committee (November 18, 2015)**
The Nominating Committee, Commissioners Snyder and Sanossian, reported that the Committee met and recommended Clayton Kazan, M.D., to serve as Chairman and Erick Cheung, M.D., to serve as Vice Chairman for 2016.

***M/S/C: Commissioners Sanossian/Hisserich to support the Nominating Committee's recommendations.***

**5.2 Community Paramedicine (July 18, 2012)**
Ms. Chidester reported that OSHPD and the State EMS Authority came to LA County to review the community paramedic program and reported that it is going well. Five patients have been transported to alternate care sites since the start of the ALTRANS program. The number is low because there is an issue with insurance covering ambulance transports to clinics and informed consent. Ambulance companies are not reimbursed for transport of Medicare and MediCal patients unless they are taken to an emergency department. The CHF program is going well.

**5.3 EMSC Ad Hoc Committee Report**
Commissioner Kazan reported that the EMSC Ad Hoc Committee met on Tuesday, January 19 at the EMS Agency. The Committee voted to establish a work group of the Ad Hoc Committee to review the algorithm developed by the Committee and identify standards of field practice for responders and bring back findings to the Ad Hoc Committee. The Ad Hoc anticipates two more meetings before it can report back to the EMSC.

**NEW BUSINESS**

**5.4 EMSC Sub-Committee Appointments**

***M/S/C: Commissioners Ower/White to ratify appointments to the EMSC Sub-Committees.***

**6. Commissioners Comments/Requests**
Commissioner Sanossian announced that there will be an International Stroke Conference sponsored by the American Heart Association in Los Angeles on February 17-19.

**7. Legislation**

Ms. Chidester reported that it was early in the Legislative session and that not many bills are up for discussion. The EMS Agency is currently watching SB 867 introduced by Roth which CAL/ACEP has sponsored, the existing law, which expires on January 1, 2017, authorizes county boards of supervisors to elect to levy an additional penalty, for deposit into the EMS Fund, in the amount of $2 for every $10 upon fines, penalties, and forfeitures collected for criminal offenses. The existing law, until January 1, 2017, requires 15% of the funds collected pursuant to that provision to be used to provide funding for pediatric trauma centers. The Roth bill would extend the operative date of these provisions indefinitely.

**8. Director's Report**

- Ms. Chidester reported that the Emergency Ambulance Transportation contracts which are ten year contracts will expire on May 30, 2016. As presented to the EMSC previously the draft Request for Proposal to select the ambulance companies to cover the Exclusive Operating Areas for the next ten year period is pending approval by the State. It is anticipated that the RFP will be released in early February. The RFP will be available on the EMS Agency website and also be placed on Health Services Contracts and Grants website.

- The EMS Agency did an initial analysis of wall time data reported by the EMS Provider Agencies. Richard Tadeo reported that 33% of EMS records have been reviewed and the findings show that 50% of the providers have good data. The offload time is less than 30 minutes about 80% of the time. Specific data requirements has been forwarded to the providers agencies but there are some mapping issues with the various ePCRs that needed to be corrected. Commissioner Ower stated that the Ambulance Association reviewed the data as well and much of it looks incomplete. Commissioner Peterson asked for clarification of the measurement criteria.

- Dr. Gausche-Hill reported on plans to expand the Stroke Program to include the designation of Comprehensive Stroke Centers in addition to Primary Stroke Centers. A task force met in December to discuss how to move forward with the development of a system for establishing comprehensive stroke centers. Eight hospitals of twelve surveyed responded with interest in being designated as comprehensive stroke centers. Dr. Gausche-Hill stated that 10-11 comprehensive stroke centers in the County would be ideal.

- Ms. Chidester reported that EMS Agency staff is preparing for the upcoming EMS Update. The train-the-trainer class will be in early March. EMS Update will be delivered using the regional training centers that the fire departments have developed. The train-the-trainers sessions will be delivered at the Santa Fe Springs Regional Training Center. In addition, a DVD is being developed for off-site training at hospitals and fire departments that will host the training as well.

- Ms. Chidester reported that the State EMS Authority will host the America College of Surgeons for a state-wide assessment of trauma care. This assessment will be held in March in San Diego.

- Ms. Chidester reported that a letter was sent to all LEMSAs and EMS provider agencies from the EMS Authority regarding data/data collection, specifically NEMSIS compliance. Some providers are not clear about compliance requirements and the EMS Agency will be sending out a clarification letter soon.

- Ms. Chidester reported that Dr. Mitch Katz, DHS Director, has been involved with Housing for Health which works with homeless people who also have health issues and provides housing and connects them with needed services to address their health issues. This program includes opening a sobering center in the Skid Row area of Los Angeles, 24 hours access to a social worker, and community services.

**9. Adjournment**

The Meeting was adjourned by Chairman Kazan at 2:12 PM. The next meeting will be held on March 16, 2016.

**Next Meeting:** **Wednesday, March 16, 2016**
**EMS Agency**
**10100 Pioneer Blvd.**
**Santa Fe Springs, CA 90670**

Recorded by:
Marilyn E. Rideaux
EMS Agency

**CORRESPONDENCE 2.1**

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY



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

Tel: (562) 347-1500
Fax: (562) 941-5835

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

February 25, 2016

**VIA FAX/EMAIL**

TO: Distribution

FROM: Cathy Chidester CC
Director, EMS Agency

**SUBJECT: COLLEGE MEDICAL CENTER PERINATAL STATUS**

This is to advise you that, **effective March 1, 2016**, College Medical Center (PLB) will no longer be an approved Perinatal Receiving Center. Pregnant patients who are at least 20 weeks gestation shall not be transported to PLB. All 9-1-1 transports of perinatal patients shall be in accordance with Reference No. 511, Perinatal Patient Destination.

Please ensure that all affected personnel are aware of this change and are familiar with the Perinatal Centers in their area. If you have any questions or need additional information, please contact Chris Clare, Chief of Hospital Programs at (562) 347-1661.

CC:cac
02-08

c: Emergency Medical Services Commission
Manager, Medical Alert Center
CEO, College Medical Center
Director ED, College Medical Center

Distribution:
ED Director, Community Hospital of Long Beach
PCC, LAC Harbor-UCLA Medical Center
PCC, Long Beach Memorial Medical Center
PCC, Saint Francis Medical Center
PCC, Saint Mary Medical Center
Paramedic Coordinator, Care Ambulance
Paramedic Coordinator, Compton Fire Department
Paramedic Coordinator, Los Angeles City Fire Department
Paramedic Coordinator, Los Angeles County Fire Department
Paramedic Coordinator, Long Beach Fire Department

**CORRESPONDENCE 2.2**

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY



10100 Pioneer, Suite 200
Santa Fe Springs, CA 90670

Tel: (562) 347-1500
Fax: (562)941-5835

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

February 23, 2016

Bocki Park
Chief Executive Officer
Encino Hospital Medical Center
16237 Ventura Boulevard
Encino, CA 91436

Dear Ms. Park,

The Emergency Medical Services (EMS) Agency is pleased to announce that Encino Hospital Medical Center has been designated as an Approved Stroke Center (ASC).

Effective Monday, February 29, 2016, Encino Hospital Medical Center (ENH) may begin receiving patients who are transported by the 9-1-1 system and meet the criteria outlined in Reference No. 521, Stroke Patient Destination.

The EMS Agency requires each ASC to participate in data submission of all patients transported by 9-1-1 providers and meet the inclusion criteria as stated in the Los Angeles County EMS Agency Stroke Data Definitions.

Please complete and return the attached Confirmation Agreement within 15 days. Upon receipt, the EMS Agency will sign the Agreement and return the original to your facility.

Congratulations and thank you again for your commitment to the ASC program. If you have any questions, please feel free to contact me at (562) 347-1600 or Christine Clare, Chief of Hospital Programs at (562) 347-1661.

Very truly yours,

Marianne Gausche-Hill, M.D.
Medical Director

MH:cac
02-04

Enclosure

c: Director, EMS Agency
Emergency Medical Services Commission
Medical Director Stroke Program, ENH
Stroke Program Coordinator, ENH

# LOS ANGELES COUNTY
# DEPARTMENT OF HEALTH SERVICES
***EMERGENCY MEDICAL SERVICES AGENCY***

## APPROVED STROKE CENTER CONFIRMATION CERTIFICATE


| | |
|---|---|
| Chief Executive Officer | Director, Emergency Medical Services Agency |
| Name as Above (Print or type) | Interim Medical Director, Emergency Medical Services Agency |
| Date | Date |

Confirmation of ASC status is granted for the period of February 13, 2016 – February 12, 2018 based upon concurrent Joint Commission certification as a Primary Stroke Center. Should the above named hospital not adhere to the provisions set forth in the Joint Commission Standards for Primary Stroke Center certification, they shall immediately forward written notice to the Director of the EMS Agency. The EMS Agency reserves the right to perform a scheduled on-site survey or request additional data of the ASC at any time. A 90-day notice shall be submitted to the EMS Agency Director for withdrawal from the ASC program.

**CORESPONDENCE 2.3**

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

February 22, 2016



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

Tel: (562) 347-1500
Fax: (562) 941-5835



TO: Fire Chief, Each Fire Department
CEO/President, Each Ambulance Company

FROM: Marianne Gausche-Hill, MD. FACEP, FAAP
Medical Director, LA County EMS Agency

SUBJECT: **ALS UNIT, ASSESSMENT UNIT AND ALS EMS AIRCRAFT UNIT MEDICAL SUPPLY INVENTORIES**

This is to provide you advanced notice on the changes to the minimum inventory equipment for ALS Units, Assessment Units and ALS EMS Aircraft Units. These changes are being implemented to align with current prehospital patient care standards that are being rolled out through EMS Update 2016.

Changes to Reference Nos; 703 (ALS Unit Inventory), 704 (Assessment Unit Inventory), and 706 (ALS EMS Aircraft Inventory) include:

1. Replacing "needle thoracostomy kit or 14G angiocatheter 3.0-3.5 inches" with "Chest Decompression Needles 3.0-3.5 inches". Studies have shown that angiocathers are not adequate for needle thoracostomy procedures. Angiocatheters are not rigid enough to maintain patency and often times kink during needle thoracostomy.

2. 12-lead electrocardiogram (ECG) machines need to have the capability to transmit the 12-lead ECG to the receiving STEMI Receiving Center (SRC). Transmission is best practice in the management of patients with STEMI in order to effectively activate the cath lab personnel and provide timely percutaneous coronary intervention.

If you have any questions or need additional information, please do not hesitate to contact me or Dr. Nichole Bosson, Assistant Medical Director, at (562) 347-1602.

Attachments

MGH:rt

c. Director, EMS Agency
Assistant Medical Director, EMS Agency
Assistant Director, EMS Programs, EMS Agency
Chief, Prehospital Care Operations, EMS Agency
Medical Directors, Each EMS Provider Agency

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

February 22, 2016



TO: Fire Chief/CEO, Each EMS Provider Agency

FROM: Cathy Chidester
Director

SUBJECT: **NEW STATE EMS DATA SYSTEM REQUIREMENTS**

This is to provide clarification to the memorandum dated January 5, 2016, issued by the California Emergency Medical Services Authority (EMSA) regarding the new data system requirements.

The Los Angeles County EMS Agency recognizes the importance of implementing AB1129 but also acknowledges that EMS providers are in varying stages of procurement and development of their electronic patient care records (ePCR). The EMS Agency also appreciates the complex and lengthy process of procuring an ePCR as well as obtaining NEMSIS "compliant" certification.

The following guidance was developed, following discussion with EMSA, to provide a road map towards complying with AB1129 by the EMS Agency as well as EMS providers operating in Los Angeles County.

I. The EMS Agency's current vendor for maintaining the Trauma and Emergency Medicine Information System (TEMIS) is in the process of obtaining NEMSIS compliant certification. This will allow the EMS Agency to provide NEMSIS compliant data that has been submitted by EMS providers to TEMIS. The EMS Agency is confident that it will be have the capability to submit NEMSIS compliant data by January 1, 2017.

II. The EMS Agency will incrementally revise its EMS Data Dictionary and data submission requirements to obtain appropriate data elements requested by NEMSIS. The first priority is to revise or add data elements that have direct impact to patient care (e.g., provider impression). The EMS Agency is actively participating in stakeholder groups that have been tasked to identify applicable provider impressions. In preparation for this revision, the concept of "provider impression" is being introduced at this year's EMS Update 2016 mandatory training. These incremental changes to data collection and submission requirements will be implemented through the customary annual updates.

III. For the purpose of data collection, the EMS Agency defines EMS providers that are required to submit data to TEMIS include those involved with 9-1-1 emergency response and transportation. This includes interfacility transfers in which the 9-1-1 system was activated. EMS providers that are solely involved in interfacility transports (without 9-1-1 system involvement)

**Cathy Chidester**
Director

**Marianne Gausche-Hill, MD**
Medical Director

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are not required to submit data to the EMS Agency but are highly encouraged to start transitioning to an electronic health record to comply with AB1129.

IV. Hospital electronic health care record systems are not fully developed for bi-directional data exchanges between hospital and prehospital information. The EMS Agency will continue to work with the Hospital Association of Southern California regarding the integration of prehospital and hospital data as technology continues to evolve and hospitals become ready to accept bi-directional data exchanges.

We will continue to provide you updates as information becomes available. Please do not hesitate to contact me or Richard Tadeo, Assistant Director, at (562) 347-1610 if you have any questions.

CC:rt

c. Medical Director, EMS Agency
Director, EMSA
CEO, Digital EMS
CEO, Sansio
CEO, Source Code 3

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

Health Services
http://ems.dhs.lacounty.gov

February 8, 2016

TO: Distribution

FROM: Cathy Chidester
Director

Hodes for cc

**SUBJECT: COUNTYWIDE SIDEWALK CARDIAC RESUSCITATION DAY – THURSDAY, JUNE 2, 2016**

Los Angeles (LA) County Emergency Medical Services (EMS) Agency, in collaboration with the American Heart Association (AHA), is coordinating a countywide SideWalk Cardio Pulmonary Resuscitation (CPR) public education event on Thursday, **June 2, 2016**. June 1st through June 7th, has been designated as National CPR Week and provides a perfect opportunity for public education on this vital skill.

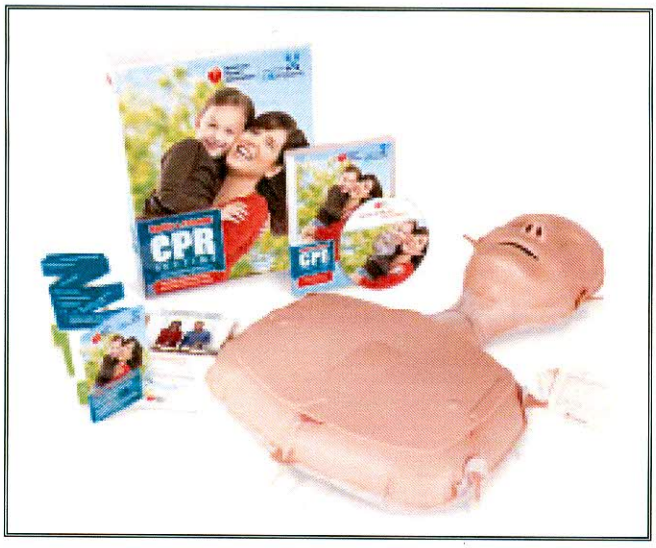
We would like to invite your facility/agency to participate in this exciting campaign. The EMS Agency will coordinate the participation through pre-registration (Attached). Registration provides a contact for us to distribute the basic curriculum, sample press release, program ideas, and rosters/sign-in sheets to track the number of persons trained for the day. **Early registration** allows us to list your training site on our informational web page for press coverage and community information.

The EMS Agency and AHA will coordinate press releases, but each participating entity will also need to publicize the time and location for their training to the local community. You may choose to have one or more CPR training stations and utilize an area in or close to your facility. Instructors do not need a CPR instructor card, but will need to be comfortable performing CPR and utilize the curriculum provided by the EMS Agency. CPR Anytime Kits (Attachment) are available for purchase through the AHA at the cost of $38.50 if your facility does not have manikins available.

Training sites may choose their hours of operation. At the end of the day, the number of people trained at each site will be reported to the EMS Agency. The EMS Agency will tabulate the total number of people trained in LA County and report back to the AHA and interested parties. Last year approximately 10,000 people in LA County were trained in one day.

We hope that you will choose to participate in the LA County Sidewalk CPR event. Please complete the attached registration form and return it to the EMS Agency by May 30, 2016.

Attachment


CPR

# SIDEWALK CPR DAY

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

## REGISTRATION FORM

DATE: Thursday, June 2, 2016
TIME: To be determined by agency providing the training

Please complete the following registration form and submit it to the EMS Agency by **May 30, 2016**.

**PLEASE PRINT**

Facility/Provider Name

Name of Designated Coordinator

Mailing Address

Email Address

Phone Number

Location(s) of Sidewalk CPR Training

Site(s) name and address:

Time that Sidewalk CPR Training will occur

**Order disposable CPR manikins from the AHA by contacting Sylvia Beanes at Sylvia.Beanes@Heart.org or (213) 291-7079**

**Email or fax completed forms to: Marilyn Rideaux at Mrideaux@dhs.lacounty.gov or Fax No. (562) 941-5835**

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY



10100 Pioneer Blvd, Suite 200
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Fax: (562) 941-5835

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

February 7, 2016

TO: FAX/E-Mail Distribution

FROM: Cathy Chidester
Director

**SUBJECT: LOS ANGELES (LA) MARATHON 2016**

This is to advise you of the *LA Marathon* scheduled for February 14, 2016, which will start at 6:30 a.m. with an anticipated ending time of 7:00 p.m. As this event is expected to draw an estimated amount of 26,000 participants, surrounding hospitals may be impacted by Emergency Department visits.

Last year, the marathon resulted in 34 patients transported to surrounding emergency departments with sport related injuries and medical conditions. The Emergency Medical Services (EMS) Agency encourages Emergency Departments in the area to prepare and staff adequately. The Medical Alert Center (MAC) will conduct a Reddi-Net multi-casualty incident (MCI) poll to manage patient destinations. It is imperative that hospitals complete the MCI poll "Victim List" for patient tracking purposes of all event-related patients, including those who may self-transport.

Please ensure that all affected personnel are properly informed in advance. If you have any questions or need further information, please contact the MAC Supervisor at (562) 941-1037.

CC:rb

**Distribution**:

Paramedic Coordinator, Los Angeles Fire Department
Paramedic Coordinator, Los Angeles County Fire Department
Paramedic Coordinator, Beverly Hills Fire Department
Paramedic Coordinator, Santa Monica Fire Department
Prehospital Care Coordinator, Each Hospital
Emergency Department Director, California Hospital Medical Center
Emergency Department Director, Cedars-Sinai Medical Center
Emergency Department Director, Centinela Hospital Medical Center
Emergency Department Director, Childrens Hospital of Los Angeles
Emergency Department Director, East Los Angeles Doctors Hospital
Emergency Department Director, Encino Hospital Medical Center
Emergency Department Director, Glendale Adventist Medical Center/Adventist Health
Emergency Department Director, Glendale Memorial Hospital and Health Center
Emergency Department Director, Good Samaritan Hospital
Emergency Department Director, Huntington Memorial Hospital
Emergency Department Director, Hollywood Presbyterian Medical Center
Emergency Department Director, Kaiser Foundation Hospital - Sunset
Emergency Department Director, Kaiser Foundation Hospital - West Los Angeles
Emergency Department Director, LAC+USC Medical Center
Emergency Department Director, Marina Del Rey Hospital
Emergency Department Director, Olympia Medical Center
Emergency Department Director, Providence Saint Joseph Medical Center
Emergency Department Director, Ronald Reagan – UCLA Medical Center
Emergency Department Director, Santa Monica / UCLA Medical Center
Emergency Department Director, Southern California Hospital at Culver City
Emergency Department Director, White Memorial Medical Center / Adventist Health

**CORRESPONDENCE 2.7**

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY



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

Tel: (562) 347-1500
Fax: (562) 941-5835

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

January 27, 2016

Mario Rueda, Fire Chief
San Gabriel Fire Department
1303 S. Del Mar Avenue
San Gabriel, California 91776

Dear Chief Rueda:

**NEWLY APPOINTED MEDICAL DIRECTOR – GRACE TING, MD**

This letter is to acknowledge that the Emergency Medical Services (EMS) Agency has received notification from San Gabriel Fire Department (SG) that effective January 13, 2016, Grace Ting, M.D., has been appointed as Medical Director and will be providing medical oversight to SG's paramedic program.

Based on the documents provided to the EMS Agency, Dr. Ting meets the requirements as Medical Director set forth in the Los Angeles County Prehospital Care Manual, Reference No. 411, Provider Agency Medical Director.

The EMS Agency will continue providing oversite of SG's narcotic program to ensure that the storage and security of the controlled substances is consistent with local, state, and federal regulations.

I would like to welcome Dr. Ting as SG's new Medical Director. If there are any questions during this transition or in the future, please don't hesitate to contact me directly.

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:gw
01-15

c. Medical Director, San Gabriel Fire Department
EMS Director, San Gabriel Fire Department
Paramedic Coordinator, San Gabriel Fire Department

**CORRESPONDENCE 2.8**

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY



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

Tel: (562) 347-1500
Fax: (562) 941-5835



Health Services
http://ems.dhs.lacounty.gov

January 25, 2016

Roger E. Seaver
President & Chief Executive Officer
Henry Mayo Newhall Hospital
23845 McBean Parkway
Valencia, CA 91355

Dear Mr. Seaver:

**Henry Mayo Newhall Hospital SRC Medical Director**

This is follow-up to the October 26, 2015 correspondence from Henry Mayo Newhall Hospital (HMN) indicating that an appointment of a replacement Medical Director for the ST-elevation Myocardial Infarction Receiving Center (SRC) program was expected by December 1, 2015. To date, the EMS Agency has not received notice on the appointment of a SRC Medical Director.

Currently HMN is out of compliance with the SRC Standards. Please provide the EMS Agency within 15 days of receipt of this letter with an update on HMN's progress in appointing a SRC Medical Director, who is board certified in internal medicine with sub-specialty certification in Cardiovascular Disease.

Thank you for your commitment to the SRC program. If you have any questions, please feel free to contact me at (562) 347-1600, or Paula Rashi, SRC Programs Manager, at (562) 347-1656.

Very truly yours,

Marianne Gausche-Hill, M.D.
Medical Director

MGH:pr:cac
(01-13)

c: Director, EMS Agency
SRC Program Clinical Director, Henry Mayo Newhall Hospital

**CORRESPONDENCE 2.9**

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY



Cathy Chidester
Director

Marianne Gausche-Hill, MD
Medical Director

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

Tel: (562) 347-1500
Fax: (562) 941-5835

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

January 19, 2016

Martin Serna, Fire Chief
Torrance Fire Department
1701 Crenshaw Boulevard
Torrance, California 90501

Dear Chief Serna:

**NEWLY APPOINTED MEDICAL DIRECTOR – MARC COHEN, MD**

This letter is to acknowledge that the Emergency Medical Services (EMS) Agency has received notification from Torrance Fire Department (TF) that effective October 1, 2015, Marc Cohen, M.D., has been appointed as Medical Director and will be providing medical oversight to TF's paramedic program.

Based on the documents provided to the EMS Agency, Dr. Cohen meets the requirements as Medical Director set forth in the Los Angeles County Prehospital Care Manual, Reference No. 411, Provider Agency Medical Director.

The EMS Agency has also received the necessary documentation confirming that Dr. Cohen has agreed to purchase drugs and medical supplies for TF and will be providing complete oversight to TF's controlled substance program.

I would like to welcome Dr. Cohen to the Los Angeles County EMS system. If there are any questions during this transition or in the future, please don't hesitate to contact me directly.

Sincerely,

Marianne Gausche-Hill, MD
Medical Director

MGH:gw
01-08

c. Medical Director, Torrance Fire Department
EMS Director, Torrance Fire Department
Paramedic Coordinator, Torrance Fire Department
Nurse Educator, Torrance Fire Department

# EMERGENCY MEDICAL SERVICES COMMISSION
# BASE HOSPITAL ADVISORY COMMITTEE
# MINUTES
# February 10, 2016

| | REPRESENTATIVES | | EMS AGENCY STAFF |
|---|---|---|---|
| ☑ | Carole Snyder, RN, Chair | EMS Commission | Dr. Nichole Bosson |
| * | Margaret Peterson, Ph.D., Vice Chair | EMS Commission | Richard Tadeo<br>Christine Clare |
| ☐ | Robert Flashman, M.D. | EMS Commission | Lucy Hickey |
| * | Erick Cheung, Ph.D. | EMS Commission | Cathy Jennings |
| ☐ | Lila Mier | County Hospital Region | Susan Mori |
| ☐ | Emerson Martell | County Hospital Region | Paula Rashi |
| ☐ | Jose Garcia | County Hospital Region, Alternate | Jacqueline Rifenburg |
| ☐ | Yvonne Elizarraraz | County Hospital Region, Alternate | Karen Rodgers |
| ☑ | Jessica Strange | Northern Region | Gary Watson |
| ☑ | Karyn Robinson | Northern Region | |
| ☑ | Mark Baltau | Northern Region, Alternate | |
| ☑ | Kristina Crews | Southern Region | |
| ☑ | Samantha Verga-Gates | Southern Region | |
| ☐ | Laurie Mejia | Southern Region | |
| ☑ | Lindy Galloway | Southern Region, Alternate | |
| ☑ | Paula Rosenfield | Western Region | |
| ☑ | Ryan Burgess | Western Region | |
| ☑ | Alejandro Perez-Sandi | Western Region, Alternate | |
| ☐ | Rosie Romero | Western Region, Alternate | |
| ☑ | Laurie Sepke | Eastern Region | |
| ☑ | Alina Candal | Eastern Region | |
| ☑ | Jenny Van Slyke | Eastern Region, Alternate | |
| ☑ | Mike Hansen | Provider Agency Advisory Committee | |
| ☐ | Isaac Yang | Provider Agency Advisory Committee, Alt. | |
| ☐ | Jennifer Webb | MICN Representative | |
| ☐ | Jeff Warsler | MICN Representative, Alt. | |
| ☑ | Robin Goodman | Pediatric Advisory Committee | |
| ☐ | Kerry Gold-Tsakonas | Pediatric Advisory Committee, Alt. | |

| PREHOSPITAL CARE COORDINATORS | | GUESTS |
|---|---|---|
| ☑ Jennifer Hunt (SMM) | ☑ Adrienne Roel (AMH) | Nichole Steeneken, LACoFD |
| ☑ Heidi Ruff (NRH) | | E. Jean Kirby, LACoFD |
| | | Paula Park, LACoFD |
| | | Victoria Hernandez, LACoFD |
| | | Jason Dobin, TFD |

1. **CALL TO ORDER:** The meeting was called to order at 1:05 P.M. by Carole Snyder, Chairperson.

2. **APPROVAL OF MINUTES -** The December 9, 2015 meeting minutes were approved with the following changes:

   MICN Development Courses: As we focus on protocols and policies for MICN development teaching, the Base Hospital group and EMS Agency will work together to ensure testing reflects the objectives of the MICN development course.

   **M/S/C (Verga-Gates/Candal) Approve the December 9, 2015 meeting minutes with changes.**

3. **INTRODUCTIONS/ANNOUNCEMENTS**

   Christine Clare was introduced as the new Chief of Hospital Programs and Interim Chief of EMS System Data Management.

   Richard Tadeo announced that Carolyn Naylor has retired from the EMS Agency.

Countywide Sidewalk CPR day will be on Thursday, June 2, 2016. Application is now available. More information will be sent to all hospitals and providers. In 2015 LA County trained close to 12,000 individuals, with 17,000 individuals trained in the three counties (LA, Orange and Ventura).

## 4. REPORTS & UPDATES

4.1 Provider Agency Wall Time Report

Richard Tadeo presented the 3rd quarter 2015 wall time report. Challenges have been identified for linking Public and Private Provider EMS records. The report shows that only about 30% of the EMS records have the necessary times documented to accurately calculate wall time. Once compliance is between 70-80%, the report will be run by hospital.

4.2 Memorial Hospital of Gardena Service Area Pilot Project

On January 4, 2016, a 90-day pilot project was implemented to determine the impact of eliminating Memorial Hospital of Gardena's (MHG) south and west service area boundaries. They are in their second month and the EMS Agency is monitoring their diversion hours which are not excessive. The EMS Agency is receiving wall time reports from the providers and are analyzing the October through December information. At this time the EMS Agency has not received any complaints related to MHG eliminating their boundaries. The Agency will be scheduling a meeting with the area hospitals and providers for next month.

4.3 Behavioral Emergency Work Group

A workgroup has been created which includes law enforcement, District Attorney, and mental health representation. They have developed a 16-hour training program for law enforcement to help them identify and deal with patients exhibiting behavioral complaints.

4.4 EMS Update 2016

The Regional Smart-Classroom Training Centers will be used for the Train-The Trainer sessions and additional information will be sent out to all stakeholders.

## 5. UNFINISHED BUSINESS

## 6. NEW BUSINESS

6.1 Electronic Base Form Documentation

A request was made by the Association of Prehospital Care Coordinators (APCC) to create an electronic version of the Base Hospital Form to eliminate the current 2-step data entry. A presentation was given by John Bennett from Lancet Technology, Inc., the current County vendor for TEMIS, with possible options for an electronic base hospital form.

6.2 Reference No. 506, Trauma Triage

Reference No. 506, Trauma Triage addition of 9-1-1 trauma triage. Recommended adding Reference No. 803 to Policy VI, C and Cross Reference.

**M/S/C (Van Slyke/Galloway) Approve Reference No. 506, Trauma Triage with recommended changes.**

6.3 Reference No. 511, Perinatal Patient Destination

Reference No. 511, addition of perinatal and post-partum patients with hypertension.

**M/S/C (Van Slyke/Galloway) Approve Reference No. 511, Perinatal Patient Destination.**

6.4 Reference No. 521, Stroke Patient Destination

Reference No. 521, addition of Comprehensive Stroke Centers and Los Angeles Motor Score (LAMS).

**M/S/C (Rosenfield/Sepke) Approve Reference No. 521, Stroke Patient Destination.**

6.5 Reference No. 703, ALS Unit Inventory

Reference No. 703, change of needle thoracostomy kit to chest decompression needle; minor revisions to make consistent with other policies.

**M/S/C (Baltau/Candal) Approve Reference No. 703, ALS Unit Inventory.**

6.6 Reference No. 704, Assessment Unit Inventory

Reference No. 704, change of needle thoracostomy kit to chest decompression needle; minor revisions to make consistent with other policies.

**M/S/C (Baltau/Candal) Approve Reference No. 704, Assessment Unit Inventory.**

6.7 Reference No. 706, ALS EMS Aircraft Inventory

Reference No. 706, change of needle thoracostomy kit to chest decompression needle; minor revisions to make consistent with other policies.

**M/S/C (Baltau/Candal) Approve Reference No. 706, ALS EMS Aircraft Inventory.**

6.8 Reference No. 806.1, Procedures Prior to Base Contact

Reference No. 806.1, several revisions related to medication dosages and standardizing to make consistent with other policies. Recommendations to add IM/IN for pediatric fentanyl and ensure consistent blood pressure parameters with other policies.

**M/S/C (Van Slyke/Sepke) Approve Reference No. 806.1, Procedures Prior to Base Contact with recommended changes.**

6.9 Reference No. 808, Base Hospital Contact and Transport Criteria

Reference No. 808, added reference for perinatal and post-partum hypertension.

**M/S/C (Van Slyke/Baltau) Approve Reference No. 808, Base Hospital Contact and Transport Criteria.**

6.10 Reference No. 808.1, Base Hospital Contact and Transport Criteria (Field Reference)

Reference No. 808.1, added reference for perinatal and post-partum hypertension.

**M/S/C (Van Slyke/Baltau) Approve Reference No. 808, Base Hospital Contact and Transport Criteria (Field Reference).**

6.11 Reference No. 1202, Treatment Protocol, General ALS

Reference No. 1202, added pediatric fluid challenge. Recommendation to change adult fluid challenge to: “10ml/kg in 250ml increments”.

**M/S/C (Baltau/Burgess) Approve Reference No. 1202, Treatment Protocol, General ALS with recommended changes.**

6.12 Reference No. 1251, Stroke/Acute Neurological Deficits

Reference No. 1251 added Comprehensive Stroke Centers.

**M/S/C (Baltau/Burgess) Approve Reference No. 1251, Stroke/Acute Neurological Deficits.**

6.13 Reference No. 1261, Emergency Childbirth- Mother

Reference No. 1261, addition of hypertension.

**M/S/C (Baltau/Burgess) Approve Reference No. 1261, Emergency Childbirth-Mother.**

6.14 Reference No. 1275, Treatment Protocol, General Trauma

Reference No. 1275, changed considerations for needle thoracostomy and additional revision to maintain consistency throughout policies.

Recommendation to maintain two systolic blood pressure parameters; <70 mmHg infants and <90mmHg all others.

**M/S/C (Baltau/Candel) Approve Reference No. 1275, Treatment Protocol, General Trauma with recommended changes.**

6.15 Reference No. 1277, Traumatic Arrest

Reference No. 1277, minor changes to ensure consistency with other policies.

**M/S/C (Baltau/Sepke) Approve Reference No. 1277, Traumatic Arrest.**

6.16 Reference No. 1320, Medical Control Guideline: Needle Thoracostomy

Reference No. 1320, changed considerations for needle thoracostomy. Recommendation to maintain two systolic blood pressure parameters; <70 mmHg infants and <90mmHg all others.

**M/S/C (Baltau/Verga-Gates) Approve Reference No. 1277, Medical Control Guideline: Needle Thoracostomy with recommended changes.**

## 7. OPEN DISCUSSION

Electronic Copies of "Do Not Resuscitate (DNR) Orders"

Committee members questioned if copies of DNR orders, printed from an electronic medical record (EMR), are valid as they do not have a physician's signature. Reference No. 815, Honoring Prehospital Do Not Resuscitate Orders and Physician Orders for Life Sustaining Treatment does not support orders printed from an EMR as they do not have a physician's signature .

## 8. NEXT MEETING: April 13, 2016

## 9. ADJOURNMENT: The meeting was adjourned at 2:58 P.M.

**EMERGENCY MEDICAL SERVICES COMMISSION**
**DATA ADVISORY COMMITTEE**
**WEDNESDAY, February 10, 2016**

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

| MEMBERSHIP / ATTENDANCE | | |
|---|---|---|
| MEMBERS | ORGANIZATION | EMS AGENCY |
| ☒ Nerses Sanossian , Chair | EMS Commissioner (MD) | Nichole Bosson |
| ☒ John Hisserich, Vice Chair | EMS Commissioner (Community Member) | Richard Tadeo |
| □ Clayton Kazan | EMS Commissioner (MD) | Christine Clare |
| □ Colin Tudor | EMS Commissioner (League of CA Cities) | Susan Mori |
| ☒ Matt Armstrong | Ambulance Advisory Board (LACAA) | |
| ☒ Trevor Stonum | Ambulance Advisory Board (alternate) | |
| □ Mark Baltau | Base Hospital Advisory Committee (BHAC) (RN) | |
| □ Alina Candal | BHAC (alternate) | |
| ☒ Ryan Burgess | Hospital Association of Southern California (HASC) | |
| □ Nathan McNeil | HASC (alternate) | |
| □ Joanne Dolan | Long Beach Fire Department (LBFD) (RN) | OTHERS |
| ☒ Don Gerety | LBFD (alternate) | |
| * Dan France | Los Angeles Area Fire Chiefs Association | |
| * Sean Stokes | LA Area Fire Chiefs Association (alternate) | |
| ☒ Nicole Steeneken | Los Angeles County Fire Department (LACoFD) | |
| □ Victoria Hernandez | LACoFD (alternate) | |
| ☒ Al Flores | Los Angeles Fire Department (LAFD) | |
| * John Smith | LAFD (alternate) | |
| □ Dipesh Patel | Medical Council (MD) | |
| □ VACANT | Medical Council (alternate) | |
| □ Jeffrey Elder | Provider Agency Advisory Committee (PAAC) | |
| □ VACANT | PAAC (alternate) | |
| □ Howard Belzberg | Trauma Hospital Advisory Committee (THAC) (MD) | |
| □ David Hanpeter | THAC (MD) (alternate) | |
| * Marilyn Cohen | THAC (RN) | |
| □ VACANT | THAC (RN) (alternate) | |
| ☒ Present *Excused □ Absent | | |

1. **CALL TO ORDER:** The meeting was called to order at 10:02 am by Commissioner Sanossian. No quorum present. Meeting informational only.

2. **APPROVAL OF MINUTES:** The minutes of the December 9, 2015 meeting were held as there was no quorum.

3. **INTRODUCTIONS/ANNOUNCEMENTS**

- Chris Clare started as the new Chief of Hospital Programs and Interim Chief of EMS Data Systems on January 16, 2016.
- The LA Stroke Coordinator Network is hosting a Clippers Stroke Awareness night, March 11, 2016.
- The annual EMSAAC Conference will be held on May 10-11, 2016 at the Loews Coronado Bay, San Diego.

4. **REPORTS AND UPDATES**

4.1. TEMIS Update *(Christine Clare)*

County Fire (CF) Update: All of CF's records through May of 2015 have been imported. Currently importing June 2015.

4.2. Electronic Data Systems *(Christine Clare)*

Compton Fire started on 1/15/16 with Digital EMS. Beverly Hills Fire completed their trial with Source Code 3 and started a trial with Digital EMS on 2/3/16.

4.3. Service Changes *(Richard Tadeo)*

On January 4, 2016, a 90-day pilot project was implemented to determine the impact of eliminating Memorial Hospital of Gardena's (MHG) south and west service area boundaries. They are in their second month and the EMS Agency is monitoring their diversion hours which are not excessive. The EMS Agency is receiving wall time reports from the providers and are analyzing the October through December information. At this time the EMS Agency has not received any complaints related to MHG eliminating their boundaries.

4.4 EMS Update 2016 *(Richard Tadeo)*

Will be using Regional Smart-Classroom Training Centers for the Train-The Trainer sessions and additional information has been sent out to all stakeholders.

4.5 Wall Time Report *(Richard Tadeo)*

The 3rd quarter 2015 wall time report was presented. Challenges have been identified for linking Public and Private Provider EMS records. The report shows that only about 30% of the EMS records have the necessary times documented to accurately calculate wall time. Once compliance is between 70-80%, the report will be run by hospital.

4.6 Data Use Agreement *(Richard Tadeo)*

The agreement is still being reviewed by County Counsel. Reference No. 622, Release of EMS Agency Data is being revised to differentiate between research and QI, and determine level of EMS support requested. Hope to have a draft policy for the next meeting.

**5. UNFINISHED BUSINESS**

5.1 Data Cleanup Process *(Richard Tadeo)*

A draft Data Cleanup Process algorithm, sample data reports and the Public Provider Data Collection survey results were presented.

**6. NEW BUSINESS**

6.1. Core Measures 2015 *(Richard Tadeo)*

The draft EMS Core Measure Report for 2015 was presented. These data elements are submitted annually to the California EMS Authority.

6.2 Electronic Base Hospital Form *(Richard Tadeo)*

A request was made by the Base Hospitals to create an electronic version of the Base Hospital Form to eliminate the current 2-step data entry. A presentation was given by John Bennett from Lancet Technology, Inc., the current County vendor for TEMIS, with possible options for an electronic base hospital form.

**7. NEXT MEETING:** April 13, 2015 at 10:00 a.m. (EMS Agency Hearing Room – First Floor)

**8. ADJOURNMENT:** The meeting was adjourned at 10:55 a.m. by Commissioner Sanossian.

COUNTY OF LOS ANGELES
EMERGENCY MEDICAL SERVICES COMMISSION
10100 Pioneer Blvd, Suite 200 Santa Fe Springs, CA 90670
(562) 347-1500 FAX (562) 941-5835

# EDUCATION ADVISORY COMMITTEE

## MEETING CANCELLATION NOTICE

DATE: February 4, 2016

TO: Education Advisory Committee Members

**SUBJECT: CANCELLATION OF MEETING**

Due to a lack of agenda items, the Education Advisory Committee meeting scheduled for February 17, 2016, has been cancelled.

**INFORMATION IN LIEU OF MEETING:**

1. EMS Update 2016 train-the-trainer is scheduled for March with system-wide training commencing in April. The topics for the update include: Provider Impression, Anaphylaxis, Comprehensive Stroke Centers, Documentation, Cardiac Arrest, LVAD, Pregnancy/Eclampsia, Emerging Infectious Diseases, Surge Plans, Hemostatic Dressings, Needle Thoracostomy, and 9-1-1 Trauma Re-triage. See attached letter.

2. The 2016 EMSAAC conference is scheduled for May 10 & 11, 2016 in San Diego. Conference information is available at emsaac.org.

3. The 2016 CFED West 10th Anniversary Conference is scheduled for May 22 – 26, 2016 in Palm Springs. Conference information is available at cfedwest.com.

4. According to EMSA, the EMT regulations will be posted for public comment in March.

5. EMS Week is May 15-21, 2016

**NEXT MEETING:**

Date: Wednesday, April 20, 2016
Time: 10:00 am
Location: EMS Agency Headquarters
EMS Commission Hearing Room
10100 Pioneer Blvd, Room 128
Santa Fe Springs, CA 90670

If you have any questions, please contact David Wells at dwells@dhs.lacounty.gov.

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY



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

Health Services
http://ems.dhs.lacounty.gov

February 2, 2016

TO: All ALS Provider Chiefs or CEO's
All Paramedic Coordinators
All Prehospital Care Coordinators
All Paramedic Program Directors
All Paramedic Nurse Educators

FROM: Mark Ferguson, BRN, RN, MICN
Program Director
Paramedic Training Institute

**SUBJECT: EMS UPDATE 2016 TRAIN-THE-TRAINER**

Train-the-Trainer classes will be held on the following dates:

Monday March 14, 2016 9:00 a.m. – 12 p.m.
Tuesday March 22, 2016 9:00 a.m. – 12 p.m.

Main Location:
Santa Fe Springs Regional Training Center
11300 Greenstone Avenue, Santa Fe Springs, CA 90670

This year's Train-the-Trainer will be comprised of a video presentation of each topic followed by a short question and answer session with the presenter. The program will be filmed and recorded with a live audience at the Santa Fe Springs Regional Training Center. We would like to have 15 - 25 EMS educators make up the audience at the training center to interact with the presenters.

Other options for Train-the-Trainer attendance will be the various fire department Smart Classroom with connectivity to Regional Training Centers. Since these off site classrooms need to be prescheduled and arranged with the individual fire departments, the locations will be announced at a later date. Those attending at an alternate site will also have the ability to ask questions in real time.

Once both trainings have been completed, a DVD will be set to each trainer, allowing for training by DVD or through the Smart Classroom network.

The following topics will be covered in EMS Update 2016: Provider Impression, Anaphylaxis, Comprehensive Stroke Centers, Documentation, Cardiac Arrest, Ventricular Assist Device, Pregnancy/Eclampsia, Emerging Infectious Diseases, Surge Plans, Hemostatic Dressings, Needle Thoracostomy, and 9-1-1 Re-triage.

Due to the additional coordination with the training sites, please contact me by March 8, 2016 for training reservations and/or questions at:
e-mail: maferguson@dhs.lacounty.gov (preferred)
phone (562) 347-1571
fax (562) 941- 5835

c: EMS Commission
Director, EMS Agency
Program Approvals

County of Los Angeles
Department of Health Services

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

## EMERGENCY MEDICAL SERVICES COMMISSION

# PROVIDER AGENCY ADVISORY COMMITTEE

## MINUTES

Wednesday, February 17, 2016

### MEMBERSHIP / ATTENDANCE

| MEMBERS | ORGANIZATION |
|---|---|
| ☑ Dave White, Chair | EMSC, Commissioner |
| ☑ Robert Ower, Vice-Chair | EMSC, Commissioner |
| ☐ *LAC Ambulance Association* | EMSC, Commissioner |
| ☐ *LAC Police Chiefs' Association* | EMSC, Commissioner |
| ☑ Jodi Nevandro | Area A |
| ☐ Sean Stokes | Area A Alt (Rep to Med Council, Alt) |
| ☑ Kevin Klar | Area B |
| ☐ Scott Salhus | 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. |
| ☑ Mike Hansen | Area G (Rep to BHAC) |
| ☐ Michael Murrey | Area G, Alt. (Rep to BHAC, Alt.) |
| ☐ Corey Rose | Area H (Rep to DAC) |
| ☑ Douglas Zabilski | Area H, Alt. |
| ☑ Brandon Greene | Employed EMT-P Coordinator (LACAA) |
| ☑ Jesus Cardoza | Employed EMT-P Coordinator, Alt. (LACAA) |
| ☑ Lindy Galloway | 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) |
| ☑ Scott Buck | 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 | Richard Tadeo |
| Lucy Hickey | Cathlyn Jennings |
| Susan Mori | Paula Rashi |
| Karen Rodgers | John Telmos |
| Michelle Williams | Gary Watson |

| OTHER ATTENDEES | |
|---|---|
| Jesse Vela | LACoFD |
| Al Flores | LAFD |
| Antonio Negrete | San Gabriel FD |
| David Ybarra | West Coast Amb |
| Alex Wilkie | GCTI Amb |
| Mike Beeghly | Santa Fe Springs FD |
| Lance Lawson | American Prof. Amb |
| Dierdra Cohen | MedReach Amb |
| Trevor Stonum | MedCoast Amb |
| Jason Dobine | Torrance FD |
| Clayton Kazan, MD | LACoFD |
| Ivan Orloff | Downey FD |

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 Dave White called meeting to order at 1:05 p.m.

**1. APPROVAL OF MINUTES: (Klar/Greene)** December 18, 2015 minutes were approved as written.

**2. INTRODUCTIONS / ANNOUNCEMENTS**

**2.1** 2016 PAAC Commissioners

- David White, Culver City Fire Chief, introduced as Committee's Chair.
- Robert Ower, General Manager, RSI Ambulance, introduced as Committee's Vice-Chair.

**2.2** BHAC Representative to PAAC

- Lindy Galloway, Little Company of Mary – Torrance, introduced as Committee's Representative from Base Hospital Advisory Committee.

## 3. REPORTS & UPDATES

**3.1** Wall Time Report by Provider Agency *(Richard Tadeo)*

Wall Time Report for July 1 through September 30, 2015 was reviewed and presented to Committee. Eventually, data will be reviewed on individual hospitals.

**3.2** EMS Commission - Behavioral Health Workgroup *(Richard Tadeo)*

Workgroup is reviewing how EMS is confronting behavioral health. Topics of discussion include education from law enforcement and triage from law enforcement to determine if certain patients can be transported to urgent care centers or to an emergency department to address a medical complaint. As the workgroup progresses, updates will be provided.

**3.3** National Research Project - SRC / Cath Lab Activation *(Nicole Bosson, MD)*

- Los Angeles County is involved in a National Research project to evaluate the effectiveness of our system's protocol on cardiac cath-lab team activation. There are five Los Angeles County hospitals that are submitting additional QI data for this project.
- Paramedics are reminded to follow the Los Angeles County Prehospital Care policy, Reference No. 1303, Medical Control Guideline: Cath Lab Activation Algorithm, when caring for a patient suspected of having an acute MI. SRCs are to be contacted directly when an MI is identified and if the SRC is not a base hospital, initiate base contact after the SRC has been notified.

**3.4** EMS Update 2016, Train-The-Trainer *(Richard Tadeo)*

- Train-The-Trainer dates are March 14 and March 22, 2016. It will be conducted through the regional SMART class rooms. The primary location will be at the Santa Fe Springs Regional Training Center, 11300 Greenstone Avenue, Santa Fe Springs. There will be four other sites and the sites will be provided to the educators.
- Providers will be responsible for ensuring each of their sponsored paramedics (or MICNs) will have completed the EMS update. Providers who do not have the capability of providing the class will have to verify completion by verifying course completion certificates issued the CE providers. The completion deadline is July 1, 2016.
- Questions may be directed to Mark Ferguson at maferguson@dhs.lacounty.gov

## 4. UNFINISHED BUSINESS

**There were no unfinished business.**

## 5. NEW BUSINESS

***The following policies will be included in EMS Update 2016 and go into effect July 1, 2016:***

**5.1** Reference No. 506, Trauma Triage *(Richard Tadeo)*

Policy reviewed and approved with the following recommendations:

- Page 4 of 4, Policy VI, First paragraph, combine last two sentences to state (paraphrased):

  To expedite transfer arrangements and rapid transport to the trauma center, this process should be reserved for patients requiring emergent surgical intervention and other surgical criteria, such as: (followed by the 8 trauma complaints already listed).

- Page 4 of 4, Policy VI, A, 6: Add the word "torso".

**M/S/C (Hernandez/Nevandro): Approve Reference No. 506, Trauma Triage, with the above recommendations.**

**5.2** Reference No. 511, Perinatal Patient Destination *(Richard Tadeo)*

Policy reviewed and approved as presented.

**M/S/C (Nevandro/Hernandez): Approve Reference No. 511, Perinatal Patient Destination**

**5.3** Reference No. 521, Stroke Patient Destination *(Richard Tadeo)*

Policy reviewed and approved with the following recommendation:

- Page 1 of 4, DEFINITIONS: Clearer distinction between the definitions of Primary Stroke Center and Comprehensive Stroke Center.

**M/S/C (Kazan/Galloway): Approve Reference No. 521, Stroke Patient Destination, with the above recommendation.**

**5.4** Reference No. 703, ALS Unit Inventory *(Richard Tadeo)*

Policy reviewed and approved as presented.

**M/S/C (Nevandro/Kazan): Approve Reference No. 703, ALS Unit Inventory.**

**5.4** Reference No. 704, Assessment Unit Inventory *(Richard Tadeo)*

Policy reviewed and approved as presented.

**M/S/C (Nevandro/Kazan): Approve Reference No. 704, Assessment Unit Inventory.**

**5.5** Reference No. 706, ALS EMS Aircraft Inventory *(Richard Tadeo)*

Policy reviewed and approved as presented.

**M/S/C (Nevandro/Kazan): Approve Reference No. 706, ALS EMS Aircraft Inventory.**

**5.7** Reference No. 806.1, Procedures Prior To Base Contact *(Richard Tadeo)*

Policy reviewed and approved with the following recommendation:

- Throughout Policy where Epinephrine (1:1000) IM is mentioned, specify “deep IM”

**M/S/C (Hernandez/Galloway): Approve Reference No. 806.1, Procedures Prior To Base Contact, with the above recommendation.**

**5.8** Reference No. 808, Base Hospital Contact and Transport Criteria *(Richard Tadeo)*

Policy reviewed and approved as presented.

**M/S/C (Nevandro/Dolan): Approve Reference No. 808, Base Hospital Contact and Transport Criteria.**

**5.9** Reference No. 808.1, Base Hospital Contact and Transport Criteria – Field Reference *(RichardTadeo)*

Policy reviewed and approved as presented.

**M/S/C (Nevandro/Dolan): Approve Reference No. 808, Base Hospital Contact and Transport Criteria – Field Reference.**

**5.10** Reference No. 1202, Treatment Protocol: General ALS *(Richard Tadeo)*

Policy reviewed and approved as presented.

**M/S/C (Klar/Greene): Approve Reference No. 1202, Treatment Protocol: General ALS.**

**5.11** Reference No. 1251, Treatment Protocol: Stroke / Acute Neurological Deficits *(Richard Tadeo)*

Policy reviewed and approved with the following recommendation:

- Number 9 and Special Considerations: Delete Footnote No.1.

**M/S/C (Galloway/Greene): Approve Reference No. 1251, Treatment Protocol: Stroke / Acute Neurological Deficits, with the above recommendation.**

**5.12** Reference No. 1261, Treatment Protocol: Emergency Childbirth (Mother) *(Richard Tadeo)*

Policy reviewed and approved as presented.

**M/S/C (Nevandro/Hernandez): Approve Reference No. 1251, Treatment Protocol: Emergency Childbirth (Mother).**

**5.13** Reference No. 1275, Treatment Protocol: General Trauma *(Richard Tadeo)*

Policy reviewed and approved as presented.

**M/S/C (Hernandez/Zabilski): Approve Reference No. 1275, Treatment Protocol: General Trauma.**

**5.14** Reference No. 1277, Treatment Protocol: Traumatic Arrest *(Richard Tadeo)*

Policy reviewed and approved as presented.

**M/S/C (Greene/Hansen): Approve Reference No. 1277, Treatment Protocol: Traumatic Arrest.**

**5.15** Reference No. 1320, Medical Control Guideline: Needle Thoracostomy *(Richard Tadeo)*

Policy reviewed and approved with the following recommendation:

- Page 2, Number 5: Clarification of wording “just lateral to the nipple line”.

**M/S/C (Hernandez/Galloway): Approve Reference No. 1320, Medical Control Guideline: Needle Thoracostomy, with the above recommendation.**

## 6. OPEN DISCUSSION

**6.1** Narcan Carried on BLS Units in Los Angeles County *(Douglas Zabilski)*

Discussion on whether Los Angeles County will be allowing BLS units to carry the medication, Narcan.

Once the EMS Authority has published the final version of the California EMT regulations, Los Angeles County EMS Agency will consider and advise.

## 7. NEXT MEETING: April 20, 2016

## 8. ADJOURNMENT: Meeting adjourned at 2:35 p.m.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

***DRAFT 01-22-16***

(EMT, PARAMEDIC, MICN)

SUBJECT: **TRAUMA TRIAGE** REFERENCE NO. 506

PURPOSE: To establish criteria and standards which ensure that patients requiring the care of a trauma center are appropriately triaged and transported.

AUTHORITY: California Code of Regulations, Title 13, Section 1105(c) California Code of Regulations, Title 22, Section 100236 et seq. Health and Safety Code, Div. 2.5, Section 1797 et seq., and 1317.

PRINCIPLES:

1. Trauma patients should be secured and transported from the scene as quickly as possible, consistent with optimal trauma care.

2. ~~An emergency patient should be transported to the most accessible medical facility appropriate to their needs. The base hospital physician's determination in this regard is controlling.~~ Rationale for deletion: this concept already exist in Ref. No. 502 although the actual verbiage is not consistent with Ref. No. 502.

3. Paramedics shall make base hospital contact or Standing Field Treatment Protocol (SFTP) notification for approved provider agencies with the ~~designated~~ receiving trauma center, when it is also a base hospital, on all injured patients who meet Base Contact and Transport Criteria (Prehospital Care Policy, Ref. No. 808), trauma triage criteria and/or guidelines, or if in the paramedic's judgment it is in the patient's best interest to be transported to a trauma center. Contact shall be accomplished in such a way as not to delay transport.

4. Do not delay transport of hypotensive patients with penetrating torso trauma in order to apply spinal ~~immobilization~~ motion restriction.

5. EMT personnel may immediately transport hypotensive patients with life-threatening, penetrating injuries to the torso to the closest trauma center, not the Most Accessible Receiving (MAR), when the transport time is less than the estimated time of paramedic arrival. The transporting unit should make every effort to contact the receiving trauma center.

6. When pediatric and adult trauma patients are transported together in one aircraft, the receiving trauma center shall ~~also~~ be both a trauma center and a pediatric trauma center.

7. Patients in blunt traumatic full arrest, not meeting Reference No. 814, should be transported to the most accessible medical facility appropriate to their needs.



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

POLICY:

I. Trauma Criteria – Requires immediate transportation to a designated trauma center

Patients who fall into one or more of the following categories are to be transported directly to the designated trauma center, if transport time does not exceed 30 minutes.

A. Systolic blood pressure less than 90 mmHg, or less than 70 mmHg in infants age less than one year

B. Respiratory rate greater than 29 breaths/minute (sustained), less than 10 breaths/minute, less than 20 breaths/minute in infants age less than one year, or requiring ventilatory support

C. Cardiopulmonary arrest with penetrating torso trauma unless based upon the paramedic's thorough assessment is found apneic, pulseless, asystolic, and without pupillary reflexes upon arrival of EMS personnel at the scene

D. All penetrating injuries to head, neck, torso, and extremities proximal to the elbow or knee

E. Blunt head injury associated with a suspected skull fracture, altered level of consciousness (Glasgow Coma Score less than or equal to 14), seizures, unequal pupils, or focal neurological deficit

F. Injury to the spinal column associated with acute sensory or motor deficit

G. Blunt injury to chest with unstable chest wall (flail chest)

H. Diffuse abdominal tenderness

I. Suspected pelvic fracture (excluding isolated hip fracture from a ground level fall)

J. Extremity injuries with:
1. Neurological/vascular compromise and/or crushed, degloved, or mangled extremity
2. Amputation proximal to the wrist or ankle
3. Fractures of two or more proximal (humerus/femur) long-bones

K. Falls:
1. Adult patients from heights greater than 15 feet
2. Pediatric patients from heights greater than 10 feet, or greater than 3 times the height of the child

L. Passenger space intrusion of greater than 12 inches into an occupied passenger space

M. Ejected from vehicles (partial or complete)

N. Auto versus pedestrian/bicyclist/motorcyclist thrown, run over, or with significant (greater than 20 mph) impact

O. Unenclosed transport crash with significant (greater than 20 mph) impact

II. Trauma Guidelines – Mechanism of injury and patient history are the most effective methods of selecting critically injured patients before unstable vital signs develop. Paramedics and base hospital personnel should consider mechanism of injury and patient history when determining patient destination. At the discretion of the base hospital or approved SFTP provider agency, transportation to a trauma center is advisable for:

A. Passenger space intrusion of greater than 18 inches into any unoccupied passenger space

B. Automobile versus pedestrian/bicyclist/motorcyclist (impact equal to or less than 20 mph)

C. Injured victims of vehicular crashes in which a fatality occurred in the same vehicle

D. Patients requiring extrication

E. Vehicle telemetry data consistent with high risk of injury

F. Injured patients (excluding isolated minor extremity injuries):
1. On anticoagulation therapy other than aspirin-only
2. With bleeding disorders

III. Special Considerations – Consider transporting injured patients with the following to a trauma center:

A. Adults age greater than 55 years

B. Systolic blood pressure less than 110 mmHg may represent shock after age 65 years

C. Pregnancy greater than 20 weeks gestation

D. Prehospital judgment

IV. Extremis Patients - Requires immediate transportation to the MAR:

A. Patients with an obstructed airway

B. Patients, as determined by the base hospital personnel, whose lives would be jeopardized by transportation to any destination but the MAR

V. When, for whatever reason, base hospital contact cannot be made, the destination decision for injured patients will be made by paramedics using the principles set forth above.

VI. 9-1-1 Trauma Re-Triage – This section applies to injured patients in emergency departments of non-trauma centers whose injuries were initially estimated by EMS to be less serious (under triaged) or patients who self-transported (walk-in) to a non-trauma center, and subsequently assessed by the non-trauma center physician to require immediate trauma center care. This process should be reserved for patients with life-threatening traumatic injuries requiring emergent surgical intervention. To expedite transfer arrangements and rapid transport to the trauma center, the referring facility shall:

A. Determine if the injured patient meets any of the following 9-1-1 Trauma Re-Triage criteria:
   1. Persistent signs of poor perfusion
   2. Need for immediate blood replacement therapy
   3. Intubation required
   4. Glasgow Coma Score less than 9
   5. Glasgow Coma Score deteriorating by 2 or more points during observation
   6. Penetrating injuries to head, neck, chest or abdomen
   7. Extremity injury with neurovascular compromise or loss of pulses
   8. Patients, who in the judgement of the evaluating emergency physician, have high likelihood of requiring emergent life- or limb-saving intervention within two (2) hours.

B. Contact the designated receiving trauma center or pediatric trauma center if the patient is less than or equal to 14 years of age and transport does not exceed 30 min. Do not delay transfer by initiating any diagnostic procedures that do not have direct impact on immediate resuscitative measures.

C. Contact 9-1-1 for transportation. The paramedic scope of practice does not include paralyzing agents and blood products.

D. Prepare patient and available medical records for immediate transport. Do not delay transport for medical records which could be sent at a later time.

CROSS REFERENCE:

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. 504, **Trauma Patient Destination**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 808, **Base Hospital Contact and Transport Criteria**
Ref. No. 814, **Determination/Pronouncement of Death in the Field**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

***DRAFT 1-22-16***

(EMT, PARAMEDIC, MICN)

SUBJECT: **PERINATAL PATIENT DESTINATION**

REFERENCE NO. 511

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

DEFINITIONS:

1. Perinatal – For the purpose of this policy, "perinatal" refers to patients who are at least 20 weeks pregnant.

2. Perinatal Center – For the purpose of this policy, "perinatal center" refers to a general acute care hospital with a basic emergency department permit and obstetrical service. This terminology is not intended to indicate the absence or presence of a neonatal intensive care unit (NICU).

3. EDAP – Emergency Department Approved for Pediatrics.

4. PMC – Pediatric Medical Center.

5. PTC – Pediatric Trauma Center.

PRINCIPLES:

1. Perinatal patients 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 (MICN) after consideration of the guidelines established in this policy. Final authority for patient destination rests with the base hospital handling the call.

2. If delivery occurs prior to arrival at a hospital, the mother and the newborn should be transported to the same facility.

3. BLS units shall call for an ALS unit or transport perinatal patients to the most accessible perinatal center as outlined in Reference No. 808, Base Hospital Contact and Transport Criteria.

4. 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 illness or injury; current status of the pediatric receiving facility; anticipated transport time; and request by the patient, family, guardian or physician.



APPROVED: _____ _____

Director, EMS Agency Medical Director, EMS Agency

POLICY:

I. The following perinatal patients should be transported to the most accessible perinatal center:

A. Patients who appear to be in active labor, whether or not delivery appears imminent.

B. Patients whose chief complaint appears to be related to the pregnancy. Patients who appear to be having perinatal complications.

C. Injured patients who do not meet trauma criteria or guidelines.

D. Patients with hypertension (blood pressure 140/90 mmHg or greater)

II. Post-partum patients (up to 6 weeks) with hypertension (blood pressure 140/90 mmHg or greater) shall be transported to a perinatal center.

III. Perinatal patients who have delivered prior to arriving at a health facility should be transported to the most accessible perinatal center which is also an EDAP (consider a perinatal center with a NICU).

IV. Perinatal patients meeting trauma criteria and/or guidelines should be transported to a trauma center.

V. Perinatal patients for whom transportation to a perinatal center would exceed 30 minutes should be transported to a receiving facility which is also an EDAP.

VI. The following perinatal patients should be transported to the most accessible receiving facility:

A. Patients in acute respiratory distress.

B. Patients in full arrest.

C. Patients whose chief complaint is clearly not related to the pregnancy.

VII. Consideration may be given by the base hospital to:

A. Direct patients who are equal to or less than 34 weeks pregnant, whose chief complaint appears to be related to the pregnancy, to a perinatal receiving facility with a NICU, regardless of service area considerations/rules.

B. Honor patient destination requests for those patients who have made previous arrangements for obstetrical care at a given hospital. This consideration should be based on the following:

1. If the condition of the patient permits such transport.

2. Transportation to the requested obstetrical facility would not exceed 30 minutes and would not unreasonably remove the ALS unit from its area of primary response.

CROSS REFERENCES:

Prehospital Care Manual:
Reference No. 502, **Patient Destination**
Reference No. 506, **Trauma Triage**
Reference No. 510, **Pediatric Patient Destination**
Reference No. 808, **Base Hospital Contact and Transport Criteria**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

***DRAFT 1-22-16***

(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**~~ **Primary Stroke Center (~~A~~PSC):** 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.

**Comprehensive Stroke Center (CSC):** A 9-1-1 receiving hospital that has met the standards of a CMS approved accreditation body as a Comprehensive Stroke Center and has been approved as a Comprehensive Stroke Center by the LA County EMS Agency.

**Local Neurological Signs:** Signs and symptoms 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.

**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 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~~

**Los Angeles Motor Score (LAMS):** A scoring tool utilized by prehospital care providers to determine the severity of stroke on patients who meet mLAPSS criteria. A large vessel involvement is suspected if the total LAMS score from the three categories is 4 or greater.

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



APPROVED:

Director, EMS Agency

Medical Director, EMS Agency

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.

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.

4. Service area rules and/or considerations do not apply to suspected stroke patients.

POLICY:

I. Responsibility of the Provider Agency

A. Perform ~~a~~ mLAPSS ~~for~~ on all patients exhibiting local neurological signs ~~or symptoms of a possible stroke~~. The mLAPSS is positive if all of the following criteria are met:

1. Symptom duration less than 6 hours
2. No history of seizures or epilepsy
3. Age 40 years or older
4. At baseline, patient is not wheelchair bound or bedridden
5. Blood glucose between 60 and 400 mg/dL
6. Obvious asymmetry-unilateral weakness with any of the following motor exams:
   a. Facial Smile/Grimace
   b. Grip
   c. Arm Strength

B. If mLAPSS is positive, conduct LAMS:

1. Facial droop Total Possible Score = 1
   a. Absent = 0
   b. Present = 1

2. Arm drift Total Possible Score = 2
   a. Absent = 0
   b. Drifts down = 1
   c. Falls rapidly = 2

3. Grip strength Total Possible Score = 2
   a. Normal = 0
   b. Weak grip = 1
   c. No grip = 2

C. Transport the patient to the ~~nearest ASC if mLAPSS screening criteria are met~~ most appropriate stroke center in accordance with base hospital direction or section IV of this policy.

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

D. Document the results of mLAPSS, LAMS, and last known well date and time in the designated areas on the EMS Report Form or electronic patient care ~~report~~ record (ePCR).

E. 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 based on stroke center status via the ReddiNet® system and section IV of this policy.

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

D. Document the results of mLAPSS, LAMS and last known well date and time in the designated areas 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~~ Stroke Center

A. Maintain current certification as a Primary Stroke Center or Comprehensive Stroke Center by a CMS approved accreditation body for stroke certification, and comply with EMS Agency data collection and quality improvement requirements.

B. Provide specialized stroke patient care services 24 hours a day/7 days a week ~~for stroke patients as required for Primary Stroke Center certification~~.

C. ~~Diversion of stroke patients is allowed for internal disaster or on current CT diversion.~~ Stroke centers may request diversion of suspected stroke patients for any of the following conditions:

1. Internal Disaster

2. Computerized Tomography (CT) Scanner - hospital is unable to provide essential diagnostic procedures due to lack of a functioning CT scanner

IV. ~~Transportation~~ Destination of Stroke Patients ~~to an ASC~~

All patients who have a positive mLAPSS shall be transported to a LA County EMS Agency designated stroke center as follows:

A. ~~All suspected stroke shall be transported to the most accessible ASC~~ Patients with a LAMS of less than 4 shall be transported to the most accessible PSC, if ground transport is 30 minutes or less regardless of service area rules and/or considerations.

B. Patients with a LAMS of 4 or greater, should be transported to the most accessible CSC if transport time is less than 30 minutes. If transport time to the CSC is greater than 30 minutes, the patient shall be transported to the most accessible PSC.

C. If there are no stroke centers (PSC or CSC) that are accessible by ground transport ~~time to an ASC is greater than~~ within 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**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

***DRAFT 1-22-16***

(PARAMEDIC/MICN)

SUBJECT: **ALS UNIT INVENTORY** REFERENCE NO. 703

PURPOSE: To provide a standardized minimum inventory on all Advanced Life Support (ALS) Units.

PRINCIPLE: Any equipment or supplies carried for use in providing emergency medical care must be maintained in good working order. Providers may only carry one narcotic analgesic on the ALS units. Provider Agency Medical Directors may request approval from the EMS Agency's Medical Director to carry Fentanyl.

POLICY: ALS ~~vehicles~~ Units shall carry the following equipment. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Transport vehicles shall also be equipped and supplied according to the Department of the California Highway Patrol, California Administrative Code, Title 13.

| **MEDICATIONS*** (minimum required amounts) | | | |
|---|---|---|---|
| Albuterol (pre-mixed with NS) | **20 mgs** | Epinephrine (1:10,000) | **10 mgs** |
| Adenosine | **24 mgs** | Fentanyl [2] | **500 mcgs** |
| Amiodarone | **900 mgs** | Glucagon | **1 mg** |
| Aspirin (chewable 81 mg) | **648 mgs** | Midazolam [3] | **20 mgs** |
| Atropine sulfate (1 mg/10 ml) | **4 mgs** | Morphine sulfate [4] | **32 mgs** |
| Calcium chloride | **1 gm** | Naloxone | **4 mgs** |
| Dextrose 50% | **150 mls** | Normal saline (for injection) | **2 vials** |
| Dextrose solution 100 gm (glucose paste may be substituted) | **1** | Nitroglycerin spray or tablets | **1** |
| Diphenhydramine | **100 mgs** | Ondansetron 4mg ODT | **16 mgs** |
| Disaster Cache (mandatory for 9-1-1 responders) [5] | | Ondansetron 4mg IV | **16 mgs** |
| Epinephrine (1:1,000) | **7 mgs** | Sodium bicarbonate | **50 mls** |

*** All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens**
[2] **Fentanyl carried on ALS Unit is not to exceed 1500 mcgs.**
[3] **Midazolam carried on ALS Unit is not to exceed 40 mgs.**
[4] **Morphine sulfate carried on ALS Unit is not to exceed 60 mgs.**
[5] **Disaster Cache minimum contents include:**
**(30) DuoDote kits or equivalent**
**(12) Atropen 1.0 mg**
**(12) Pediatric Atropen 0.5 mg**



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

## INTRAVENOUS FLUIDS
(minimum required amounts)

| | | | |
|---|---|---|---|
| 1000 ml normal saline | **8 bags** | 250 or 500 ml normal saline | **2 bags** |

## SUPPLIES*
(minimum required amounts)

| | | | |
|---|---|---|---|
| Adhesive dressing (bandaids) | **1 box** | End Tidal $CO_2$ Detector and Aspirator<br>Adult | **1** |
| Airways – Nasopharyngeal<br>Large, medium, small<br>(34-36, 26-28, 20-22) | **1 each** | Extrication device or short board | **1** |
| | | Flashlight | **1** |
| Airways – Oropharyngeal<br>Large | **1** | Gauze sponges (sterile) | **12** |
| Medium | **1** | Gauze bandages | **5** |
| Small Adult/Child | **1** | Gloves Sterile | **2 Pairs** |
| Infant | **1** | Gloves Unsterile | **1 Box** |
| Neonate | **1** | Glucometer with strips | **1** |
| Alcohol swabs | **1 box** | Hand-held nebulizer pack | **2** |
| Backboards | **2** | Hemostats, padded | **1** |
| Bag-valve device with $O_2$ inlet and reservoir<br>Adult and Pediatric | **1 each** | Intravenous catheters (~~14~~16G-22G) | **5 each** |
| Bag-valve mask<br>Large | **1** | Intravenous Tubing<br>Microdrip | **6** |
| Medium | **1** | Macrodrip | **6** |
| Small Adult/Child | **1** | Intraosseous Device [7,8]<br>Adult<br>Pediatric | **1**<br>**1** |
| Toddler | **1** | **9-1-1 paramedic provider agencies only** | |
| Infant | **1** | King LTS-D (Disposable Supraglottic Airway device)<br>Small Adult (Size 3) | **1** |
| Neonate | **1** | Adult (Size 4) | **1** |
| Burn pack or burn sheets | **1** | Large Adult (Size 5) | **1** |
| Cervical collars (rigid)<br>Adult (various sizes) | **4** | Lancets, automatic retractable | **5** |
| Pediatric | **2** | Laryngoscope Handle<br>Adult (compatible with pediatric blades) | **1** |
| Chest Decompression Needles 3.0-3.5” ~~Needle thoracostomy kit or 14G 3.0-3.5” angiocath~~ | **2** | Laryngoscope Blades<br>Adult, curved and straight | **1 each** |
| Color Code Drug Doses LA County Kids | **1** | Pediatric, Miller #1 & #2 | **1 each** |
| Contaminated needle container | **1** | Magill Forceps Adult and Pediatric | **1 each** |
| Continuous Positive Airway Pressure (CPAP) Device [7, 8]<br>**9-1-1 paramedic provider agencies only** | **1** | Mucosal Atomization Device (MAD) | **2** |
| Defibrillator with oscilloscope | **1** | Normal saline for irrigation | **1 bottle** |
| Defibrillator electrodes (including pediatric) or paste | **2** | Needle, filtered-5micron | **2** |
| ECG Electrodes Adult and Pediatric | **6 each** | OB pack and bulb syringe | **1** |
| ECG, 12-lead capable & transmission capable<br>**9-1-1 paramedic provider agencies only** | **1** | Oxygen cannulas | **3** |
| Endotracheal tubes with stylets Sizes 6.0-8.0 | **2 each** | Oxygen non-rebreather masks<br>Adult and Pediatric | **3 each** |

| | | | |
|---|---|---|---|
| Pediatric Resuscitation Tape | **1** | Suction Unit (portable) | **1** |
| Personal Protective Equipment/<br>Body Substance Isolation Equipment<br>mask, gown, eye protection | **~~2 each~~**<br>**1 each per provider** | Suction Instruments<br>(8Fr.-12Fr. Catheters)<br>Tonsillar tip | **1 each**<br>**1** |
| Procedures Prior to Base Contact<br>Field Reference No. 806.1 | **1** | Syringes 1ml – 60 ml | **assorted** |
| Pulse Oximeter | **1** | Tape (various types, must include cloth) | **1** |
| Radio transmitter receiver [6] | **1** | Tourniquets | **2** |
| Saline locks | **4** | Tourniquets<br>(commercial, for control of bleeding) | **2** |
| Scissors | **1** | Transcutaneous Pacing [7,8] | **1** |
| Sphygmomanometer<br>Adult/pediatric/thigh cuff | **1 each** | Tube Introducer | **2** |
| Splints – (long and short) | **2 each** | Vaseline gauze | **2** |
| Splints – traction (adult and pediatric) | **1 each** | Waveform Capnography | |
| Stethoscope | **1** | | |

| **SUPPLIES*** (approved optional equipment) | |
|---|---|
| Dextrose 25% | Pediatric Laryngoscope Handle FDA-Approved |
| Dopamine | Resuscitator with positive pressure demand valve (flow rate not to exceed 40L/min) |
| Hemostatic Dressings [8] | Vacutainer Tubes |
| Intravenous Tubing Blood/Shock | |

*** All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens.**
[6] **Los Angeles County Department of Communications, Spec. No. 2029/2031/2033**
[7] **Only for providers that respond to medical emergencies via the 9-1-1 system**
[8] **Requires EMS Agency approval, which includes an approved training program and QI method prior to implementation**

This policy is intended as an ALS Unit inventory only. Supply and resupply shall be in accordance with Reference No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles.

CROSS REFERENCES:

Prehospital Care Policy Manual:
Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**
Ref. No. 710, **Basic Life Support Ambulance Equipment**
Ref. No. 712, **Nurse Staffed Critical Care Inventory**
Ref. No. 1104, **Disaster Pharmaceutical Caches Carried by First Responders**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

***DRAFT 01-22-16***

(PARAMEDIC/MICN)

SUBJECT: **ASSESSMENT UNIT INVENTORY** REFERENCE NO. 704

PURPOSE: To provide a standardized minimum inventory on all Assessment Units.

PRINCIPLE:

1. Any equipment or supplies carried for use in providing emergency medical care must be maintained in good working order.

2. The minimum required amounts may be augmented according to anticipated needs in consultation with the Medical Advisor of the Provider Agency or the Medical Director of the EMS Agency.

POLICY: Assessment Units shall carry the following equipment. Reasonable variations may occur.

| **MEDICATIONS*** (minimum required amounts) | | | |
|---|---|---|---|
| Albuterol (pre-mixed with NS) | **5 mg** | Epinephrine (1:10,000) | **2 mgs** |
| Aspirin (81 mg chewable) | **648 mgs** | Glucagon | **1 mg** |
| Atropine Sulfate ( 1mg/10 ml) | **1 mg** | Naloxone | **2 mgs** |
| Adenosine | **6mg** | Nitroglycerin Spray or tablets | **1** |
| Dextrose 50% | **50 mls** | Normal Saline (for injection) | **1 vial** |
| Epinephrine (1:1,000) | **1 mg** | Ondansetron 4mg ODT and IV | **16 mgs** |

| **INTRAVENOUS FLUIDS** (minimum required amounts) | |
|---|---|
| 250 or 500 ml normal saline | **1** |

| **SUPPLIES*** (minimum required amounts) | | | |
|---|---|---|---|
| Airways – Oropharyngeal | | | |
| Large | **1** | Medium | **1** |
| Medium | **1** | Small Adult/Child | **1** |
| Small Adult/Child | **1** | Toddler | **1** |
| Infant | **1** | Infant & neonate | **1 each** |
| Alcohol prep pads | **5** | Burn pack or burn sheets | **1** |
| Adhesive dressing (band-aids) | **5** | Cardiac Monitor/Defibrillator oscilloscope | **1** |
| Bag-valve device with $O_2$ inlet & reservoir | | Cervical collars (rigid) | |
| Adult & Pediatric | **1 each** | Adult (adjustable) | **1** |
| Bag-valve mask | | | |
| Large | **1** | Pediatric | **1** |



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

| **SUPPLIES*** (minimum required amounts) | | | |
|---|---|---|---|
| Contaminated needle container | **1** | Mucosal Atomization Device (MAD) | **1** |
| Chest Decompression Needles 3.0-3.5” | **2** | | |
| ~~Needle thoracostomy kit or 14G 3.0-3.5” angiocath~~ | | Needle, filtered 5-micron | **1** |
| Color Code Drug Doses LA County Kids | **1** | Normal saline for irrigation | **1 bottle** |
| Defibrillator pads or paste (including pediatric) | **1 set each** | OB pack & bulb syringe | **1** |
| ECG electrodes | **6 each** | Oxygen cannulas | **1** |
| Endotracheal tubes with stylets Sizes 6.5-7.5 | **1 each** | Oxygen non-rebreather masks Adult and Pediatric | **1 each** |
| End Tidal $CO_2$ Detector/Aspirator (adult) | **1** | Pediatric resuscitation tape | **1** |
| Penlight | **1** | Personal Protective Equipment mask, gown, eye protection | **1 each per provider** |
| Gauze pads 4x4 (sterile) | **4 packages** | Procedures Prior to Base Contact Field Reference No. 806.1 | **1** |
| Gauze Bandages | **2** | Saline locks | **2** |
| Gloves, unsterile | **6 pairs** | Scissors | **1** |
| Glucometer with strips | **1** | Sphygmomanometer Adult, pediatric, thigh cuff | **1 each** |
| Hand-held nebulizer pack | **1** | Stethoscope | **1** |
| Intravenous Tubing (macrodrip) | **1** | Suction Unit (portable) | **1** |
| Intravenous catheters 16G-22G | **2 each** | Suction Instruments 8 Fr.; 10 Fr.; 12 Fr. catheters | **1 each** |
| King LTS-D (Disposable Supraglottic Airway device) [1] Small Adult (Size 3) | **1** | Tonsillar Tip | **1** |
| Adult (Size 4) | **1** | Syringes: 1ml – 60ml | **assorted** |
| Lancets (automatic retractable) | **2** | Tape, porous and cloth | **1 each** |
| Laryngoscope blades Adult | **1** | Tourniquets | **2** |
| Pediatric, Miller #1 & #2 | **1 each** | Tourniquets (commercial, for bleeding control) | **2** |
| Laryngoscope handle Adult (compatible with pediatric blades) | **1** | Tube introducer | **2** |
| Magill Forceps, Adult & Pediatric | **1 each** | Vaseline gauze | **2** |

| **SUPPLIES*** (approved optional equipment) | |
|---|---|
| Radio transmitter receiver** | Splints, traction |
| Intraosseous device Adult **1 each** Pediatric **1 each** (requires EMS Agency approved training program and QI method prior to implementation) | Splints, long and short |
| Continuous Positive Airway Pressure (CPAP) Device (requires EMS Agency approved training program and QI method prior to implementation). | |

*** All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens**
****Los Angeles County Department of Communications, Spec. No. 2029/2031/2033**
[1] **Providers are to have one type of airway adjunct only.**

This policy is intended as an Assessment Unit inventory only, supply and resupply shall be in accordance with Ref. No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles.

CROSS REFERENCE:
Prehospital Care Manual:
Ref. No. 4l6, **Assessment Units**
Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

***DRAFT 01-11-22***

(PARAMEDIC/MICN)

SUBJECT: **ALS EMS AIRCRAFT INVENTORY** REFERENCE NO. 706

PURPOSE: To provide a standardized minimum inventory on all Advanced Life Support (ALS) EMS aircraft.

POLICY: Each EMS aircraft shall have on board equipment and supplies commensurate with the scope of practice of the medical flight crew. This requirement may be fulfilled through the utilization of appropriate kits (cases/packs) which can be carried aboard a given flight. ALS EMS aircraft shall have sufficient space to carry the following minimum medical equipment and supplies. Reasonable variations may occur; however, any exceptions must have prior approval of the EMS Agency. Controlled drugs shall be secured on the EMS aircraft in accordance with Reference No. 702, Controlled Drugs Carried on ALS Units.

| **MEDICATIONS*** (minimum required amounts) | | | |
|---|---|---|---|
| Albuterol (pre-mixed with NS) | **20 mgs** | Fentanyl [1] | **500 mcgs** |
| Adenosine | **18 mgs** | Glucagon | **1 mg** |
| Amiodarone | **600 mgs** | Midazolam [2] | **15 mgs** |
| Aspirin (chewable 81 mg) | **648 mgs** | Morphine sulfate [3] | **20 mgs** |
| Atropine sulfate (1 mg/10 ml) | **3 mgs** | Naloxone | **2 mgs** |
| Calcium chloride | **2 gm** | Normal saline (for injection) | **3 vials** |
| Dextrose 50% | **100 mls** | Nitroglycerin spray or tablets | **1** |
| Dextrose solution 100 gm (glucose paste may be substituted) | **1** | Ondansetron 4mg ODT | **16 mgs** |
| Diphenhydramine | **100 mgs** | Ondansetron 4mg IV | **16 mgs** |
| Epinephrine (1:1,000) | **7 mgs** | Sodium bicarbonate | **100 mls** |
| Epinephrine (1:10,000) | **6 mgs** | | |

*** All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens**
[1] **Fentanyl carried on ALS EMS Aircraft is not to exceed 1500 mcgs.**
[2] **Midazolam carried on ALS EMS Aircraft is not to exceed 40 mgs.**
[3] **Morphine sulfate carried on ALS EMS Aircraft is not to exceed 60 mgs.**

| **INTRAVENOUS FLUIDS** (minimum required amounts) | | | |
|---|---|---|---|
| 1000 ml Normal Saline | **4** | 250 or 500 ml Normal Saline | **1** |



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

## SUPPLIES*
(minimum required amounts)

| | | | |
|---|---|---|---|
| Adhesive dressing (bandaids) | **10** | Flashlight | **1** |
| Airways – Nasopharyngeal 4.5 – 9.0 | **1 each** | Gauze sponges (sterile) | **12** |
| Airways – Oropharyngeal Large | **1** | Gauze bandages | **5** |
| Medium | **1** | Gloves Sterile | **2 Pairs** |
| Small Adult/Child | **1** | Gloves Unsterile | **1 Box** |
| Infant | **1** | Glucometer with strips | **1** |
| Neonate | **1** | Hand-held nebulizer pack | **2** |
| Alcohol swabs | **20** | Intravenous catheters 16G-22G | 4 **each** |
| Backboards | **1** | ~~14G (3" long)~~ | ~~**2**~~ |
| Bag-valve device with $0_2$ inlet and reservoir Adult and Pediatric | **1 each** | Intravenous Tubing Microdrip | **1** |
| Bag-valve mask Large | **1** | Macrodrip | **4** |
| Medium | **1** | Intraosseous Device FDA-Approved [7] Adult | **1** |
| Small Adult/Child | **1** | Pediatric | **1** |
| Toddler | **1** | King LTS-D (Disposable Supraglottic Airway device) Small Adult (Size 3) | **1** |
| Infant | **1** | Adult (Size 4) | **1** |
| Neonate | **1** | Large Adult (Size 5) | **1** |
| Burn pack or burn sheets | **1** | Lancets, automatic retractable | **5** |
| Cervical collars (rigid) Adult (various sizes) | **2** | Laryngoscope Handle Adult ~~and Pediatric~~ (compatible with pediatric blades) | **1 each** |
| Pediatric | **2** | Laryngoscope Blades Adult, curved and straight | **1 each** |
| Chest Decompression Needles 3.0-3.5" ~~Needle thoracostomy kit or 14G 3.0-3.5" angiocath~~ | **2** | Pediatric, Miller #1 & #2 | **1 each** |
| Color Code Drug Doses LA County Kids | **1** | Magill Forceps Adult and Pediatric | **1 each** |
| Contaminated needle container | **1** | Mucosal Atomization Device (MAD) | **2** |
| Continuous Positive Airway Pressure (CPAP) Device | **1** | Needle, filtered-5micron | **2** |
| Defibrillator with oscilloscope | **1** | Noninvasive blood pressure monitor | **1** |
| Defibrillator pads or paste | **2** | Normal saline for irrigation (may stock the smaller 100ml bottle) | **1 bottle** |
| ECG, 12-lead capable | **1** | OB pack and bulb syringe | **1** |
| ECG Electrodes Adult and Pediatric | **8-10 multi-use** | Oxygen cannulas | **2** |
| Endotracheal tubes with stylets Sizes 6.0-8.0 | **2 each** | Oxygen non-rebreather masks Adult and Pediatric | **2 each** |
| End Tidal $CO_2$ Detector and Aspirator Adult | **1** | Pediatric Resuscitation Tape | **1** |
| End Tidal $CO_2$ Monitor Adult | **1** | Personal Protective Equipment/ Body Substance Isolation Equipment | ~~**2 each**~~ |
| Extrication device or short board | **1** | mask, gown, eye protection | **1 each per provider** |

| **SUPPLIES*** (minimum required amounts) | | | |
|---|---|---|---|
| Pulse Oximeter | **1** | Suction Unit (portable) | **1** |
| Procedures Prior to Base Contact Field Reference No. 806.1 | **1** | Syringes 1ml – 60 ml | **assorted** |
| Radio transmitter receiver [4] | **1** | Sphygmomanometer Adult/pediatric/thigh cuff | **1 each** |
| Saline locks | **4** | Stethoscope | **1** |
| Scissors | **1** | Tape (various types, must include cloth) | **assorted** |
| Splints – cardboard (long and short) (or air splints for 4 extremities) | **2 each** | Tourniquets | **2** |
| Splints – traction (adult and pediatric) [5] | **1 each** | Tourniquets (commercial, for control of bleeding) | **2** |
| Suction unit (portable) | **1** | Transcutaneous Pacing [6,7] | **1** |
| Suction Instruments 8Fr.-12Fr. Catheters | **1 each** | Tube Introducer | **2** |
| Tonsillar tip | **1** | Waveform Capnography | |

| **SUPPLIES*** (approved optional equipment) | |
|---|---|
| Dextrose 25% | Resuscitator with positive pressure demand valve (flow rate not to exceed 40L/min) |
| Dopamine | Transcutaneous Pacing [7] |
| Hemostatic Dressings [7] | Vacutainer Tubes |

*** All sharps must comply with CCR, Title 8, Section 5193, Bloodborne Pathogens.**
**[4] Los Angeles County Department of Communications, Spec. No. 2029/2031/2033**
**[5] One Sager splint may be used for both adult and pediatric**
**[6] Only for providers that respond to medical emergencies via the 9-1-1 system**
**[7] Requires EMS Agency approval, which includes an approved training program and QI method prior to implementation**

This policy is intended as an ALS EMS aircraft inventory only. Supply and resupply shall be in accordance with Reference No. 701, Supply and Resupply of Designated EMS Provider Units/Vehicles.

CROSS REFERENCES:

Prehospital Care Policy Manual:
Ref. No. 701, **Supply and Resupply of Designated EMS Provider Units/Vehicles**
Ref. No. 702, **Controlled Drugs Carried on ALS Units**
Ref. No. 710, **Basic Life Support Ambulance Equipment**

Title 22, Chapter 8, Prehospital EMS Aircraft Regulations
Los Angeles County, Code of Ordinances, Title 7, Business Licenses, Division 2, Chapter 7.16, Ambulances

**PROCEDURES PRIOR TO BASE CONTACT -** REFERENCE NO. 806.1 ***DRAFT 1-22-16***

Prior to base hospital contact, paramedics may utilize the following treatment protocols:

## GENERAL ALS

1. Basic airway/$O_2$ prn
   BVM & advanced airway prn
2. Cardiac monitor/document rhythm prn
3. Venous access prn; 10ml/kg fluid challenge prn, reassess at 250ml increments
   **Pediatric:**
   20ml/kg, reassess after initial fluid challenge
4. If indicated, blood glucose test; if <60mg/dl administer:
   **Dextrose** 50% 50ml slow IVP
   **Pediatric:**
   1month-<2yrs of age: 25% 2ml/kg slow IVP
   ≥2yrs age: 50% 1ml/kg slow IVP up to 50 ml
5. Pediatric resuscitation tape prn
6. **Ondansetron:** may give 4mg IV, IM or ODT one time for nausea/vomiting/morphine administration

## RESPIRATORY DISTRESS

1. General ALS

**ARREST/HYPOVENTILATION (RR< 8/MIN):**

2. If suspected narcotic OD with hypoventilation, **Naloxone** 2mg IM/IN prior to venous access or advanced airway
   **Adult**: 0.8-2mg IVP, titrate to adequate RR/TV or 2mg IM/IN
   **Pediatric**: 0.1mg/kg IV/IM/IN
3. May repeat PRN

**BRONCHOSPASM/WHEEZING**

2. **Albuterol**
   **Adult:** 5mg via hand-held nebulizer
   **Pediatric:** age < 1yr=2.5mg
   age ≥ 1yr=5.0mg
3. May repeat one time prn
4. Consider CPAP if available: max pressure 10cm$H_20$

**BASILAR RALES – CARDIAC ORIGIN (ADULTS ONLY)**

2. **Nitroglycerin** (NTG) SL:
   SBP ≥ 100=0.4mg (1 puff or 1 tablet)
   SBP ≥ 150=0.8mg (2 puffs or 2 tablets)
   SBP ≥ 200=1.2mg (3 puffs or 3 tablets)
3. May repeat two times in 3-5min based on repeat BP
4. Albuterol 5mg via hand-held nebulizer if wheezing
5. Consider CPAP if available; max pressure 10cm$H_20$

## CHEST PAIN (Adult)

1. General ALS
2. 12-lead ECG for suspected acute cardiac event
   Transport to MAR if ECG=no MI
   Transport to SRC if ECG=suspected acute MI
3. **NTG** 0.4mg SL, may repeat 2 times every 3-5min if SBP less than100mmHg
4. **Aspirin** 162-325mg, chewable

## ACTIVE SEIZURE

1. General ALS
2. **Midazolam****
   **Adult:** 2-5mg slow IVP, titrate to control seizure activity; if unable to establish IV, 5mg IN/IM**
   **Pediatric:** Up to 0.1mg/kg IVP titrate to control seizure activity; if unable to establish IV, 0.1mg/kg IM/IN
3. May repeat one time in 5min. Maximum adult dose10mg all routes, max pediatric dose 5mg all routes

**Controlled substances are **NOT** in the Assessment Unit Inventory

## ALTERED LOC

1. General ALS
2. If blood glucose <60mg/dl and unable to obtain IV, **Glucagon** 1mg IM
   If narcotic overdose, **Naloxone** 2mg IM/IN prior to venous access or advanced airway
   **Adult**: 0.8-2mg IVP, titrate to adequate RR/TV or 2mg IM/IN
   **Pediatric**: 0.1mg/kg IV/IM/IN

## SHOCK

1. General ALS
2. Normal saline fluid challenge. If basilar rales or cardiogenic shock suspected, reduce rate to TKO
   **Adult**: 10ml/kg, assess lung sounds frequently
   **Pediatric**: 20ml/kg
3. Perform needle thoracostomy enroute if suspected tension pneumothorax with SBP ≤ 90mmHg
4. If uncontrollable traumatic hemorrhage utilize tourniquets and/or hemostatic agents *If an approved provider

## ANAPHYLAXIS

1. General ALS

**ADEQUATE PERFUSION**

2. **Epinephrine:**
   **Adult:** 0.5mg (1:1,000) Deep IM
   **Pediatric:** 0.01mg/kg (1:1,000) Deep IM, maximum single dose 0.5mg
3. **Albuterol,** if wheezing:
   **Adult**: 5mg via hand-held nebulizer
   **Pediatric**: age <1yr=2.5mg
   age ≥1yr=5.0mg

**POOR PERFUSION**

2. **Epinephrine**
   **Adult:** 0.5mg (1:1,000) Deep IM
   **Pediatric:** 0.01mg/kg (1:1,000) Deep IM, maximum single dose 0.5mg
3. Normal saline fluid challenge if lungs are clear.
   Adult: 10ml/kg, assess lung sounds frequently
   Pediatric: 20ml/kg

## PAIN MANAGEMENT

1. General ALS
2. Traction/splints/dressings prn
3. **Morphine** for moderate to severe pain
   2-4mg slow IVP, titrate to pain relief; max. of 8mg
   **Pediatric:** 0.1mg/kg slow IVP; do not repeat
   **OR**
   **Fentanyl** for moderate to severe pain
   50mcg slow IVP/IM/IN, titrate to pain relief; do not repeat
   **Pediatric:** 1mcg/kg slow IVP/I/IN; do not repeat pediatric dose; maximum

**CRUSH INJURY/BURN**

3. **Morphine** 2-12mg slow IVP, titrate to pain relief; maximum total adult dose 20mg
   **Pediatric:** 0.1mg/kg slow IVP; do not repeat pediatric dose; maximum total dose 4mg **OR**
   **Fentanyl** see above for dosing

**Controlled substances are **NOT** in the Assessment Unit Inventory

## SYMPTOMATIC BRADYCARDIA

1. General ALS

**ADULT: HR < 40/MINUTE AND SBP <80MMHG:**

2. **Atropine** 0.5mg IVP
3. If suspected hyperkalemia, **Albuterol** 5mg via continuous mask nebulization two times
4. If no improvement, TCP; follow department guidelines

**PEDIATRIC: HR <60/MINUTE:**

2. Assist respirations with BVM prn
   Rescue airway: King LTs-D if ≥12yrs and 4ft. tall
3. Advanced airway prn.
4. CPR if ≤8yrs and HR <60bpm after effective ventilations

## SUPRAVENTRICULAR TACHYCARDIA NARROW QRS >150bpm

1. General ALS

**ADEQUATE PERFUSION**

**Adult:**

2. Valsalva maneuver
3. If no conversion, **Adenosine** 6mg rapid IVP immediately followed by a 10-20ml NS bolus
4. If no conversion, **Adenosine** 12mg rapid IVP immediately followed by a 10-20ml NS bolus

**Pediatric (infant HR>220bpm, child HR >180bpm):**

5. Rapid transport. Monitor closely.

**POOR PERFUSION**

**Adult:**

2. If IV access, **Adenosine** 12mg rapid IVP immediately followed by a 10-20ml rapid IV flush. If no conversion, may repeat one time in 1-2min
3. Synchronized cardioversion❖ May repeat one time.

**Pediatric:**

4. NS fluid challenge 20ml/kg IV

## WIDE QRS TACHYCARDIA

1. General ALS

**ADEQUATE PERFUSION >150BPM**

**Adult:**

2. **Adenosine** 6mg rapid IVP immediately followed by a 10-20ml NS bolus
3. If no conversion, **Adenosine** 12mg rapid IVP immediately followed by a 10-20ml NS bolus.

**Pediatric**

4. Rapid transport. Monitor closely.

**POOR PERFUSION**

**Adult:**

2. Synchronized cardioversion, may repeat one time❖

**Pediatric:**

3. Synchronized cardioversion 0.5-1J/kg mono- or biphasic
4. If no conversion, synchronized cardioversion 2J/kg
5. Rapid transport

❖Adult biphasic: administer according to departmental or manufacturer's recommendations. If unknown, use highest setting.

## CARDIOPULMONARY ARREST

**Non-Traumatic**

1. BCLS/capnography/cardiac monitor

**IF V-FIB/PULSELESS V-TACH:**

**Unwitnessed:** 2min CPR at 100/min or greater then defibrillate, minimize interruptions to CPR and immediately resume CPR for 2min
**Witnessed:** CPR while charging monitor; defibrillate

2. Defibrillation
   **Adult:** biphasic,120-200J❖ monophasic 360J
   **Pediatric:** 2J/kg monophasic or biphasic❖
3. Venous access; if unable, place IO*
   If hypovolemia, NS fluid challenge:
   **Adult:** 10ml/kg rapid IV/IO*
   **Pediatric:** 20ml/kg IV/IO*
4. Defibrillation
   **Adult:** biphasic❖ monophasic 360J
   **Pediatric:** 4J/kg monophasic or biphasic❖
5. **Epinephrine** (1:10,000)
   **Adult:** 1mg IV/IO*
   **Pediatric:** 0.01mg/kg IV/IO*
6. If no conversion, defibrillate and immediately resume CPR for 2min
   **Adult:** biphasic❖ monophasic 360J
   **Pediatric:** 4 J/kg monophasic or biphasic❖
7. If no conversion, immediately resume CPR for 2min

**ASYSTOLE OR PEA**

2. Venous access, if unable, place IO*
3. **Adult: Epinephrine** (1:10,000) 1mg IV or IO*
   **Pediatric:** 0.01mg/kg IV/IO*
4. If narrow complex and HR >60bpm: NS fluid challenge 10ml/kg IV or IO* in 250cc increments
5. Advanced airway prn

**Traumatic**

1. BCLS - do not delay transport for treatment, maintain spinal motion restriction if indicated
2. Cardiac monitor
   **If V-Fib/Pulseless V-Tach:**
3. Defibrillation
   **Adult:** biphasic 120-200J❖ monophasic 360J
   **Pediatric:** 2J/kg monophasic or biphasic
4. Perform needle thoracostomy enroute if suspected tension pneumothorax
5. Advanced airway prn.
6. Venous access en route. If unable to establish IV, place IO*

**Adult:** 10ml/kg rapid IV/IO*
**Pediatric:** 20ml/kg IV/IO* * If IO is available

## HAZARDOUS MATERIAL

1. General ALS
2. If base contact cannot be established, refer to Ref. No. 1225, Nerve Agent Exposure, and Ref. No. 1235, Radiological Exposure.

**Base hospital contact shall be made following each treatment protocol. If communication cannot be established, base contact shall be made with a full patient report prior to leaving the facility.**

DEPARTMENT OF HEALTH SERVICES

***DRAFT 1-22-16***

COUNTY OF LOS ANGELES

SUBJECT: **BASE HOSPITAL CONTACT AND TRANSPORT CRITERIA** (EMT, PARAMEDIC, MICN)
REFERENCE NO. 808

PURPOSE: To identify the signs, symptoms, chief complaints, or special circumstances of patients for whom base hospital contact is required for medical direction and/or patient destination. This policy delineates when transport to an appropriate and approved facility is indicated.

AUTHORITY: California Health and Safety Code, Division 2.5, Section 1798 et seq.,
California Code of Regulations, Title 22, Section 100169
California Welfare and Institution Code, Section 5008(h)(1)

PRINCIPLES:

1. Paramedics should contact their assigned base hospital.

2. In situations not described in this policy, paramedics and EMTs should exercise their clinical judgment as to whether ALS intervention, base hospital contact and/or transport is anticipated or indicated.

3. Children ≤ 36 months of age require base hospital contact and/or transport in accordance with this policy.

4. When base hospital contact and/or transport are not performed in accordance with this policy, appropriate explanation and documentation shall be recorded on the EMS Report Form. **This does not apply to patients ≤ 36 months of age.**

5. Circumstances may dictate that transport be undertaken immediately with attempts to contact the base hospital enroute.

6. In situations where EMTs arrive on scene prior to the paramedics, EMTs shall not cancel the paramedic response if a patient meets any criteria outlined in Section I of this policy. An ALS unit shall be requested if one has not been dispatched, unless Principle 7 applies.

7. In life-threatening situations in which the estimated time of arrival (ETA) of the paramedics exceeds the ETA to the most accessible receiving facility (MAR), EMTs should exercise their clinical judgment as to whether it is in the patient's best interest to be transported prior to the arrival of paramedics. EMTs shall make every effort to notify the MAR via the VMED28, telephone, dispatch, or other appropriate means of communication when exercising this principle.

8. Paramedics shall contact their designated receiving trauma center on all injured patients meeting trauma triage criteria and/or guidelines or if, in the paramedics' judgment, it is in



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

the patient's best interest to be transported to a trauma center. When the receiving trauma center is not a base hospital (only applies to Children's Hospital Los Angeles), paramedics shall contact their assigned base hospital.

9. A paramedic team may transfer care of a patient to an EMT team in cases where, in the paramedics' judgement, the patient does not require ALS level care. If the patient's condition meets base hospital contact criteria, the base hospital must approve the EMT transport.

POLICY:

I. Paramedics shall make base hospital contact for medical direction and/or patient destination on all patients meeting one or more of the following criteria:

A. Signs or symptoms of shock

B. Cardiopulmonary arrest (excluding patients defined in Ref. Nos. 814 and 815)

C. Chest pain or discomfort

D. Shortness of breath and/or tachypnea

E. Pediatric Medical Care (PMC) guidelines as defined in Ref. No. 510

F. Situations involving five or more patients who require transport (Contacting the Medical Alert Center constitutes base hospital contact)

G. Altered level of consciousness as defined in the Medical Control Guidelines

H. Suspected ingestion of potentially poisonous substances

I. Exposure to hazardous materials with a medical complaint

J. Abdominal pain in a pregnant or in a suspected pregnant patient greater than or equal to 20 weeks gestation

K. Hypertension (blood pressure 140/90 mmHg or greater) in pregnant patient greater than or equal to 20 weeks gestation or post-partum patient (up to 6 weeks)

L. Childbirth or signs of labor

M. Suspected femur fracture

N. Facial, neck, electrical, or extensive burns:

1. 20% or greater BSA in adults

2. 15% or greater BSA in children

3. 10% or greater BSA in infants

O. Trauma Triage Criteria and Guidelines as defined in Ref. No. 506

P. Traumatic Crush Syndrome

Q. Syncope or loss of consciousness, or acute neurological symptoms (suspected signs and symptoms of stroke) prior to or upon EMS personnel arrival.

R. A patient meeting any criteria in Section I who refuses transport against medical advice (AMA). Base contact is required prior to the patient leaving the scene.

II. EMT or paramedic personnel shall transport all patients meeting one or more of the following criteria:

A. Abdominal pain

B. Suspected isolated fracture of the hip

C. Abnormal vaginal bleeding

D. Suspected allergic reaction

E. Asymptomatic exposure to hazardous material known to have delayed symptoms

G. Gastrointestinal bleeding

H. Near drowning

I. Patients who are gravely disabled or a danger to themselves or others.

III. Prehospital personnel shall manage pediatric patients $\leq$ 36 months of age as follows:

A. All children $\leq$ twelve (12) months of age shall be transported, regardless of chief complaint and/or mechanism of injury **unless** the child meets the criteria outlined in Reference No. 814, Determination/Pronouncement of Death in the Field, e.g., rigor mortis, post-mortem lividity, evisceration of the heart, lung or brain, etc.

B. All children thirteen (13) months to thirty-six (36) months of age require base hospital contact and/or transport, except in isolated minor extremity injury.

C. If a parent or legal guardian refuses transport (AMA), base contact is required prior to the patient leaving the scene.

IV. Paramedics utilizing Standing Field Treatment Protocols (SFTPs) shall make base hospital contact for medical direction and/or patient destination on all patients meeting one or more of the following criteria:

A. If indicated in the SFTPs

B. For any criteria listed in Section I of this policy that is not addressed by SFTPs

C. Anytime consultation with the base hospital is indicated

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 411, **Provider Agency Medical Director**
Ref. No. 502, **Patient Destination**
Ref. No. 506, **Trauma Triage**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 515, **Air Ambulance Trauma Transport**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 802, **Emergency Medical Technician Scope of Practice**
Ref. No. 813, **Standing Field Treatment Protocols**
Ref. No. 814, **Determination/Pronouncement of Death in the Field**
Ref. No. 815, **Honoring Prehospital DNR Orders**
Ref. No. 816, **Physician at Scene**
Ref. No. 832, **Treatment/Transport of Minors**
Ref. No. 834, **Patient Refusal of Treatment or Transport**

Medical Control Guidelines

# TREATMENT PROTOCOL: GENERAL ALS *

**4.9 (Info only)**

1. Basic airway
2. Spinal immobilization prn
3. Control major bleeding prn
4. Pulse oximetry
5. Oxygen prn
6. Advanced airway prn
   - **Pediatric**: ETT 12 years of age or older or height greater than the length of the pediatric resuscitation tape
7. Cardiac monitor prn: document rhythm, attach ECG strip if dysrhythmia identified and refer to appropriate treatment protocol
8. Venous access prn; 10ml/kg fluid challenge prn, reassess at 250ml increments
   - **Pediatric**: 20ml/kg IV, reassess after initial fluid challenge
9. Perform blood glucose test prn, if blood glucose less than 60mg/dl:
   Consider oral glucose preparation if patient awake and alert
10. If indicated, **Dextrose**
    50% 50ml slow IV push
    - **Pediatric:** See Color Code Drug Doses/L.A. County Kids
      **1month-less than 2yrs of age:** Dextrose 25% 2ml/kg slow IV push
      **2yrs of age and older:** Dextrose 50**%** 1ml/kg slow IV push up to 50ml
11. If nausea/vomiting/morphine administration
    **Ondansetron**
    4mg slow IV push, IM or ODT (Orally Disintegrating Tablet)
    - **Pediatric:**
      **4yrs of age and older:** 4mg ODT one time
      Do not administer to children less than 4yrs of age
      Maximum pediatric dose 4mg
12. **CONTINUE SFTP or BASE CONTACT**
13. If blood glucose remains less than 60mg/dl:
    **Dextrose**
    50% 50ml slow IV push
    - **Pediatric:** If blood glucose remains less than 60mg/dl and symptomatic:
      See Color Code Drug Doses/L.A. County Kids
      **1month- less than 2yrs of age:** Dextrose 25% 2ml/kg slow IV push one time
      **2yrs of age and older:** Dextrose 50**%** 1ml/kg slow IV push up to 50ml one time
13. Reassess for deterioration and refer to the appropriate treatment protocol, if applicable
14. If fluid challenge is indicated, obtain base hospital order
15. If nausea and/or vomiting persists 10 minutes after initial dose:
    **Ondansetron**
    4mg slow IV push, IM or ODT
    Maximum adult dose 8mg all routes

**This protocol includes, but is not limited to, vague complaints such as:**

- **General weakness/dizziness**
- **Nausea and vomiting**
- **Palpitations without dysrhythmia**
- **Vaginal bleeding (less than 20wks gestation, no pain, normal vital signs)**
- **Malaise**
- **Near syncope**

# TREATMENT PROTOCOL: STROKE / ACUTE NEUROLOGICAL DEFICITS *

**4.10 (Info only)**

1. Basic airway
2. Spinal motion restriction prn
3. Pulse oximetry
4. Oxygen prn
5. Advanced airway prn
6. If shock, treat by Ref. No. 1246, Non-Traumatic Hypotension Treatment Protocol
7. Cardiac monitor: document rhythm and attach ECG strip if dysrhythmia identified
8. Venous access prn
9. Perform blood glucose test, if blood glucose is less than 60mg/dl:
   Consider oral glucose preparation if patient is awake and alert
   **Dextrose**
   50% 50ml slow IV push
   **Pediatric:** See Color Code Drug Doses/L.A. County Kids
   **Less than 2yrs of age:** Dextrose 25% 2ml/kg slow IV push
   **2yrs of age or older:** Dextrose 50**%** 1ml/kg slow IV push up to 50ml
   If unable to obtain venous access:
   **Glucagon**
   1mg IM
   May repeat one time in 20 mins
   **Pediatric:** See Color Code Drug Doses/L.A. County Kids
10. **CONTINUE SFTP or BASE CONTACT**
11. SFTP providers are responsible for assuring the Primary Stroke Center (PSC) or Comprehensive Stroke Center (CSC) is notified of the patient's pending arrival and contacting the base hospital to provide minimal patient information, including the results of the Modified Los Angeles Prehospital Stroke Screen (mLAPSS), Los Angeles Motor Score (LAMS), last known well date and time, and patient destination (may be done after transfer of care).

## SPECIAL CONSIDERATIONS

Document time of symptom onset

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.

Transport the patient in accordance with Ref. No. 521, Stroke Patient Destination.

# TREATMENT PROTOCOL: EMERGENCY CHILDBIRTH (MOTHER) *

**4.11 (Info only)**

1. Basic airway
2. Pulse oximetry
3. Oxygen prn
4. Advanced airway prn
5. Venous access prn
   Venous access should not take precedence over controlled delivery or emergency transport
6. Immediate base contact for abnormal presentation, multiple gestation (i.e., twins) or maternal hypotension or hypertension (blood pressure 140/90 mmHg or greater)
7. If suspected eclampsia, DO NOT delay transport for treatment
8. If the amniotic sac is intact with presenting part showing, pinch and twist the membrane to rupture
9. If delivery occurs in the field, transport the mother and newborn to a Perinatal Center with EDAP designation

| NORMAL DELIVERY | BREECH DELIVERY | PROLAPSED CORD |
|---|---|---|
| 10. Assist delivery, see Ref. No. 1262, Newborn/ Neonatal Resuscitation Treatment Protocol<br>11. Massage uterine fundus after placental delivery<br>12. If maternal hypotension, **ESTABLISH BASE CONTACT**<br>**Normal Saline**<br>10ml/kg IV at 250ml increments<br>May repeat prn | 10. Support presenting part and allow newborn to deliver<br>11. If newborn delivers, see NORMAL DELIVERY<br>12. If head does not deliver, attempt to provide airway<br>13. **ESTABLISH BASE CONTACT (ALL)**<br>14. Consultation with base physician strongly recommended | 10. Elevate the mother's hips<br>11. Check cord for pulses<br>12. If no cord pulsation, manually displace presenting fetal part off cord<br>13. **ESTABLISH BASE CONTACT (ALL)**<br>14. Consultation with base physician strongly recommended |

## TREATMENT PROTOCOL: GENERAL TRAUMA *

1. Basic airway
2. Spinal motion restriction prn: do not delay transport of hypotensive patients with penetrating torso trauma in order to apply spinal motion restriction
3. Control bleeding – with direct pressure, if unsuccessful, utilize tourniquets and/or hemostatic agents ❽
4. Pulse oximetry
5. Oxygen prn
6. Advanced airway prn
7. Apply commercial vented chest seal or 3-sided dressing to sucking chest wounds
8. If tension pneumothorax suspected perform needle thoracostomy ❶
9. Venous access en route
   Poor perfusion:
   **Normal Saline** Fluid Challenge
   250ml one time
   **Pediatric:** 20ml/kg IV
   See Color Code Drug Doses/L.A. County Kids ❼
10. Blood glucose prn
11. Cardiac monitor prn: document rhythm and attach ECG strip if dysrhythmia identified, treat by the appropriate protocol
12. Splints/dressings prn, treatment for specific extremity injuries:
    - Poor neurovascular status – realign and stabilize long bones
    - Joint injury – splint as the extremity lies
    - Midshaft femur – splint with traction
13. Consider other protocols for altered level of consciousness with possible medical origin: Ref. No. 1243, Altered Level of Consciousness; Ref. No. 1247, Overdose/Poisoning (Suspected)
14. If evisceration of organs is present, apply moist saline and non-adhering dressing, do not attempt to return organs to body cavity
15. For pain management:
    **Fentanyl** ❷❸❻
    50mcg slow IVP, titrate for pain relief, do not repeat
    50-100mcg IM/IN one time
    **Pediatric:** 1mcg/kg slow IV push, do not repeat
    1mcg/kg IM one time
    1.5mcg/kg IN one time; maximum pediatric dose 50 mcg
    **Morphine** ❷❸❻
    2-4mg slow IV push, titrated to pain relief maximum 8mg
    **Pediatric:** 0.1mg/kg slow IV push
    See Color Code Drug Doses/L.A. County Kids ❼
    Do not repeat pediatric dose, maximum pediatric dose 4mg
16. **CONTINUE SFTP or BASE CONTACT ❹❺**
17. If pain unrelieved,
    **Fentanyl** ❷❸❻
    50-100mcg slow IV push, titrate to pain relief
    May repeat every 5min, maximum total adult dose 200mcg
    50-100mcg IM/IN one time
    **Pediatric:** 1mcg/kg slow IV push (over 2 minutes)
    May repeat every 5min, maximum pediatric dose 50mcg
    1mcg/kg IM one time
    1.5mcg/kg IN one time See Color Code Drug Doses/L.A. County Kids ❼
    **Morphine** ❷❸

## TREATMENT PROTOCOL: GENERAL TRAUMA *

2-12mg slow IV push, titrate to pain relief
May repeat every 5min, maximum total adult dose 20mg

18. If continued poor perfusion:
**Normal Saline** Fluid resuscitate
IV fluid administration in 250ml increments until SBP is equal to or greater than 90mmHg or signs of improved perfusion
**Pediatric:** 20ml/kg IV
See Color Code Drug Doses/L.A. County Kids ❼

### SPECIAL CONSIDERATIONS

❶ Indications for needle thoracostomy include trauma patients with obvious chest trauma (e.g., open chest wounds, evidence of crush or flail segment) or with mechanism consistent with chest trauma who demonstrate:
a. Decreased or absent breath sounds on affected side, **and**
b. SBP less than 90mmHg (adult), less than 70mmg (child/infant), **and**
c. Two or more of the following:
i. Altered mental status
ii. Severe respiratory distress, with RR greater than 30 breaths per minute or less than 10 breaths per minute
iii. Severe hypoxia, with less than 90% oxygen saturation
iv. Cool, pale, moist skin

❷ Use with caution: in elderly; if SBP less than 100mmHg; sudden onset acute headache; suspected drug/alcohol intoxication; suspected active labor; nausea/vomiting; respiratory failure or worsening respiratory status

❸ Absolute contraindications: Altered LOC, respiratory rate less than 12 breaths/min, hypersensitivity or allergy

❹ Base hospital contact must be established for all patients who meet trauma criteria and/or guidelines; generally, this is the designated trauma center. SFTP providers may call the trauma center directly or establish base contact if transporting the patient to a non-trauma hospital.

❺ Receiving Hospital Report
Provider Code/Unit #
Sequence Number
Age/Gender
Level of distress
Mechanism of Injury/Chief Complaint
Location of injuries
Destination/ETA
<u>If patient meets trauma criteria/guidelines/judgment:</u>
Regions of the body affected
Complete vital signs/Glasgow Coma Scale (GCS)
Airway adjuncts utilized
Pertinent information (flail segment, rigid abdomen, evisceration)

❻ Ondansetron 4mg IV, IM or ODT may be administered prior to fentanyl or morphine administration to reduce potential for nausea/vomiting

## TREATMENT PROTOCOL: GENERAL TRAUMA *

❼ If the child is longer than the pediatric length-based resuscitation tape (e.g., Broselow™) and adult size, move to the Adult protocol and Adult dosing.

❽ Hemostatic agents are for use by approved providers only

# TREATMENT PROTOCOL: TRAUMATIC ARREST *

1. Consider Ref. No. 814, Determination/Pronouncement of Death in the Field
2. Rapid transport, do not delay transport for treatment
3. Basic airway
4. CPR
5. Cardiac monitor: document rhythm and attach ECG strip
6. If initial rhythm is V-fib or pulseless V-tach:
   Defibrillate
   Biphasic at 120-200J (typically), Monophasic at 360J, refer to manufacturer's guidelines
7. Spinal motion restriction prn. If life threatening penetrating torso trauma with hypotension, **DO NOT** delay transport for spinal motion restriction.
8. Control bleeding prn
9. If unable to maintain basic airway, proceed to advanced airway
   **Pediatric:**
   ET tube placement approved for patients who are:
   12yrs of age and older **or** height greater than the length of the pediatric resuscitation tape;
   King airway approved as a rescue airway for patients who are:
   12yrs of age and older **and** 4 feet tall
10. If chest trauma and suspected pneumothorax, perform bilateral needle thoracostomy.
11. Venous access en route. Consider immediate placement of IO if any difficulty or delay in IV access
12. Fluid resuscitate
    **Normal Saline** Fluid Resuscitate
    Wide open IV fluid administration through large lumen tubing, preferably using two sites
    **Pediatric:** 20ml/kg IV
    See Color Code Drug Doses/L.A. County Kids ❶
13. CPR for 2min (5 cycles) prior to pulse check and additional defibrillations
14. **CONTINUE SFTP or BASE CONTACT**

## SPECIAL CONSIDERATIONS

❶ If the child is longer than the pediatric length-based resuscitation tape (e.g., Broselow™) and adult size, move to the Adult protocol and Adult dosing.

# MEDICAL CONTROL GUIDELINE: NEEDLE THORACOSTOMY

**4.14 (Info only)**

**PRINCIPLES:**

1. Needle thoracostomy is an uncommon procedure that may provide life-saving treatment of a tension pneumothorax during prehospital care and transport.

2. Risk of tension pneumothorax increases significantly after initiation of positive pressure ventilation (e.g., bag-mask ventilation, placement of advanced airway), which can convert a simple pneumothorax into a tension pneumothorax.

3. Needle thoracostomy should be performed prior to base contact on patients in PEA cardiac arrest with multisystem blunt trauma or penetrating trauma which includes the thorax and abdomen or who have evidence of chest trauma with profound shock and signs of tension pneumothorax, as defined in Guidelines 2.1 below.

4. PEA cardiac arrest maybe due to tension pneumothorax after positive pressure ventilation.

5. Current guidelines recommend needle thoracostomy at the 2$^{nd}$ intercostal space in the mid-clavicular line, inserted just above the upper border of the 3$^{rd}$ rib. An alternate site is the 4$^{th}$ or 5$^{th}$ intercostal space at the anterior axillary line.

6. ALS and Paramedic Assessment Units should carry 8cm (3.0 – 3.5 inches) commercial needle decompression for the performance of emergency needle thoracostomy.

7. The procedure for needle thoracostomy in pediatric patient is unchanged from that of adults. It is expected that a shorter distance will need to be traversed to enter the pleural space in children due to the thinner chest wall.

8. Maintenance of skills requires regular in-service training on recognition and treatment of tension pneumothorax. It is strongly recommended that this training be completed in a simulation environment, rather than through slide-based or didactic learning.

**GUIDELINES:**

1. Assess patient with traumatic injuries as per Reference No. 1275 or 1277.

2. Consider tension pneumothorax in the following patients.

   2.1. Trauma patients with obvious chest trauma (e.g., open chest wounds, evidence of crush or flail segment) or with mechanism consistent with chest trauma who demonstrate:

      a. Decreased or absent breath sounds on affected side , **and**

      b. SBP less than 90mmHg (adult), less than 70mmHg (child and infant), **and**

      c. Two or more of the following:

i. Altered mental status
ii. Severe respiratory distress, with RR greater than 30 breaths per minute or less than 10 breaths per minute
iii. Severe hypoxia, with less than 90% oxygen saturation
iv. Cool, pale, moist skin

2.2. Traumatic full arrest with PEA rhythm (bilateral needle thoracostomy should be performed if evidence of chest wall trauma)

2.3. Trauma patients requiring positive-pressure ventilation who develop hypoxia or severe hypotension (SBP less than 90mmHg), without alternate cause, after initiation of positive pressure ventilation

2.4. PEA cardiac arrest patient after positive pressure ventilation

3. Immediately place all patients with suspected pneumothorax on high flow oxygen by non-rebreather mask.

4. If the patient is awake and alert, explain medical condition and rationale for the procedure to the patient.

5. Palpate the chest wall for the 2nd and 3rd rib approximately 2 finger breaths below the clavicle, at the mid-clavicular line. If the entire extent of the clavicle is not easily assessed, the midclavicular line may be approximated as just medial to the midpoint between the sternal notch and the shoulder.

6. If unable to identify landmarks in the anterior chest, or if obstructed due to presence of wounds, body armor, or other obstruction, palpate the lateral chest wall for the 4th and 5th rib at the anterior axillary line.

7. Prepare skin of chest with alcohol or chlorhexidine prior to skin puncture.

8. Insert the needle-catheter perpendicular to chest just above the 3rd rib at the mid-clavicular line or just above the 5th rib anterior axillary line.

9. Attach a syringe to the thoracostomy needle during procedure, if possible. Advance needle perpendicular to the chest wall while withdrawing on syringe until air is easily aspirated into the syringe (confirming penetration of lung pleura). Advance needle an additional 1 centimeter, then over the needle advance catheter further before withdrawing needle and disconnecting the syringe.

10. Secure catheter to skin with tape or commercial device, if available. Do not place a 1-way valve on the catheter hub.

11. If the patient has an open or sucking chest wound, cover the wound with a commercially available vented chest seal or vented (3-sided) occlusive dressing. Placement of a vented dressing can prevent conversion of an open pneumothorax to a tension pneumothorax. However, tension pneumothorax may still develop in the presence of a vented dressing and should be treated with needle thoracostomy. Furthermore, needle thoracostomy in a patient with evidence of tension pneumothorax should not be delayed for placement of dressing.

12. If a patient does not improve after needle thoracostomy, or improves but later decompensates, and there is concern for catheter dislodgement or obstruction, needle thoracostomy may be repeated on the same side or at an alternate location.