



AGENDA

**ICEMA
MEDICAL ADVISORY COMMITTEE
Virtual Only
April 25, 2024**

1300

Purpose: Information Sharing
 Meeting Facilitator: Stephen Patterson
 Timekeeper: Michelle Hatfield
 Record Keeper: Michelle Hatfield

AGENDA ITEM		PERSON(S)	DISCUSSION/ACTION
I.	Welcome/Introductions	Stephen Patterson	
II.	Approval of Minutes	All	Discussion
III.	Discussion/Action Items		
	A. Standing EMS System Updates		
	1. Trauma Program 2. STEMI Program 3. Stroke Program 4. Pediatric AC	1. Loreen Gutierrez 2. Loreen Gutierrez 3. Loreen Gutierrez 4. Loreen Guterrez	1. Discussion 2. Discussion 3. Discussion 4. Discussion
	B. Prehospital Ultrasound	Brian Strain	Discussion/Action
	C. Pediatric I-Gel	Brian Strain	Discussion/Action
	D. Mono/Inyo County Updates	Lisa Davis/Jessica Wagner	Discussion
	E. MBA CCP program	Craig Bell	Discussion
	F. EMSBUP	Michelle Hatfield/Reza Vaezazizi	Discussion
	G. California Resuscitation Outcomes Consortium (CAL-ROC) Trial update.	Reza Vaezazizi	Discussion
	H. Protocol Review 3070 Ambulance Exemption 6120 Special Event and Mass Gathering Event 7010 Standard Drug and Equipment List- BLS/LALS/ALS 8010 Interfacility Transfer Guidelines 10050 Opioid Withdrawal 11010 Medication- Standard Orders 11020 Procedures-Standard Orders	Michelle Hatfield /Loreen Gutierrez	Discussion/Action

	12010 Patient Care Guidelines 14090 Trauma-Adult (15 years of age and older) 14180 Trauma-Pediatric (Less than 15 years of age) 14280 Sepsis Administrative Changes 3030 Adoption of Policies and Protocols 4090 Emergency Medical Dispatch Center Requirements 6020 Responsibility for Patient Management 7020 Standard Drug and equipment list -EMS Aircraft 8010 Interfacility Guidelines 14050 Cardiac Arrest- Adult 14070 Burns-Adult (15 years of age and older) 14080 Stroke Treatment-Adult 14110 Behavioral Emergencies 14140 Allergic Reactions- Pediatric (Less than 15 years of age) 14210 Obstetrical Emergencies 14230 Shock (Non-Traumatic)		
IV.	Public Comment Period	All	Discussion
V.	Future Agenda Items	All	Discussion
VI.	Next Meeting Date: June 25, 2024		Discussion
VII.	Adjournment		Action
VIII.	Closed Session Case Review -N/A	MAC Committee	Discussion/Action
	A. Loop Closure Cases		
	B. Case Reviews		



MINUTES

ICEMA MEDICAL ADVISORY COMMITTEE

February 29, 2024

1300

AGENDA ITEM		DISCUSSION/FOLLOW UP	RESPONSIBLE PERSON(S)
I.	Welcome/Introductions	Meeting was called to order at 1300	Stephen Patterson
II.	Approval of Minutes	<p>The December 14, 2023, minutes were approved.</p> <p>Motion to approve. MSC: Brian Savino/Amanda Ward APPROVED AYES: Jessica Wagner, Leslie Parham, Susie Moss, Amanda Ward, Craig Bell, Lisa Davis, Steven Patterson, Troy Pennington, Seth Dukes, Kevin Dearden, Debbie Bervel, Sharon Brown, Michael Neeki, Alp Arkun, Brian Savino</p>	
III.	Discussion/Action Items		
	A. Standing EMS System Updates		
	<ol style="list-style-type: none"> 1. Trauma Program 2. STEMI Program 3. Stroke Program 4. Pediatric AC 	<ol style="list-style-type: none"> 1. TAC reviewed and endorsed push dose epinephrine for shock in trauma. Working on Trauma arrest protocol. Toradol was endorsed with limited use. Versed for TBI is still being reviewed. 2. STEMI CARES data is due this week. Reviewed STEMI regulations, no policy update needed. 3. State STEMI/Stroke Summit will not be held this year. Reviewed stroke regulation, no policy update needed. 4. PAC reviewed and endorsed pediatric i-gel. Committee will assist with education for pediatric AMA, Brue and 	Loreen Gutierrez

MINUTES - MEDICAL ADVISORY COMMITTEE

February 29, 2024

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		i-gel. Working on Pediatric Tachycardia policy.	
	B. Prehospital Ultrasound	Ultrasound policy was presented. LOSOP will be submitted for state approval in June.	Brian Strain
	C. Pediatric i-gel	<p>Policy updates were presented. LOSOP application will be submitted to the state when complete and implemented next year.</p> <p>Motion to approve. MSC: Amanda Ward/Leslie Parham APPROVED AYES: Jessica Wagner, Leslie Parham, Susie Moss, Amanda Ward, Craig Bell, Lisa Davis, Steven Patterson, Troy Pennington, Seth Dukes, Kevin Dearden, Debbie Bavel, Sharon Brown, Michael Neeki, Alp Arkun, Brian Savino</p>	Brian Strain
	D. Inyo/ Mono County Updates	Staffing is good, no concerns currently.	Lisa Davis
	E. MBA CCP Program	Finished clinical rotations. Has 14 transports completed with RN supervision; no issues identified.	Craig Bell
	F. EMSBUP	Buprenorphine was changed to Suboxone on the Opioid Withdrawal policy due to logistical issues with purchasing and storing medication. Project is moving forward, and more agency participation is expected.	Michelle Hatfield
	G. TXA for Postpartum Hemorrhage	<p>TXA for postpartum hemorrhage was presented. Motion to add postpartum hemorrhage as indication for TXA.</p> <p>APPROVED AYES: Jessica Wagner, Leslie Parham, Susie Moss, Amanda Ward, Craig Bell, Lisa Davis, Steven Patterson, Troy Pennington, Seth Dukes, Kevin Dearden, Debbie Bavel, Sharon Brown, Michael Neeki, Alp Arkun, Brian Savino</p>	Chris Hummel
	H. Sepsis Protocol	Sepsis protocol was presented. Education will be worked on and returned to MAC.	Patty Eickholt

	I. PLN MAC Endorsement	Shawn Reynolds was endorsed for EMS Nurse representative position. Motion to approve. MSC: Amanda Ward/Brian Savino APPROVED AYES: Jessica Wagner, Leslie Parham, Susie Moss, Amanda Ward, Craig Bell, Lisa Davis, Steven Patterson, Troy Pennington, Seth Dukes, Kevin Dearden, Debbie Bervel, Sharon Brown, Michael Neeki, Alp Arkun, Brian Savino	Loreen Gutierrez
IV	Public Comment Period	LOSOP presentation will be at EMS Commission in July.	All
V	Future Agenda Items	Dr. Downes- Role of Base Hospital Dr. Dukes- Toradol	All
VI.	Next Meeting Date	April 25, 2024	
VII.	Adjournment	Meeting was adjourned at 1435	
VIII.	Closed Session A. Case Reviews B. Loop Closure Cases	None	

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Attendees:

NAME	MAC POSITION	EMS AGENCY STAFF	POSITION
<input checked="" type="checkbox"/> P. Brian Savino - LLUMC <input type="checkbox"/> Brandon Woodward - ARMC	Trauma Hospital Physicians (2)	<input checked="" type="checkbox"/> Reza Vaezazizi, MD	Medical Director
<input type="checkbox"/> Melanie Randall - LLUMC	Pediatric Critical Care Physician	<input type="checkbox"/> Demis Cano	EMS Specialist
<input type="checkbox"/> Phong Nguyen - RDCH <input type="checkbox"/> VACANT	Non-Trauma Base Physicians (2)	<input checked="" type="checkbox"/> Loreen Gutierrez	Specialty Care Coordinator
<input checked="" type="checkbox"/> Alp Arkun- Kaiser	Non-Base Hospital Physician	<input checked="" type="checkbox"/> Jeff Copeland	Sr. EMS Specialist
<input checked="" type="checkbox"/> Michael Neeki - Rialto FD	Public Transport Medical Director	<input checked="" type="checkbox"/> Michelle Hatfield	Sr. EMS Specialist
<input checked="" type="checkbox"/> Seth Dukes - AMR	Private Transport Medical Director		
<input type="checkbox"/> Kevin Parkes - Ontario FD	Fire Department Medical Director		
<input checked="" type="checkbox"/> Shawn Reynolds	EMS Nurses Representative		
<input checked="" type="checkbox"/> Leslie Parham - Chino Valley FD	EMS Officers Representative		
<input checked="" type="checkbox"/> Kevin Dearden - Rialto FD	Public Transport Medical Representative (Paramedic/RN)		
<input checked="" type="checkbox"/> Susie Moss - AMR	Private Transport Medical Representative (Paramedic/RN)		
<input type="checkbox"/> Lance Brown - LLUMC	Specialty Center Medical Director		
<input checked="" type="checkbox"/> Sharon Brown - ARMC	Specialty Center Coordinator		
<input checked="" type="checkbox"/> Troy Pennington - Mercy Air	Private Air Transport Medical Director		
<input checked="" type="checkbox"/> Stephen Patterson - Sheriff's Air Rescue	Public Air Transport Medical Director		
<input checked="" type="checkbox"/> Debbie Bervel	PSAP Medical Director		
<input checked="" type="checkbox"/> Lisa Davis - Sierra Lifeflight	Inyo County Representative		

<input checked="" type="checkbox"/> Jessica Wagner	Mono County Representative
<input type="checkbox"/> Tonya Henkes	Trauma Program Manager Representative
<input checked="" type="checkbox"/> Amanda Ward - Crafton Hills	EMT-P Training Program Representative
<input type="checkbox"/> Kenneth Fox	Public Safety Field Paramedic
<input checked="" type="checkbox"/> Craig Bell	Private Transport Field Paramedic
<input type="checkbox"/> VACANT	ICEMA Medical Director Appointee



INLAND COUNTIES EMERGENCY MEDICAL AGENCY POLICY AND PROTOCOL MANUAL

Reference No. 3070
Effective Date: 05/01/24
Supersedes: N/A
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AMBULANCE EXEMPTION POLICY

I. **PURPOSE**

To define the process for ambulance exemption approval and response time compliance.

II. **POLICY/PROCEDURE**

A. **RESPONSE TIME MANAGEMENT**

Ambulance dispatch CAD data and the FirstWatch On-line Compliance Utility (OCU) program shall be used to calculate response times. Until such time as the OCU provides performance data directly to ICEMA, ambulance providers shall submit a monthly report to ICEMA in a manner specified by the ICEMA Administrator in accordance with contractual obligation and this policy.

Ambulance Response Time measures are designed to provide the appropriate prehospital clinical care in a time frame that is appropriate to the patient situation and set forth in contract with the ambulance contractor. Response Time shall be measured in minutes and integer (whole) seconds and compliance determined on a fractile percentage basis in accordance with the ambulance contract.

Ambulance providers shall commit to employ whatever level of resources is necessary to achieve the contractual response time requirements for ambulance service requests located within each EOA. Once the ambulance provider has determined the level of resources necessary to achieve the contractual Response Time requirements for each EOA, but in no case exceeding thirty (30) days from the effective date of this policy, the ambulance provider shall provide an ongoing current deployment plan for review and approval by ICEMA.

III. **CALCULATION OF RESPONSE TIMES**

A. **START OF RESPONSE TIMES:**

1. Calculation of Response Time shall begin when the following information, is transmitted to the assigned ambulance provider's communications center:
 - a. Exact address or descriptive location such as building or landmark, intersection, or freeway / highway location.
 - b. For dispatching agencies that are designated secondary PSAPs, the response time calculation will start after pre-dispatch questioning and/or caller instruction is completed (including approved EMD steps if used), and the call is in queue to send to the responding unit. For agencies that are not designated as a secondary PSAP, the response time calculation will start when the call is received from the secondary PSAP."
 - c. If an ambulance is not available at the time that the ambulance provider dispatch center receives the call, the dispatcher will make a note in the automated dispatch system record that no ambulance was available.

2. Each incident is a separate response: Each incident will be counted as a single response regardless of the number of units that are utilized.
3. The Response Time of the ambulance provider's first arriving emergency ambulance will be used to compute ambulance Response Time for that incident.

B. STOP OF RESPONSE TIMES:

- a. The time stamp in provider's CAD that indicates that the responding crew has advised, either electronically or verbally via radio or telephone communications, that they have arrived at the assigned address/location.
- b. If the responding crew arrives on the scene of the incident but fails to transmit this information to providers dispatch, a geofence distance from the incident address within 100 meters where 0.00 m.p.h. would be recognized as ON SCENE or policy when crew pushes "On Scene" which is defined as fully stopped (wheels not in motion or 0.00 m.p.h.) at the location where it shall be parked during the incident shall be used.
- c. In the case of encumbered/restricted access to the patient, the term "On Scene" shall be understood to mean the time the emergency ambulance arrives at the restricted access point, e.g., staging area at the gate of a closed gated area, or rendezvous point to be escorted to the patient by another individual.
- d. At the time that dispatch notifies the assigned ambulance to cancel its response.

C. RESPONSE TIME CORRECTIONS AND EXEMPTIONS

1. Ambulance provider may request Response Time Correction(s) of arrival on scene time(s). In incidents when the assigned ambulance crew fails to report their arrival on scene, the time of the next communication to dispatch by crew or other on scene personnel that indicates that the ambulance has already arrived at the scene shall be used as the arrival on scene time. Alternatively, on scene time may be validated by CAD timestamp and Global Positioning System (GPS) based on Automatic Vehicle Location (AVL) technology playback.
 - a. In some cases, certain specified responses will be corrected by ICEMA and thereby deemed as compliant responses to be included in Response Time compliance calculations. These Response Time Correction(s) will be for good cause only, as reasonably determined by ICEMA. The burden of proof that there is good cause for the correction shall rest with the ambulance provider.
 - b. Ambulance provider shall file a request for each desired Response Time Correction or Exemption monthly with ICEMA via the online compliance utility (OCU) within 15 business days from the end of the compliance period or in a written report until OCU is established. Such request shall list the date, the time, and the specific circumstances causing the delayed response. ICEMA contract monitor personnel shall grant or deny corrections to performance standards and shall advise the ambulance provider utilizing the OCU.
 - c. Until such time as the OCU provides performance data directly to ICEMA, the Ambulance provider shall submit these requests in a report to ICEMA in a manner specified by ICEMA contract monitor personnel in accordance with the

standard data formatting outlined in the ICEMA Response Time Submissions Guideline (8/30/2013).

Response time exemptions include, and are limited to:

See Attachment A (ICEMA Exemption List)

D. RESPONSE TIME EXEMPTIONS

1. Ambulance provider shall maintain sufficient resources to achieve the specified Response Time Standards. Ambulance provider shall be responsible for prudent and reasonable planning and action related to system deployment as set forth in the provider's contract. In the monthly calculation of Ambulance provider's performance to determine compliance with Response Time Standards, every request for ambulance service from the primary or secondary PSAP shall be included. Exemptions may be made on specified responses which will be excluded from Response Time compliance calculations and liquidated damages. It is the Ambulance provider's responsibility to demonstrate good cause for the Exemption. Ambulance provider may request that a response be excluded from the calculation of Response Time Standards, if that call meets the criteria defined below. If ICEMA contract monitor personnel grants an Exemption, the call will be neither late nor compliant and the call will be removed from the compliance calculation. Ambulance provider shall file a request for each desired Response Time Exemption monthly with ICEMA via the OCU within 15 business days of the end of the previous month. Such request shall list the specific Exemption Code from attachment A along with the date, time, and specific circumstances causing the delayed response. ICEMA contract monitor personnel shall grant or deny Exemptions to performance standards and shall so advise the Ambulance provider. ICEMA contract monitor personnel will respond to Exemption requests utilizing the OCU. Until such time as the OCU provides performance data directly to ICEMA, the Ambulance provider shall submit these requests in a report to ICEMA in a manner specified by ICEMA contract monitor personnel.

E. RESPONSE TIME REPORTING REQUIREMENTS

1. Response Time performance reporting requirements and documentation of incident time shall include, but is not limited to:
 - a. Time call received by ambulance dispatch center from a Secondary PSAP. In the case where the secondary PSAP is dispatching its own ambulance, the time when the incident is sent to queue for dispatching.
 - b. Time ambulance crew assigned.
 - c. Time enroute to scene
 - d. Arrival on scene time or canceled enroute.
 - e. Total on scene time.
 - f. Time canceled on scene or enroute to transport destination.
 - g. Total time to transport to destination:
 - h. Arrival time at the destination.

- i. Time available at the destination (i.e., return to in service status).
2. Ambulance provider must synchronize its clocks with the Universal Time Coordinated (UTC) according to Pacific Standard Time PST. UTC is the basis for civil time. This 24-hour time standard is kept using highly precise atomic clocks combined with the earth's rotation.

F. SUPPORTING DOCUMENTATION

1. Requests for Exemptions should include documentation to support the request.

This report shall include but is not limited to:

- Run number with response date and time
- Unit number
- Units on duty across all of provider's EOA's at time of call
- Number of available units across all EOA's (Level number) at time of call
- Deployment Plan
- Busy units
- Exemption code / reason and note

Requests for Ambulance Patient Offload Delay (APOD) should also include:

- Units on bed delay
- Unit numbers
- Unit destination
- Time call was received
- Time arrived at destination
- Transfer of care time
- Time the unit is back in service
- Number of deployed units
- Level of service (ALS or BLS)
- Deployment plan with baseline percentage of fully staffed units
- Shift start
- Shift end

ICEMA may request the following verification tools:

- CAD snapshot
- Posting locations
- Map or description of route taken by responding unit

III. DEFINITIONS

Ambulance Patient Offload Delay (APOD): The occurrence of a patient remaining on the ambulance gurney and/or the emergency department has not assumed responsibility for patient care beyond the local emergency medical system authority approved ambulance patient offload time.

Exemption: Any response or group of responses that should be exempt from response time standards due to unusual circumstances beyond a provider's reasonable control.

Response Time Performance Requirement: The overall response time performance requirement for services under contractual agreement is intended to ensure that the provider responds to each incident with an appropriate resource in accordance with ICEMA policies and procedures. The standards set forth herein establish the level of response time performance required by provider for calls within the designated EOA.

Response Time Performance Calculation: Response times are measured and calculated on a fractile basis using CAD data, where available.

Computer Aided Dispatch (CAD): A combination of hardware and software that provides data entry, makes resource recommendations, and notifies and tracks those resources before, during, and after emergency 911 calls, preserving records of those emergency 911 calls and status changes for later analysis

CAD to CAD: A dedicated electronic connection between two or more CAD systems that provides a reciprocal flow of specified data elements that can populate designated fields in each of the connected CAD systems.

Automatic Vehicle Locating (AVL): A Global Positioning System based tool used for determining the precise geographic location of a vehicle or other resource, and transmitting this information to dispatchers, supervisors and/or into a CAD or other tracking/recording system.

Automatic Vehicle Locating (AVL) Playback: A software program that uses historic AVL records from tracked vehicles to plot a path in a mapping environment showing the routes and speed that the vehicle traveled during a specific time.

Recognition Time: Time that an incident is recognized as a reportable emergency.

Date Incident Report: The date the call is received by the Public Service Answering Point or other designated entity.

Time Incident Reported- Primary PSAP: Time call is first received by the Primary Public Safety answering Point.

Time Dispatch Notified- Secondary PSAP: Time call is first received by the Secondary Public Safety answering Point.

Call in dispatch queue: The point in time where pre-dispatch questioning/EMD is completed, and the call is ready to be dispatched to a response unit.

Date Unit Notified: Date response unit is notified by EMS dispatch.

Time Unit Notified: Time response unit is notified by the EMS dispatch.

Time Unit Responding: Time that the response unit begins physical motion, i.e., wheels begin to turn.

Time Arrival at scene/Staging: Time EMS unit stops physical motion at scene or staging area, i.e., wheels stop turning.

Time Unit Left Scene: Time when the response unit begins physical motion from scene, i.e., when the wheels begin to turn.

Time Arrival at Destination: Time when patient arrives at destination or transfer point, i.e., wheels stop turning.

Time of Receipt of Patient at receiving Facility: Time when receiving facility or transfer agency accepts transfer and care of the patient.

Time back in Service- Not Available: Time response unit back in service and not available for response.

Time back in Service- Available: Time response unit back in service and available for response.

Time Unit Canceled Enroute: Time provider agency dispatch is notified that call is canceled.

Time Unit Upgraded Code 3: Time when provider agency dispatch is notified that response is upgraded to code 3 from Code 2.

Time Unit Downgraded Code 2: Time when provider agency dispatch is notified that response is downgraded to code 2 from Code 3.

ICEMA Response Time Submissions Guideline (8/30/2013) File Format:

BUCode
ResponseDate
MapBook
Response_Area
ServiceType
Unit_Number
Run_Number
ResponseTimecode
OperatingArea
OnsetDateTime
RecognitionTime
PrimaryPSAP
DispNtfScnd
Time_Call_Received
Time_Assigned
Time_Enroute
Time_At_Scene
ArrivePatient
Time_Depart_Scene
Time_Arrived_Destination
RecFac
BackInService
Time_Call_Cleared
Time_Call_Canceled
Time_Upgrade
Time_Downgrade
Exemption_Reason
Exemption_Note
Longitude
Latitude

ATTACHMENT A

ICEMA Exemption Criteria List Performance Based Contracts/ MOUs Effective 2022

To be used for flagging purposes- these are not automatic exemptions

THE EXEMPTION REQUEST MUST BE THE SOLE REASON FOR THE LATE RESPONSE

Exemption Code	Type	Definition	Minimum Supporting Information (All exemptions require reporting of point of origin of responding unit.)
13	Incorrect Information	Any significant change(s) in response location initiated by the caller or dispatch agency, which directly affects the ability of the unit to meet the response requirement.	Time of notification of location change and notifying agency. CAD, recording, Automatic Vehicle Location (AVL) if available.
14	Mechanical Failure	Unit unable to respond due to non-preventable mechanical failure.	Critical failure report.
16	Off Road Incidents	Extended response time area with no road access to patient involved in off road incident.	Latitude/ Longitude or Thomas Brother map grid, CAD, voice recording, AVL, if available.
17	Hospital Bed Delay	Delays of greater than 25 minutes that are the result of a prolonged drop-off of a previous transport (e.g., bed delay), outside the control of the provider. This time does not include time needed by provider to get ready to respond. Requires more than one unit be on bed delay at time of call and system level depletion due to bed delay must be at least 20%.	Name of facilities and number of units at each facility experiencing prolonged drop off. System level at time of call. Thomas Brother's map grid location of responding unit. Screen shot, CAD, voice recording, AVL, if available.
19	Road Closure/ Construction	Unavoidable delays caused by unscheduled road construction or closure. Only one (1) exemption can be requested for each construction/closure location/event unless no other route is available.	Name of road and nearest cross street. Latitude/ Longitude or Thomas Brother map grid, CAD, voice recording, AVL, if available.
20	Second Unit or Subsequent	More than one unit to the same location.	Incident number of first unit on-scene. CAD tape.
21	Traffic	Any significant, unscheduled, unanticipated delay caused by traffic where a sufficient alternate route was not available (e.g., auto accident on a freeway, major prolonged gridlock, train).	Name of road and nearest cross street. Latitude/ Longitude or Thomas Brother map grid, CAD, voice recording, AVL, if available.
24	Weather	Any unusual weather conditions (e.g., major flooding, dense fog, snow accumulation, icy conditions, etc.) in the area affecting transport, which could impair or create significant unsafe driving conditions.	Type of weather, name of road and nearest cross street. Latitude/ Longitude or Thomas Brother map grid, CAD, Voice recording, AVL, if available.
99	Other	Any other mitigating circumstances falling outside the list of exemptions that may impede the response of a unit. The reason must be explained in exemption report. This exemption is to be used only when the reason is outside of the control of the provider; accident (provider not at fault), disaster, MCI, upgraded, downgraded, etc.	Documentation sufficient to justify request. Latitude/ Longitude or Thomas Brother map grid, CAD, voice recording, AVL, if available.

Rural Wilderness EOAs Only

ATTACHMENT A

15	Mutual Aid	Rural/Wilderness Areas Only. Mutual aid provided to outside jurisdiction or mutual aid requested within jurisdiction of provider, if mutual aid exemptions are specifically referenced in Performance Based Contract (PBC) or MOU.	Incident number and unit number for units on other calls. CAD, voice recording, AVL, if available.
23	Unavailable Ambulance	Rural/ wilderness areas only. Delayed response time due to ambulance unavailability due to response to other 9-1-1 calls or having to respond from outside of the operating area due to patient transport.	Incident number and unit number for units on other calls. CAD, voice recording, AVL, if available.



INLAND COUNTIES EMERGENCY MEDICAL AGENCY POLICY AND PROTOCOL MANUAL

Reference No. 6120
Effective Date: 05/01/24
Supersedes: N/A
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SPECIAL EVENT AND MASS GATHERING EVENT

I. PURPOSE

To establish a policy and procedure for approval of special event providers within the ICEMA region.

II. DEFINITIONS

Special Event/Mass Gathering includes all types of planned public and private gatherings including carnivals, community celebrations, off-road vehicle races, outdoor festivals, sporting events, parades, fairs, animal races, religious festivals, revival meetings, electronic dance music (EDM), and similar public gatherings. Special Events/Mass Gatherings are categorized as follows:

1. Minor Event

- a. Class I – Anticipated attendance of less than or up to one thousand (1,000) persons per day such as a community celebration, religious festivals, revivals, meetings, and similar public gatherings.
- b. Class II – Intensive sporting events, such as off-road vehicle races or rodeos and music events with anticipated attendance of less than or up to five hundred (500) persons per day. Included in this class are any such events that are advertised by a means of social and/or mass media (i.e., radio, television, newspaper, Internet, phone trees, fliers, etc.) and when limiting attendees to five hundred (500) persons per day is available and is strictly enforced.

2. Major Event

- a. Class I – Anticipated attendance of over one thousand (1,000) persons per day.
- b. Class II – Intensive sporting events, such as off-road races or rodeos, etc., or music events with anticipated attendance of over five hundred (500) persons per day. Included in this class are any such events that are advertised by a means of social and/or mass media (i.e., radio, television, newspaper, Internet, phone trees, fliers, etc.) including where a means of limiting attendees is not available.

Medical Action Plan (MAP) is a plan for the delivery of medical care and services to the public, attendees, participants, staff, or others at, near, during or immediately before or after a special event/mass gathering. The MAP shall be consistent and compliant with all applicable ICEMA regulations, guidelines, policies, and protocols.

III. POLICY

- Only special event providers approved through ICEMA will be permitted to work special events throughout San Bernardino County.
- All providers working special events must be accredited and licensed through ICEMA.
- Special event providers must have all medical equipment and supplies certified by ICEMA.
 - Medical equipment and supplies must be equivalent to the level of service being provided (BLS and/or ALS).

- Providers must submit a medical action plan (MAP) that meets the minimum standards of care for the size and type of event, as defined in this policy, for review and approval by ICEMA.
- The MAP must include:
 - Clearly defined goals and objectives
 - Staff titles, roles, and responsibilities
 - Background specifics of event (encounter data of previous or similar events)
 - Flow chart/diagram of anticipated operational process
 - List of all event staff providing medical services and their specific license/certification including state and local affiliation(s)
 - Disaster and Multiple Casualty Planning to include Incident Command System (ICS) Incident Action Plan (IAP) guidelines and forms ICS 200, 202, 203, 204, 205, 206, (208 optional)
 - Plan for oversight including a Continuous Quality Improvement (CQI) plan
 - Number and type of anticipated injuries in which emergency medical care is expected or required
 - Proximity to and name of closest hospitals
 - Plans for provision of onsite medical care and access to EMS
 - Method of interface with EMS including number of ambulances on standby at the event
 - Documentation that ambulances on standby at the event are from an ICEMA-permitted special event provider and that ambulances meet ICEMA minimum equipment and staffing requirements for BLS or ALS ambulances, depending on level of service being provided, in the ICEMA region.
 - Plans to collect pertinent injury data, number of patients treated, and reporting process.
 - Provisions for patient care documentation and submission to ICEMA

NOTE: This policy does not replace any and is in addition to applicable federal, state, county or city requirements, applications, or permits necessary to conduct the special event.

IV. PROCEDURE

It is the responsibility of the organizer/promoter to submit a Special Events Provider application and MAP to ICEMA for approval. In preparing the MAP, event organizers must:

- Identify a liaison from the venue to provide information from the venue that will assist medical responders with gathering accurate patient information and treat a patient who transitioned from the venue to EMS care.
- Consult with local EMS first responder and medical transport entities during the planning phase to ensure information sharing prior to the event.
- Base any MAP on predictive crowd attendance, size, and other considerations such as the history of substance use (legal or illegal) at previous or similar events.
- Require event medical personnel to comply with existing statues and regulations concerning record keeping and/or reporting during all events.

- An independent on-site physician, PA or registered nurse may be required for supervision and observation of medical care provided by non-EMS event medical personnel.
- Application packet must be submitted at least ninety (90) days prior to the date of the event/gathering.
- ICEMA will review application within 30 days and either approved or returned to the organizer/promoter for additional information or changes.
- The organizer/promoter will return application within thirty (30) days of the event with any requested changes and/or additions.
- All special event providers must notify ICEMA 7 days prior to the event for final review.
- Submission of a full report to ICEMA indicating the number and types of patients encountered and patient care reports for all contacts for medical care within 30 days of the end of the event is required

NOTE: Final authority for approval of the MAP rests with the ICEMA EMS Administrator and/or Medical Director.

IV. FEES

It is the responsibility of the organizer/promoter to submit applicable fees to ICEMA at the time of application per Resolution of the Board of Supervisors

V. REFERENCES

<u>Number</u>	<u>NAME</u>
5020	Minimum requirements for transfer of patient care
5030	Requirements for patient care reports
6010	Physician on scene
6020	Responsibility for patient management
6080	Patient refusal of care-adult
8080R1	Medical response to a multi casualty incident



**INLAND COUNTIES
EMERGENCY MEDICAL AGENCY
POLICY AND PROTOCOL MANUAL**

Reference No. 7010
Effective Date: 05/01/24
Supersedes: 04/01/23
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STANDARD DRUG AND EQUIPMENT LIST - BLS/LALS/ALS

Each ambulance and first responder unit shall be equipped with the following functional equipment and supplies. **This list represents mandatory items with minimum quantities** excluding narcotics, which must be kept within the range indicated. All expiration dates must be current. All packaging of drugs or equipment must be intact. No open products or torn packaging may be used.

All ALS (transport and non-transport) and BLS transport vehicles shall be inspected annually.

MEDICATIONS/SOLUTIONS

Exchanged Medications/Solutions	BLS	LALS	ALS Non-Transport	ALS Transport
Acetaminophen (Tylenol) 1 gm IV			1	1
Adenosine (Adenocard) 6 mg			1	1
Adenosine (Adenocard) 12 mg			2	2
Albuterol Aerosolized Solution (Proventil) - unit dose 2.5 mg		4 doses	4 doses	4 doses
Aspirin, chewable - 81 mg tablet		2	1 bottle	1 bottle
Atropine 1 mg preload			2	2
Calcium Chloride 1 gm preload			1	1
Dextrose 10% in 250 ml Water (D10W)		2	2	2
Diphenhydramine (Benadryl) 50 mg		2	1	1
Epinephrine 1 mg/ml 1 mg		2	2	2
Epinephrine 0.1 mg/ml 1 mg preload			4	4
Glucagon 1 mg		1	1	1
Glucose paste	1 tube	1 tube	1 tube	1 tube
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5 mg			4	4
Irrigating Saline and/or Sterile Water (1000 cc)	2	1	1	2
Lidocaine 2% 100 mg			3	3
Magnesium Sulfate 10 gm			1	1
Naloxone (Narcan) 2 mg preload	2	2	2	2
Nitroglycerine (NTG) - Spray 0.4 mg metered dose and/or tablets (tablets to be discarded 90 days after opening)		2	1	2
Nitroglycerine Paste 2% - 1 gm packets, or Nitroglycerine Paste 2% - 30 gm tube, or Nitroglycerine Paste 2% - 60 gm tube				2 1 1
Normal Saline for Injection (10 cc)		2	2	2
Normal Saline 100 cc			1	2
Normal Saline 250 cc			1	1
Normal Saline 500 ml and/or 1000 ml		2000 ml	3000 ml	6000 ml
Ondansetron (Zofran) 4 mg Oral Disintegrating Tablets (ODT)			4	4
Ondansetron (Zofran) 4 mg IM/IV			4	4
Sodium Bicarbonate 50 mEq preload			2	2
Tranexamic Acid (TXA) 1 gm			2	2

Non-Exchange Controlled Substance Medications MUST BE DOUBLE LOCKED	BLS	LALS	ALS Non- Transport	ALS Transport
<u>Buprenorphine-Naloxone (Suboxone) SL</u>			48 mg <i>optional</i>	48 mg
<u>Diazepam (optional alternative when midazolam is commercially unavailable)</u>			40-80 mg	40-80 mg
Fentanyl			200-400 mcg	200-400 mcg
Midazolam			20-40 mg	20-40 mg
Ketamine			120-1000 mg	120-1000 mg

AIRWAY/SUCTION EQUIPMENT

Exchanged Airway/Suction Equipment	BLS	LALS	ALS Non- Transport	ALS Transport
CPAP circuits - all manufacture's available sizes			1 each	2 each
End-tidal CO2 device - Pediatric and Adult (may be integrated into bag)			1 each	1 each
Endotracheal Tubes cuffed - 6.0 and/or 6.5, 7.0 and/or 7.5 and 8.0 and/or 8.5 with stylet			2 each	2 each
ET Tube holders - adult		1 each	1 each	2 each
i-gel - Size <u>1.1, 1.5, 2.2, 2.5</u> , 3, 4, and 5			1 each	2 each
Mask - Adult & Pediatric non-rebreather oxygen mask	2 each	2 each	2 each	2 each
Mask - Infant Simple Mask	1	1	1	1
Nasal cannulas - pediatric and adult	2 each	2 each	2 each	2 each
Naso/Orogastric feeding tubes - 5fr or 6fr, and 8fr			1 each	1 each
Naso/Orogastric tubes - 10fr or 12fr, 14fr, 16fr or 18fr			1 each	1 each
Nasopharyngeal Airways - (infant, child, and adult)	1 each	1 each	1 each	1 each
Needle Cricothyrotomy Device - Pediatric and adult or Needles for procedure 10, 12, 14 and/or 16 gauge			1 each 2 each	1 each 2 each
14 gauge 3.25 inch and 18 gauge 1.75-2 inch needles for Needle Thoracostomy			2 each	1
Oropharyngeal Airways - (infant, child, and adult)	1 each	1 each	1 each	1 each
Rigid tonsil tip suction	1		1	1
Small volume nebulizer with universal cuff adaptor		2	2	2
Suction Canister	1		1	1
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each		1 each	1 each
Ventilation Bags - Infant 250 ml Pediatric 500 ml (or equivalent) Adult	1 1 1	1 1 1	1 1 1	1 1 1
Water soluble lubricating jelly		1	1	1

Non-Exchange Airway/Suction Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
Ambulance oxygen source -10 L / min for 20 minutes	1			1
CPAP - (must be capable of titrating pressure between 2 and 15 cm H ₂ O)			1	1
Flashlight/penlight	1	1	1	1
Laryngoscope blades - #0, #1, #2, #3, #4 curved and/or straight			1 each	1 each
Laryngoscope handle with batteries - or 2 disposable handles			1	1
Magill Forceps - Pediatric and Adult			1 each	1 each
Manual powered suction device		1		
Portable oxygen with regulator - 10 L /min for 20 minutes	1	1	1	1
Portable suction device (battery operated)	1		1	1
Pulse Oximetry device	(SEE OPTIONAL EQUIPMENT SECTION, PG. 5)	1	1	1
Stethoscope	1	1	1	1
Wall mount suction device	1 (BLS TRANSPORT ONLY)			1

IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT

Exchanged IV/Needles/Syringes/Monitor Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
Conductive medium or Pacer/Defibrillation pads			2 each	2 each
Disposable Tourniquets		2	2	2
ECG electrodes			20	20
Mechanical (i.e. SAM) or Powered (i.e.EZ) IO Driver. <i>*manual insertion of IO needle is not permitted.</i>			1 each	1 each
Mechanical/Powered IO Needles: 25 mm 45 mm			2 each 1 each	2 each 1 each
Glucose monitoring device with compatible strips and OSHA approved single use lancets	1	1	1	1
3-way stopcock with extension tubing			2	2
IV Catheters - sizes 14, 16, 18, 20, 22, 24		2 each	2 each	2 each
Macro drip Administration Set		3	3	3
Microdrip Administration Set (60 drops / cc)		1	1	2
Mucosal Atomizer Device (MAD) for nasal administration of medication	2	2	2	4
Pressure Infusion Bag (disposable)		1	1	1
Razors		1	2	2
Safety Needles - 20 or 21gauge and 23 or 25 gauge		2 each	2 each	2 each

Exchanged IV/Needles/Syringes/Monitor Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
Saline Lock Large Bore Tubing Needleless		2	2	2
Sterile IV dressing		2	2	2
Syringes w/wo safety needles - 1 cc, 3 cc, 10 cc catheter tip		2 each		
Syringes w/wo safety needles - 1 cc, 3 cc, 10 cc, 20 cc, 60 cc catheter tip			2 each	2 each

Non-Exchange IV/Needles/Syringes/ Monitor Equipment	BLS	LALS	ALS Non-Transport	ALS Transport
12-lead ECG Monitor and Defibrillator with TCP and printout			1	1
Blood pressure cuff - large adult or thigh cuff, adult, child and infant (one of each size)	1	1	1	1
Capnography monitor and supplies, may be integrated in the cardiac monitor			1	1
Needle disposal system (OSHA approved)	1	1	1	1
Thermometer - Mercury Free with covers	1	1	1	1

OPTIONAL EQUIPMENT/MEDICATIONS

Non-Exchange Optional Equipment/ Medications	BLS	LALS	ALS Non-Transport	ALS Transport
AED/defib pads - Adult (1), Pediatric (1)	1 each	1 each		
Albuterol MDI with spacer		4 doses	4 doses	4 doses
Automatic CPR device (FDA approved)	1	1	1	1
Automatic transport ventilator (Specialty Program Only - ICEMA approved device)			1	1
Backboard padding	1	1	1	1
Buprenorphine Naloxone (Suboxone) SL (for agencies participating in LOSOP)			48mg total	48mg total
Buretrol			1	1
Chemistry profile tubes			3	3
Epinephrine 0.15 mg Auto-Injector	2	2		
Epinephrine 0.3 mg Auto-Injector	2	2		
Nerve Agent Antidote Kit (NAAK) - DuoDote or Mark I	3	3	3	3
EMS Tourniquet	1		1	1
Gum Elastic intubation stylet			2	2
Hemostatic Dressings *	1	1	1	1
IO Needles - Manual, Adult and Pediatric, Optional		Pediatric sizes only IO needles and drivers	1 each	1 each
IV infusion pump			1	1
IV warming device		1	1	1
Manual IV Flow Rate Control Device			1	1
Manual powered suction device	1	1	1	1
Multi-lumen peripheral catheter			2	2
Needle Thoracostomy Kit (prepackaged)			2	2
Naloxone (Narcan) Nasal Spray 4 mg	2	2	2	2
Pulse Oximetry device	1			
Sodium Bicarbonate 50 mEq / 50cc Vial			2	2

Non-Exchange Optional Equipment/ Medications	BLS	LALS	ALS Non- Transport	ALS Transport
Translaryngeal Jet Ventilation Device			1	1
Vacutainer			1	1

* Hemostatic Dressings

- Quick Clot, Z-Medica
 - Quick Clot, Combat Gauze LE
 - Quick Clot, EMS Rolled Gauze, 4x4 Dressing, TraumaPad
- Celox
 - Celox Gauze, Z-Fold Hemostatic Gauze
 - Celox Rapid, Hemostatic Z-Fold Gauze
- HemCon ChitoFlex Pro Dressing

NOTE:

- The above products are "packaged" in various forms (i.e., Z-fold, rolled gauze, trauma pads, 4"x4"pads) and are authorized provided they are comprised of the approved product.
- Hemostatic Celox Granules, or granules delivered in an applicator, are not authorized.

DRESSING MATERIALS/OTHER EQUIPMENT/SUPPLIES

Exchanged Dressing Materials/Other Equipment/ Supplies	BLS	LALS	ALS Non- Transport	ALS Transport
Adhesive tape - 1 inch	2	2	2	2
Air occlusive dressing	1	1	1	1
Ankle and wrist restraints, soft ties acceptable	1		1	1
Antiseptic swabs/wipes	10	10	10	10
Bedpan or fracture pan	1 (BLS TRANSPORT UNITS ONLY)			1
Urinal	1 (BLS TRANSPORT UNITS ONLY)			1
Cervical Collars - Rigid Pediatric and Adult all sizes or	2 each	2 each	2 each	2 each
Cervical Collars - Adjustable Adult and Pediatric	2 each	2 each	2 each	2 each
Cold Packs	2	2	2	2
Emesis basin or disposable bags and covered waste container	1	1	1	1
Head immobilization device	2	2	2	2
OB Kit	1	1	1	1
Pneumatic or rigid splints capable of splinting all extremities	4	2	2	4
Provodine/Iodine swabs/wipes or antiseptic equivalent		4	10	10
Roller bandages - 4 inch	6	3	3	6
Sterile bandage compress or equivalent	6	2	2	6
Sterile gauze pads - 4x4 inch	4	4	4	4
Sterile sheet for Burns	2	2	2	2
Universal dressing 10x30 inches	2	2	2	2

Non-Exchange Dressing Materials/Other Equipment/Supplies	BLS	LALS	ALS Non-Transport	ALS Transport
800 MHz Radio		1	1	1
Ambulance gurney	1 (BLS TRANSPORT UNITS ONLY)			1
Bandage shears	1	1	1	1
Blood Borne Pathogen Protective Equipment - (nonporous gloves, goggles face masks and gowns meeting OSHA Standards)	2	1	2	2
Pediatric Emergency Measuring Tape (Broselow, etc.)		1	1	1
Drinkable water in secured plastic container or equivalent	1 gallon			1 gallon
Long board with restraint straps	1	1	1	1
Pediatric immobilization board	1	1	1	1
Pillow, pillow case, sheets and blanket	1 set (BLS TRANSPORT UNITS ONLY)			1 set
Short extrication device	1	1	1	1
Straps to secure patient to gurney	1 set (BLS TRANSPORT UNITS ONLY)			1 set
Traction splint	1	1	1	1
Triage Tags - ICEMA approved	20	20	20	20



INLAND COUNTIES EMERGENCY MEDICAL AGENCY POLICY AND PROTOCOL MANUAL

Reference No. 8010
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INTERFACILITY TRANSFER GUIDELINES

I. PURPOSE

To identify patient care responsibilities for emergency medical technicians (EMTs), advanced EMTs (AEMTs) and paramedics (EMT-Ps) during interfacility transports.

II. BLS INTERVENTIONS

During an interfacility transport, an EMT may monitor the following if the patient is non-critical and deemed stable by the transferring physician and the physician has approved transport via BLS ambulance:

Appropriate transfer paperwork and medical records must accompany the patient to their destination.

- Monitor a saline lock or peripheral lines delivering fluids in any combination/concentration of Normal Saline, Lactated Ringers or Dextrose and Water provided the following conditions are met:
 - No medications have been added to the IV fluid.
 - Maintain the IV at a pre-set rate.
 - Check tubing for kinks and reposition arm if necessary.
 - Turn off IV fluid if signs/symptoms of infiltration occur.
 - Control any bleeding at insertion site.
- Transport a patient with a urinary catheter provided the following:
 - The catheter is able to drain freely.
 - No action is taken to impede flow or contents of drainage collection bag.
- Transport a patient with a nasogastric or gastrostomy tube provided the tube is clamped.
- If the patient's condition deteriorates, the patient should be transported to the closest receiving hospital.

III. LIMITED ALS (LALS) INTERVENTIONS

During an interfacility transport, if the patient is non-critical and deemed stable by the transferring physician and the physician has approved transport via LALS ambulance, an AEMT may monitor or perform the following:

- Peripheral lines delivering fluids in any combination/concentration of normal saline, lactated ringers or dextrose and water.
- Saline locks.
- Tracheo-bronchial suction of an intubated patient.

- Initiate prior to contact protocols if the patient's condition deteriorates, then must contact the base hospital per ICEMA Reference #3040 - Radio Communication.

Appropriate transfer paperwork and medical records must accompany the patient to their destination.

AEMTs may not transport a patient with IV drips that are not in the AEMT scope of practice.

AEMTs may not transport patients with blood or blood products.

IV. ALS INTERVENTIONS

Appropriate transfer paperwork and medical records must accompany the patient to their destination.

If the transfer is a STEMI patient, refer to ICEMA Reference #8020 - Specialty Care Transport.

EMT-Ps may not transport a patient with IV drips that are not in the EMT-P scope of practice.

EMT-Ps may not transport patients with blood or blood products.

During an interfacility transport, an ICEMA accredited EMT-P may:

- Monitor peripheral lines delivering fluids in any combination/concentration of normal saline, lactated ringers or dextrose and water.
- Transport intravenous solutions with added medication(s) as follows:
 - Lidocaine
 - Dopamine
 - Magnesium Sulfate
- Monitor and administer medications through a pre-existing vascular access.
- Monitor ~~heparin lock~~ or saline lock.
- Monitor IV solutions containing potassium $\leq 40\text{mEq/L}$.
- Monitor thoracostomy tubes to water or dry sealed drainage.
- Monitor nasogastric tubes.

EMT-Ps may initiate prior to contact protocols if the patient's condition deteriorates, then must contact the base hospital per ICEMA Reference #5040- Radio Communication Policy.

- If ~~EMT-P~~ **paramedic** personnel are requested for the transfer, the transferring physician shall submit written orders designating treatment during transport that are within ICEMA protocols. ~~designating the precise level of care deemed necessary during the transport.~~
- Any change in the patient's status that may require a deviation from the transferring physician's orders or jeopardize the continued safe transport of the patient to the receiving facility, the EMT-P shall ~~necessitate~~ contacting the transferring physician

(primarily) or base station hospital (secondarily), transferring physician may then be consulted by base hospital personnel to facilitate care by transport personnel.

V. NURSE ASSISTED ALS TRANSPORT

In the event of a critical patient that needs transport with medication or IV drips that are outside of the EMT-P scope of practice and CCT transport is not possible, a Registered Nurse (RN) from the transferring hospital may accompany the patient. The RN will be responsible for orders from the transferring physician. In the event the patient condition deteriorates, the EMT-P will contact the base hospital for orders and destination change. The RN will continue to provide care consistent with the transferring physician's orders. The base hospital physician may consider discontinuing or continuing the prior orders based on patient condition. The RN will document the base hospital physician orders on the transferring facility's patient care record. The EMT-P will document on the ePCR or O1A.

VI. REFERENCES

<u>Number</u>	<u>Name</u>
3040	Radio Communication
8020	Specialty Care Transport



OPIOID WITHDRAWAL

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Patient exhibiting signs/symptoms of possible opioid withdrawal characterized by tachycardia, gastrointestinal distress, hot and cold flashes, poor concentration, diaphoresis, rhinorrhea, restlessness, piloerection, and/or yawning.

II. EXCLUSION CRITERIA

- Under 16 years of age
- Any methadone use within the last 10 days
- Altered mental status and unable to give consent
- Severe medical illness (sepsis, respiratory distress, etc.)
- Recent benzodiazepine, alcohol, or intoxicants suspected within 24 hours
- Unable to comprehend potential risks and benefits for any reason
- Not a candidate for buprenorphine maintenance treatment for any reason

III. BLS INTERVENTIONS

- Oxygen therapy as clinically indicated.
- If patient exhibiting signs/symptoms of possible altered level of consciousness refer to ICEMA Reference #14060-Altered Level of Consciousness/Seizure-Adult
- Assess and document response to therapy.

IV. LIMITED ALS (LALS) INTERVENTIONS

- Perform activities identified in the BLS interventions.
- Obtain vascular access.

V. ALS INTERVENTIONS

Note: Administration of Buprenorphine-Naloxone (Suboxone) is authorized for transport providers and approved non-transport providers.

- Perform activities identified in the BLS and LALS interventions.
- Place on cardiac monitor and obtain a 12-lead ECG as clinical indicated.
- Use Clinical Opioid Withdrawal Scale (COWS ≥ 8) assessment tool to determine if patient meets criteria for treatment.
- Provide counseling and assess patient interest in **buprenorphine-naloxone (Suboxone®)**.

- Administer **buprenorphine-naloxone (Suboxone®)** per ICEMA Reference #11010 – Medication – Standard Orders. **(16 mg/ 4mg buprenorphine-naloxone SL)**.
- Reassess patient after 10 minutes.
- If symptoms worsen or persist, administer second dose **buprenorphine-naloxone (Suboxone®)** per ICEMA Reference #11010 – Medication – Standard Orders **(8mg/2mg buprenorphine-naloxone (Suboxone®) SL to max dose 24 mg/ 6mg)**.
- Transport to a California Bridge Hospital and inform patient that the hospital navigator will initiate contact within 72 hours to offer additional treatment.
- If patient declines transport, provide MAT information, coaching, and brochure.
- Provide Leave Behind Naloxone kit and education if available.

V. REFERENCES

<u>Number</u>	<u>Name</u>
11010	Medication - Standard Order
14060	Altered Level of Consciousness/Seizures-Adult



**INLAND COUNTIES
EMERGENCY MEDICAL AGENCY
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MEDICATION - STANDARD ORDERS

Medications listed in this protocol may be used only for the purposes referenced by the associated ICEMA Treatment Protocol.

For Nerve Agent Antidote Kit (NAAK) or medications deployed with the ChemPack see Appendix I (Page 12).

Acetaminophen (Tylenol) - Adult (ALS)

For mild to moderate pain scales of 1-5 or in moderate to severe pain where other medications are contraindicated or deferred.

Tylenol, 1 gm IV/IO infusion over fifteen (15) minutes. Single dose only

Acetaminophen (Tylenol) – Pediatric (ALS)

For mild to moderate pain scales of 1-5 or in moderate to severe pain where other medications are contraindicated or deferred.

2 years to 14 years:

Tylenol, 15mg/kg to max of 1000mg or 1 gm IV/IO infusion over fifteen (15) minutes. Single dose only

Reference #s 7010, 7020, 14100

Adenosine (Adenocard) - Adult (ALS)

Stable narrow-complex SVT or Wide complex tachycardia:

Adenosine, 6 mg rapid IVP followed immediately by 20 cc NS bolus, and Adenosine, 12 mg rapid IVP followed immediately by 20 cc NS bolus if patient does not convert. May repeat one (1) time.

Reference #s 7010, 7020, 14040

Albuterol (Proventil) Aerosolized Solution - Adult (LALS, ALS)

Albuterol, 2.5 mg nebulized, may repeat two (2) times.

Reference #s 4060, 7010, 7020, 14010, 14070

Albuterol (Proventil) Metered-Dose Inhaler (MDI) - Adult (BLS**, LALS, ALS)**

Albuterol MDI, four (4) puffs every 10 minutes for continued shortness of breath and wheezing.

Reference #s 4060, 4080, 7010, 7020, 14120, 14140, 14190

Albuterol (Proventil) - Pediatric (LALS, ALS)

Albuterol, 2.5 mg nebulized, may repeat two (2) times.

Reference #s 7010, 7020, 14120, 14140, 14190

Albuterol (Proventil) Metered-Dose Inhaler (MDI) - Pediatric (BLS, LALS, ALS)

Albuterol MDI, four (4) puffs every 10 minutes for continued shortness of breath and wheezing.

Reference #s 4060, 4080, 7010, 7020, 14120, 14140, 14190

Aspirin, chewable -Adult (LALS, ALS)

Aspirin, 325 mg PO chewed (one (1) adult non-enteric coated aspirin) or four (4) chewable 81 mg aspirin.

Reference #s 4060, 4080, 5010, 7010, 7020

Atropine (ALS) - Adult

Atropine, 1 mg IV/IO. May repeat every five (5) minutes up to a maximum of 3 mg or 0.04 mg/kg.

Organophosphate poisoning:

Atropine, 2 mg IV/IO, repeat at 2 mg increments every five (5) minutes if patient remains symptomatic.

Reference #s 4060, 4080, 7010, 7020, 13010, 14030, 14260

Atropine - Pediatric (ALS)**Organophosphate poisoning - Pediatrics less than 14 years of age:**

Atropine, 0.05 mg/kg IV/IO not to exceed adult dose of 2 mg, repeat at 0.1 mg/kg increments every five (5) minutes if patient remains symptomatic.

Reference #s 4060, 4080, 7010, 7020, 13010

Buprenorphine-Naloxone (Suboxone ®)-Adult (ALS):**Opioid Withdrawal- Clinical Opioid Withdrawal Scale \geq 8:**

Buprenorphine-Naloxone, 16 mg/4mg sublingual, may repeat at 8 mg/2mg sublingual after ten (10) minutes if patient remains symptomatic, to a maximum total dose of 24 mg/6mg.

Reference #s 7010, 10050

Calcium Chloride - Adult (ALS) (base hospital order only):**Calcium Channel Blocker Poisonings (base hospital order only):**

Calcium Chloride, 1 gm (10 ml of a 10% solution) IV/IO.

Reference #s 5010, 7010, 7020, 13010

For cardiac arrest with suspected hypocalcemia, hyperkalemia, hypermagnesemia or calcium channel blocker poisoning (base hospital order only):

Calcium Chloride, 1 gm (10 ml of a 10% solution) IV/IO.

Reference #s 7010, 7020, 14050

For End Stage Renal Disease (ESRD) patients on dialysis with suspected hyperkalemia and hemodynamic instability with documented sinus bradycardia, 3rd degree AV Block, 2nd degree Type II AV Block, slow junctional and ventricular escape rhythms, or slow atrial fibrillation. (Base hospital order only).

Calcium Chloride, 1 gm (10 ml of a 10% solution) IV/IO

Reference #s 5010, 7010, 7020, 14030

Calcium Chloride - Pediatric (ALS) (base hospital order only):

Calcium Channel Blocker Poisonings (base hospital order only):

Calcium Chloride, 20 mg/kg IV/IO over five (5) minutes.

Reference #s 7010, 7020, 13010

Dextrose - Adult (LALS, ALS)

Hypoglycemia - Adult with blood glucose less than 80 mg/dL:

Dextrose 10% /250 ml (D10W 25 gm) IV/IO Bolus

Reference #s 4060, 4080, 5010, 7010, 7020, 8010, 13020, 13030, 14040, 14060

Dextrose - Pediatric (LALS, ALS)

Hypoglycemia - Neonates (0 - 4 weeks) with blood glucose less than 35 mg/dL or pediatric patients (more than 4 weeks) with glucose less than 60 mg/dL:

Dextrose 10%/250 ml (D10W 25 gm) 0.5 gm/kg (5 ml/kg) IV/IO

Reference #s 5010, 7010, 7020, 13020, 13030, 14150, 14160, 14170

Diazepam – Adult (ALS) only when midazolam is not commercially available.

Seizures:

Diazepam , 5 mg IV/IO

Diazepam 10mg IM

Diazepam- Pediatric (ALS) only when midazolam is not commercially available.

Seizures:

Diazepam 0.1mg/kg IV/IO max 5mg

Diazepam 0.2mg/kg IM max 10mg

Reference #s 7010, 7020, 14170

Diphenhydramine - Adult (ALS)

Diphenhydramine, 25 mg IV/IO

Diphenhydramine, 50 mg IM

Reference #s 4060, 4080, 7010, 7020, 13010, 14010

Diphenhydramine - Pediatric (ALS)

Allergic reaction:

2 years to 14 years Diphenhydramine, 1 mg/kg slow IV/IO, not to exceed adult dose of 25 mg, **or**

Diphenhydramine, 2 mg/kg IM not to exceed adult dose of 50 mg IM.

Reference #s 7010, 7020, 14140

Epinephrine (1 mg/ml) - Adult (LALS, ALS)

Severe Bronchospasm, Asthma Attack, Pending Respiratory Failure, Severe Allergic Reactions:

Epinephrine, 0.3 mg IM. May repeat after 15 minutes one (1) time if symptoms do not improve.

Reference # 14010

Epinephrine (0.1 mg/ml) - Adult (ALS)

For persistent severe anaphylactic reaction:

Epinephrine (0.1 mg/ml), 0.1 mg slow IVP/IO. May repeat every five (5) minutes as needed to total dosage of 0.5 mg.

Reference # 14010

Cardiac Arrest, Asystole, PEA:

Epinephrine (0.1 mg/ml), 1 mg IV/IO.

Reference #s 4060, 4080, 5010, 7010, 7020, 14010, 14050, 14260

Epinephrine (0.3 Auto injector) - Adult (BLS, LALS, ALS)

For severe asthma and/or anaphylaxis only

Epinephrine 0.3 mg auto-injector, may repeat once after 15 minutes

Epinephrine (0.3 Auto injector) - Pediatric (BLS, LALS, ALS)

For anaphylaxis only

Epinephrine 0.3 mg auto-injector

Epinephrine (0.01 mg/ml) - Adult (ALS)

Post resuscitation, persistent profound nontraumatic shock and hypotension, and for persistent shock due to trauma where cardiac arrest is imminent:-(Push Dose Epinephrine).

Prepare Epinephrine 0.01 mg/ml solution by mixing 9 ml of normal saline with 1 ml of Epinephrine 0.1 mg/ml in a 10 ml syringe. Administer 1 ml every one (1) to five (5) minutes titrated to maintain SBP more than 90 mm Hg.

Reference #s 4060, 4080, 5010, 7010, 7020, 11010, 14050, 14090, 14230

Epinephrine (1 mg/ml) - Pediatric (LALS, ALS)

Severe Bronchospasm, Asthma Attack, Pending Respiratory Failure, Severe Allergic Reactions:

Epinephrine, 0.01 mg/kg IM not to exceed adult dosage of 0.3 mg. May repeat after 15 minutes one (1) time if symptoms do not improve.

Reference #s 4060, 5010, 7010, 7020, 14120, 14140

Epinephrine (0.1 mg/ml) - Pediatric (ALS)

Anaphylactic reaction (no palpable radial pulse and depressed level of consciousness):

Epinephrine (0.1 mg/ml), 0.01 mg/kg IV/IO, no more than 0.1 mg per dose. May repeat to a maximum of 0.5 mg.

Cardiac Arrest:

1 day to 8 years Epinephrine (0.1 mg/ml), 0.01 mg/kg IV/IO (do not exceed adult dosage)

9 to 14 years Epinephrine (0.1 mg/ml), 1.0 mg IV/IO

Newborn Care:

Epinephrine (0.1 mg/ml), 0.01 mg/kg IV/IO if heart rate is less than 60 after one (1) minute after evaluating airway for hypoxia and assessing body temperature for hypothermia.

Epinephrine (0.1 mg/ml), 0.005 mg/kg IV/IO every 10 minutes for persistent hypotension as a base hospital order or in radio communication failure.

Reference # 14200

Epinephrine (0.01 mg/ml) - Pediatric (ALS)

Post resuscitation, profound shock and hypotension, for persistent shock due to trauma where cardiac arrest is imminent (Push Dose Epinephrine):

Prepare Epinephrine 0.01 mg/ml solution by mixing 9 ml of normal saline with 1 ml of Epinephrine 0.1 mg/ml in a 10 ml syringe. Administer 0.1 ml/kg (do not exceed adult dosage), every one (1) to five (5) minutes. Titrate to maintain a SBP more than 70 mm Hg.

Reference #s 5010, 7010, 7020, 11010, 14150, 14180, 14230

Fentanyl - Adult (ALS)

Chest Pain (Presumed Ischemic Origin):

Fentanyl, 50 mcg slow IV/IO over one (1) minute. May repeat every five (5) minutes titrated to pain, not to exceed 200 mcg.

Fentanyl, 100 mcg IM/IN. May repeat 50 mcg every 10 minutes titrated to pain, not to exceed 200 mcg.

Acute traumatic injuries, acute abdominal/flank pain, burn injuries, Cancer pain, Sickle Cell Crisis:

Fentanyl, 50 mcg slow IV/IO push over one (1) minute. May repeat every five (5) minutes titrated to pain, not to exceed 200 mcg IV/IO, **or**

Fentanyl, 100 mcg IM/IN. May repeat 50 mcg every 10 minutes titrated to pain, not to exceed 200 mcg.

Pacing, synchronized cardioversion:

Fentanyl, 50 mcg slow IV/IO over one (1) minute. May repeat in five (5) minutes titrated to pain, not to exceed 200 mcg.

Fentanyl, 100 mcg IN. May repeat 50 mcg every 10 minutes titrated to pain, not to exceed 200 mcg.

Any combination of IV/IO/IM/IN may be administered, not to exceed 200 mcg. Contact base hospital for additional orders and to discuss further treatment options.

Reference #s 3050, 4060, 4080, 5010, 7010, 7020, 11020, 13030, 14070, 14090, 14100, 14240

Fentanyl - Pediatric (ALS)

Fentanyl, 0.5 mcg/kg slow IV/IO over one (1) minute. May repeat in five (5) minutes titrated to pain, not to exceed 50 mcg for a single dose.

Fentanyl, 1 mcg/kg IM/IN, may repeat every 10 minutes titrated to pain not to exceed 100 mcg for a single dose.

Any combination of IV/IO/IM/IN may be administered, not to exceed four (4) doses or cumulative maximum of 200 mcg. Contact base hospital for additional orders and to discuss further treatment options.

Reference #s 3050, 4080, 5010, 7010, 7020, 13030, 14180, 14190, 14240

Glucose - Oral - Adult (BLS, LALS, ALS)

Adult with blood glucose less than 80 mg/dL:

Glucose - Oral, one (1) tube for patients with an intact gag reflex and hypoglycemia.

Reference #s 7010, 7020, 13020, 14060, 14080, 14230

Glucose - Oral - Pediatric (BLS, LALS, ALS)

Hypoglycemia - Neonates (0 - 4 weeks) with blood glucose less than 35 mg/dL or pediatric patients (more than 4 weeks) with glucose less than 60 mg/dL:

Glucose - Oral, one (1) tube for patients with an intact gag reflex and hypoglycemia.

Reference #s 7010, 7020, 14170, 14160

Glucagon - Adult (LALS, ALS)

Glucagon, 1 mg IM/SC/IN, if unable to establish IV. May administer one (1) time only.

Beta blocker Poisoning (base hospital order only):

Glucagon, 1 mg IV/IO

Reference #s 4060, 4080, 7010, 7020, 13010, 13030, 14060

Glucagon - Pediatric (LALS, ALS)

Hypoglycemia, if unable to establish IV:

Glucagon, 0.03 mg/kg IM/IN, if unable to start an IV. May be repeated one (1) time after 20 minutes for a combined maximum dose of 1 mg.

For refractory VT (*pulseless*)/VF, may administer an additional 0.75 mg/kg IV/IO, repeat one (1) time in five (5) to 10 minutes; maximum total dose of 3 mg/kg.

V-Tach, Wide Complex Tachycardia - with Pulses:

Lidocaine, 1.5 mg/kg slow IV/IO

May administer an additional 0.75 mg/kg slow IV/IO; maximum total dose of 3 mg/kg.

Reference #s 4060, 5010, 7010, 7020, 8010, 11020, 14040, 14050, 14090

Lidocaine - Pediatric (ALS)

Cardiac Arrest:

1 day to 8 years Lidocaine, 1.0 mg/kg IV/IO

9 to 14 years Lidocaine, 1.0 mg/kg IV/IO

May repeat Lidocaine at 0.5 mg/kg after five (5) minutes; maximum total dose of 3 mg/kg.

Reference #s 5010, 7010, 7020, 14150

Lidocaine 2% (Intravenous Solution) - Pediatric and Adult (ALS)

Pain associated with IO infusion:

Lidocaine, 0.5 mg/kg slow IO push over two (2) minutes, not to exceed 40 mg total.

Reference #s 5010, 7010, 7020, 11020

Magnesium Sulfate-Adult (ALS)

Polymorphic Ventricular Tachycardia:

Magnesium Sulfate, 2 gm IV/IO bolus over five (5) minutes for polymorphic VT if prolonged QT is observed during sinus rhythm post-cardioversion.

Eclampsia (Seizure/Tonic/Clonic Activity):

Magnesium Sulfate, 4 gm IV/IO slow IV push over three (3) to four (4) minutes.

Magnesium Sulfate, 10 mg/min IV/IO drip to prevent continued seizures.

Reference #s 5010, 7010, 7020, 8010, 14210

Severe Asthma/Respiratory Distress (ALS) (base hospital order only):

Magnesium Sulfate, 2 gm slow IV drip over 20 minutes. Do not repeat.

Reference# 14010

Magnesium Sulfate - Pediatric (ALS)

Severe Asthma/Respiratory Distress (base hospital order only):

Magnesium Sulfate, 50 mg/kg slow IV drip over 20 minutes. Do not exceed the adult dosage of 2 gm total. Do not repeat.

Reference # 14120

Midazolam (Versed) - Adult (ALS)

Behavioral Emergencies, if patient meets criteria for potentially fatal and dangerous agitation:

Midazolam, 2.5 mg IV/IO. May repeat in five (5) minutes, **or**

Midazolam, 5 mg IM/IN. May repeat in 10 minutes.

Maximum of three (3) doses using any combination of IV/IO/IM/IN may be administered. Contact base hospital for additional orders and to discuss further treatment options.

Reference # 14110

Post ROSC Agitation (base hospital order only): Agitation following ROSC that hinders patient's care, i.e. biting or attempting to remove ET tube/lines, **Not to be used for sedation during intubation of any patients.**

Midazolam, 2.5 mg IV/IO or

Midazolam 5 mg IM/IN

Patient must have advanced airway (endotracheal tube or i-gel.)

Repeat dose requires base hospital contact.

Reference # 14050

Seizure:

Midazolam, 2.5 mg IV/IO. May repeat in five (5) minutes for continued seizure activity, or

Midazolam, 5 mg IM/IN. May repeat in 10 minutes for continued seizure activity.

Assess patient for medication related reduced respiratory rate or hypotension.

Maximum of three (3) doses using any combination of IV/IO/IM/IN may be administered for continued seizure activity. Contact base hospital for additional orders and to discuss further treatment options.

Pacing, synchronized cardioversion:

Midazolam, 2.5 mg slow IV/IO. May repeat in five (5) minutes.

Midazolam, 5 mg IM/IN. May repeat in ten (10) minutes.

Maximum of three (3) doses using any combination of IV/IO/IM/IN may be administered. Contact base hospital for additional orders and to discuss further treatment options.

CPAP:

Midazolam, 1 mg IV/IO/IM/IN may be administered one (1) time for anxiety related to application of CPAP. Contact base hospital for additional orders.

Reference #s 4060, 4080, 7010, 7020, 11020, 13020, 14060, 14210

Midazolam (Versed) - Pediatric (ALS)

Seizures:

Midazolam, 0.1 mg/kg IV/IO with maximum dose 2.5 mg. May repeat Midazolam in five (5) minutes, or

Midazolam, 0.2 mg/kg IM/IN with maximum dose of 5 mg. May repeat Midazolam in 10 minutes for continued seizure.

Assess patient for medication related reduced respiratory rate or hypotension.

Maximum of three (3) doses using any combination of IV/IO/IM/IN may be administered for continued seizure activity. Contact base hospital for additional orders and to discuss further treatment options.

Behavioral Emergencies, if patient meets criteria for potentially fatal and dangerous agitation (base hospital order):

Midazolam, 0.1 mg/kg IV/IO. May repeat in five (5) minutes, or

Midazolam, 0.2 mg/kg IM/IN. May repeat in 10 minutes.

Assess patient for medication related reduced respiratory rate or hypotension.

Maximum of three (3) doses using any combination of IV/IO/IM/IN may be administered. Not to exceed adult dose. Contact base hospital for additional orders and to discuss further treatment options.

Reference #s 7010, 7020, 14170, 14110

Naloxone (Narcan) - Adult (BLS)

For resolution of respiratory depression related to suspected opiate overdose:

Naloxone, 0.5 mg IM/IN, may repeat Naloxone 0.5 mg IM/IN every two (2) to three (3) minutes if needed to improve respiratory effort.

For suspected Fentanyl overdose with respiratory depression:

Consider a loading dose of 4 mg IN Naloxone. If no signs of respiratory improvement, consider Naloxone 0.5 mg IM/IN every two (2) to three (3) minutes if needed.

Do not exceed 10 mg of Naloxone total regardless of route administered.

Reference #s 7010, 7020, 8030, 14060

Naloxone (Narcan) - Adult (LALS, ALS)

For resolution of respiratory depression related to suspected opiate overdose:

Naloxone, 0.5 mg IV/IO/IM/IN, may repeat Naloxone 0.5 mg IV/IO/IM/IN every two (2) to three (3) minutes if needed to improve respiratory effort.

For suspected Fentanyl overdose with respiratory depression:

Consider a loading dose of 4 mg IN Naloxone, may repeat one (1) time. If no signs of respiratory improvement, consider Naloxone 0.5 mg IV/IO/IM/IN every two (2) to three (3) minutes if needed.

Do not exceed 10 mg of Naloxone total regardless of route administered.

Reference #s 4080, 7010, 7020, 14060

Naloxone (Narcan) - Pediatric (BLS)

For resolution of respiratory depression related to suspected opiate overdose:

1 day to 8 years	Naloxone, 0.1 mg/kg IM/IN (do not exceed the adult dose of 0.5 mg per administration)
9 to 14 years	Naloxone, 0.5 mg IM/IN

May repeat every two (2) to three (3) minutes if needed. Do not exceed the adult dosage of 10 mg total IM/IN.

Reference #s 7010, 7020, 8030, 14150, 14160

Naloxone (Narcan) - Pediatric (LALS, ALS)

For resolution of respiratory depression related to suspected opiate overdose:

1 day to 8 years Naloxone, 0.1 mg/kg IV/IO/IM/IN (do not exceed the adult dose of 0.5 mg per administration)
 9 to 14 years Naloxone, 0.5 mg IV/IO/IM/IN

May repeat every two (2) to three (3) minutes if needed. Do not exceed the adult dosage of 10 mg total IV/IO/IM/IN.

Reference #s 7010, 7020, 14150, 14160

Nitroglycerin (NTG) -Adult (LALS, ALS)

Nitroglycerin, 0.4 mg sublingual/transmucosal.

One (1) every three (3) minutes as needed. May be repeated as long as patient continues to have signs of adequate tissue perfusion. **If a Right Ventricular Infarction is suspected, the use of nitrates requires base hospital contact.**

Nitroglycerin Paste, 1 inch (1 gm) transdermal, may not repeat.

Nitroglycerin sublingual is the preferred route of administration for ACS. Nitro Paste is a one (1) time dose and intended for when sublingual cannot be easily administered (i.e., CPAP).

Nitroglycerin is contraindicated if there are signs of inadequate tissue perfusion or if sexual enhancement medications have been utilized within the past 48 hours.

Reference #s 4060, 4080, 7010, 7020, 14010, 14240

Ondansetron (Zofran) - Patients four (4) years old to Adult (ALS)

Nausea/Vomiting:

Ondansetron, 4 mg slow IV/IO/ODT

All patients four (4) to eight (8) years old: May administer a total of 4 mgs of Ondansetron prior to base hospital contact.

All patients nine (9) and older: May administer Ondansetron 4 mg; may repeat two (2) times, at 10 minute intervals, for a total of 12 mgs prior to base hospital contact.

May be used as prophylactic treatment of nausea and vomiting associated with narcotic administration.

Reference #s 4080, 7010, 7020, 14090, 14180, 14220

Oxygen - Pediatric and Adult (BLS, LALS, ALS) (non-intubated patient per appropriate delivery device)

General Administration (Hypoxia):

Titrate Oxygen at lowest rate required to maintain SPO₂ at 94%. Do not administer supplemental oxygen for SPO₂ more than 95%.

Chronic Obstructive Pulmonary Disease (COPD):

Titrate Oxygen at lowest rate required to maintain SPO₂ at 90%. Do not administer supplemental oxygen for SPO₂ more than 91%.

Reference #s 12010, 13010, 13020, 13030, 13050, 14010, 14020, 14030, 14040, 14060, 14070, 14090, 14120, 14130, 14140, 14160, 14170, 14180, 14190, 14200, 14210, 14220, 14230, 14240

Sodium Bicarbonate - Adult (ALS)

Tricyclic Poisoning (base hospital order only):

Sodium Bicarbonate, 1 mEq/kg IV/IO

Reference #s 5010, 7010, 7020, 13010

For cardiac arrest with suspected metabolic acidosis, hyperkalemia or tricyclic poisoning (base hospital order only):

Sodium Bicarbonate, 50 mEq IV/IO/ 50cc preload or 50cc single-dose vial

Reference #'s 7010, 7020, 14050

Sodium Bicarbonate - Pediatric (ALS)

Tricyclic Poisoning (base hospital order only):

Sodium Bicarbonate, 1 mEq/kg IV/IO

Reference #'s 7010, 7020, 13010

Tranexamic Acid (TXA) - Patients 15 years of age and older (ALS)

Signs of hemorrhagic shock meeting inclusion criteria:

Administer TXA 1 gm in 50 - 100 ml of NS via IV/IO over 10 minutes. Do not administer IVP as this will cause hypotension.

Reference #s 7010, 7020, 14090

APPENDIX I

Medications for self-administration or with deployment of the ChemPack.

Medications listed below may be used only for the purposes referenced by the associated ICEMA Treatment Protocol. Any other use, route or dose other than those listed, must be ordered in consultation with the Base Hospital physician.

Atropine - Pediatric (BLS, AEMT-Auto-injector only with training, ALS)

Known nerve agent/organophosphate poisoning with deployment of the ChemPack using:

Two (2) or more mild symptoms: Administer the weight-based dose listed below as soon as an exposure is known or strongly suspected. If severe symptoms develop after the first dose, two (2) additional doses should be repeated in rapid succession 10 minutes after the first dose; do not administer more than three (3) doses. If profound anticholinergic effects occur in the absence of excessive bronchial secretions, further doses of atropine should be withheld.

One (1) or more severe symptoms: Immediately administer (3) three weight-based doses listed below in rapid succession.

Weight-based dosing:

Less than 6.8 kg (less than 15 lbs):	0.25 mg, IM using multi-dose vial
6.8 to 18 kg (15 to 40 lbs):	0.5 mg, IM using AtroPen auto-injector
18 to 41 kg (40 to 90 lbs):	1 mg, IM using AtroPen auto-injector
More than 41 kg (more than 90 lbs):	2 mg, IM using multi-dose vial

Symptoms of insecticide or nerve agent poisoning, as provided by manufacturer in the AtroPen product labeling, to guide therapy:

Mild symptoms: Blurred vision, bradycardia, breathing difficulties, chest tightness, coughing, drooling, miosis, muscular twitching, nausea, runny nose, salivation increased, stomach cramps, tachycardia, teary eyes, tremor, vomiting, or wheezing.

Severe symptoms: Breathing difficulties (severe), confused/strange behavior, defecation (involuntary), muscular twitching/generalized weakness (severe), respiratory secretions (severe), seizure, unconsciousness, urination (involuntary).

NOTE: Infants may become drowsy or unconscious with muscle floppiness as opposed to muscle twitching.

Reference #s 11010, 13010, 13040

Diazepam (Valium) - Adult (ALS)

For seizures associated with nerve agent/organophosphate exposure ONLY with the deployment of the ChemPack:

Diazepam 10 mg (5 mg/ml) auto-injector IM (if IV is unavailable), **or**
 Diazepam 2.5 mg IV

Reference # 13040

Diazepam (Valium) - Pediatric (ALS)

For seizures associated with nerve agent/organophosphate exposure ONLY with the deployment of the ChemPack:

Diazepam 0.05 mg/kg IV

Reference # 13040

Nerve Agent Antidote Kit (NAAK)/Mark I or DuoDote (containing Atropine/Pralidoxime Chloride for self-administration or with deployment of the ChemPack) - Adult

Nerve agent exposure with associated symptoms:

One (1) NAAK auto-injector IM into outer thigh. May repeat up to two (2) times every 10 to 15 minutes if symptoms persist.

Reference #s 7010, 7020, 13010, 13040



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PROCEDURE - STANDARD ORDERS

12-lead Electrocardiography (EMT-P)

- ECG should be performed prior to medication administration.
- ECG should be performed on any patient whose medical history and/or presenting symptoms are consistent with acute coronary syndrome including typical or atypical chest pain, syncopal episode, prior AMI, heart disease, or other associated risk factors.

Capnography (EMT-P)

- Utilize capnography in patients with respiratory distress, respiratory failure, cardiac arrest, and critically ill patients
- Capnography is required for continuous monitoring of patients given medications that may cause respiratory depression.
- Perform capnography after administration of Midazolam for behavioral emergencies.
- Monitor waveform, numerical value and document in ePCR.

Continuous Positive Airway Pressure Device (CPAP) - Adult (EMT-P)

- Start at lowest setting and increase slowly until patient experiences relief or until a maximum of 15 cm H₂O is reached.

External Jugular Vein Access (AEMT and EMT-P)

- Not indicated for patients eight (8) years of age and younger.
- Patient condition requires IV access and other peripheral venous access attempts are unsuccessful.

Blood Glucose Check (EMT, AEMT, and EMT-P)

- Should be assessed if the patient meets key indicators consistent with high or low blood sugar.

Intraosseous Insertion (AEMT pediatric patients only and EMT-P)

- EMT-Ps may administer Lidocaine slowly per ICEMA Reference #11010 - Medication - Standard Orders, to control infusion pain.
- Approved insertion sites:
 - Eight (8) years of age or younger (LALS and ALS):
 - Proximal Tibia - Anterior medial surface of tibia, 2 cm below tibial tuberosity.

- Nine (9) years of age and older (ALS only):
 - Proximal Tibia - Anterior medial surface of tibia, 2 cm below tibial tuberosity.
 - Distal Tibia - Lower end of tibia, 2 cm above the medial malleolus.
 - Humeral Head (~~EZ-IO~~ only).
 - Anterior distal femur, 2 cm above the patella - Base hospital contact only.
- Leave site visible and monitor for extravasation.

Nasogastric/Orogastric Tube (EMT-P)

- Use a water-soluble lubricating jelly.

Needle Cricothyrotomy (EMT-P)

- Absolute contraindication: Transection of the distal trachea.
- Monitor end-tidal CO₂ and wave form capnography.
- Monitor pulse oximetry.
- Contact base hospital if unable to ventilate adequately and transport immediately to the closest hospital for airway management.

Needle Thoracostomy (EMT-P)

- As a temporary method for chest decompression in the management of suspected tension pneumothorax.
 - **Clinical Indications:**
 - Patients with hypotension (SBP less than 90), clinical signs of shock, and at least one of the following signs:
 - Jugular vein distention.
 - Tracheal deviation away from the side of the injury (often a late sign).
 - Absent or decreased breath sounds on the affected side.
 - Increased resistance when ventilating a patient.
- The midaxillary line at the 5th intercostal space is the preferred site.
- Consider bilateral needle thoracostomy if no improvement or in traumatic cardiac arrest.

Oral Endotracheal Intubation - Adult (EMT-P)

- Oral endotracheal intubation is permitted only in patients who are taller than the maximum length of a pediatric emergency measuring tape (Broselow, etc.) or equivalent measuring from the top of the head to the heel of the foot.
- Monitor end-tidal CO₂ and wave form capnography.
- Monitor pulse oximetry.

- If unable to place ET after a maximum of three (3) intubation attempts (defined as placement of the laryngoscope in the mouth). If unsuccessful, continue with BVM airway management and transport to the nearest receiving hospital. If BVM is ineffective then attempt placement of supraglottic airway.
- Document verification of tube placement (auscultation, visualization, capnography).

Supraglottic Airway —~~Pediatric and Adult~~ Adult (EMT-P)

- ~~Supraglottic airway is permitted only as a Backup airway in patients who have failed attempts with BLS airway and oral endotracheal intubation in patients who are unsuccessfully managed with BLS airway and oral endotracheal intubation~~
- ~~Supraglottic airway is permitted only in patients who are taller than the maximum length of a pediatric emergency measuring tape (Broselow, etc.) equivalent measuring from the top of the head to the heel of the foot.~~
- Monitor end-tidal CO₂ and wave form capnography.
- Monitor pulse oximetry.
- If unable to place after three (3) attempts (defined as placement of the soft gel into the mouth), continue with BLS airway and proceed to nearest receiving hospital ~~!~~.
- Document verification of SGA (auscultation, continuous capnography).

Spinal Motion Restriction (EMT, AEMT and EMT-P)

- Should be placed if patient meets the indicators, per ICEMA Reference #14090 - Trauma - Adult (Neuro Deficits present, Spinal Tenderness present, Altered Mental status, Intoxication, or Distracting Injury).
- An AEMT and/or EMT-P may remove if placed by BLS crew and it does not meet indicators.

Synchronized Cardioversion (EMT-P)

- For anxiety prior to cardioversion, consider Midazolam per ICEMA Reference #11010 - Medication - Standard Orders.
- For pain, consider Fentanyl per ICEMA Reference #11010 - Medication - Standard Orders.
- If rhythm deteriorates to v-fib, turn off the sync button and defibrillate.
- Select initial energy level setting at 100 joules or a clinically equivalent biphasic energy level per manufacture guidelines. Procedure may be repeated at 200, 300 and 360 joules or a clinically equivalent biphasic energy level per manufacture guidelines.
- With base hospital order, repeated cardioversion attempts at 360 joules or clinically equivalent biphasic energy level per manufacturer's guidelines may be attempted.

Transcutaneous Cardiac Pacing (EMT-P)

- Start at a rate of 60 and adjust output to the lowest setting to maintain capture. Assess peripheral pulses and confirm correlation with paced rhythm.
- Reassess peripheral pulses. Adjust output to compensate for loss of capture.
- Increase rate (**not to exceed 100**) to maintain adequate tissue perfusion.
- For anxiety, consider Midazolam per ICEMA Reference #11010 - Medication - Standard Orders.
- For pain, consider Fentanyl per ICEMA Reference #11010 - Medication - Standard Orders.
- Contact the base hospital if rhythm persists or for continued signs of inadequate tissue perfusion.

Vagal Maneuvers (EMT-P)

- Relative contraindications for patients with hypertension, suspected STEMI, or suspected head/brain injury.
- Reassess cardiac and hemodynamic status. Document rhythm before, during and after procedure.
- If rhythm does not convert within ten (10) seconds, follow ICEMA Reference #14040 - Tachycardias - Adult.



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PATIENT CARE GUIDELINES

I. PURPOSE

To establish guidelines for the minimum standard of care and transport of patients.

II. BLS INTERVENTIONS

- Obtain a thorough assessment of the following:
 - Airway, breathing and circulatory status.
 - Subjective assessment of the patient's physical condition and environment.
 - Objective assessment of the patient's physical condition and environment.
 - Vital signs (blood pressure, pulse, respiration, GCS, skin signs, etc.).
 - Prior medical history and current medications.
 - Any known medication allergies or adverse reactions to medications, food or environmental agents.
- Initiate care using the following tools as clinically indicated or available:
 - Spinal motion restriction.
 - Airway control with appropriate BLS airway adjunct.
 - Oxygen as clinically indicated.
 - Assist the patient into a physical position that achieves the best medical benefit and maximum comfort.
 - Automated External Defibrillator (AED).
 - Administer Naloxone by intranasal and/or intramuscular routes.
 - Blood glucose monitoring.
 - Consider the benefits of early transport and/or intercept with ALS personnel if clinically indicated.
- Assemble necessary equipment for ALS procedures or treatment under direction of EMT-P.
 - Cardiac monitoring.
 - IV/IO.
 - Endotracheal intubation.
- Under EMT-P supervision, assemble pre-load medications as directed (excluding controlled substances).

III. LIMITED ALS (LALS) INTERVENTIONS

- Evaluation and continuation of all initiated BLS care.
- Augment BLS assessment with an advanced assessment including, but not limited to the following:
 - Qualitative lung assessment.
 - Blood glucose monitoring.
- Augment BLS treatment measures with LALS treatments as indicated by LALS protocols.
- Initiate airway control as needed with the appropriate LALS adjunct.
- Initiate vascular access as clinically indicated.

IV. ALS INTERVENTIONS

- Evaluation and continuation of all initiated BLS and/or LALS care when indicated by patient's condition.
- Augment BLS and/or LALS assessment with clinically indicated advanced assessments including but not limited to the following:
 - Cardiac monitor and/or 12-lead ECG.
 - Capnography.
 - Blood glucose monitoring.
- Augment BLS and/or LALS treatment with advanced treatments as clinically indicated.
 - Initiate airway control when clinically indicated using an appropriate airway adjunct to achieve adequate oxygenation and ventilation.
 - Initiate fluid resuscitation when clinically indicated.~~Initiate airway control only when clinically indicated for the appropriate administration of medications and/or fluids.~~
- Review and evaluate treatments initiated by BLS, LALS, or ALS personnel.
 - Consider discontinuing treatments not warranted by patient's clinical condition. Intermittent monitoring may be used instead of continuous monitoring when clinically indicated.



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TRAUMA - ADULT (15 years of age and older)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Any trauma patient meeting Trauma Triage Criteria requiring rapid transportation to the closest Trauma Center.
- Refer to ICEMA Reference #9040 - Trauma Triage Criteria and ICEMA Reference #9030 - Destination.
- Contact the Trauma Center as soon as possible in order to activate the trauma team.
 - If the closest Trauma Center is outside ICEMA region, and no base orders or consult is needed, EMS field personnel may contact the hospital they will be transporting the patient to.
 - In Inyo and Mono Counties, the assigned base hospital shall be contacted for determination of appropriate destination.

NOTE: EMS field personnel are not authorized to evaluate patients with suspected concussion for purpose of return to play clearance.

II. BLS INTERVENTIONS

- Ensure thorough initial assessment.
- Ensure patent airway, protecting cervical spine.
- Obtain oxygen saturation (if BLS equipped).
- Administer oxygen and/or ventilate as needed.
- Keep patient warm.
- For a traumatic full arrest, provide CPR, utilize the AED if indicated and transport to the closest most appropriate hospital.
- Mechanical cardiopulmonary resuscitation (mCPR) devices are contraindicated for trauma patients
- Transport to ALS intercept or to the closest receiving hospital.

A. Manage Special Considerations

- **Spinal Motion Restriction:** If the patient meet(s) any of the following indicators using the acronym (NSAID):
 - N**-euro Deficit(s) present?
 - S**-pinal Tenderness present?
 - A**-ltered Mental Status?
 - I**-ntoxication?
 - D**-istracting Injury?

- Consider maintaining spinal alignment on the gurney, or using spinal motion restriction on an awake, alert and cooperative patient, without the use of a rigid spine board.
- Penetrating trauma without any NSAID indicators are not candidates for spinal motion restriction.

NOTE: The long backboard (LBB) is an extrication tool, whose purpose is to facilitate the transfer of a patient to a transport stretcher and is not intended, or appropriate for achieving spinal motion restriction. Judicious application of the LBB for purposes other than extrication necessitates that EMS field personnel ensure the benefits outweigh the risks. If a LBB is applied for any reason, patients should be removed as soon as it is safe and practical. LBB does not need to be reapplied on interfacility transfer (IFT) patients.

- **Abdominal Trauma:** Cover eviscerated organs with saline dampened gauze. Do not attempt to replace organs into the abdominal cavity.
- **Amputations:** Control bleeding. Rinse amputated part gently with sterile irrigation saline to remove loose debris/gross contamination. Place amputated part in dry, sterile gauze and in a plastic bag surrounded by ice (if available). Prevent direct contact with ice. Document in the narrative who the amputated part was given to.

Partial Amputation: Splint in anatomic position and elevate the extremity.

- **Bleeding:**
 - Apply direct pressure and/or pressure dressing.
 - When direct pressure or pressure dressing fails, control life threatening bleeding of a severely injured extremity with the application of a tourniquet.
- **Chest Trauma:** If a wound is present, cover it with an occlusive dressing. If the patient's ventilations are being assisted, dress wound loosely, (do not seal). Continuously reevaluate patient for the development of tension pneumothorax.
- **Flail Chest:** Stabilize chest, observe for tension pneumothorax. Consider assisted ventilations.
- **Fractures:** Immobilize above and below the injury. Apply splint to injury in position found except:
 - **Femur:** Apply traction splint if indicated.
 - **Grossly angulated long bone with distal neurovascular compromise:** Apply gentle unidirectional traction to improve circulation.
 - **Check and document distal pulse before and after positioning.**
- **Genital Injuries:** Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding. Treat amputations the same as extremity amputations.

- **Head and Neck Trauma:** Place brain injured patients in reverse Trendelenburg (elevate the head of the backboard 15 - 20 degrees), if the patient exhibits no signs of shock.
 - **Eye:** Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe, stabilize it in place with sterile saline soaked gauze. Cover uninjured eye.
 - **Avulsed Tooth:** Collect teeth, place in moist, sterile saline gauze and place in a plastic bag.
- **Impaled Object:** Immobilize and leave in place. Remove object if it interferes with CPR, or if the object is impaled in the face, cheek or neck and is compromising ventilations.
- **Determination of Death on Scene:** Refer to ICEMA Reference #14250 - Determination of Death on Scene.

III. LIMITED ALS (LALS) INTERVENTIONS

- Perform identified BLS interventions and additional LALS interventions.
- Advanced airway (as indicated).
 - **Unmanageable Airway:** Transport to the closest most appropriate receiving hospital when the patient requires advanced airway and an adequate airway cannot be maintained with a BVM device.
- Establish IV access.
 - **Unstable:** If BP less than 90 mm Hg and/or signs of inadequate perfusion, start 2nd IV access.
 - **Stable:** Maintain IV if BP more than 90 mm Hg and/or signs of adequate tissue perfusion.

Blunt Trauma:

- **Unstable:** Establish IV NS administer 250 ml bolus. May repeat one (1) time to a maximum of 500 ml.
- **Stable:** Saline lock only, do not administer IV fluids.

Penetrating Trauma:

- Saline lock only, do not administer IV fluids.

Isolated Closed Head Injury:

- **Unstable:** Establish IV NS, administer 250 ml bolus. May repeat one (1) time to a maximum of 500 ml.
- **Stable:** Saline lock only, do not administer IV fluids.

Isolated Extremity Trauma:

- *Unstable:* Establish IV NS, administer 250 ml bolus. May repeat one (1) time to a maximum of 500 ml.
- *Stable:* Saline lock only, do not administer IV fluids.
- Transport to appropriate hospital.

A. A. Manage Special Considerations

- [Consider Push Dose Epi for persistent shock due to trauma where cardiac arrest is imminent, per ICEMA Reference #11010 - Medication - Standard Orders.](#)
 - **Spinal Motion Restriction:** LALS personnel should remove LBB devices from patients placed in full spinal motion restriction precautions by first responders and BLS personnel if the patient does not meet any of the following indicators using the acronym (NSAID):
 - N-euro Deficit(s) present?
 - S-pinal Tenderness present?
 - A-ltered Mental Status?
 - I-ntoxication?
 - D-istracting Injury?
 - **Impaled Object:** Remove object upon Trauma base hospital physician order, if indicated.
- B. Determination of Death on Scene:** Refer to ICEMA Reference #14250 - Determination of Death on Scene.
- *Severe Blunt Force Trauma Arrest:* If indicated, transport to the closest receiving hospital.
 - *Penetrating Trauma Arrest:* If indicated, transport to the closest receiving hospital.
 - If the patient does not meet the "Obvious Death Criteria" per ICEMA Reference #14250 - Determination of Death on Scene, contact the Trauma base hospital for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.
 - Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without Trauma base hospital contact.
 - **Precautions and Comments:**
 - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
 - Consider cardiac etiology in older patients in cardiac arrest with low probability of mechanism of injury.

- If the patient is not responsive to trauma-oriented resuscitation, consider medical etiology and treat accordingly.
- Unsafe scene may warrant transport despite low potential for survival.

IV. ALS INTERVENTIONS

- Perform identified BLS and LALS intervention and the additional ALS interventions.
- Advanced Airway (as indicated):
 - Unmanageable Airway: If an adequate airway cannot be maintained with a BVM device; **and** the paramedic is unable to intubate or insert SGA or perform a successful needle cricothyrotomy (if indicated), **then** transport to the closest receiving hospital and follow ICEMA Reference #9010 - Continuation of Care (San Bernardino County Only).
- Monitor ECG.
- Establish IV/IO access.
 - *Unstable:* If BP less than 90 mm Hg and/or signs of inadequate perfusion, start 2nd IV access.
 - *Stable:* Maintain IV/IO if BP more than 90 mm Hg and/or signs of adequate tissue perfusion.
- **Blunt Trauma:**
 - *Unstable:* Establish IV/IO NS administer 250 ml bolus. May repeat one (1) time to a maximum of 500 ml.
 - *Stable:* Saline lock only, do not administer IV fluids.
- **Penetrating Trauma:**
 - Saline lock only, do not administer IV fluids.
- **Isolated Closed Head Injury:**
 - *Unstable:* Establish IV/IO NS, administer 250 ml bolus. May repeat one (1) time to a maximum of 500 ml.
 - *Stable:* Saline lock only, do not administer IV fluids.
- **Isolated Extremity Trauma:**
 - *Unstable:* Establish IV/IO NS, administer 250 ml bolus. May repeat one (1) time to a maximum of 500 ml (avoid placement on injured extremity).
 - *Stable:* Saline lock only, do not administer IV fluids.
- Tranexamic Acid (TXA) administration for blunt or penetrating traumas:

- Must be within three (3) hours of injury and must have either:
 - Signs and symptoms of hemorrhagic shock with SBP less than 90 mm Hg.
 - Significant hemorrhage with heart rate greater than or equal to 120.
 - Bleeding not controlled by direct pressure or tourniquet.
 - Pediatric administration is not indicated.
- **Blunt Trauma:**
 - For signs of hemorrhagic shock meeting inclusion criteria above, administer TXA per ICEMA Reference #11010 - Medication - Standard Orders.
- **Penetrating Trauma:**
 - For signs of hemorrhagic shock meeting inclusion criteria above, administer TXA per ICEMA Reference #11010 - Medication - Standard Orders.
- Transport to appropriate Trauma Center.
- Insert nasogastric/orogastric tube as indicated.
- A. **Manage Special Considerations**
 - As a temporary method for chest decompression, in the management of suspected tension pneumothorax, perform needle thoracostomy.
 - **Clinical Indications:**
 - *Patients with hypotension (SBP less than 90), clinical signs of shock, and at least one of the following signs:*
 - *Jugular vein distention.*
 - *Tracheal deviation away from the side of the injury (often a late sign).*
 - *Absent or decreased breath sounds on the affected side.*
 - *Increased resistance when ventilating a patient*
 - The midaxillary line at the 5th intercostal space is the preferred site.
 - Consider bilateral needle thoracostomy if no improvement or in traumatic cardiac arrest.
- **Pain Relief for Acute Traumatic Injuries:**
 - Administer an appropriate analgesic per ICEMA Reference #14100 - Pain Management. Document vital signs and pain scales every five (5) minutes until arrival at destination
 - Consider Ondansetron per ICEMA Reference #11010 - Medication - Standard Orders.

B. Determination of Death on Scene: Refer to ICEMA Reference #14250 - Determination of Death on Scene.

- *Severe Blunt Force Trauma Arrest:* If indicated, pronounce on scene.
- *Penetrating Trauma Arrest:* If indicated, transport to the closest receiving hospital.
- If the patient does not meet the "Obvious Death Criteria" per ICEMA Reference #14250 - Determination of Death on Scene, contact the Trauma base hospital for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma with documented asystole in at least two (2) leads, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.

V. REFERENCES

<u>Number</u>	<u>Name</u>
9010	Continuation of Care
9030	Destination
9040	Trauma Triage Criteria
11010	Medication - Standard Orders
14050	Cardiac Arrest - Adult
14100	Pain Management
14250	Determination of Death on Scene



**INLAND COUNTIES
EMERGENCY MEDICAL AGENCY
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TRAUMA - PEDIATRIC (Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Any pediatric trauma patient less than 15 years of age meeting trauma triage criteria requiring rapid transportation to the closest pediatric trauma center.

- Refer to ICEMA Reference #9040 - Trauma Triage Criteria and ICEMA Reference #9030 - Destination.
- Contact the receiving pediatric trauma center as soon as possible in order to activate the pediatric trauma team.
 - Inyo and Mono Counties contact the assigned base hospital for determination of appropriate destination.

NOTE: EMS field personnel are not authorized to evaluate patients with suspected concussion for the purpose of return to play clearance.

II. BLS INTERVENTIONS

- Ensure thorough initial assessment.
- Ensure patient airway, protecting cervical spine.
- Oxygen and/or ventilate as needed, O₂ saturation (if BLS equipped).
- Keep patient warm and reassure.
- For a traumatic full arrest, an AED may be utilized, if indicated.
- Transport to ALS intercept or to the closest receiving hospital.

A. Manage Special Considerations

- **Spinal Motion Restriction:** Using age appropriate assessments, if the patient meet(s) any of the following indicators using the acronym (NSAID):
 - N**-euro Deficit(s) present?
 - S**-pinal Tenderness present?
 - A**-ltered Mental Status?
 - I**-ntoxication?
 - D**-istracting Injury?
 - Consider maintaining spinal alignment on the gurney, or using spinal motion restriction on an awake, alert and cooperative patient, without the use of a rigid spine board.
 - Penetrating trauma without any NSAID indicators are not candidates for spinal immobilization using spine board.

- **Spinal Motion Restriction with use of a Rigid Spine Board:** If the use of a rigid, spine board is indicated, and the level of the patient's head is greater than that of the torso, use approved pediatric spine board with a head drop or arrange padding on the board so that the ears line up with the shoulders and keep the entire lower spine and pelvis in line with the cervical spine and parallel to the board.
- **Abdominal Trauma:** Cover eviscerated organs with saline dampened gauze. Do not attempt to replace organs into the abdominal cavity.
- **Amputations:** Control bleeding. Rinse amputated part gently with sterile irrigation saline to remove loose debris/gross contamination. Place amputated part in dry, sterile gauze and in a plastic bag surrounded by ice (if available). Prevent direct contact with ice. Document in the narrative who the amputated part was given to.
 - **Partial amputation:** Splint in anatomic position and elevate the extremity.
- **Chest Trauma:** If a wound is present, cover it with an occlusive dressing. If the patient's ventilations are being assisted, dress wound loosely, (do not seal). Continuously re-evaluate patient for the development of tension pneumothorax.
- **Flail Chest:** Stabilize chest, observe for tension pneumothorax. Consider assisted ventilations.
- **Fractures:** Immobilize above and below the injury. Apply splint to injury in position found except:
 - **Femur:** Apply traction splint if indicated.
 - **Grossly angulated long bone with distal neurovascular compromise:** Apply gentle unidirectional traction to improve circulation.
 - **Check and document distal pulse before and after positioning.**
- **Genital Injuries:** Cover genitalia with saline soaked gauze. If necessary, apply direct pressure to control bleeding. Treat amputations the same as extremity amputations.
- **Head and Neck Trauma:** Place brain injured patients in reverse Trendelenburg (elevate the head of the backboard 15 - 20 degrees), if the patient exhibits no signs of shock.
 - **Eye:** Whenever possible protect an injured eye with a rigid dressing, cup or eye shield. Do not attempt to replace a partially torn globe - stabilize it in place with sterile saline soaked gauze. Cover uninjured eye.
 - **Avulsed Tooth:** Collect teeth, place in moist, sterile saline gauze and place in a plastic bag.
- **Impaled Object:** Immobilize and leave in place. Remove object if it interferes with CPR, or if the object is impaled in the face, cheek or neck and is compromising ventilations.

- **Traumatic Arrest:** CPR if indicated. May utilize an AED if indicated.
- **Determination of Death on Scene:** Refer to ICEMA Reference #14250 - Determination of Death on Scene.

III. LIMITED ALS (LALS) INTERVENTIONS

- Perform identified BLS interventions and additional LALS interventions.
 - **Unmanageable Airway:** When an adequate airway cannot be maintained by a BVM device, transport to the closest most appropriate receiving hospital.
- IV Access (warm IV fluids when available).
 - **Unstable:** Vital signs (age appropriate) and/or signs of inadequate tissue perfusion, start 2nd IV access.
Administer 20 ml/kg NS bolus IV.
 - **Stable:** Vital signs (age appropriate) and/or signs of adequate tissue perfusion.
Saline lock only, do not administer IV fluids.
- Transport to appropriate hospital. Pediatric patients identified as CTP will be transported to a Pediatric Trauma Center when there is less than a 20 minute difference in transport time to the Pediatric Trauma Center versus the closes Trauma Center.

A. Manage Special Considerations

- Consider Push Dose Epi for persistent shock due to trauma where cardiac arrest is imminent, per ICEMA Reference #11010 - Medication - Standard Orders
- **Spinal Motion Restriction :** LALS personnel should remove LBB devices from patients placed in full spinal motion restriction precautions by first responders and BLS personnel if the patient does not meet any of the following indicators while considering age-appropriate assessments when using the acronym (NSAID):
 - N-euro Deficit(s) present?
 - S-pinal Tenderness present?
 - A-ltered Mental Status?
 - I-ntoxication?
 - D-istracting Injury?
- **Impaled Object:** Remove object upon trauma base hospital physician order, if indicated.

B. **Determination of Death on Scene:** Refer to ICEMA Reference #14250 - Determination of Death on Scene.

- **Severe Blunt Force Trauma Arrest:** If indicated, transport to the closest receiving hospital.
- **Penetrating Trauma Arrest:** If indicated, transport to the closest receiving hospital.

- If the patient does not meet the "Obvious Death Criteria" in ICEMA Reference #14250 - Determination of Death on Scene, contact the Trauma base hospital for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.
- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without trauma base hospital contact.
- **Precautions and Comments:**
 - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
 - Confirm low blood sugar in children and treat as indicated with altered level of consciousness.
 - Suspect child maltreatment when physical findings are inconsistent with the history. Remember reporting requirements for suspected child maltreatment.
 - Unsafe scene may warrant transport despite low potential for survival.

IV. ALS INTERVENTIONS

- Perform identified BLS and LALS interventions and the additional ALS interventions.
- Establish advanced airway as indicated per ICEMA Reference #11020 -Procedure - Standard Orders.
 - Unmanageable Airway: If an adequate airway cannot be maintained with a BVM device; **and** the paramedic is unable to intubate, [insert SGA](#) or perform a successful needle cricothyrotomy (if indicated), **then** transport to the closest receiving hospital and follow ICEMA Reference #9010 - Continuation of Care.
- Establish IV/IO Access (warm IV fluids when available).
 - *Unstable:* Vital signs (age appropriate) and/or signs of inadequate tissue perfusion, start 2nd IV access.
Administer 20 ml/kg NS bolus IV.
 - *Stable:* Vital signs (age appropriate) and/or signs of adequate tissue perfusion.
Saline lock only, do not administer IV fluids.
- Monitor ECG.
- Insert nasogastric/orogastric tube as indicated.

A. Manage Special Considerations

- As a temporary method for chest decompression, in the management of suspected tension pneumothorax, perform needle thoracostomy.

- **Clinical Indications:**

- *Patients with hypotension (SBP less than 90), clinical signs of shock, and at least one of the following signs:*
 - *Jugular vein distention.*
 - *Tracheal deviation away from the side of the injury (often a late sign).*
 - *Absent or decreased breath sounds on the affected side.*
 - *Increased resistance when ventilating a patient*

- The midaxillary line at the 5th intercostal space is the preferred site.
- Consider bilateral needle thoracostomy if no improvement or in traumatic cardiac arrest.

- **Fractures**

- **Pain Relief:**

- Fentanyl per ICEMA Reference #11010 - Medication - Standard Orders.
- For patients four (4) years old and older, consider Ondansetron per ICEMA Reference #11010 - Medication - Standard Orders.

- **Pain Relief for Acute Traumatic Injuries:**

- Administer an appropriate analgesic per ICEMA Reference #14100 - Pain Management. Document vital signs and pain scales every five (5) minutes until arrival at destination.
- Consider Ondansetron per ICEMA Reference #11010 - Medication - Standard Orders

- **Impaled Object:** Remove object upon Trauma base hospital physician order, if indicated.

B. Determination of Death on Scene: Refer to ICEMA Reference #14250 - Determination of Death on Scene.

- *Severe Blunt Force Trauma Arrest:* If indicated, transport to the closest receiving hospital.
- *Penetrating Trauma Arrest:* If indicated, transport to the closest receiving hospital.
- If the patient does not meet the "Obvious Death Criteria" in ICEMA Reference #14250 - Determination of Death on Scene, contact the Trauma base hospital for determination of death on scene for those patients who suffer a traumatic cardiac arrest in the setting of penetrating trauma with documented asystole in at least

two (2) leads, and no reported vital signs (palpable pulse and/or spontaneous respirations) during the EMS encounter with the patient.

- Resuscitation efforts on a penetrating traumatic arrest victim are not to be terminated without Trauma base hospital contact.

V. REFERENCES

<u>Number</u>	<u>Name</u>
9010	Continuation of Care
9030	Destination
9040	Trauma Triage Criteria
11010	Medication - Standard Orders
11020	Procedure - Standard Orders
14150	Cardiac Arrest - Pediatric (Less than 15 years of age)
14250	Determination of Death on Scene
14100	Pain Management



**INLAND COUNTIES
EMERGENCY MEDICAL AGENCY
POLICY AND PROTOCOL MANUAL**

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SEPSIS

I. PURPOSE: To facilitate rapid identification and treatment of patients with suspected sepsis.

II. FIELD ASSESSMENT/TREATMENT INDICATORS

For possible infection and two or more of the following:

- Temperature > 100.4 F or < 96.8 F
- Sustained HR >90
- EtCO₂ ≤ 25 mmHg
- Sustained Respiratory rate >20

III. BLS INTERVENTIONS

- Oxygen therapy as clinically indicated.
- Position patient as tolerated and cover to avoid shivering. If altered, place in left lateral position.
- Obtain and assess blood glucose level. If indicated, administer Glucose - Oral per ICEMA Reference #11010 Medication - Standard Orders.

IV. LIMITED ALS INTERVENTIONS

- Perform activities identified in the BLS Interventions
- Obtain vascular access.
- Administer 500 ml IV bolus, may repeat one (1) time.
- If hypoglycemic;
 - Dextrose per ICEMA Reference #11010 - Medication - Standard Orders, **or**
 - If unable to establish IV, Glucagon may be given one (1) time per ICEMA Reference #11010 - Medication - Standard Orders.
- If hyperglycemic;
 - Administer 500 ml IV bolus may repeat one (1) time.

V. ALS INTERVENTIONS

- Perform activities identified in the BLS and LALS Interventions.
- Place on cardiac monitor and obtain a 12-lead ECG as clinically indicated.
- Monitor EtCO₂

For profound hypotension, unresponsive to fluid boluses, administer Push Dose Epinephrine per ICEMA Reference #11010 - Medication - Standard Orders

VI. SPECIAL CONSIDERATIONS

- Risk Factors:
 - Indwelling catheters (foley, PICC line etc.)
 - Recent surgery
 - Open wounds
 - Bedridden or immobile patients
 - Compromised Immune system due to comorbidities (cancer, autoimmune disease, etc.)
- Prioritize early recognition, IV fluids and rapid hospital notification and transport.
- If signs of pulmonary edema, stop or limit fluid boluses.
- Hypotension is a late indicator for septic shock.

VII. REFERENCES

<u>Number</u>	<u>Name</u>
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11020	Procedure - Standard Orders

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6030	Reporting Incidents of Suspected Abuse
6040	Organ Donor Information
6050	Local Medical Emergency
6060	Patient Restraints
6070	Care of Minors in the Field
6080	Patient Refusal of Care - Adult
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14030	Bradycardias – Adult
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INLAND COUNTIES EMERGENCY MEDICAL AGENCY POLICY AND PROTOCOL MANUAL

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ADOPTION OF POLICIES AND PROTOCOLS

I. PURPOSE

To establish procedures for the review of EMS system policies and patient care/treatment protocols.

The ICEMA Medical Director and EMS Administrator are responsible for the development and approval of policies and protocols that establish operating procedures and medical control according to State regulations. ICEMA recognizes that stakeholder collaboration is an essential component of policy and protocol development and accepts input from the Medical Advisory Committee (MAC), ~~System Advisory Committee (SAC)~~, standing ICEMA subcommittees and/or other interested parties through a review process as established below. EMS stakeholder input is advisory to ICEMA for the formulation of these policies, protocols and procedures and the final authority rests with the ICEMA Medical Director and EMS Administrator.

II. POLICY

- ICEMA will review all EMS system policies and protocols, as necessary, to ensure time critical and appropriate changes.
- ICEMA will solicit input from appropriate external agencies, organizations and established advisory committees such as those listed below, as necessary:
 - Medical Advisory Committee (MAC)
 - ~~System Advisory Committee (SAC)~~ Pediatric Advisory Committee
 - ST Elevation Myocardial Infarction QI Committee (STEMI QI)
 - Stroke QI Committee (Stroke QI)
 - Trauma Advisory Committee (TAC)
(Joint San Bernardino County and Riverside County Quality Improvement Committee)
- ICEMA will review EMS system policies and protocols as required. Changes that may occur without specific input from committees include, but are not limited to:
 - Changes in wording necessary to clarify the objective.
 - Changes in the listed order or numbering necessary for clarity or flow.
 - Changes to assure policy or protocol continuity and consistency.
 - Changes required to comply with State and local laws and/or regulations to maintain public health and safety.
 - Correction of typographical, grammar, spelling or formatting errors.
 - Changes required for medical control or to maintain system integrity.

- ICEMA will prepare a detailed grid of proposed policy and protocol changes for input from MAC ~~and SAC~~.
- ICEMA will consider all relevant input presented to it before accepting, amending or deleting any EMS system policy or protocol, but the authority for final determination remains with the Medical Director and EMS Administrator.
- ICEMA will submit changes in EMS system policies and protocols to public comment as noted below under Section V - Notification and Public Comment Period.
- EMS system policies and protocols, approved by the Medical Director and EMS Administrator, shall become effective no later than 30 days after the date of approval except as noted under Section IV - Emergency Policies and Protocols.

III. REQUEST FOR REVIEW OF EMS SYSTEM POLICIES/ PROTOCOLS

- Any interested party may request the review of EMS system policies or protocols as provided in this section. Such requests shall be in writing and clearly and concisely state:
 - The substance or nature of the requested review.
 - The reason for the request.
 - Any supporting documentation and/or research that would support the request.
- Upon receipt of a written request for the review of a policy or protocol, ICEMA will notify the petitioner or group in writing of the receipt of the request and then shall, within 30 business days, either deny the request, in writing, indicating why the agency has reached such a decision or schedule the policy or protocol for review, in the appropriate committee(s), in accordance with this policy.
- ICEMA may grant or deny such a request or take such other action as it may determine to be warranted and will notify the petitioner in writing of such action.

IV. EMERGENCY POLICIES AND PROTOCOLS

- If ICEMA determines that an emergency policy or protocol is necessary for the immediate preservation of the public health and safety or general welfare, a policy or protocol may be changed as an emergency action.
- Any finding of an emergency will include a written statement describing the specific facts showing the need for immediate action. The statement and the policy or protocol shall be immediately forwarded to MAC ~~and/or SAC~~ and EMS providers (as appropriate). The emergency policy or protocol will become effective no sooner than five (5) days following dissemination to the committee, unless there is an immediate need determined by ICEMA.
- Policies or protocols adopted under the emergency provision shall remain in effect until reviewed by the appropriate committee.

V. NOTIFICATION AND PUBLIC COMMENT PERIOD

- Consistent with a policy of encouraging the widest possible notification and distribution to interested persons, ICEMA will:
 - Post proposed changes to policies or protocols on the ICEMA website at ICEMA.net at least 30 days prior to the MAC ~~meeting and/or SAC meetings~~. The notice of change will include a statement of the time and place of proceedings for public comment.
 - E-mail notification of proposed changes to members of the Emergency Medical Care Committee (EMCC), MAC, ~~and SAC~~.
 - E-mail notification of proposed changes to each EMS provider.
 - E-mail notification of proposed changes to any person who has filed a request for notification with ICEMA.
 - Conduct official public comment during the MAC ~~and/or SAC~~ meeting.
- The provisions of this section shall not be construed in any manner to invalidate a policy or protocol due to perceived inadequacy of the notice.
- When necessary to fulfill its responsibilities, ICEMA will revise and/or initiate policies or protocols without following this process. Any oversight in notification described above shall not invalidate any action taken by ICEMA pursuant to this policy.



INLAND COUNTIES EMERGENCY MEDICAL AGENCY POLICY AND PROTOCOL MANUAL

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EMERGENCY MEDICAL DISPATCH CENTER REQUIREMENTS (*San Bernardino County Only*)

I. PURPOSE

To establish ICEMA authorized Emergency Medical Dispatch (EMD) Centers to dispatch emergency medical services (EMS) resources and establish the minimum response levels of those resources.

Currently, Medical Priority Dispatch System (MPDS) is the only ICEMA recognized EMD program.

II. DISPATCH OPERATIONS

- EMD Dispatch Centers shall:
 - Operate twenty-four (24) a day, seven (7) days a week, except under certain circumstances such as infrequent dispatcher overload or under disaster conditions as specified by the State of California Code, California Emergency Services Act, Chapter 7, Division 1, Title 2, Section 8558.
 - Provide dispatch services necessary to receive and respond to requests for emergency and advanced life support (ALS) ambulance services and monitor system status.
 - Be approved by the State of California as a public safety answering point (PSAP).
 - Receive and process calls for emergency medical assistance from primary and secondary 9-1-1 PSAPs.
 - Provide required data and reports to ICEMA.
- Emergency Medical Dispatchers shall:
 - Determine the nature and severity of medical incidents consistent with MPDS protocols.
 - Dispatch appropriate EMS resources.
 - Provide post-dispatch and pre-arrival instructions to callers.
 - Notify responding personnel and agencies of pertinent information.
 - Monitor and track responding resources of their agency.
 - Coordinate with law enforcement, first responders and other EMS providers as needed and provide education to enhance cooperation between agencies.
 - Participate in the ICEMA Continuous Quality Improvement (CQI) process.

III. STAFFING

- The EMD Dispatch Center shall be staffed with sufficient International Academies of Emergency Dispatch (IAED) NAEMD trained dispatchers to accomplish all dispatch and EMD functions as indicated by the CQI process.

- All dispatchers interrogating calls must have continuous certification be certified by the INAEMD and maintain cardiopulmonary resuscitation (CPR) certification.
- All emergency medical dispatchers shall receive the required amount of continuing dispatch education to meet INAEMD training standard.

IV. PROCEDURE

- Each dispatch center shall submit a completed EMD Center Application to ICEMA, which is on the ICEMA website at ICEMA.net. This will include a response plan for each agency it services. Compliance with this policy will be reviewed by ICEMA every two (2) years. Any changes in service shall be reported to ICEMA immediately.
- All EMD Dispatch Centers that dispatch 9-1-1 medical response shall follow medical priority dispatch procedures that are compliant with current INAEMD guidelines.
- All EMS providers using tiered response as detailed by INAEMD, shall provide the EMD Dispatch Center with a detailed response plan using the appropriate response codes that are compliant with current INAEMD guidelines and ICEMA Reference #4100 - Medical Priority Dispatch Minimum Response Assignments for Emergency Medical Dispatch (EMD) Categories. The EMD Dispatch Center will then forward the response plan to ICEMA for review by the ICEMA Medical Director. Any changes must be authorized by ICEMA Medical Director.
- Maintain compliance with local medical control approval of all current and future applicable protocols (e.g., protocols 9, 10, 14, 18, 24, 28, 33, 34, 36 & 37) ICEMA local medical control approved cards are as follows:

MPDS Card #	Card Name	Approved Yes/No	Description	Special Instructions
Card 9	Cardiac Arrest/ Death	Yes	Authorized based on current protocols.	Follow ICEMA Reference #14250 and 14260.
Card 10	Aspirin Diagnostic and Instruction	Yes	Use of Aspirin prior to EMS arrival.	Approved for use throughout the ICEMA region.
Card 24	Pregnancy/ Childbirth	Yes	Authorized based on current protocols.	Follow ICEMA Reference #14210.
Card 28	Stroke	Yes	Authorized based on current protocols.	Follow ICEMA Reference #14080.
Card 33	Transfer	No		

V. CQI PLAN

- EMD Dispatch Centers shall submit a CQI plan to ICEMA following the model of the INAEMD. Data will be submitted at a frequency as determined by the CQI Committee to ICEMA as outlined in the CQI plan. Specific additional indicators may be determined by ICEMA as needed.
- EMD Dispatch Centers shall participate on the ICEMA EMD Quality Review Taskforce CQI Committee. Meetings will be held as needed to review the QI data and will include at minimum, each EMD Center's Program Coordinator or their designee and an ICEMA

~~representative dispatch supervisors, data entry personnel, dispatch representatives and ICEMA representatives.~~

- Updates to the INAEMD authorized dispatch system must be implemented in a timely manner as soon as the education and hardware are completed and compatible and documentation of the re-training must be sent to ICEMA once complete.
- A quarterly QI report will be submitted to ICEMA as per the CQI plan. Indicators and education that were reviewed and completed will be documented in this report.

IV. EMD Time Analysis by Dispatch level

- EMD performance report

VI. REFERENCES

<u>Number</u>	<u>Name</u>
4100	Medical Priority Dispatch Minimum Response Assignments for Emergency Medical Dispatch (EMD) Categories
10010	Determination of Death on Scene
10020	End of Care and Decisions
14100	Stroke Treatment - Adult
15080	Obstetrical Emergencies



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STANDARD DRUG AND EQUIPMENT LIST - EMS AIRCRAFT

Each Aircraft shall be equipped with the following functional equipment and supplies. This list represents mandatory items with minimum quantities, to exclude narcotics, which must be kept within the range indicated. All expiration dates must be current. All packaging of drugs or equipment must be intact. No open products or torn packaging may be used.

MEDICATIONS/SOLUTIONS	AMOUNT
Acetaminophen (Tylenol) 1 gm IV	1
Adenosine (Adenocard) 12 mg	2
Albuterol Aerosolized Solution (Proventil) - unit dose 2.5 mg	3 doses
Aspirin, chewable - 81 mg tablet	1 bottle
Atropine 1 mg preload	2
Calcium Chloride 1 gm preload	1
Dextrose 10% in 250 ml Water (D10W) *	1
Diphenhydramine (Benadryl) 50 mg	1
Epinephrine 30 mg/30 ml	1
Epinephrine 0.1 mg/ml 1mg preload	0
Dextrose 50% 25 gm	1
Ipratropium Bromide Inhalation Solution (Atrovent) unit dose 0.5 mg	2
Lidocaine 2% prefilled 100 mg syringe	2
Magnesium Sulfate 10 gms	1
Naloxone (Narcan) 2 mg preload	2
Nitroglycerin (NTG) - Spray 0.4 mg metered dose and/or tablets (tablets to be discarded 90 days after opening.)	1
Normal Saline for Injection (10 cc)	2
Normal Saline 100ml	3
Normal Saline 500 ml	1
Normal Saline 1000 ml	3
Ondansetron (Zofran) 4 mg Oral Disintegrating Tablets (ODT)	2
Ondansetron (Zofran) 4 mg IM/ IV	2
Sodium Bicarbonate 50 mEq preload	1
Tranexamic Acid (TXA) 1 gm	2

CONTROLLED SUBSTANCE MEDICATIONS-MUST BE DOUBLE LOCKED	AMOUNT
Fentanyl	200-400 mcg
Midazolam	20-40 mg
Ketamine	120-1000 mg

AIRWAY/SUCTION EQUIPMENT	AMOUNT
Aircraft Oxygen source -10 L /min for 20 minutes	1
C-PAP circuits - all manufacture's available sizes	1 each
End-tidal CO2 device - pediatric and adult (may be integrated into bag)	1 each
Endotracheal Tubes cuffed - 6.0 and/or 6.5, 7.0 and/or 7.5 2 each and 8.0 (1) each	2 each
ET Tube holders - adult	1 each
Flashlight/penlight	1
Laryngoscope handle with batteries - or 2 disposable handles	1
Laryngoscope blades - #0, #1, #2, #3, #4 curved and/or straight	1 each
Magill Forceps - Pediatric and Adult	1 each

AIRWAY/SUCTION EQUIPMENT	AMOUNT
RAM cannulas- Multiple Sizes	2 each
Naso/Orogastric tubes - 10fr or 12fr, 14fr, 16fr or 18fr	1 each
Naso/Orogastric feeding tubes - 5fr or 6fr, and 8fr	1 each
Nasopharyngeal Airways - child, and adult	1 each
Needle Cricothyrotomy Device (Approved) - Pediatric and adult or	1 each
Needles for procedure 10, 12, 14 and/or 16 gauge	2 each
Non Re-Breather O ₂ Mask - Pediatric and Adult, Infant Simple Mask	1 each
14 gauge 3.25 inch and 18 gauge 1.75-2 inch needles for Needle Thoracostomy	2 each
Oropharyngeal Airways - infant, child, and adult	1 each
Portable Oxygen with regulator - 10 L /min for 20 minutes	1
Portable suction device (battery operated) and/or Wall mount suction device	1 each
Pulse Oximetry device	1
Small volume nebulizer with universal cuff adaptor	1
Stethoscope	1
Suction catheters - 6fr, 8fr or 10fr, 12fr or 14fr	1 each
Ventilation Bags - Infant 250 ml, Pediatric 500 ml and Adult 1 L	1 each
Water soluble lubricating jelly	1
Ridged tonsil tip suction	1

IV/NEEDLES/SYRINGES/MONITORING EQUIPMENT	AMOUNT
12-Lead ECG Monitor and Defibrillator with TCP and printout	1
800 MHz Radio	1
Blood pressure cuff - large adult or thigh cuff, adult, child and infant	1 set
Capnography monitor and supplies, may be integrated in the cardiac monitor	1
Conductive medium or Adult and Pediatric Pacer/Defibrillation pads	2 each
ECG - Pediatric and Adult	20 patches
Mechanical (SAM) or Power IO (EZ) Needles and Driver 25 mm and 45 mm	2 each 1 each
<i>*manual insertion of IO needle is not permitted.</i>	
3-way stopcock with extension tubing	2
IO Needles - Manual, Adult and Pediatric, Optional	1 each
IV Catheters - sizes 14, 16, 18, 20, 22, 24	2 each
Glucose monitoring device	1
Macro drip Administration Set or equivalent	1
Micro drip Administration Set (60 drops/ml) or equivalent	1
Mucosal Atomizer Device (MAD) for nasal administration of medication	2
Needle disposal system (OSHA approved)	1
Pressure infusion bag	1
Safety Needles - 20 or 21 gauge and 23 or 25 gauge	2 each
Saline Lock	2
Syringes w/wo safety needles - 1 ml, 3 ml, 10 ml, 20 ml	2 each
Syringe - 60 ml catheter tip	1
Thermometer - Mercury free with covers	1

DRESSING MATERIALS/OTHER EQUIPMENT SUPPLIES	AMOUNT
Adhesive tape - 1 inch	2
Air occlusive dressing	1
Aircraft stretcher or litter system with approved FAA straps that allows for Axial Spinal Immobilization	1
Ankle and wrist restraints, soft ties acceptable	1

DRESSING MATERIALS/OTHER EQUIPMENT SUPPLIES	AMOUNT
Antiseptic swabs/wipes	
Bandage shears	1
Blanket or sheet	2
Blood Borne Pathogen Protective Equipment - (nonporous gloves, goggles face masks and gowns meeting OSHA Standards)	2
Cervical Collars - Rigid Pediatric & Adult all sizes or Cervical Collars - Adjustable Adult and Pediatric	1 each 1 each
Emesis basin or disposable bags and covered waste container	1
OB Kit	1
Pediatric Emergency Measuring Tape (Broselow, etc.)	1
Providence/Iodine swabs/wipes or antiseptic equivalent	
Roller bandages - 4 inch bandage compress or equivalent	2 2
gauze pads - 4x4 inch	
Sterile Sheet for Burns	1

OPTIONAL EQUIPMENT/MEDICATIONS	Amount
Automatic ventilator (Approved)	1
Backboard padding	1
BLS AED/defib pads	1
Chemistry profile tubes	3
Nerve Agent Antidote Kit (NAAK) - DuoDote or Mark I	3
D5W in bag	1
Hemostatic Dressing *	1
IV infusion pump	1
IV warming device	1
Manual powered suction device	1
Medical Tourniquet	1
Naloxone (Narcan) Nasal Spray 4 mg	2
Needle Thoracostomy Kit (prepackaged)	2
Pediatric immobilization board	1
Translaryngeal Jet Ventilation Device	1
Vacutainer	1

* Hemostatic Dressings

- Quick Clot, Z-Medica
 - Quick Clot, Combat Gauze LE
 - Quick Clot, EMS Rolled Gauze, 4x4 Dressing, TraumaPad
- Celox
 - Celox Gauze, Z-Fold Hemostatic Gauze
 - Celox Rapid, Hemostatic Z-Fold Gauze

NOTE:

- The above products are "packaged" in various forms (i.e., Z-fold, rolled gauze, trauma pads, and 4"x4" pads) and are authorized provided they are comprised of the approved product.
- Hemostatic Celox Granules, or granules delivered in an applicator, are not authorized.



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INTERFACILITY TRANSFER GUIDELINES

I. PURPOSE

To identify patient care responsibilities for emergency medical technicians (EMTs), advanced EMTs (AEMTs) and paramedics (EMT-Ps) during interfacility transports.

II. BLS INTERVENTIONS

During an interfacility transport, an EMT may monitor the following if the patient is non-critical and deemed stable by the transferring physician and the physician has approved transport via BLS ambulance:

Appropriate transfer paperwork and medical records must accompany the patient to their destination.

- Monitor a saline lock or peripheral lines delivering fluids in any combination/concentration of Normal Saline, Lactated Ringers or Dextrose and Water provided the following conditions are met:
 - No medications have been added to the IV fluid.
 - Maintain the IV at a pre-set rate.
 - Check tubing for kinks and reposition arm if necessary.
 - Turn off IV fluid if signs/symptoms of infiltration occur.
 - Control any bleeding at insertion site.
- Transport a patient with a urinary catheter provided the following:
 - The catheter is able to drain freely.
 - No action is taken to impede flow or contents of drainage collection bag.
- Transport a patient with a nasogastric or gastrostomy tube provided the tube is clamped.
- If the patient's condition deteriorates, the patient should be transported to the closest receiving hospital.

III. LIMITED ALS (LALS) INTERVENTIONS

During an interfacility transport, if the patient is non-critical and deemed stable by the transferring physician and the physician has approved transport via LALS ambulance, an AEMT may monitor or perform the following:

- Peripheral lines delivering fluids in any combination/concentration of normal saline, lactated ringers or dextrose and water.
- Saline locks.
- Tracheo-bronchial suction of an intubated patient.

- Initiate prior to contact protocols if the patient's condition deteriorates, then must contact the base hospital per ICEMA Reference #3040 - Radio Communication.

Appropriate transfer paperwork and medical records must accompany the patient to their destination.

AEMTs may not transport a patient with IV drips that are not in the AEMT scope of practice.

AEMTs may not transport patients with blood or blood products.

IV. ALS INTERVENTIONS

Appropriate transfer paperwork and medical records must accompany the patient to their destination.

If the transfer is a STEMI patient, refer to ICEMA Reference #8020 - Specialty Care Transport.

EMT-Ps may not transport a patient with IV drips that are not in the EMT-P scope of practice.

EMT-Ps may not transport patients with blood or blood products.

During an interfacility transport, an ICEMA accredited EMT-P may:

- Monitor peripheral lines delivering fluids in any combination/concentration of normal saline, lactated ringers or dextrose and water.
- Transport intravenous solutions with added medication(s) as follows:
 - Lidocaine
 - Dopamine
 - Magnesium Sulfate
- Monitor and administer medications through a pre-existing vascular access.
- Monitor ~~heparin lock or~~ saline lock.
- Monitor IV solutions containing potassium ≤ 40 mEq/L.
- Monitor thoracostomy tubes to water or dry sealed drainage.
- Monitor nasogastric tubes.
- EMT-Ps may initiate prior to contact protocols if the patient's condition deteriorates, then must contact the base hospital per ICEMA Reference #5040 - Radio Communication Policy.

V. NURSE ASSISTED ALS TRANSPORT

In the event of a critical patient that needs transport with medication or IV drips that are outside of the EMT-P scope of practice and CCT transport is not possible, a Registered Nurse (RN) from the transferring hospital may accompany the patient. The RN will be responsible for orders from the transferring physician. In the event the patient condition deteriorates, the EMT-P will contact the

base hospital for orders and destination change. The RN will continue to provide care consistent with the transferring physician's orders. The base hospital physician may consider discontinuing or continuing the prior orders based on patient condition. The RN will document the base hospital physician orders on the transferring facility's patient care record. The EMT-P will document on the ePCR or O1A.

VI. REFERENCES

<u>Number</u>	<u>Name</u>
3040	Radio Communication
8020	Specialty Care Transport



CARDIAC ARREST - ADULT

High performance (HP) CPR is an organized approach to significantly improve the chance of survival for patients who suffer an out-of-hospital cardiac arrest (OHCA). Return of spontaneous circulation (ROSC) is resumption of sustained perfusing cardiac activity associated with significant respiratory effort after cardiac arrest. Signs of ROSC include breathing, coughing, patient movement and a palpable pulse, or a measurable blood pressure without the use of an automatic compression device.

The principles for HP CPR include:

- Minimize interruptions of chest compressions.
- Ensure proper depth of chest compressions of 2" - 2.5" allowing full chest recoil (no leaning on chest).
- Proper chest compression rate at 100 - 120 per minute.
- Avoid compressor fatigue by rotating compressors every two (2) minutes. Ventilations shall be sufficient to cause minimal chest rise, avoiding hyperventilation as it can decrease survival.
- For cardiac arrest related to drowning, refer to ICEMA Reference # 13060- Drowning/Submersion Injuries.

Advanced airways can be safely delayed in OHCA patients until ROSC is achieved if the airway is effectively managed by BLS Interventions. BVM offers excellent oxygenation and ventilation without disrupting high quality compressions.

Base hospital contact is not required to terminate resuscitative measures, if the patient meets criteria set forth below in the Termination of Efforts in the Prehospital Setting.

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Cardiac arrest in a non-traumatic setting.

II. BLS INTERVENTIONS

- Assess patient, begin HP CPR and maintain appropriate BLS airway measures.
- Place patient on AED, if available. To minimize the "hands off" interval before a rhythm analysis/shock, complete chest compression cycle without an added pause for ventilations or pulse check just before rhythm analysis.
- If shock is advised, perform HP CPR compressions while AED is charging. Remove hands from patient and deliver shock then immediately resume uninterrupted HP CPR for two (2) minutes.
- Do not delay HP CPR for post-shock pulse check or a rhythm analysis.
- After two (2) minutes of HP CPR, analyze rhythm using AED while checking for pulse.

III. LIMITED ALS (LALS) INTERVENTIONS

- Perform activities identified in the BLS interventions.

- Establish peripheral intravenous access and administer a 500 ml bolus of normal saline (NS).
- BLS airway with BVM is the airway of choice during active HP CPR.

IV. ALS INTERVENTIONS

- Initiate HP CPR and continue appropriate BLS Interventions while applying the cardiac monitor without interruption to chest compressions.

♦ **Note: Automatic compression device may only be used for non-traumatic cardiac arrest.**

- Determine cardiac rhythm and defibrillate if indicated. After defibrillation, immediately began HP CPR. Begin a two (2) minute cycle of HP CPR.
- Obtain IV/IO access.
- BLS airways should be maintained during active CPR. Endotracheal intubation is the advanced airway of choice if BLS airway does not provide adequate ventilation. Establish advanced airway per ICEMA Reference #11020 - Procedure - Standard Orders without interruption to chest compressions.
- Utilize continuous quantitative waveform capnography, for the monitoring of patients airway, the effectiveness of chest compressions and for possible early identification of ROSC. Document the waveform and the capnography number in mm HG in the ePCR.

NOTE: Capnography **shall** be used for all cardiac arrest patients.

- Insert NG/OG tube to relieve gastric distension per ICEMA Reference #11020 - Procedure - Standard Orders.

Ventricular Fibrillation/Pulseless Ventricular Tachycardia

- Defibrillate at 360 joules for monophasic or biphasic equivalent per manufacture. If biphasic equivalent is unknown use maximum available.
- Perform HP CPR immediately after each defibrillation for two (2) minutes, without assessing the post-defibrillation rhythm.
- Administer Epinephrine per ICEMA Reference #11010 - Medication - Standard Orders every five (5) minutes, without interruption of HP CPR unless capnography indicates possible ROSC.
- Reassess rhythm for no more than ten (10) seconds after each two (2) minute cycle of HP CPR. If VF/VT persists, defibrillate as above.
- After two (2) cycles of HP CPR, consider administering: Lidocaine per ICEMA Reference #11010 - Medication - Standard Orders, may repeat.
- If patient remains in pulseless VF/VT after 20 minutes of CPR, consult base hospital.

Pulseless Electrical Activity (PEA) or Asystole

- Assess for reversible causes and initiate treatment.

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- Continue HP CPR with evaluation of rhythm (no more than 10 seconds) every two (2) minutes.
- Administer fluid bolus of 300 ml NS IV, may repeat.
- Administer Epinephrine per ICEMA Reference #11010 - Medication - Standard Orders every 5 (five) minutes without interruption of HP CPR.
- Base hospital may order the following:
 - Sodium Bicarbonate per ICEMA Reference #11010 - Medication Standard Orders.
 - Calcium Chloride per ICEMA Reference #11010 - Medication Standard Orders.

Stable ROSC

- Obtain a 12-lead ECG, regardless of 12-lead ECG reading, transport to the closest STEMI Receiving Center, per ICEMA Reference #9030 - Destination.
- Monitor ventilation to a capnography value between 35 mm Hg and 45 mm Hg.
- Utilize continuous waveform capnography to identify loss of circulation.
- For persistent profound shock and hypotension, administer Push Dose Epinephrine per ICEMA Reference #11010 - Medication - Standard Orders.
- Base hospital may order the following:
 - For post ROSC agitation, administer Midazolam per ICEMA Reference # 11010- Medication Standard Orders

Termination of Efforts in the Prehospital Setting

- The decision to terminate efforts in the field should take into consideration, first, the safety of personnel on scene, and then family and cultural considerations.
- Consider terminating resuscitative efforts in the field if no ROSC is achieved and capnography waveform reading remains less than 15 mm Hg after 20 minutes of HP CPR with ALS Interventions, and any of the following criteria are met:
 - No shocks were delivered.
 - Arrest not witnessed by EMS field personnel.
 - Persistent asystole, agonal rhythm or pulseless electrical activity (PEA) at a rate of less than 40 bpm.
- If patient has any signs of pending ROSC (i.e., capnography waveform trending upwards, PEA greater than 40 bpm), then consider transportation to a STEMI Receiving Center.
- Contact local law enforcement to advise of prehospital determination of death.
- Provide comfort and care for survivors.

V. REFERENCES

<u>Number</u>	<u>Name</u>
9030	Destination
11010	Medication - Standard Orders
11020	Procedure - Standard Orders
13060	Drowning/Submersion Injuries



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BURNS - ADULT (15 years of age and older)

Burn patient requires effective communication and rapid transportation to the closest receiving hospital.

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Refer to ICEMA Reference #9030 - Destination policy.

II. BLS INTERVENTIONS

- Break contact with causative agent (stop the burning process).
- Remove clothing and jewelry quickly, if indicated.
- Keep patient warm.
- Estimate % TBSA burned and depth using the "Rule of Nines".
 - An individual's palm represents 1% of TBSA and can be used to estimate scattered, irregular burns.
- Transport to ALS intercept or to the closest receiving hospital.

A. Manage Special Considerations

- **Thermal Burns:** Stop the burning process. Do not break blisters. Cover the affected body surface with dry, sterile dressing or sheet.
- **Chemical Burns:** Brush off dry powder, if present. Remove any contaminated or wet clothing. Irrigate with copious amounts of saline or water.
- **Tar Burns:** Cool with water, do not remove tar.
- **Electrical Burns:** Remove from electrical source (without endangering self) with a nonconductive material. Cover the affected body surface with dry, sterile dressing or sheet.
- **Eye Involvement:** Continuous flushing with NS during transport. Allow patient to remove contact lenses if possible.
- **Determination of Death on Scene:** Refer to ICEMA Reference #14250 - Determination of Death On Scene.

III. LIMITED ALS (LALS) INTERVENTIONS

- Advanced airway as indicated.
- Airway Stabilization:

Burn patients with respiratory compromise or potential for such, will be transported to the closest most appropriate receiving hospital for airway stabilization.
- IV access (warm IV fluids when available).

- *Unstable:* BP less than 90 mm HG and/or signs of inadequate tissue perfusion, start 2nd IV access.

IV NS 500250 ml boluses, may repeat to a maximum of 1000 ml.
- *Stable:* BP more than 90 mm HG and/or signs of adequate tissue perfusion.

IV NS 500 ml per hour.
- Transport to appropriate facility.
 - *Minor Burn Classification:* Transport to the closest most appropriate receiving hospital.
 - *Moderate Burn Classification:* Transport to the closest most appropriate receiving hospital.
 - *Major Burn Classification:* Transport to the closest most appropriate Burn Center (San Bernardino County contact ARMC).
 - *Critical Trauma Patient (CTP) with Associated Burns:* Transport to the most appropriate Trauma Center.
- Burn patients with associated trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.

A. Manage Special Considerations

- **Electrical Burns:** Place AED on patient.
 - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
- **Respiratory Distress:** Use BVM as needed and transport to the nearest facility for airway control. Contact receiving hospital ASAP. Albuterol with Atrovent per ICEMA Reference #11010 -Medication - Standard Orders.
- **Deteriorating Vital Signs:** Transport to the closest most appropriate receiving hospital. Contact base hospital.
- **Pulseness and Apneic:** Transport to the closest most appropriate receiving hospital and treat according to ICEMA policies. Contact base hospital.
- **Determination of Death on Scene:** Refer to ICEMA Reference #14250 - Determination of Death on Scene.
- **Precautions and Comments:**
 - High flow oxygen is essential with known or potential respiratory injury. Beware of possible smoke inhalation.
 - Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact.

- Do not apply ice or ice water directly to skin surfaces, as additional injury will result.

IV. ALS INTERVENTIONS

- Advanced airway (as indicated).
- Airway Stabilization:

Burn patients with respiratory compromise or potential for such, will be transported to the closest most appropriate receiving hospital for airway stabilization.
- Monitor ECG.
- IV/IO Access (Warm IV fluids when available).
 - *Unstable:* BP less than 90 mm HG and/or signs of inadequate tissue perfusion, start 2nd IV access.

IV/IO NS 250 ml boluses, may repeat to a maximum of 1000 ml.
 - *Stable:* BP more than 90 mm HG and/or signs of adequate tissue perfusion.

IV/IO NS 500 ml per hour.
- Treat pain as indicated.

Pain Relief: Administer an appropriate analgesic per ICEMA Reference #14100 - Pain Management - Adult. Document vital signs and pain scales every five (5) minutes until arrival at destination.
- Transport to appropriate facility:
 - *CTP with associated burns,* transport to the closest Trauma Center.
 - Burn patients with associated trauma, should be transported to the closest Trauma Center. Trauma base hospital contacted shall be made.
- Insert nasogastric/orogastric tube as indicated.
- Refer to Section V - Burn Classifications below.

A. Manage Special Considerations

- **Electrical Burns:** Monitor for dysrhythmias, treat according to ICEMA protocols.
 - Electrical injuries that result in cardiac arrest shall be treated as medical arrests.
- **Respiratory Distress:** Intubate patient if facial/oral swelling are present or if respiratory depression or distress develops due to inhalation injury.
 - Albuterol with Atrovent per ICEMA Reference #11010 - Medication - Standard Orders.

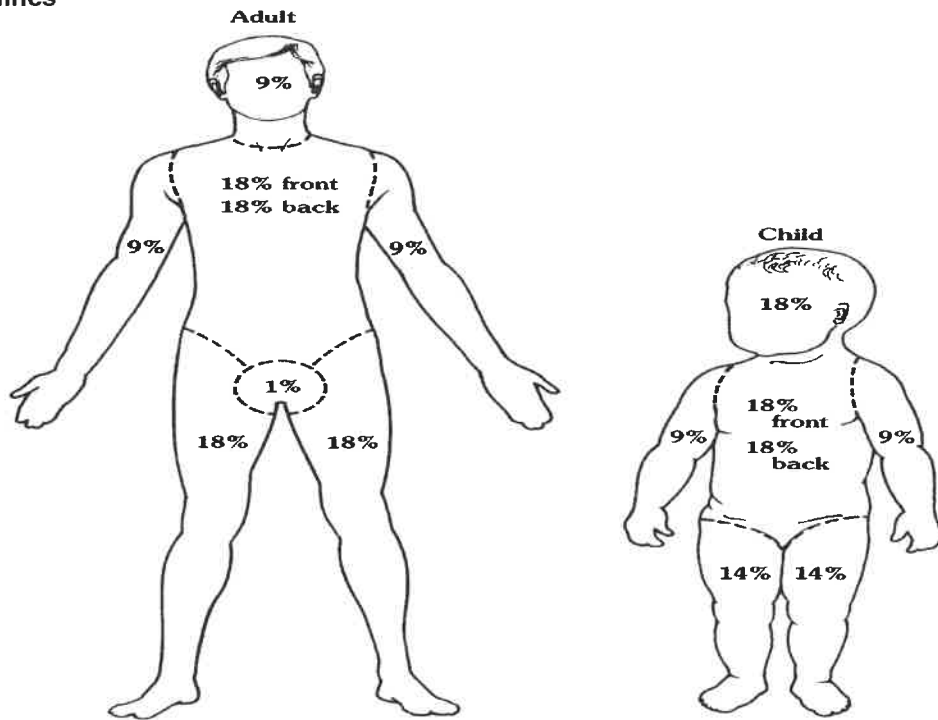
- Administer humidified oxygen, if available.
- Apply capnography.
- Awake and breathing patients with potential for facial/inhalation burns are not candidates for nasal tracheal intubation. CPAP may be considered, if indicated, after consultation with base hospital.
- **Deteriorating Vital Signs:** Transport to the closest receiving hospital. Contact base hospital.
- **Pulseness and Apneic:** Transport to the closest receiving hospital and treat according to ICEMA policies. Contact base hospital.
- **Determination of Death on Scene:** Refer to ICEMA Reference #14250 - Determination of Death on Scene.
- **Precautions and Comments:**
 - Contact with appropriate advisory agency may be necessary for hazardous materials, before decontamination or patient contact.
 - Do not apply ice or ice water directly to skin surfaces, as additional injury will result.
- **Base Hospital Orders:** May order additional medications, fluid boluses and CPAP.

V. BURN CLASSIFICATIONS

ADULT BURN CLASSIFICATION CHART	DESTINATION	
<p><u>MINOR</u> - ADULT</p> <ul style="list-style-type: none"> • Less than 10% TBSA • Less than 2% Full Thickness 	<p>CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL</p>	
<p><u>MODERATE</u> - ADULT</p> <ul style="list-style-type: none"> • 10 - 20% TBSA • 2 - 5% Full Thickness • High Voltage Burn • Suspected Inhalation Injury • Circumferential Burn • Medical problem predisposing to infection (e.g., diabetes mellitus, sickle cell disease) 	<p>CLOSEST MOST APPROPRIATE RECEIVING HOSPITAL</p>	

<p>MAJOR - ADULT</p> <ul style="list-style-type: none"> • More than 20% TBSA burn in adults • More than 5% Full Thickness • Known Inhalation Injury • Any significant burn to face, eyes, ears, genitalia, or joints 	<p>CLOSEST MOST APPROPRIATE BURN CENTER</p> <p>In San Bernardino County, contact: Arrowhead Regional Medical Center (ARMC)</p>	
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“Rule of Nines”



VI. REFERENCES

<u>Number</u>	<u>Name</u>
9030	Destination
11010	Medication - Standard Orders
14100	Pain Management - Adult
14250	Determination of Death on Scene



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STROKE TREATMENT - ADULT

I. FIELD ASSESSMENT/TREATMENT INDICATORS

Patient exhibiting signs/symptoms of a possible stroke. These signs may include: speech disturbances, altered level of consciousness, parasthesias, new onset seizures, dizziness unilateral weakness and visual disturbances.

II. BLS INTERVENTIONS

- Obtain patient oxygen saturation on room air. Titrate oxygen if clinically indicated, to maintain an oxygen saturation of 94% per ICEMA Reference #11010 - Medication - Standard Orders.
- Obtain blood glucose.

III. LIMITED ALS (LALS)/ALS INTERVENTIONS

- Perform activities identified in the BLS Interventions.
- Obtain vascular access.
- **Modified Los Angeles County Prehospital Stroke Screen (mLAPSS):** A screening tool used by EMS field personnel to assist in identifying patients who may be having a stroke.

mLAPSS Criteria: The patient is **mLAPSS positive**, if “yes” on Criteria #1 - 4 and exhibits unilateral weakness on Criteria #6.

mLAPSS Criteria	Yes	No	
1. Age over 17 years?			
2. No prior history of seizure disorder?			
3. New onset of neurologic symptoms in last 24 hours?			
4. Patient was ambulatory at baseline prior to event?			
5. Blood glucose between 60 and 400?			
6. Exam (<i>look for obvious asymmetry</i>):	<u>Normal-Bilaterally</u>	<u>Right</u>	<u>Left</u>
• Facial Smile/Grimace		Droop Normal	Droop Normal
• Grip		Weak Grip Normal	Weak Grip Normal
		No Grip Normal	No Grip Normal
• Arm Weakness		Drifts Down Normal	Drifts Down Normal
		Falls Down Rapidly Normal	Falls Down Rapidly Normal

- If patient is mLAPSS positive, use LAMS to determine the stroke severity.
- Patients less than 17 years of age presenting as a suspected stroke, consider transporting to the closest stroke center.
- **Los Angeles Motor Score (LAMS):** A scoring tool used by EMS providers to determine the severity of stroke on patients who are mLAPSS positive. If the total LAMS score is four (4) or greater, consider Large Vessel Occlusion (LVO).

LAMS Score Criteria		
FACE	0	Both sides move normally
	1	One side is weak or flaccid
ARM	0	Both sides move normally
	1	One side is weak
	2	One side is flaccid/does not move
GRIP	0	Both sides move normally
	1	One side is weak
	2	One side is flaccid/does not move
TOTAL SCORE		

- Ask when “last seen normal” or without stroke symptoms.
- If “last seen normal” plus transport time is less than 24 hours, or a “wake-up stroke”, transport to closest Stroke Receiving Center.
- If “last seen normal” plus transport time is greater than 24 hours, transport to the closest receiving hospital.
- If mLAPSS negative and stroke is still suspected, consult base hospital for destination.
- To ensure that there is no delay in treatment obtain and document on scene family phone number.
 - If family member is not present, it is recommended that the EMS field personnel bring the patients cell phone.
- Consider 12-lead ECG (ALS only).
- **Thrombolytic Assessment:** If time is available, and the patient or family can provide the information, assess the patient using the criteria listed below and report to ED personnel:

Thrombolytic Assessment Criteria	Yes	No
Onset greater than 4.5 hours?		
History of recent bleeding?		
Use of anticoagulant?		
Major surgery or serious trauma in the previous 14 days?		
Sustained systolic blood pressure above 185 mm Hg?		
Recent stroke or intracranial hemorrhage?		

IV. REFERENCE

Number Name

11010 Medication - Standard Orders



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PSYCHIATRIC/BEHAVIORAL EMERGENCIES - ADULT

I. PURPOSE

To provide timely and appropriate treatment for patients that are violent, potentially violent, or who may harm themselves or others, including the potential use of restraints in the field or during transport.

II. FIELD ASSESSMENT/TREATMENT INDICATORS

Symptoms of dangerous agitation, confusion and hallucinations, erratic behavior, profuse diaphoresis, elevated vital signs, hyperthermia, unexplained strength and endurance, and behaviors that include clothing shedding, shouting, and extreme thrashing when restrained.

This policy is not intended to negate the need for law enforcement personnel to use appropriate restraint equipment to establish scene-management control. Restraints should be applied by law enforcement whenever possible. If applied, an officer is required to remain available at the scene or during transport to remove or adjust the restraints for patient safety per ICEMA Reference #6060 - Patient Restraints.

III. BLS INTERVENTIONS

- Approach patient in a calm and cautious manner.
- Ensure patent airway, obtain oxygen saturation and apply oxygen as needed.
- Restraint equipment must be either padded leather restraints or soft restraints (e.g., posey, velcro or seat-belt type).
- Apply four (4) point restraints as clinically indicated. Transport of a restrained patient should be in low to high Fowlers position. Never transport a patient in a prone position while restrained. Transport of a patient supine, while restrained, can affect respiratory function and constant monitoring of respiratory status is required.
- Perform cooling measures as clinically indicated.
- If suspected hypoglycemia, obtain a blood glucose.

IV. LIMITED ALS (LALS) INTERVENTIONS

- Perform activities identified in the BLS Interventions.

V. ALS INTERVENTIONS

- Perform activities identified in the BLS and LALS Interventions.
- If patient meets criteria for potentially fatal and dangerous agitation, administer Midazolam per ICEMA Reference #11010 - Medication - Standard Orders. Do not delay administration of Midazolam due to lack of vascular access as IM or IN is preferred in this circumstance. May repeat one (1) time using same method as first administered.
- Minors under the age of nine (9) base hospital order only.

- Place on cardiac monitor. Continuous monitoring of a patient after administration of Midazolam is required.
- Obtain capnography, monitor waveform and numerical value. Apnea can be the result of the use of Midazolam and other medications.
- Once conditions are safe, establish IV.
- Base hospital may order:
 - For potentially fatal and dangerous agitation and suspected metabolic acidosis/hyperkalemia administer Sodium Bicarbonate per ICEMA Reference #11010 - Medication - Standard Orders.

VI. REFERENCES

<u>Number</u>	<u>Name</u>
6060	Patient Restraints
11010	Medication - Standard Orders



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ALLERGIC REACTIONS - PEDIATRIC (Less than 15 years of age)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Signs and Symptoms of an acute allergic reaction.
- History of Exposure to possible allergen.

II. BLS INTERVENTIONS

- Recognize signs/symptoms of respiratory distress for age.
- Reduce anxiety, assist patient to assume POC.
- Oxygen administration as clinically indicated (humidified oxygen preferred).
- Assist patient with self-administration of prescribed Epinephrine device if available.
- For anaphylaxis only, administer Epinephrine Auto-Injector per ICEMA Reference #11010 - Medication - Standard Orders.
- Assist patient with self-administration of prescribed Diphenhydramine.

III. LIMITED ALS (LALS) INTERVENTIONS - PEDIATRIC (Less than 15 years of age)

- Perform activities identified in the BLS Interventions.
- Maintain airway with appropriate adjuncts, obtain oxygen saturation on room air if possible.
- Albuterol per ICEMA Reference #11010 - Medication - Standard Orders.
- If no response to Albuterol, consider Epinephrine per ICEMA Reference #11010 - Medication - Standard Orders.
- For symptomatic hypotension with poor perfusion, consider fluid bolus of 20 ml/kg of NS not to exceed 300 ml NS and repeat as indicated.
- Establish IV/IO access if indicated.
- For anaphylactic shock (e.g., no palpable radial pulse and a depressed level of consciousness), administer Epinephrine per ICEMA Reference #11010 - Medication - Standard Orders.

IV. ALS INTERVENTIONS

- Perform activities identified in the BLS and LALS Interventions.
- Albuterol with Atrovent per ICEMA Reference #11010 - Medication - Standard Orders.
- If no response to Albuterol and Atrovent, consider Epinephrine per ICEMA Reference #11010 - Medication - Standard Orders.

- Administer Diphenhydramine per ICEMA Reference #11010 - Medication - Standard Orders for patients two (2) years of age or older.
- If apneic and unable to ventilate, consider oral endotracheal intubation per ICEMA Reference #11020 - Procedure - Standard Orders for patients who are taller than the maximum length of a pediatric emergency measuring tape (Broselow, etc.) or equivalent measuring from the top of the head to the heel of the foot.
- Base hospital may order additional medication dosages and additional fluid boluses.

V. REFERENCES

<u>Number</u>	<u>Name</u>
11010	Medication - Standard Orders
11020	Procedure - Standard Orders



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RESPONSIBILITY FOR PATIENT MANAGEMENT ALS Downgrade

I. PURPOSE

To define the responsibility for patient care management in the prehospital setting. Within the ICEMA region, in the event both public and private emergency medical services (EMS) field personnel arrive on the scene with the same qualifications, patient care management responsibility will rest with the first to arrive.

II. PROCEDURE

An advanced emergency medical technician (AEMT) or paramedic (EMT-P) may transfer patient management responsibility to an emergency medical technician (EMT) for transportation, only under the following conditions:

- When the ALS transport paramedic determines that additional ALS assistance is NOT required AND the patient's condition meets the criteria below, the patient may be downgraded to BLS level of care.
 - No acute cardiac dysrhythmias
 - The patient does not require specialty care services
 - Airway is open and intact, SpO2 saturations are above 93% and not requiring supplemental O2
 - Blood glucose is not less than 60mg/dl or glucometer does not read LO
 - Patient is not altered or is at their baseline
 - Vital signs are within normal range
 - There is no known or suspected overdose, poisoning or ingestion
 - The patient does not have chest pain
 - There are no OB or pregnancy related complications
 - The patient is not postictal or presenting with seizure activity

GENERAL CONSIDERATIONS PRIOR TO DOWNGRADE

- Patients who require immediate medical attention will be transported to the closest most appropriate hospital.
- Patients who have received ALS interventions, or those who would likely benefit from ALS interventions cannot be downgraded to a BLS level of care.
- Patients, parents, or guardians must be alert, oriented, and acting appropriately for their age and do not present with any significant impairment due to drugs, alcohol, organic causes, or mental illness.

DOCUMENTATION REQUIREMENTS WHEN DOWNGRADING FROM ALS TO BLS

- The following must be documented in the PCR:
 - Select: Patient treated and care transferred to another EMS unit as the disposition. "BLS" must be selected as the transporting ambulance level of care in the ground transport panel.
 - Physical exam findings must include a full head-to-toe exam within the assessment panel.
 - Document all treatments provided.
 - The patient is stable for transport and no ALS measures have been initiated.

- When operating under ICEMA Reference #8030 - Transport of Patients (BLS).
- When operating under ICEMA Reference #8080 - Medical Response to a Multiple Casualty Incident.
- When operating under ICEMA Reference #6050 - Local Medical Emergency.
- The base hospital should be contacted if at any time transfer of patient management responsibility is in question or for any patient not meeting the above criteria.

III. REFERENCES

<u>Number</u>	<u>Name</u>
6050	Local Medical Emergency
8030	Transport of Patients (BLS)
8080	Medical Response to a Multiple Casualty Incident



OBSTETRICAL EMERGENCIES

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Obstetrical emergencies (field delivery) with or without complications.

II. BLS INTERVENTIONS

UNCOMPLICATED DELIVERY

- Administer oxygen as clinically indicated.
- Prepare for delivery.
- Massage fundus if placenta delivered.

COMPLICATED DELIVERY

- Excessive vaginal bleeding prior to delivery:
 - Attempt to control bleeding. Do not place anything into vagina.
 - Place in trendelenburg position.
- Prolapsed Cord:
 - Elevate hips.
 - Gently push presenting part of head away from cord.
 - Consider knee/chest position for mother.
- Postpartum Hemorrhage:
 - Massage fundus to control bleeding.
 - Encourage immediate breast feeding.
 - Place in trendelenburg position.
- Cord around infant's neck:
 - Attempt to slip cord over the head.
 - If unable to slip cord over the head, deliver the baby through the cord.
 - If unable to deliver the baby through the cord, double clamp cord, then cut cord between clamps.
- Breech presentation and head not delivered within three (3) to four (4) minutes:
 - Administer oxygen.

- Place in trendelenburg position.
- Transport Code 3 to closest appropriate facility.
- Pregnancy Induced Hypertension and/or Eclampsia:
 - Initiate and maintain seizure precautions.
 - Attempt to reduce stimuli.
 - Limit fluid intake.
 - Monitor and document blood pressure.
 - Consider left lateral position.

III. LIMITED ALS (LALS) INTERVENTIONS

COMPLICATED DELIVERY

- Obtain IV access, and maintain IV rate as appropriate.
- Excessive vaginal bleeding or post-partum hemorrhage:
 - Administer fluid challenge of 500 ml, if signs of inadequate tissue perfusion persist may repeat fluid bolus.
 - Maintain IV rate at 150 ml per hour.
 - Establish second large bore IV en route.
- Pregnancy Induced Hypertension and/or Eclampsia:
 - IV TKO, limit fluid intake.
 - Obtain O₂ saturation on room air, if possible.
 - Place in left lateral position, and obtain blood pressure after five (5) minutes.
- Consider immediate notification of base hospital physician.

IV. ALS INTERVENTIONS

COMPLICATED DELIVERY

- Obtain IV access, and maintain IV rate as appropriate.
- Excessive vaginal bleeding or post-partum hemorrhage:
 - Administer fluid challenge of 500 ml. If signs of inadequate tissue perfusion persist may repeat fluid bolus.
 - Maintain IV rate at 150 ml per hour.
 - Establish second large bore IV en route.

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- Pregnancy induced hypertension:
 - Administer IV TKO. Limit fluid intake.
 - Obtain O₂ saturation on room air, if possible.
 - Place in left lateral position, and obtain blood pressure after five (5) minutes.
 - Obtain rhythm strip with copy to receiving hospital.
- Eclampsia (Seizure/Tonic/Clonic Activity):
 - Administer Magnesium Sulfate per ICEMA Reference #11010 - Medication - Standard Orders.
 - Administer Midazolam per ICEMA Reference #11010 - Medication - Standard Orders.
- Consider immediate notification of base hospital physician.

POSTPARTUM HEMMORHAGE (base hospital order only)

- Tranexamic Acid (TXA) administration:
 - Must be within three (3) hours of onset and must have either:
 - Signs and symptoms of hemorrhagic shock with SBP less than 90 mm
 - Significant hemorrhage with heart rate greater than or equal to 120.

V. REFERENCE

<u>Number</u>	<u>Name</u>
11010	Medication - Standard Orders

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SHOCK (NON-TRAUMATIC)

I. FIELD ASSESSMENT/TREATMENT INDICATORS

- Patient exhibits signs/symptoms of profound shock and hypotension with a SBP of less than 90 mm Hg for adults and a SBP less than 70 mm Hg for pediatrics.
- Determine history of illness.
- History of GI bleeding, vomiting, diarrhea, fever/sepsis or vaginal bleeding.
- Post ROSC for Out of Hospital Cardiac Arrest (OHCA).
- Consider hypoglycemia or narcotic overdose.

II. LIMITED ALS (LALS) INTERVENTIONS

- Maintain airway with appropriate adjuncts, including perilaryngeal airway adjunct if indicated.
- Obtain oxygen saturation on room air or on home oxygen if possible.
- Place AED pads on patient as precaution in event patient goes into sudden cardiac arrest.
- Obtain vascular access.
- If hypotensive or have signs or symptoms of inadequate tissue perfusion, administer fluid challenges:
 - ADULT
 - Administer 500 ml IV bolus, may repeat one (1) time until tissue perfusion improves
 - PEDIATRIC
 - Administer 20 ml/kg IV bolus, may repeat one (1) time for tachycardia, change in central/peripheral pulses or altered level of consciousness.
- For patients with no respiratory difficulties and adequate signs of tissue perfusion:
 - ADULT/PEDIATRIC
 - Maintain IV at TKO.

III. ALS INTERVENTIONS

- Perform activities identified in LALS Interventions.
- Maintain airway with appropriate adjuncts, including advanced airway if indicated. Obtain oxygen saturation on room air or on home oxygen if possible.

- Place on cardiac monitor.
- Obtain vascular access.
- If hypotensive or has signs or symptoms of inadequate tissue perfusion, administer fluid challenges:
 - ADULT
 - Administer 500 ml IV bolus, may repeat one (1) time to sustain a SBP of more than 90 mm Hg or until tissue perfusion improves.
 - If no response to fluid administration, stop fluids and administer Push Dose Epinephrine per ICEMA reference #11010 - Medication - Standard Orders.
 - PEDIATRIC
 - Administer 20 ml/kg IV bolus, may repeat one (1) time for tachycardia, change in central/peripheral pulses or altered level of consciousness.
 - If no response to fluid administration, stop fluids and administer Push Dose Epinephrine per ICEMA reference #11010 - Medication - Standard Orders.

For postpartum hemorrhage with continued signs of inadequate tissue perfusion, not responsive to fluid challenge consider administration of TXA (base hospital order) per ICEMA reference #11010 – Medication – Standard Orders.

- Must be within three (3) hours of onset and must have either:
- Signs and symptoms of hemorrhagic shock with SBP less than 90 mm Hg.
- Significant hemorrhage with heart rate greater than or equal to 120.
- For adults with sustained SBP of more than 90 mm Hg, pediatrics with sustained SBP more than 70 mm Hg, no respiratory difficulties and adequate signs of tissue perfusion:
 - ADULT
 - Maintain IV at TKO.
 - PEDIATRIC
 - Maintain IV at TKO.

Base Hospital May Order

- Establish 2nd large bore IV en route.

IV. REFERENCE

<u>Number</u>	<u>Name</u>
11010	Medication -Standard Orders