PURPOSE
To provide definitions for common terms used throughout the County of Riverside EMS Agency (REMSA) Policy Manual.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.4405

GUIDELINES
California EMS Authority’s Prehospital EMS Aircraft Guidelines

Definitions
These definitions are used throughout the REMSA Policy Manual:

1. **Advanced Directive**
   An advanced directive may also be known as a living will, health care power of attorney or durable power of attorney (DPOA). Regardless of the term, an advanced directive is a legal document that tells who the patient wants making medical treatment decisions for them when they are unable to make them for themselves. It also gives general directions on treatments the patient does or does not want to help create a treatment plan. An advanced directive does NOT take the place of a Do Not Resuscitate (DNR) order or a Physician’s Order for Life Sustaining Treatment (POLST); rather, it is a complementary form

2. **American College of Cardiology (ACC)**
The ACC nonprofit medical society comprised of physicians, surgeons, nurses, physician assistants, pharmacists, and practice managers, and bestows credentials upon cardiovascular specialists who meet its stringent qualifications. The ACC is a leader in the formulation of health policy, standards and guidelines, and cardiovascular research. The ACC provides professional education and operates national registries for the measurement and improvement of quality care.

3. **American Heart Association (AHA)**
The AHA is a nonprofit organization that funds cardiovascular medical research, educates consumers on healthy living and fosters appropriate cardiac care in an effort to reduce disability and deaths caused by cardiovascular disease and stroke. They are known for publishing guidelines on cardiovascular disease and prevention, standards on basic life support, advanced cardiac life support (ACLS) and pediatric advanced life support (PALS).

4. **Ambulance Arrival at ED**
The time the ambulance stops (actual wheel stop) at the location outside the hospital ED where the patient is unloaded from the ambulance.

5. **Ambulance Patient Offload Delay (APOD)**
   Any delay in ambulance patient offload time (APOT) that exceeds the local ambulance patient offload time standard of 25/30 minutes. This shall also be synonymous with “non-standard patient offload time” as referenced in the Health and Safety Code.

6. **Anatomic Criteria**
   A standard based on the severity of bodily injury/injuries.
7. **Apparent Life-Threatening Event (ALTE – occurs in the infant and pediatric patient populations)**
   An episode that is frightening to the observer and is characterized by some combination of apnea (central or obstructive), color change (cyanotic, pallid, erythematous or plethoric), change in muscle tone (usually diminished) and choking or gagging. In some cases, the observer fears that the child has died.

8. **Base Hospital (BH)**
   A hospital that is approved by REMSA to give online medical direction (base hospital orders) to prehospital personnel.

9. **Base Hospital Order (BHO)**
   Verbal / online medical direction and/or consultation between a mobile intensive care nurse (MICN), and/or a base hospital physician (BHP), and prehospital personnel, in accordance with REMSA policies and protocols. Base hospital orders / medical direction shall include, but is not limited to, ordering interventions based upon patient presentation per prehospital provider description during online contact and medical consultation as requested by a prehospital provider.

10. **Base Hospital Physician (BHP)**
    A physician at a base hospital who is responsible for providing base hospital orders (BHOs) to prehospital personnel and medical direction to base hospital mobile intensive care nurses (MICNs)

11. **Base Hospital Physician Order (BHPO)**
    Verbal / online medical direction and/or consultation between a base hospital physician (BHP) and prehospital personnel, in accordance with REMSA policies and protocols. These orders are usually relayed to the prehospital provider by the mobile intensive care nurse (MICN) after speaking directly with the base hospital physician (BHP)

12. **Catastrophic Event**
    Any disaster, or other public health emergency, that overwhelms the standard response capabilities of the responding agencies in Riverside County.

13. **Centers for Medicare & Medicaid Services (CMS)**
    The federal agency which administers Medicare, Medicaid, and the State Children's Health Insurance Program.

14. **Continuous Quality Improvement (CQI)**
    A formal approach to the analysis of system performance and efforts to improve it.

15. **DEA Registrant**
    An entity registered with the Drug Enforcement Administration (DEA) to dispense controlled substances such as a medical practitioner, hospital, pharmacy, or teaching institution.

16. **Do Not Resuscitate (DNR) Order**
    A DNR order is a medical order that specifies the type of medical treatment a patient wishes to receive at the end of their life; specifically, whether CPR is performed or withheld in the event that they experience cardiac arrest. To be valid, the DNR order must be signed and dated by a physician, a nurse practitioner, or a physician assistant acting under the supervision of the physician, and the patient or legally recognized health care decisionmaker. A DNR does NOT take the place of an advanced directive; rather, it is a complementary form. A DNR differs from a Physician’s Order for Life Sustaining Treatment (POLST) in that, a DNR pertains to the performance of CPR only; a POLST provides further instruction, in addition to the performance of CPR, regarding the amount and types of care that the patient wishes to have rendered.

17. **Emergency Department (ED) Medical Personnel**
    An ED physician, mid-level practitioner (e.g., Physician Assistant, Nurse Practitioner) or Registered Nurse (RN).
18. **EMS Personnel**
   EMTs, AEMTs, EMT-II and/or EMT-Ps responsible for out of hospital patient care and transport consistent with the scope of practice as authorized by their level of credentialing.

19. **Emergency STEMI Patient Transport**
   A transport utilizing a Riverside County permitted ambulance to rapidly respond and transport a patient who has been identified by the STEMI Referral Hospital as experiencing a STEMI, whose condition may measurably deteriorate by delay in transport, as determined by the transferring physician.

20. **Hemodynamic instability**
   A patient exhibiting the following signs and symptoms of systemic poor perfusion:
   - Hypotension
   - Altered mental status
   - Chest pain
   - Dyspnea/tachypnea
   - Diaphoresis
   - Pale/cool skin

21. **Last Reviewed Date**
   *In reference to REMSA policies and protocols:* indicates the most recent date that the policy or protocol was reviewed in its entirety.

22. **Last Revised Date**
   *In reference to REMSA policies and protocols:* indicates the most recent date that a change was made to the policy or protocol. These changes may include but not be limited to grammar, syntax, spelling, formatting and/or content.

23. **Mass Casualty Incident / Mass Patient Incident (MCI / MPI)**
   An incident in which EMS resources, such as personnel and equipment, are overwhelmed by the number and severity of casualties or patients

24. **Mechanism of Injury (MOI)**
   The event and kinetic force that caused an injury.

25. **Medical Triage**
   Medical sorting and prioritization of a patient by ED medical personnel. Medical triage includes acceptance of a verbal patient report from EMS personnel.

26. **Mobile Intensive Care Nurse (MICN)**
   A nurse in the ED at a base hospital who is assigned to provide BHOs, medical direction or consultation.

27. **“NSAID Criteria”**
   The assessment tool that is used to determine the necessity for cervical spine stabilization:
   - Neuro deficits
   - Spinal Tenderness
   - Altered Mental Status
   - Intoxication
   - Distracting Injury

28. **Online Contact / Direction**
   Direct verbal contact, direction or consultation provided to prehospital personnel by an MICN, or BHP, from a base hospital
29. **Patient**
   Any person that:
   i. Has experienced an event that could cause illness or injury; or
   ii. Is in a circumstance or situation that creates a suspicion of illness or injury; or
   iii. Makes a request for assistance, examination, or treatment; or
   iv. Has a chief complaint; or
   v. Has signs or symptoms of illness or injury; or
   vi. Has spoken of or acted toward suicide; or
   vii. Is dead

30. **Patient, Geriatric**
    A patient appearing or known to be 65 years of age or more.

31. **Patient, Adult**
    A patient appearing or known to be 15 years of age or more.

32. **Patient, Pediatric**
    A patient appearing or known to be older than 29 days but less than or equal to 14 years of age.

33. **Patient, Neonate**
    A patient appearing or known to be newborn, and up to 28 days old.

34. **Patient, Critical Trauma (CTP)**
    A patient who meets REMSA’s trauma triage criteria.

35. **Patient Preference**
    The patient’s spoken or written request, including an advance directive. In the absence of a direct request, the patient’s immediate family, physician, or health care organization may dictate the patient’s preference. In the minor patient, the patient’s parent or guardian may decide.

36. **Percutaneous Coronary Intervention (PCI)**
    PCI, formerly known as angioplasty with stent, is a non-surgical procedure that uses a catheter to place a stent in cardiac blood vessels that have been narrowed by plaque buildup.

37. **Physician’s Order for Life Sustaining Treatment (POLST)**
    The POLST form is a medical order that specifies the type of medical treatment a patient wishes to receive at the end of their life. To be valid, the POLST form must be signed and dated by a physician, a nurse practitioner, or a physician assistant acting under the supervision of the physician, and the patient or legally recognized health care decisionmaker. A POLST does NOT take the place of an advanced directive; rather, it is a complementary form. A POLST differs from a DNR, in that, a DNR pertains to the performance of CPR only while a POLST provides further instruction, in addition to the performance of CPR, regarding the level of care that the patient wishes to have rendered.

38. **Physiologic Criteria**
    A standard based on the severity of shock, or inadequate tissue perfusion.

39. **Prehospital Receiving Center (PRC)**
    A hospital that has been approved by REMSA to receive patients via ambulance.

40. **Public Safety Personnel**
    Any individual who has received the minimum training standards for EMS personnel, which includes first aid, CPR and AED operation, and who also respond to tactical casualty care situations.
41. **Shock (signs and symptoms)**
   Greater than or equal to 15 years:
   - Systolic BP less than 80 mmHg OR
   - Systolic BP less than 90 mmHg **AND**
     - An altered mental status
     - Tachycardia
     - Pallor
     - Diaphoresis
   
   Less than 15 years:
   - Any of the following signs of inadequate perfusion
     - An altered mental status
     - Tachycardia
     - Pallor, mottling or cyanosis
     - Diaphoresis
     - Comparison of peripheral versus central pulses
     - Capillary refill of greater than two (2) seconds
     - Systolic BP less than \([70 + (\text{age} \times 2)]\)

42. **ST Elevation Myocardial Infarction (STEMI)**
   A specific heart attack that can be identified on 12-lead ECG by trained personnel. The ECG of a STEMI patient will show greater than 1 mm ST segment elevation in two (2) or more contiguous leads.

43. **Symptomatic hypoglycemia**
   Known, or suspected, diabetic patients who present with or complain of:
   - Fatigue
   - Pale skin
   - Shakiness
   - Anxiety
   - Sweating
   - Hunger
   - Irritability
   - Tingling or numbness of the lips, tongue, or cheek
   - Confusion, abnormal behavior or both, such as the inability to complete routine tasks
   - Visual disturbances, such as blurred vision
   - Seizures
   - Loss of consciousness

   **AND**
   - Have a blood glucose less than 80 mg/dl in adults
   - Have a blood glucose less than 70 mg/dl in pediatrics and neonates

44. **Transfer of Patient Care**
   The orderly transition of patient care duties from EMS personnel to receiving hospital ED medical personnel.
45. **Unstable bradycardia**
   Patients experiencing symptomatic bradycardia who are exhibiting the following signs and symptoms of systemic poor perfusion:
   - Hypotension
   - Altered mental status
   - Chest pain
   - Dyspnea/tachypnea
   - Diaphoresis
   - Pale/cool skin

   **AND**

   - Have a heart rate less than 60 bpm in adults

46. **Unstable tachycardia**
   Patients experiencing symptomatic supraventricular tachycardia (SVT) or VT with pulses who are exhibiting the following signs and symptoms of systemic poor perfusion:
   - Hypotension
   - Altered mental status
   - Chest pain
   - Dyspnea/tachypnea
   - Diaphoresis
   - Pale/cool skin

   **AND**

   - Have a heart rate greater than 150 bpm in adults
   - Have a heart rate greater than 180 bpm in pediatrics
   - Have a heart rate greater than 220 bpm in neonates

47. **Unusual Event**
   An incident that significantly impacts or threatens public health, environmental health, or emergency medical services.

48. **Verbal Patient Report**
   The face-to-face, or two-way radio, verbal exchange of key patient information between EMS personnel and ED medical personnel.

49. **Written EMS Report**
   The written report supplied to ED medical personnel (either through the electronic patient care record- ePCR, or actual written report, if ePCR is not available) that details patient assessment and care that was provided by EMS personnel.
# REMSA Approved Abbreviations

## Administrative Policy

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<tr>
<th>Abbreviation</th>
<th>Definition</th>
<th>Abbreviation</th>
<th>Definition</th>
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<tbody>
<tr>
<td>ACS</td>
<td>acute coronary syndrome</td>
<td>CPAP</td>
<td>continuous positive airway pressure</td>
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<td>AEMT</td>
<td>advanced emergency medical technician</td>
<td>CPR</td>
<td>cardiopulmonary resuscitation</td>
</tr>
<tr>
<td>AED</td>
<td>automated external defibrillator</td>
<td>DNR</td>
<td>do not resuscitate order</td>
</tr>
<tr>
<td>AICD</td>
<td>automatic implantable cardioverter defibrillator</td>
<td>ECG</td>
<td>electrocardiogram</td>
</tr>
<tr>
<td>ALOC</td>
<td>altered level of consciousness</td>
<td>EMT</td>
<td>emergency medical technician</td>
</tr>
<tr>
<td>ALS</td>
<td>advanced life support</td>
<td>EMT-P</td>
<td>emergency medical technician - paramedic</td>
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<tr>
<td>AMS</td>
<td>altered mental status</td>
<td>ePCR</td>
<td>electronic patient care record</td>
</tr>
<tr>
<td>APGAR</td>
<td>appearance, pulse, grimace, activity, respiration</td>
<td>EtCO₂</td>
<td>end-tidal carbon dioxide</td>
</tr>
<tr>
<td>BG</td>
<td>blood glucose</td>
<td>ETT</td>
<td>endotracheal tube – (refers to the tube itself)</td>
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<tr>
<td>BLS</td>
<td>basic life support</td>
<td>FBAO</td>
<td>foreign body airway obstruction</td>
</tr>
<tr>
<td>BP</td>
<td>blood pressure</td>
<td>FR</td>
<td>French sizing</td>
</tr>
<tr>
<td>BVM</td>
<td>bag-valve-mask</td>
<td>ga</td>
<td>gauge</td>
</tr>
<tr>
<td>CHF</td>
<td>congestive heart failure</td>
<td>GCS</td>
<td>Glasgow coma score</td>
</tr>
<tr>
<td>cm</td>
<td>centimeter</td>
<td>gm</td>
<td>gram(s)</td>
</tr>
<tr>
<td>CO2</td>
<td>carbon dioxide</td>
<td>GSW</td>
<td>gunshot wound</td>
</tr>
<tr>
<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
<td>H₂O</td>
<td>water</td>
</tr>
<tr>
<td>CP</td>
<td>chest pain</td>
<td>HTN</td>
<td>hypertension</td>
</tr>
<tr>
<td>MRI</td>
<td>magnetic resonance imaging</td>
<td>RUQ</td>
<td>right upper quadrant</td>
</tr>
</tbody>
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**Last Reviewed:** October 4, 2022  
**Last Revised:** December 2, 2022
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>NIDDM</td>
<td>non-insulin-dependent diabetes mellitus / Type II diabetes</td>
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<tr>
<td>NKDA</td>
<td>no known drug allergies</td>
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<tr>
<td>NPA</td>
<td>nasopharyngeal airway</td>
</tr>
<tr>
<td>NPO</td>
<td>&quot;nil per os,&quot; nothing by mouth</td>
</tr>
<tr>
<td>NS</td>
<td>normal saline</td>
</tr>
<tr>
<td>NSAID</td>
<td>non-steroidal anti-inflammatory drug</td>
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<tr>
<td>&quot;NSAID criteria&quot;</td>
<td>criteria used to determine the need for cervical spine immobilization</td>
</tr>
<tr>
<td>NTG</td>
<td>nitroglycerin</td>
</tr>
<tr>
<td>O₂</td>
<td>oxygen</td>
</tr>
<tr>
<td>OD</td>
<td>overdose</td>
</tr>
<tr>
<td>ODT</td>
<td>oral dissolving tablet</td>
</tr>
<tr>
<td>OPA</td>
<td>oropharyngeal airway</td>
</tr>
<tr>
<td>OTI</td>
<td>orotracheal intubation <em>(refers to the skill only)</em></td>
</tr>
<tr>
<td>PO</td>
<td>&quot;per os,&quot; by mouth</td>
</tr>
<tr>
<td>POLST</td>
<td>physician orders for life-sustaining treatment</td>
</tr>
<tr>
<td>PRN</td>
<td>&quot;pro re nata,&quot; when necessary</td>
</tr>
<tr>
<td>PSP</td>
<td>public safety personnel</td>
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<tr>
<td>RLQ</td>
<td>right lower quadrant</td>
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<tr>
<td>RN</td>
<td>registered nurse</td>
</tr>
<tr>
<td>ROSC</td>
<td>return of spontaneous circulation</td>
</tr>
<tr>
<td>RSV</td>
<td>respiratory syncytial virus</td>
</tr>
<tr>
<td>SL</td>
<td>sublingual</td>
</tr>
<tr>
<td>SNF</td>
<td>skilled nursing facility</td>
</tr>
<tr>
<td>SOB</td>
<td>shortness of breath</td>
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<tr>
<td>SpO₂</td>
<td>oxygen saturation of peripheral hemoglobin</td>
</tr>
<tr>
<td>STD</td>
<td>sexually transmitted disease</td>
</tr>
<tr>
<td>STEMI</td>
<td>ST elevated myocardial infarction</td>
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<tr>
<td>Sx</td>
<td>symptoms</td>
</tr>
<tr>
<td>TCP</td>
<td>transcutaneous cardiac pacing</td>
</tr>
<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>VF</td>
<td>ventricular fibrillation</td>
</tr>
<tr>
<td>VT</td>
<td>ventricular tachycardia</td>
</tr>
<tr>
<td>x (Times)</td>
<td>(used as multiplication sign)</td>
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PURPOSE
To define the requirements for emergency medical dispatch (EMD) training programs in Riverside County pursuant to the California Health & Safety Code Section 1797.220.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Emergency Medical Dispatch Training
1. All Riverside County Emergency Medical Dispatch (EMD) Training Programs must meet the minimum requirements as described by the California State Emergency Medical Services Authority in the Emergency Medical Services Dispatch Program Guidelines (March 2003, EMSA #132).

2. Basic EMD training is designed to provide additional training to dispatchers who are already skilled and knowledgeable in dispatch and telecommunication procedures in order to provide medical assistance to callers.

3. Required Basic EMD Training Course Hours
   a. Basic EMD Training will consist of not less than 24 hours (one classroom hour of instruction will be defined as fifty minutes).
   b. In addition, emergency medical dispatchers will satisfactorily obtain and maintain a record of course completion in adult, child, and infant CPR.

4. The basic EMD training course content will include instruction to result in competence in the following:
   a. Introduction:
      i. Emergency Medical Dispatcher role and responsibilities
      ii. Legal and liability issues in EMD
      iii. Emergency Medical Dispatch concepts
   b. Information gathering and dispatch
      i. Obtaining information from callers
      ii. Resource identification and allocation
      iii. Providing emergency care instructions, including Automated External Defibrillation
   c. EMD protocol reference system and chief complaints
      i. Introduction to the emergency medical dispatch protocol reference system
      ii. Introduction to chief complaint types
   d. Local EMS system overview
   e. Scenario based skills/practical exercises
   f. Final examination

5. Course content will be reviewed and approved by the EMD Physician Advisor who provides oversight of the program.
6. EMD Instructor Criteria  
a. Each training program will have a principal instructor(s), approved by the EMD Training Program Manager, who:  
   i. Is a currently licensed or certified physician, registered nurse, physician assistant, EMT-P, or AEMT, who has at least two years of practical experience within the last five years in pre-hospital emergency medical services, and with training in emergency medical dispatch; or  
   ii. Is an emergency medical dispatcher with at least two years of practical experience within the last five years.

7. Course Curriculum Certification  
a. EMD course curriculum will be submitted to the training program provider’s course curriculum certification agency (POST, CSFM, LEMSA, or EMSA).  
b. It is the training program provider’s responsibility to submit the curriculum as required by their course curriculum certification agency, and to comply with the requisite policies and procedures of that agency.  
c. The training program provider will issue a course completion record to each person who has successfully completed an EMD course.

8. An emergency medical dispatcher will receive a minimum of 24 hours of continuing dispatch education (CDE) every two years.

9. CDE will be coordinated and organized through the EMD Provider Agency and approved by the EMD Physician Advisor.

10. CDE will include issues identified by the EMD continuous quality improvement process, and one or more of the following:  
a. Medical conditions, incident types, and criteria necessary when performing caller assessment and prioritization of medical calls;  
b. Use of the EMD protocol reference system;  
c. Call taking interrogation skills;  
d. Skills in providing telephone pre-arrival instructions;  
e. Technical aspects of the system (phone patching, emergency procedures, etc.);  
f. Skill practice and critique of skill performance; and/or  
g. Attendance at EMD workshops/conferences.

11. Methodologies for presenting CDE include:  
a. Formalized classroom lecture;  
b. Video, CD, Internet;  
c. Articles;  
d. Tape Review;  
e. Participation on medical dispatch committee; and/or:  
f. Field observation (e.g. ride-along with EMS personnel or Emergency Department observation of communications activities).

12. Formalized classroom CDE may be submitted to the training program provider’s course curriculum certification agency (POST, CSFM, LEMSA, or EMSA) to count towards continuing dispatch education credits.  
a. If the training program provider chooses to submit CDE curriculum to their course curriculum certification agency:  
   i. It is the training program provider’s responsibility to submit the CDE curriculum as required by their course curriculum certification agency, and to comply with the requisite policies and procedures of that agency.  
   ii. The training program provider will issue a course completion record to each person who has successfully completed a CDE course.

13. Program approval or disapproval will be made by the Riverside County EMS Agency in writing within 90 days of receipt of all required program documentation.
14. Program approval will be for a period of, initially, two years, and four years thereafter.

15. Noted program deficiencies must be corrected within 60 days of written notification from the Riverside County EMS Agency.

16. All programs may be subject to on-site evaluation by the Riverside County EMS Agency.

17. Persons or agencies conducting an approved EMD training program must notify the Riverside County EMS Agency, in writing, at least 30 days in advance of any substantial program changes.

18. All approved EMD training programs must reapply for approval a minimum of 90 days prior to the program’s current approval expiration date. The continuing approval request will contain:
   a. A list of any program changes made since the last approval or continuing approval request.
   b. Any personnel changes made during the last approval period.

19. The EMD training program will have an approved EMD Training Program Manager who is qualified by education and experienced in methods, materials, and evaluation of instruction as well as adult education theory and practice. The EMD Training Program Manager will be responsible for the administration of the training program and assure that all aspects of the EMD training program are in compliance with these policies and with state guidelines.
   a. Responsibilities of the EMD Training Program Manager will include, but not be limited to:
      i. Administering the training program.
      ii. Approval of course content.
      iii. Approval of all written and skills examinations.
      iv. Coordinating all clinical and field activities related to the course.
      v. Ensure that all emergency medical dispatchers employed by the provider meet all continuing education and update requirements, as needed to maintain continuous certification.
      vi. Approval of the principal instructor(s) and any teaching assistant(s) utilized.
      vii. Signing of all course completion records.
      viii. Assuring that all aspects of the training program are in compliance with state and county laws and policies.
      ix. Be the authorized point of contact for all matters relating to the EMD training program.
      x. Review their EMD program at least annually, retaining records to that effect for a period of four years.

20. Each training program provider will retain the following training records as provided by local ordinance:
   a. Records on each course including, but not limited to, course title, course objectives, course outlines, qualification of instructors, dates of instruction, location, participant sign-in rosters, sample course tests or other methods of evaluation, and records of course completions issued.
   b. Summaries of test results, course evaluations or other methods of evaluation. The type of evaluation used may vary according to the instructor, content of program, number of participants and method of presentation.
PURPOSE
To establish procedures which allow for the approval of emergency medical technician (EMT) training program providers in Riverside County and to assist providers in meeting the standards and requirements.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Emergency Medical Technician Training
1. An agency or institution may request approval from the Riverside County EMS Agency as an EMT training provider. Applications for initial training program approval may be submitted between April 1 and August 1 of each calendar year. Completed applications must be received by August 1.

2. Any institution/agency requesting approval as an EMT training/refresher provider must meet the qualifications for training providers as outlined in Title 22 Regulations (Section 100065).

3. Provider approval shall be for four years, ending on the final day of the final month of the approval period.

4. Any training/refresher course offered by an approved provider must be executed within the approved periods. Courses beginning or ending outside of an approval period will not be considered approved courses and certification will not be granted to the participants.

5. Approved training courses will abide by state laws, regulations, and Riverside County EMS Agency policies and procedures.

6. Minimum competency requirements for program participants to successfully complete and pass approved training/refresher programs or a challenge examination will not be less than 80% on written final examinations and 80% on skills examinations, with 100% of the skills’ critical factors attained.

7. Each course offered by an approved training program shall have a designated Principal Instructor (PI) who shall be responsible for covering the approved content as specified by the program, personally instruct a minimum of 51% of the course content, be available for student conferences and, in conjunction with the Program Director, oversee and approve all student grades.

8. Notification of each course offered by the approved provider shall be given to the EMS Agency using the “Notification of Proposed EMS Course” form, which shall be submitted as early as 60 days but not less than 30 days prior to the beginning of each course.

9. Challenge testing - test only option
   a. Approved training programs are required to offer an EMT challenge exam no less than once each time a course is offered.
   b. Challenge examinations shall be equivalent to the final written examination of a comprehensive EMT training program, with skills testing, to include, but not be limited to, patient assessment (medical and trauma), diagnostics and vital signs, all phases of airway management, spinal immobilization techniques, treatment of hemorrhage and shock, treatment of soft tissue injuries, splinting (to include traction splinting), AED, and childbirth.
10. Refresher classes must be offered no less than once per year.

11. All qualified institutions/agencies shall submit the following:
   b. The completed application packet, a minimum of 90 days prior to the beginning of the first proposed
course offering or 90 days prior to their current program expiration if applying for reapproval.
   c. The names and qualifications of their Program Director, Clinical Coordinator and Principal Instructor(s)
      using the appropriate forms.

12. The EMS Agency will notify the submitting institution/agency within 10 working days of the receipt of the
application packet that:
   a. It has been received; and
   b. It is complete or, if not, what information is missing.

The EMS Agency will notify the submitting institution/agency in writing of the approval/disapproval decision within 90
days of the receipt of the completed application packet. If approval is not granted, the reasons will be specified in
writing.
PURPOSE
To establish procedures which allow for the approval of paramedic training program providers in Riverside County and to assist providers in meeting the standards and requirements.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22, Social Security, Division 9. Prehospital Emergency Medical Services

Paramedic Training
1. An agency or institution will request approval from the Riverside County EMS Agency to become a paramedic training provider. Initial applications for paramedic training program approval will be accepted between April 1 and August 1 each year. Completed applications must be received by August 1.

2. Any institution/agency requesting approval as a paramedic training provider must meet the qualifications for training providers as outlined in Division 9, Title 22, of the California Code of Regulations, Chapter 4, Article 3.

3. Provider approval will be for four years, ending on the final day of the final month of the approval period.

4. Approved training programs will abide by state laws, regulations, and Riverside County EMS Agency policies and procedures.

5. Any training program offered by an approved provider must be executed within the approved periods. Programs beginning or ending outside of an approval period will not be considered approved programs.

6. Notification of each course offered by the approved provider will be given to the EMS Agency using the Notification of Proposed EMS Course form, which will be submitted as early as 90 days but not less than 30 days prior to the beginning of each course.

7. Minimum competency requirements for program participants to successfully complete and pass approved training programs will be not less than 80% on written final examinations and 80% on skills examinations with 100% of the skill’s critical factors attained and will include the successful completion of all clinical and field internships.
   a. Students may only sit the state licensing exam after having met all the provisions of the approved paramedic training program, including successful completion of the didactic, clinical, and field training portions.

8. All programs will submit precepting schedule information at least one week prior to students beginning their field time.
   a. This information will include:
      Student name
      Employing agency affiliation (if applicable)
      Precepting Agency Name & Crew Unit #,
      Precepting Crew Member names / titles,
      Schedule -- days assigned (ex: M, W, every other F) and hours/shift (12 versus 24)
      Apparatus type
   b. Last minute and/or in-process changes may be submitted as updates.
9. All programs will submit to the EMS Agency for immediate review any untoward patient care events and cooperate in any patient care investigation through the EMS QI Program process.

10. All programs will submit to the EMS Agency for review and maintain on-going communication on, problematic and/or unresolved student-preceptor exchanges (e.g. harassment, hazing, unsafe precepting environment).

11. Upon completion of each individual course, the training institution will submit the following:
   a. A Course Completion Record to the EMS Agency listing all students registered for the course and their status (pass/fail/incomplete).
   b. A course completion record to each passing student that:
      i. Meets the requirements as established in Title 22.
      ii. Has been reviewed and approved by the EMS Agency.
   c. All course completion records will be issued within 15 calendar days of the end of the course.

12. All qualified institutions/agencies will submit their completed application packet a minimum of 120 days prior to the beginning of the first proposed course offering or 90 days prior to their current program expiration if applying for reapproval. This packet can include, but not be limited to:
   b. The names and qualifications of their Course Director, Program Medical Director, and Principal Instructor(s) using the appropriate forms and supporting documentation.
   c. A statement that their program content is equivalent to the National Emergency Medical Services Education Standards, DOT HS 811 077A, January 2009.
   d. Course materials to include curriculum, class schedule, course objectives, major assignments/projects, all major examinations, skills performance objectives, and operational policies, procedures, and forms.
   e. Provisions for clinical and field internships to include:
      i. Student evaluation criteria and forms.
      ii. Provisions for the training and monitoring of preceptors.
      iii. Written agreements/MOUs with the providers of clinical and field internship experiences that express their ability and willingness to comply with the philosophies and policies of the training institution, and with the policies and procedures of the Riverside County EMS Agency, including quality assurance and patient care investigations.

13. The EMS Agency will notify the submitting institution/agency within 30 working days of the receipt of the application packet that:
   a. It has been received; and
   b. It is complete or, if not, what information is missing.

14. Programs/agencies applying for approval will schedule a facilities evaluation tour by the EMS Agency’s program evaluator or his designee(s).
   a. All approved programs will be subject to scheduled and unscheduled visits by the EMS Agency for the purpose of program evaluation.

15. Program staff, at minimum, must meet the qualifications as established in Title 22 and student/staff ratios will be maintained.

16. Approved programs will provide for Clinical and Field Internships as established by Title 22.
   a. Approved programs must provide mechanisms/options for a student/preceptor reassignment should conflicts arise that are not based on performance/evaluations.
   b. Approved programs must provide a mechanism/opinion for an extension of clinical and/or field internships if documentation supports borderline but improving student performance.
   c. Out of jurisdiction paramedic Training programs are subject to REMSA policies for approval PRIOR to any clinical or field internship placement(s) within Riverside County.
17. The EMS Agency will notify the submitting institution/agency in writing of the approval/disapproval decision within 90 days of the receipt of the completed application packet. If approval is not granted, the reasons will be specified in writing.

18. Approved paramedic training programs will notify the EMS Agency in writing of any changes in course objectives, hours of instruction, course director, program medical director, principal instructor and/or the provision of hospital clinical and field internship experiences. All such changes are subject to the approval of the EMS Agency.
   a. It is preferred that notification be made in advance of said changes, but in all cases, it will be no later than within 30 days of the change.
   b. Notification of changes in staff will include documentation of new staff qualifications.
   c. Site additions to the clinical and/or field experiences will include copies of the agreements/MOUs signed with each institution/agency, and an explanation of how that site will be incorporated into the student experience.
PURPOSE
To establish procedures which allow for the approval of Public Safety Personnel First Aid and CPR training program providers, including the training and standards for REMSA approved optional skills, in Riverside County and to assist providers in meeting the standards and requirements.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22. Social Security, Division 9. Ch. 1.5 Prehospital Emergency Medical Services

Public Safety Personnel First Aid and CPR Training Programs
1. An agency or institution may request approval from the Riverside County EMS Agency as a Public Safety Personnel First Aid and CPR training provider. Applications for initial training program approval may be submitted between April 1 and August 1 of each calendar year. Completed applications must be received by August 1.

2. Any institution/agency requesting approval as a Public Safety Personnel, First Aid and CPR Training provider must meet the qualifications for training providers as outlined in Title 22 Regulations (Section 100014 and/or 100021). The requesting institution/agency must have a physical headquarters located within Riverside County where the course shall be conducted and administered. Programs must also have Riverside County based personnel for Program Direction and oversight.

3. Training Program Provider approval shall be up to four years, ending on the final day of the final month of the approval period.

4. Any training/refresher course offered by an approved provider must be executed within the approved periods. Courses beginning or ending outside of an approval period will not be considered approved courses and valid course completion cannot be issued to participants.

5. Approved training courses will abide by state laws, regulations, and Riverside County EMS Agency policies and procedures.

6. Minimum competency requirements for program participants to successfully complete and pass approved training/refresher programs or a challenge examination will not be less than 80% on written final examinations and 80% on skills examinations, with 100% of the skills’ critical factors attained.

7. Program Director candidates must meet minimum qualifications as outlined in Section 100028, and are subject to clinical experience, CV/Resume review by REMSA. To be eligible, Program Director candidates must have completed a course consistent with Section 100023 within the past two years, or be an actively certified EMT, AEMT, or have an active/non-provisional: paramedic, RN, physician’s assistant, or physician license. A minimum of two (2) years of pre-hospital education experience in the past five (5) years, at a training program level may qualify for clinical proficiency.

8. Principal Instructor (PI) candidates for Public Safety Personnel First Aid and CPR Training Programs must be approved by REMSA prior to instruction of courses. To be eligible, PI candidates must have completed a course consistent with Section 100023 within the past two years, or be an actively certified EMT, AEMT, or have an active/non-provisional: paramedic, RN, physician’s assistant or physician license.
9. Each course offered by an approved training program shall have a designated Principal Instructor (PI) who shall be responsible for covering the approved content as specified by the program, personally instruct a minimum of 51% of the course content, be available for student conferences and, in conjunction with the Program Director, oversee and approve all student grades.

10. Notification of each course offered by the approved provider shall be given to the EMS Agency using the “Notification of Proposed EMS Course” form, which shall be submitted as early as 60 days but not less than 30 days prior to the beginning of each course. Courses shall be approved by REMSA prior to offering.

11. Course completion records from each class offered will be submitted to REMSA on the Course Completion Record form, within fifteen (15) calendar days of the final exam of the training course.

12. Refresher classes may be offered annually but must be offered no less than once every two years.

13. All qualified institutions/agencies shall submit the following:
   b. The completed application packet, a minimum of 120 days prior to the beginning of the first proposed course offering or 120 days prior to their current program expiration if applying for re-approval.
   c. The names and qualifications of their Program Director, and Principal Instructor(s) using the appropriate forms.

14. The EMS Agency will notify the submitting institution/agency within twenty-one (21) working days of the receipt of the application packet that:
   a. It has been received; and
   b. It is complete or, if not, what information is missing.

The EMS Agency will notify the submitting institution/agency in writing of the approval/disapproval decision within 120 days of the receipt of the completed application packet. Approval shall only be granted only in the event of a compliant application, which meets all applicable state laws, regulations, and Riverside County EMS Agency policies. If approval is not granted, the reasons will be specified in writing.

**Public Safety Personnel First Aid (PSPFA) and CPR Local Optional Scope of Practice (LOSOP) Approval**

1. An agency that utilizes Public Safety Personnel (PSPs) may request approval from the Riverside County EMS Agency to utilize any of the Public Safety Personnel level REMSA approved local optional scope of practice (reference Section 100019). All Public Safety Personnel utilizing REMSA Optional Skills for Public Safety Personnel must have completed a REMSA approved Public Safety Personnel First Aid and CPR Training Course.

2. Any agency requesting approval to utilize Public Safety Personnel, First Aid and CPR LOSOP must meet the qualifications for as outlined in Title 22 Regulations (Section 100014 and/or 100021). A formal letter of request will be sent on agency letterhead, identifying which components of LOSOP the provider is requesting to utilize.

3. Requests for LOSOP utilization will contain: a date of the request; a proposed training timeline consistent with all state laws, regulations and REMSA policies; be initiated by the agency administration, identifying also, an agency LOSOP program coordinator. The requesting agency shall have a program coordinator that is responsible for oversight of the LOSOP program, including but not limited to, training documentation, continuous quality improvement evaluation of LOSOP skills, review of unusual occurrences related to LOSOP, data collection and reporting to REMSA, continuing competencies of LOSOP skills.

4. REMSA will review LOSOP requests and respond within ten (10) working days to acknowledge request, clarify further needs and identify what if anything is missing related to (3) above. Requests will be formally approved or disapproved within forty-five (45) days of REMSA receiving a complete request (as defined above).
Public Safety Personnel First Aid and CPR Local Optional Scope of Practice Standards

1. To perform LOSOP skills, Public Safety First Aid Providers must first meet criteria for initial training and continued re-training as defined by Title 22, Division 9, Chapter 1.5, Sections 100022 and 100023.
   a. Training instructors must meet this criteria and have completed a REMSA approved training course for LOSOP instruction.

2. Training for LOSOP skills will be consistent with all applicable state laws, regulations, REMSA policies and procedures and meet/exceed the minimum standards for LOSOP training set in Section 100019.

3. Continued competency of each LOSOP skill will be demonstrated at minimum every two (2) years, or as frequently as REMSA requests or continuous quality improvement evaluation proves necessary.

4. All equipment or administration devices necessary for LOSOP skills shall be provided and maintained by the PSP agency utilizing LOSOP skills.

EPINEPHRINE AUTO-INJECTORS

1. Epinephrine auto-injectors may be used within LOSOP to treat suspected anaphylaxis.

2. Training for use of epinephrine auto-injectors will consist of REMSA approved training materials. Training shall have cognitive and psychomotor components and shall result in the public safety first aid provider being competent in the administration of epinephrine via auto-injector and managing a patient of a suspected anaphylactic reaction.

3. 9-1-1 shall be contacted for all patients suffering anaphylaxis or receiving epinephrine administration.

4. Agencies utilizing this LOSOP skill shall provide the needed personal protective equipment to PSP providers as defined by REMSA policies.

5. Data collected for this patient type shall meet all current NEMSIS standards, shall be shared with 9-1-1 providers also responding to this patient, and shall be made available to REMSIS after each epinephrine administration as REMSA documentation policies define. Prehospital providers will record this epinephrine administration as “prior to arrival” and note the applicable PSP provider agency performing the skill.

OXYGEN ADMINISTRATION

1. The administration of supplemental oxygen and/or the use of bag-valve-mask ventilation may be used in LOSOP for the patient requiring assistance with oxygenation and/or ventilation.

2. Training for use of oxygen administration shall consist of REMSA approved training materials. Training shall have cognitive and psychomotor components, and shall result in the public safety first aid provider being competent in the administration of supplemental oxygen; the use of oxygen administration devices (i.e. nasal cannula, non-rebreather mask, and bag-valve-mask); the set-up and use of any oxygen tank, regulator and liter-flow selection; and managing a patient with respiratory distress or respiratory failure.

3. Agencies utilizing this LOSOP skill shall provide the needed personal protective equipment to PSP providers as defined by REMSA policies.

4. Data collected for this patient type shall meet all current NEMSIS standards, shall be shared with 9-1-1 providers also responding to this patient, and shall be made available to REMSIS after each oxygen administration as REMSA documentation policies define. Prehospital providers will record this oxygen administration as “prior to arrival” and note the applicable PSP provider agency performing the skill.
ATROPINE AND PRALIDOXIME CHLORIDE AUTOINJECTORS FOR NERVE AGENT EXPOSURE

1. The administration of atropine and pralidoxime chloride auto-injectors in the case of self or peer exposure to nerve agents may be used in LOSOP.

2. Training for the use of atropine and pralidoxime chloride auto-injectors shall consist of REMSA approved training materials. Training shall have cognitive and psychomotor components and shall result in the public safety provider being competent in the administration of auto-injectors for nerve agent intoxication.

3. 9-1-1 shall be contacted for all agency personnel suffering from nerve agent exposure or receiving atropine and pralidoxime administration.

4. Agencies utilizing this LOSOP skill shall provide the needed personal protective equipment to PSP providers as defined by REMSA policies.

5. Data collected for this patient type shall meet all current NEMSIS standards, shall be shared with 9-1-1 providers also responding to this patient, and shall be made available to REMSIS after each atropine and pralidoxime administration as REMSA documentation policies define. Prehospital providers will record this atropine and pralidoxime administration as “prior to arrival” and note the applicable PSP provider agency performing the skill. The agency will also complete the appropriate REMSA notification form and submit to REMSA.

NALOXONE HYDROCHLORIDE

1. The administration of naloxone hydrochloride for suspected narcotic overdose may be utilized in LOSOP.

2. Training for use of naloxone hydrochloride for suspected narcotic overdose shall consist of REMSA approved training materials. Training shall have cognitive and psychomotor components, shall result in the public safety first-aid provider being competent in the administration of naloxone and managing a patient of a suspected narcotic overdose.

3. 9-1-1 shall be contacted for any patient suffering from narcotic overdose or receiving naloxone administration.

4. Agencies utilizing this LOSOP skill shall provide the needed personal protective equipment to PSP providers as defined by REMSA policies.

5. Data collected for this patient type shall meet all current NEMSIS standards, shall be shared with 9-1-1 providers also responding to this patient, and shall be made available to REMSIS after each naloxone administration as REMSA documentation policies define. Prehospital providers will record this naloxone administration as “prior to arrival” and note the applicable PSP provider agency performing the skill.

NASOPHARYNGEAL AIRWAY ADJUNCT AND OROPHARYNGEAL AIRWAY ADJUNCT

1. The use of NPA and OPA adjuncts for airway management may be utilized in LOSOP.

2. Training for use of NPA and OPA adjuncts shall consist of REMSA approved training materials. Training shall have cognitive and psychomotor components, shall result in the public safety first-aid provider being competent in the use of the devices and airway control.

3. 9-1-1 shall be contacted for all patients requiring NPA or OPA use or airway management strategies.

4. Agencies utilizing this LOSOP skill shall provide the needed personal protective equipment to PSP providers as defined by REMSA policies.

5. Data collected for this patient type shall meet all current NEMSIS standards, shall be shared with 9-1-1 providers also responding to this patient, and shall be made available to REMSIS after each NPA or OPA use as REMSA documentation policies define. Prehospital providers will record this NPA or OPA placement/use as “prior to arrival” and note the applicable PSP provider agency performing the skill.
PURPOSE
To establish procedures which allow for the approval of paramedic internship completion in Riverside County and to assist providers in meeting the standards and requirements.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Definitions
1. Paramedic Student Intern: An individual who is enrolled in an approved California paramedic training program and is required to complete a field internship in order to become eligible for a California paramedic license.

2. Paramedic Preceptor: An individual actively licensed as a paramedic, who has been working for a REMSA authorized Advanced Life Support (ALS) service provider as a licensed paramedic in the field for at least two (2) years, or an individual licensed as a paramedic who has worked a minimum of five (5) years with one year for a REMSA authorized Advanced Life Support (ALS) service provider and completed a REMSA approved preceptor training workshop. Paramedic preceptors must be in good standing with their employer and not subject to any disciplinary action against their license. Each training program is responsible for ensuring that the field preceptor has the required experience and training.

Procedure
1. Eligibility
   a. To be eligible for a paramedic student field internship within the REMSA region, a paramedic student intern must:
      i. Be currently enrolled in and have successfully completed the didactic and clinical rotations of a California approved paramedic training program.
      ii. Possess a valid American Heart Association BLS Healthcare Provider or REMSA approved equivalent.
      iii. Possess a valid American Heart Association Advanced Cardiac Life Support (ACLS) card.
      iv. Currently certified as an EMT, a California AEMT, or registered as an EMT-Intermediate with the NREMT. CPR certification, ACLS certification and EMT/California AEMT, or EMT-Intermediate certifications must be maintained throughout the field internship.
      v. Have completed their clinical internship shifts within the last 90 days.

2. REMSA approved Paramedic Training Program, Paramedic Student Internships:
   a. Program director or clinical coordinator must compile and maintain the following documentation for each student interning in the REMSA region:
      i. The agency, and name of the qualified preceptor along with the name of the student they are assigned to.
      ii. Each student should also have a designated program specific Internship liaison assigned to them.
      iii. A letter verifying the training program administered an orientation to and exam on REMSA’s performance standards, policies and protocols and that the student successfully passed the exam.
      iv. The date the student completed the clinical shifts (field internship must begin within 90 days from the end of the clinical rotation).
      v. Copy of a current EMT, California AEMT certification or NREMT EMT-Intermediate.
      vi. Copy (front and back) of a valid American Heart Association BLS Healthcare Provider, or REMSA approved equivalent. Online course is acceptable with written documentation of skills portion.
vii. Copy (front and back) of a valid American Heart Association Advanced Cardiac Life Support (ACLS) card. ACLS cards that are obtained online must have hands on skills evaluation with an approved American Heart Association instructor.

b. An electronic spreadsheet must be created for each cohort containing items (i.) and (ii.) and the dates of completion or validity for items iii – vi. This information should also include an estimated completion date for the student.

3. Non-REMSA approved Paramedic Training Program, Paramedic Student Internships:
   a. Applies to all Paramedic Training Programs out of the REMSA/ICEMA region
   b. Out of region, out of state or out of country paramedic student internships must be approved by REMSA prior to internship start.
   c. Training program must have an active Letter of Review (LoR) from CAAHEP/CoAEMSP or active (non-provisional) accreditation from CoAEMSP.
   d. Training program must be in good standing with their local or state EMS Agency
   e. Training program will submit copies of LoR or active accreditation, and active approval from local/state training program approval authority to REMSA.
      i. Training program will complete partial curricula review process prior to internship approval.
      ii. Training program must have active affiliation/contract agreement with a REMSA authorized ALS provider prior to internship start.
      iii. Training program must have designated field liaison to support and advise student and interact with assigned field internship agency.
   f. Program Director or Clinical Coordinator must compile and submit to REMSA (prior to internship approval):
      i. A letter verifying that approved curricula was used to orient the out of area paramedic student to REMSA performance standards, policies and protocols; and that the student successfully passed an exam on such content.
      ii. The date the student completed clinical shifts, and location(s) where clinical shifts were completed.
      iii. Copy of current EMT, California AEMT certification or NREMT EMT-Intermediate certification.
      iv. Copy (front and back) of a valid American Heart Association BLS Healthcare Provider, or REMSA approved equivalent. Online course is acceptable with written documentation of skills portion.
      v. Copy (front and back) of a valid American Heart Association Advanced Cardiac Life Support (ACLS) card. ACLS cards that are obtained online must have hands on skills evaluation with an approved American Heart Association instructor.
   g. REMSA will review all supporting documentation (as above) associated with internship request and respond with intent to support the request, or with notice for internship ineligibility.
   h. Internships conducted outside of this approval process are subject to formal notification to applicable accrediting, regulatory and governing authorities and will not be validated by REMSA for local accreditation.
PURPOSE
To describe the fee schedule for credentialing of the emergency medical technician (EMT), paramedic (EMT-P), and Mobile Intensive Care Nurse (MICN).

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Fee Schedule and Payment Options
1. Fees (including the EMT state fee) are to be paid via credit card (Visa, MasterCard, or Discover) through our on-line credentialing system. The payment process is explained on the final page (“Acknowledgment” page) of the electronic application. For applicants whose employer has a voucher system established with REMSA, the voucher payment method is explained on that same page.

Cash, personal checks, money orders, or cashier’s checks are not accepted. Only electronic payment via credit card or credited debit card will be accepted.

2. Certification/recertification, accreditation/reverification, and authorization/reauthorization fees are as follows:
   a. EMT
      i. Local fees charged by REMSA
         1. Application Processing Fee (certification/recertification) $25.00
         2. Late Application Fee $10.00
      ii. State Central Registry fees
         1. New certification and/or new to REMSA (fingerprints required*) $75.00
         2. Recertification continuing through REMSA (no fingerprints needed*) $37.00
   
   b. Paramedic
      i. Initial Accreditation $75.00
      ii. Reverification $50.00
      iii. Late Application Fee $25.00
   
   c. MICN
      i. Initial Authorization $75.00
      ii. Reauthorization $50.00
      iii. Late Application Fee $25.00

3. EMT Replacement card fee $10.00 (includes new card when name change occurs)
   • REMSA does not issue accreditation/authorization cards to paramedics or MICNs. A facsimile may be printed from the on-line system once the application has been approved.

EMS fees are non-refundable.

* Fingerprinting is required of all new EMT applicants, including those recertifying applicants who are new to Riverside County, and those returning after an expiration of one year or more. Fingerprinting is done by outside agencies, with fees paid directly to them. Current fees charged by the Department of Justice (DOJ) and the FBI for fingerprint analysis is $51. The agency that obtains the LiveScan fingerprints will charge a “rolling fee” as well, which is usually between $10 and $20.
PURPOSE
1. To define who is eligible to apply for initial EMT certification
2. To explain the conditions of continued certification in Riverside County
3. To explain the application process for initial EMT certification in Riverside County

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.210.]
California Code of Regulations, Title 22, Chapter 2, Sections 100056 – 100083
California Penal Code, Section 11105

Eligibility for Initial Certification
To legally practice as an EMT in the State of California, an individual must obtain, and maintain in good standing, a State certification issued by a local EMS agency (LEMSA).
   a. Certification will not be issued to anyone under the age of 18.
   b. Persons holding out-of-state or National Registry of EMTs (NREMT) certifications must apply for, and receive approval of, California certification in order to practice as an EMT in California.
   c. Foreign training and/or credentials are not eligible for reciprocity.

Conditions of Continued Certification
1. REMSA will be notified regarding changes in physical and/or mailing address, email address, telephone contact information, and/or employment within thirty (30) calendar days of the change. Notification shall be made by:
   a. Accessing and updating personal profile information in the on-line license management portal, found here: https://ca.emsbridge.com/remsa/public/portal#/login AND
   b. Emailing REMSA at emsapps@rivco.org, notifying that changes / updates have been made in the system.
2. EMTs will comply with all REMSA related requests for information that may include, but are not limited to, medical CQI, incident reviews, arrest inquiries, and disciplinary investigations / reviews.
3. Local Accreditation
   LEMSAs may require additional knowledge and/or skill competencies, or may restrict the state Scope of Practice (SoP), as determined by the Medical Director.

Scope of Practice
Once certified, EMTs:
1. Are responsible and held accountable for the knowledge and skills described in the EMT (SoP), as defined by Title 22, Sections 100063 through 100064.1, of the California Code of Regulations.
2. Complete all mandatory in-service / skills training sessions as designated by REMSA, including protocol updates and employer, or REMSA, initiated Performance Improvement Plans.

The Application Process
All applications will be submitted through REMSA’s on-line license management portal, found here: https://ca.emsbridge.com/remsa/public/portal#/login. To expedite the certification process, REMSA recommends that applicants scan and export the following documents into PDF format before initiating their application:
• **Photo I.D.:** current, valid, and legal (submission of only one (1) of the following is required)
  a. State driver’s license or military I.D. card
    i. Temporary driver’s licenses without a picture and/or military IDs where the applicant is not the primary
       issuant will not be accepted.
  b. State I.D. card
  c. Passport
    o Unexpired U.S. OR
    o Unexpired foreign, with a valid U.S. visa and approved U.S. Department of Homeland Security Lawful Record
       of Admission.
• **CPR Card:** A current and valid American Heart Association, American Red Cross, or California-approved BCLS/CPR
  card (“professional” level).
  o All information on the card must be typed.
  o Card must be valid for a minimum of thirty (30) days past the application date.
• **Live Scan Fingerprinting:** Proof of completion of fingerprinting for a California Department of Justice (DOJ) and FBI
  criminal offender record information search. Use of the preprinted REMSA fingerprint form is mandatory (found
  here: [http://www.remsa.us/policy/REMSA-EMT-Request-for-Live-Scan.pdf#View=FitV](http://www.remsa.us/policy/REMSA-EMT-Request-for-Live-Scan.pdf#View=FitV)). It is recommended that the
  applicant keep a copy of this form for their records.
  o REMSA is unable to accept Live Scan forms or results completed for any other agency or organization. Please
    refer to the Credentialing FAQ (found here: [http://remsa.us/documents/credentialing/CertificationFAQs_220623.pdf](http://remsa.us/documents/credentialing/CertificationFAQs_220623.pdf)) for more information.

In addition to the above requirements, applicants must satisfy at least one (1) criterion below:

Pass the NREMT cognitive and psychomotor examination within two (2) years from the date of application for EMT
certification and have a valid EMT course completion record or other documented proof of successful completion of any
initial EMT course approved pursuant to § 100066 of Title 22, issued within two (2) years of the date of application, OR

Pass the NREMT cognitive and psychomotor examination within two (2) years from the date of application for EMT
certification and have documentation of successful completion of an approved out-of-state initial EMT training course
that meets the requirements of this Chapter issued within two (2) years of the date of application, OR

Pass the NREMT cognitive and psychomotor examination within two (2) years from the date of application for EMT
certification and have a current and valid out-of-state EMT certificate, OR

Possess a current and valid National Registry EMT, Advanced EMT or Paramedic registration certificate, OR

Possess a current and valid out-of-state Advanced EMT or Paramedic certificate, OR

Possess a current and valid California Advanced EMT certificate or a current and valid California Paramedic license.

There may be some instances in which an applicant qualifies for California EMT certification but does not meet the
requirements to sit for NREMT examination. In such cases, an approved alternate exam / testing / application process
will be provided to the applicant by the NREMT. This will be coordinated through REMSA and the State EMS Authority.

After assembling the above materials, the application can be accessed by going directly to the online license
management portal, found here: [https://ca.emsbridge.com/remsa/public/portal#/login](https://ca.emsbridge.com/remsa/public/portal#/login). Once the applicant has logged
in, step-by-step instructions will be provided. A brief tutorial will also be available. The system will instruct the applicant
to upload / attach required documents to their application when appropriate.

It is not necessary to complete the entire application process in one sitting. The system will save entered data
if the application process gets interrupted.
At the conclusion of the application process, the option to download an abbreviated version of the completed application will be provided.

Only complete applications will be processed (completed form with all supporting materials and fees).
- Deficiency notices will be emailed to the applicant, explaining the missing or incomplete documents or information. Once the deficiencies have been corrected, the complete application will be processed by REMSA.

In certain cases, applicants may be required to submit information or documentation in addition to the standard elements described in the “Eligibility” section (above). Applicants will be permitted an extra thirty (30) calendar days to submit the additional materials.

Applications that have been started but remain incomplete will be saved in the license management system in an “Initiated” status until completed, or for a maximum of thirty (30) days, whichever is shorter. After thirty (30) days, the application will be considered abandoned, and the license management system will automatically withdraw it from the active queue. Once the status of an application is changed to “Withdrawn,” the applicant will need to initiate a new application, and pay all related fees again, if they wish to continue the certification process.

It is important that the applicant save all uploaded documents and materials for a period of four (4) years in case of State EMS Authority or REMSA audit.

**Initial Certification Fees**
The total fees for initial EMT Certification in Riverside County range from $169 - 189. Approximate costs are itemized below:

<table>
<thead>
<tr>
<th>Fee Type</th>
<th>Funds Paid To</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live Scan Fingerprinting</td>
<td>3rd Party Servicer</td>
<td></td>
</tr>
<tr>
<td>“Rolling” Fee</td>
<td>3rd Party Servicer on behalf of the CA DOJ</td>
<td>$20 - $40</td>
</tr>
<tr>
<td>CA DOJ Analysis Fee</td>
<td>3rd Party Servicer on behalf of the FBI</td>
<td>$32</td>
</tr>
<tr>
<td>FBI Analysis Fee</td>
<td>3rd Party Servicer on behalf of the FBI</td>
<td>$17</td>
</tr>
<tr>
<td>LEMSA certification fee</td>
<td>REMSA</td>
<td>$25</td>
</tr>
<tr>
<td>EMSA Personnel Registry</td>
<td>REMSA (collected on behalf of Cal EMSA)</td>
<td>$75</td>
</tr>
</tbody>
</table>

| Total due to 3rd Party Servicer = $69 - $89 | Total due to REMSA = $100 |

1 All fees associated with Live Scan Fingerprinting in this table are estimated based on historical pricing. They are assessed and collected by 3rd party servicers and are subject to change without notice or update of this policy. REMSA makes no guarantee of Live Scan Fingerprinting costs; these are simply approximations for financial planning purposes only.

The system will hold, but not process, an application until the required non-refundable fee is paid.
- All fees paid to REMSA are non-refundable.

Fees may be paid via debit card (so long as it bears a Visa, MasterCard, or Discover logo) or credit card (all issuers except for AMEX) through the on-line license management system. The payment process is explained on the final (“Acknowledgment”) page of the electronic application.
- Cash, personal checks, money orders, and cashier’s check are not accepted
- REMSA recommends using Chrome or Firefox to process applications.

For applicants whose employer has a voucher system established with REMSA, the voucher payment method is explained on the final (“Acknowledgment”) page.
- **Employer vouchers do NOT cover late fees; applicants are ultimately responsible for timely payment to REMSA. Applications will not be processed until all fees are received.**
Effective and Expiration Dates of Certification

1. The effective date of certification for all applicants will be the date that the certificate is issued.
2. Certification will be valid for two (2) years and will expire on the final day of the same calendar month in which the certification was issued.
PURPOSE
1. To define who is eligible to apply for EMT recertification
2. To explain the conditions of continued certification in Riverside County
3. To explain the application process for EMT recertification in Riverside County

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.210.]
California Code of Regulations, Title 22, Sections 100056 - 100064, 100080, 100081, & 100083
California Penal Code, Section 11105

Eligibility for Recertification
To legally practice as an EMT in the State of California, an individual must obtain and maintain in good standing a State certification issued by a local EMS agency (LEMSA).

- Only currently certified EMTs who hold an active California EMT certification are eligible to apply for recertification
- Applicants holding out-of-state or National Registry of EMTs (NREMT) certifications, or those holding other California EMS credentials (other than EMT certification), and those who have never held a California EMT certification, must apply for California EMT certification as an initial applicant; Refer to REMSA Policy #1202 (EMT Certification).
- Applicants whose EMT certification is expired are not eligible for recertification
1. Refer to REMSA Policy #1204 (EMT Reinstatement)
- Foreign training and/or credentials are not eligible for reciprocity or recertification.

Conditions of Continued Certification
1. REMSA will be notified regarding changes in physical and/or mailing address, email address, telephone contact information, and/or employment within thirty (30) calendar days of the change. Notification shall be made by:
   a. Accessing and updating personal profile information in the on-line license management portal, found here: https://ca.emsbridge.com/remsa/public/portal#/login AND
   b. Emailing REMSA at emsapps@rivco.org, notifying that changes / updates have been made in the system.
2. EMTs will comply with all REMSA related requests for information that may include, but are not limited to, medical CQI, incident reviews, arrest inquiries, and disciplinary investigations / reviews.
3. Local Accreditation
   LEMSAs may require additional knowledge and/or skill competencies, or may restrict the state SoP, as determined by the Medical Director.

Scope of Practice
Once certified, EMTs:
1. Are responsible and held accountable for the knowledge and skills described in the EMT Scope of Practice (SoP), as defined by Title 22, Sections 100063 through 100064.1, of the California Code of Regulations.
2. Complete all mandatory in-service / skills training sessions as designated by REMSA, including protocol updates and employer, or REMSA, initiated Performance Improvement Plans.

The Application Process
All applications will be submitted through REMSA’s on-line license management portal, found here: https://ca.emsbridge.com/remsa/public/portal#/login.
• **EMTs CURRENTLY CERTIFIED IN RIVERSIDE COUNTY**: All applicants applying for recertification must submit a completed recertification packet. REMSA suggests submitting all required documents a minimum of thirty (30) calendar days prior to the expiration date of their current certification to allow sufficient time for correction of deficiencies, processing, and mailing of the new certification card.

• **APPLICANTS WHO ARE NEW TO RIVERSIDE COUNTY**: applicants who possess a current and valid EMT, AEMT or EMT-P certification issued by another certifying entity / LEMSA should submit their application a minimum of thirty (30) calendar days in advance of the expiration date to allow sufficient time to validate their past credentials with the original issuing agency. Additionally, these applicants must also submit:
  o **Live Scan Fingerprinting**: Proof of completion of fingerprinting for a California Department of Justice (DOJ) and FBI criminal offender record information search. Use of the preprinted REMSA fingerprint form is mandatory. It can be found here: [http://www.remsa.us/policy/REMSA-EMT-Request-for-Live-Scan.pdf#View=FitV](http://www.remsa.us/policy/REMSA-EMT-Request-for-Live-Scan.pdf#View=FitV).
    ▪ REMSA is unable to accept Live Scan forms or results completed for any other agency or organization. Please refer to the Credentialing FAQ (found here: [http://remsa.us/documents/credentialing/CertificationFAQs_UPDATED.pdf](http://remsa.us/documents/credentialing/CertificationFAQs_UPDATED.pdf)) for more information.

AND (if not already on file with REMSA)
  o **CERTIFICATE OF COMPLETED TRAINING**: proof of successful completion of training by an approved EMT training program or approved CE provider to administer Epinephrine and Naloxone and to use a Glucometer.

To expedite the recertification process, REMSA recommends that applicants scan and export the following documents into PDF format before initiating their application:
1. **EMT Card**: current and valid.
2. **CPR Card**: A current and valid American Heart Association, American Red Cross, or California-approved BCLS/CPR card ("professional" level).
   a. All information on the card must be typed.
   b. Card must be valid for a minimum of thirty (30) days past the application date.
3. **Photo I.D.**: current, valid, and legal (submission of only one (1) of the following is required)
   a. State driver’s license or military I.D. card
      i. Temporary driver’s licenses without a picture and/or military IDs where the applicant is not the primary Issuant will not be accepted.
   b. State I.D. card
   c. Passport
      i. Unexpired U.S. OR
4. **Twenty-four (24) hours of continuing education (CE)**:
   a. Successful completion of a twenty-four (24) EMT refresher course from an approved EMT training program within the twenty-four (24) months prior to applying for recertification OR
   b. Obtaining at least twenty-four (24) hours of continuing education (CE), within the twenty-four (24) months prior to applying for renewal, from an approved CE provider in accordance with the provisions contained in Title 22, Chapter 11 (EMS Continuing Education).

Approved CE Providers in California can be found here: [https://emstraining.emsa.ca.gov/ShowTraining/ContinuingEducation/GroupByContinuingEducationTable.aspx](https://emstraining.emsa.ca.gov/ShowTraining/ContinuingEducation/GroupByContinuingEducationTable.aspx). CAPCE-accredited CE providers can be found here: [https://cecbems.org/Home/Providers](https://cecbems.org/Home/Providers). Only those course topics meeting Chapter 11 requirements will be accepted for CE credit.

More information regarding CE requirements for EMS personnel can be found here: [http://remsa.us/policy/REMSACEGuideforPersonnel.pdf](http://remsa.us/policy/REMSACEGuideforPersonnel.pdf)
After assembling the above materials, the application can be accessed by going directly to the online license management portal, found here: https://ca.emsbridge.com/remsa/public/portal#/login. Once the applicant has logged in, step-by-step instructions will be provided. A brief tutorial will also be available. The system will instruct the applicant to upload / attach the required documents to their application when appropriate.

It is not necessary to complete the entire application process in one sitting. The system will save entered data if the application process gets interrupted.

At the conclusion of the application process, the option to download an abbreviated version of the completed application will be provided.

Only complete applications will be processed (completed form with all supporting materials and fees).

- Deficiency notices will be emailed to the applicant, explaining the missing or incomplete documents or information. Once the deficiencies have been corrected, the complete application will be processed by REMSA.

In certain cases, applicants may be required to submit information or documentation in addition to the standard elements described in the “Eligibility” section (above). Applicants will be permitted an extra thirty (30) calendar days to submit the additional materials.

Applications that have been started but remain incomplete will be saved in the license management system in an “Initiated” status until completed, or for a maximum of thirty (30) days, whichever is shorter. After-thirty (30) days, the application will be considered abandoned, and the license management system will automatically withdraw it from the active queue. Once the status of an application is changed to “Withdrawn,” the applicant will need to initiate a new application and pay all related fees again should they wish to continue the recertification process.

It is important that the applicant save all uploaded documents and materials for a period of four (4) years in case of State EMS Authority or REMSA audit.

**Recertification Fees**

Total fees for EMT Recertification in Riverside County are $62 when a complete and correct application is submitted and paid on time, and $72 when the application is incomplete, incorrect, or paid after expiration. Costs are itemized below:

<table>
<thead>
<tr>
<th>Fee Type</th>
<th>Funds Paid To</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEMS A certification fee</td>
<td>REMSA</td>
<td>$25</td>
</tr>
<tr>
<td>EMSA Personnel Registry Fee</td>
<td>REMSA (collected on behalf of Cal EMSA)</td>
<td>$37</td>
</tr>
<tr>
<td><strong>Total due to REMSA</strong> = <strong>$62</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEMS A certification fee – LATE*</td>
<td>REMSA</td>
<td><strong>$35 ($25 + $10 LATE FEE)</strong></td>
</tr>
<tr>
<td>EMSA Personnel Registry Fee</td>
<td>REMSA (collected on behalf of Cal EMSA)</td>
<td>$37</td>
</tr>
<tr>
<td><strong>Total due to REMSA</strong> = <strong>$72</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recertification, New to Riverside County</td>
<td>REMSA</td>
<td>$25</td>
</tr>
<tr>
<td>EMSA Personnel Registry Fee/ Change Certifying Entity</td>
<td>REMSA (collected on behalf of Cal EMSA)</td>
<td>$75</td>
</tr>
<tr>
<td><strong>Total due to REMSA</strong> = <strong>$100</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*A late fee will be added to the certification fee the day after expiration

The system will hold, but not process, an application until the required non-refundable fee is paid.

- All fees paid to REMSA are non-refundable.

Fees may be paid via debit card (so long as it bears a Visa, MasterCard, or Discover logo) or credit card (all issuers except for AMEX) through the on-line license management system. The payment process is explained on the final (“Acknowledgment”) page of the electronic application.

- Cash, personal checks, money orders, and cashier’s check are not accepted
- REMSA recommends using Chrome or Firefox to process applications.
For applicants whose employer has a voucher system established with REMSA, the voucher payment method is explained on the final (“Acknowledgment”) page.

- **Employer vouchers do NOT cover late fees; applicants are ultimately responsible for timely payment to REMSA.**
  - Applications will not be processed until all fees are received.

**Effective and Expiration Dates of Certification**

For applicants applying for recertification within 180 days (or less) of the expiration date of their current certification period:

- Certification will be valid for two (2) years, beginning the day after the current expiration date **AND**
- Will expire on the final day of the same calendar month in which the original certification was issued.

For applicants applying for recertification greater than 180 days from the expiration date of their current certification period:

- Certification will be valid for two (2) years from the date that the new application is approved / recertification requirements were met **AND**
- Will expire on the final day of the same calendar month in which the new certification was issued.

**Extensions for Active-Duty Military Personnel**

An applicant who is a member of the Armed Forces of the United States, whose EMT certification expires while deployed on active duty, or whose EMT certification expires less than six (6) months after returning from active-duty deployment, will be given six (6) months past the date of their release from active-duty deployment to complete the recertification requirements and file a recertification application with a certifying entity. To obtain this extension, the applicant must submit documentation from their respective branch of the Armed Forces of the United States that verifies their membership in the Armed Services and confirms the dates (starting and ending) of their active-duty deployment.

Continuing education credit(s) may be given to applicants returning from active duty for training that was received while deployed that meets the requirements of Title 22, Chapter 11, (EMS CE Regulations). Documentation to receive credit must include copies of the training certificates and verification from the applicant’s Commanding Officer attesting to the training classes attended.
PURPOSE
1. To define who is eligible to apply for EMT certification reinstatement
2. To explain the conditions of continued certification in Riverside County
3. To explain the application process for EMT certification reinstatement after expiration of a previously valid California EMT certification

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.210.]
California Code of Regulations, Title 22, Sections 100056 - 100064, 100080, 100081, & 100083
California Penal Code, Section 11105

Eligibility for Reinstatement of Certification
To legally practice as an EMT in the State of California, an individual must obtain and maintain in good standing a State certification issued by a local EMS agency (LEMSA).

Applicants whose California EMT certification has been expired for more than 365 days are not eligible for recertification. They must follow the steps outlined in this policy to apply for certification reinstatement.

Certification reinstatement, as described in this policy, applies only to applicants who once held a valid State of California EMT certification, regardless of the certifying entity.

This policy does NOT apply to applicants who have never held a State of California EMT certificate. Out of state card holders must follow the steps listed in REMSA Policy #1202 (Initial EMT Certification) to become certified in California.

Conditions of Continued Certification
1. REMSA will be notified regarding changes in physical and/or mailing address, email address, telephone contact information, and/or employment within thirty (30) calendar days of the change. Notification shall be made by:
   a. Accessing and updating personal profile information in the on-line credentialing portal, found here: https://ca.emsbridge.com/remsa/public/portal#/login AND
   b. Emailing REMSA at emsapps@rivco.org, notifying that changes / updates have been made in the system.
2. EMTs will comply with all REMSA related requests for information that may include, but are not limited to, medical CQI, incident reviews, arrest inquiries, and disciplinary investigations / reviews.
3. Local Accreditation
   LEMSAs may require additional knowledge and/or skill competencies, or may restrict the state Scope of Practice (SoP), as determined by the Medical Director.

Scope of Practice
Once certified, EMTs:
1. Are responsible and held accountable for the knowledge and skills described in the EMT Scope of Practice (SoP), as defined by Title 22, Sections 100063 through 100064, of the California Code of Regulations.
2. Must complete all mandatory in-service / skills training sessions as designated by REMSA, including protocol updates and employer, or REMSA, initiated Performance Improvement Plans.
The Application Process
All applications will be submitted through REMSA’s on-line credentialing portal, found here: https://ca.emsbridge.com/remsa/public/portal#/login.

To expedite the reinstatement process, REMSA recommends that applicants scan and export the following documents into PDF format before initiating their application:

1. **Expired EMT Card**: Expired California EMT certification card or documentation regarding the former certification (cert #, effective and expiration dates, certifying agency, et al.)
2. **CPR Card**: A current and valid American Heart Association, American Red Cross, or California-approved BCLS/CPR card (“professional” level).
   a. All information on the card must be typed.
   b. Card must be valid for a minimum of thirty (30) days past the application date.
3. **Photo I.D.**: current, valid, and legal (submission of only one (1) of the following is required)
   a. State driver’s license or military I.D. card
      i. Temporary driver’s licenses without a picture and/or military IDs where the applicant is not the primary issuer will not be accepted.
   b. State I.D. card
   c. Passport
      i. Unexpired U.S. OR

If the reinstatement applicant is:
- New to Riverside County (i.e., the previous EMT certification was issued by another LEMSA in California) OR
- Their certification has been expired for over one (1) year

THEN THEY MUST ALSO SUBMIT

4. **Live Scan Fingerprinting**: Proof of completion of fingerprinting for a California Department of Justice (DOJ) and FBI criminal offender record information search. Use of the preprinted REMSA fingerprint form is mandatory. It can be found here: [http://www.remsa.us/policy/REMSA-EMT-Request-for-Live-Scan.pdf#View=FitV](http://www.remsa.us/policy/REMSA-EMT-Request-for-Live-Scan.pdf#View=FitV) and its use is mandatory.
   a. REMSA is unable to accept Live Scan results completed for any other agency or organization. Please refer to the Credentialing FAQ (found here: [http://remsa.us/documents/credentialing/CertificationFAQs_UPDATED.pdf](http://remsa.us/documents/credentialing/CertificationFAQs_UPDATED.pdf)) for more information.
   AND (if not already on file with REMSA)

5. **CERTIFICATE OF COMPLETED TRAINING**: proof of successful completion of training by an approved EMT training program or approved CE provider to administer Epinephrine and Naloxone and to use a Glucometer.

Applicants who possess a California EMT certification that has been expired between one (1) day and 180 days, must include the following in their reinstatement application packet:

1. **Twenty-four (24) hours of continuing education (CE)**:
   a. Twenty-four (24) hours of continuing education (CE), within the twenty-four (24) months prior to applying for renewal, from an approved CE provider in accordance with the provisions contained in Title 22, Chapter 11 (EMS Continuing Education) OR
   b. Successful completion of a twenty-four (24) EMT refresher course from an approved EMT training program within twenty-four (24) months prior to applying for recertification
2. **EMT SCV**: an original Skills Competency Verification (SCV) form, [EMSA-SCV (01/17)](http://www.remsa.us/policy/1402.pdf), completed by an approved verifier in accordance with Policy #1402, Skills Competency Verification, found here: [http://www.remsa.us/policy/1402.pdf](http://www.remsa.us/policy/1402.pdf), within twenty-four (24) months prior to the date of the reinstatement application.
Approved CE Providers in California can be found here: 
https://emstraining.emsa.ca.gov/ShowTraining/ContinuingEducation/GroupByContinuingEducationTable.aspx.

More information regarding CE requirements for EMS personnel can be found here:  

Applicants who possess a California EMT certification that has been expired between 181 days and 365 days, must include the following in their reinstatement application packet:

1. **Thirty-six (36) hours of continuing education (CE):**
   a. Thirty-six (36) hours of continuing education (CE), within the twenty-four (24) months prior to applying for renewal, from an approved CE provider in accordance with the provisions contained in Title 22, Chapter 11 (EMS Continuing Education) OR
   b. An EMT Refresher course from an approved EMT training program, taken within the previous 24 months, will be accepted for an equivalent number of CE hours. Applicants will still need to submit proof of completion of an additional 12 hours of CE.

2. **EMT SCV:** an original Skills Competency Verification (SCV) form, EMSA-SCV (01/17), completed by an approved verifier in accordance with Policy #1402, Skills Competency Verification, found here: http://www.remsa.us/policy/1402.pdf, within twenty-four (24) months prior to the date of the reinstatement application.

Applicants who possess a California EMT certification that has been expired for more than 365 days must include the following in their reinstatement application packet:

1. **Forty-eight (48) hours of continuing education (CE):**
   a. Forty-eight (48) hours of continuing education (CE), within the twenty-four (24) months prior to applying for renewal, from an approved CE provider in accordance with the provisions contained in Title 22, Chapter 11 (EMS Continuing Education) OR
   b. An EMT Refresher course from an approved EMT training program, taken within the previous 24 months, will be accepted for an equivalent number of CE hours. Applicants will still need to submit proof of completion of an additional 24 hours of CE.

2. **EMT SCV:** an original Skills Competency Verification (SCV) form, EMSA-SCV (01/17), completed by an approved verifier in accordance with Policy #1402, Skills Competency Verification, found here: http://www.remsa.us/policy/1402.pdf.

3. **NREMT cognitive and psychomotor examinations:** Proof of successful completion of the EMT-level National Registry of EMTs (NREMT) cognitive and psychomotor examinations within 24 months prior to the date of the reinstatement application.
   a. The NREMT psychomotor skills examination is not equivalent to the required EMT SCV (#6, above).
   b. If the applicant for reinstatement possesses a current and valid California Advanced EMT (AEMT) or paramedic license, or a current and valid NREMT EMT, AEMT or paramedic certificate, this requirement may be waived.

After assembling the above materials, the application can be accessed by going directly to the online credentialing portal, found here: https://ca.emsbridge.com/remsa/public/portal#login. Once the applicant has logged in, step-by-step instructions will be provided. A brief tutorial will also be available. The system will instruct the applicant to upload / attach their authorization documents to their profile when appropriate.

It is not necessary to complete the entire application process in one sitting. The system will save entered data if the application process gets interrupted.

At the conclusion of the application process, the option to print an abbreviated version of the completed application will be provided.

Only complete applications will be processed (completed form with all supporting materials and fees).

- Deficiency notices will be emailed to the applicant, explaining the missing or incomplete documents or information. Once the deficiencies have been corrected, the complete application will be processed by REMSA.
In certain cases, applicants may be required to submit information or documentation in addition to the standard elements described in the “Eligibility” section (above). Applicants will be permitted an extra thirty (30) calendar days to submit the additional materials.

Applications that have been started but remain incomplete will be saved in the credentialing system in an “Initiated” status until completed, or for a maximum of thirty (30) days, whichever is shorter. After thirty (30) days, the application will be considered abandoned, and the credentialing system will automatically withdraw it from the active queue. Once the status of an application is changed to “Withdrawn,” the applicant will need to initiate a new application and pay all related fees should they wish to continue the authorization process.

It is important that the applicant save all uploaded documents and materials for a period of four (4) years in case of State EMS Authority or REMSA audit.

Reinstatement Fees

When EMT certification has been expired from 1 day to 365 days after the expiration date, the total fees for EMT reinstatement are $72. Approximate costs are itemized below:

<table>
<thead>
<tr>
<th>Fee Type</th>
<th>Funds Paid To</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEMSA Reinstatement Fee</td>
<td>REMSA</td>
<td>$35 ($25 + $10 LATE FEE)</td>
</tr>
<tr>
<td>EMRSA Personnel Registry</td>
<td>REMSA (collected on behalf of Cal EMSA)</td>
<td>$37</td>
</tr>
</tbody>
</table>

Total due to REMSA = $72

When EMT certification has been expired for more than 365 days after the expiration date, the total fees for EMT reinstatement range from $179 - $199. Approximate costs are itemized below:

<table>
<thead>
<tr>
<th>Fee Type</th>
<th>Funds Paid To</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live Scan Fingerprint1, 2</td>
<td>3rd Party Servicer</td>
<td>$20 - $40</td>
</tr>
<tr>
<td>1. “Rolling Fee”</td>
<td>3rd Party Servicer on behalf of the CA DOJ</td>
<td>$32</td>
</tr>
<tr>
<td>2. CA DOJ Analysis Fee</td>
<td>3rd Party Servicer on behalf of the FBI</td>
<td>$17</td>
</tr>
<tr>
<td>3. FBI Analysis Fee</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LEMSA certification fee</td>
<td>REMSA</td>
<td>$35 ($25 + $10 LATE FEE)</td>
</tr>
<tr>
<td>EMSA Personnel Registry</td>
<td>REMSA (collected on behalf of Cal EMSA)</td>
<td>$75</td>
</tr>
</tbody>
</table>

Total due to REMSA = $110

1 All fees associated with Live Scan Fingerprinting in this table are estimated based on historical pricing. They are assessed and collected by 3rd party servicers and are subject to change without notice or update of this policy. REMSA makes no guarantee of Live Scan Fingerprinting costs, these are simply approximations for financial planning purposes only.

2 Cal EMSA requires applicants whose certification has been expired for more than 365 days to obtain new Live Scan fingerprints.

Effective and Expiration Dates of Certification

1. Certification will be valid for two (2) years from the date that the reinstatement application is approved / reinstatement requirements were met AND
2. Will expire on the final day of the same calendar month in which the new certification was issued.
PURPOSE
1. To explain the EMT certification challenge process
2. To delineate who is eligible to challenge the EMT certification process

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.210.]
California Code of Regulations, Title 22, Sections 100056 – 100064, 100078 & 100083
California Penal Code, Section 11105

Eligibility Requirements to Challenge EMT Certification
To challenge the EMT certification process, an applicant must:
1. **NOT** hold a current or expired California EMT certification (see Policy 1203 – Recertification, and Policy 1204 – Reinstatement for information on renewing an existing EMT certification)
2. Hold a current license as a physician, registered nurse, physician’s assistant, or vocational / practical nurse in the United States, **OR**
   a. have successfully completed an emergency medical service training program of the Armed Forces of the United States which meets the Department of Transportation (DOT) National EMS Education Standards (DOT HS 811 077A, January 2009) within the preceding two years; **OR**, 
   b. have functioned in a full-time capacity for the last (2) two years in a prehospital medical classification of the Armed Forces of the United States. The completion of an approved EMT refresher course, or an appropriate number of CE hours, may be required. 
      i. Applicants attempting to qualify through the Armed Forces pathways should contact the Riverside County EMS Agency (REMSA) for a review of their eligibility and documentation prior to entering the challenge process.

The Challenge Process
1. Obtain an EMT course completion certificate by successfully passing a challenge examination (written and skills) from a REMSA-approved training program.
   The applicant will complete the Verification of Eligibility for EMT Challenge Examination form (found here: http://remsa.us/documents/forms/VERIFICATIONOFELEGIBILITYforEMTCHALLENGEEEXAMINATIONv127720.pdf) and present it to the training program staff when scheduling the examination. Eligible applicants are permitted to take an EMT course challenge examination one (1) time only. Failure to achieve a passing score will require the applicant to complete an entire EMT training course prior to retaking the exam.
2. Upon completion and verification of the above item, the applicant will be eligible to sit for the National Registry of EMTs (NREMT) cognitive and psychomotor examinations.
3. Proof of successful completion of the National Registry of EMTs (NREMT) cognitive and psychomotor examinations will make the applicant eligible for EMT certification in California.

Conditions of Continued Certification After Successfully Challenging
1. REMSA will be notified regarding changes in physical and/or mailing address, email address, telephone contact information, and/or employment within thirty (30) calendar days of the change. Notification shall be made by:
   a. Accessing and updating personal profile information in the on-line license management portal, found here: https://ca.emsbridge.com/remsa/public/portal#/login AND
b. Emailing REMSA at emsapps@rivco.org, notifying that changes / updates have been made in the system.

2. EMTs will comply with all REMSA related requests for information that may include, but are not limited to, medical CQI, incident reviews, arrest inquiries, and disciplinary investigations / reviews.

3. Local Accreditation

LEMSAs may require additional knowledge and/or skill competencies or may restrict the state Scope of Practice (SoP), as determined by the Medical Director.

Scope of Practice

Once certified, EMTs:

1. Are responsible and held accountable for the knowledge and skills described in the EMT SoP, as defined by Title 22, Sections 100063 through 100064.1, of the California Code of Regulations.
2. Must complete all mandatory in-service / skills training sessions as designated by REMSA, including protocol updates and employer, or REMSA, initiated Performance Improvement Plans.

The Application Process

All applications will be submitted through REMSA’s on-line license management portal, found here: https://ca.emsbridge.com/remsa/public/portal#/login. To expedite the certification process, REMSA recommends that applicants scan and export the following documents into PDF format before initiating their application:

1. **CPR Card**: A current and valid American Heart Association, American Red Cross, or California-approved BCLS/CPR card (“professional” level).
   a. All information on the card must be typed.
   b. Card must be valid for a minimum of thirty (30) days past the application date.
2. **Photo I.D.**: current, valid, and legal (submission of only one (1) of the following is required)
   a. State driver’s license or military I.D. card
      i. Temporary driver’s licenses without a picture and/or military IDs where the applicant is not the primary issuant will not be accepted.
   b. State I.D. card
   c. Passport
      i. Unexpired U.S. OR
3. **Live Scan Fingerprinting**: Proof of completion of fingerprinting for a California Department of Justice (DOJ) and FBI criminal offender record information search. Use of the preprinted REMSA fingerprint form is mandatory. It can be found here: http://www.remsa.us/policy/REMSA-EMT-Request-for-Live-Scan.pdf#View=FitV and its use is mandatory.
   a. REMSA is unable to accept Live Scan forms or results completed for any other agency or organization. Please refer to the Credentialing FAQ (found here: http://remsa.us/documents/credentialing/CertificationFAQs_UPDATED.pdf) for more information.
4. **Current Licensure**: a valid physician’s license, registered nursing license, physician’s assistant license or vocational / practical nursing license originating in the United States OR qualifying military documents, as described in “Eligibility Requirements to Challenge EMT Certification” (above)
5. **Course Completion Certificate**: Proof of successful completion of the challenge examination (both written and skills portions) from an approved California EMT training program.
6. **NREMT cognitive and psychomotor examinations**: Proof of successful completion of the EMT-level National Registry of EMTs (NREMT) cognitive and psychomotor examinations within 24 months prior to the date of the reinstatement application.

After assembling the above materials, the application can be accessed by going directly to the online credentialing portal, found here: https://ca.emsbridge.com/remsa/public/portal#/login. Once the applicant has logged in, step-by-step instructions will be provided. A brief tutorial will also be available. The system will instruct the applicant to upload / attach their authorization documents to their profile when appropriate.
It is not necessary to complete the entire application process in one sitting. The system will save entered data if the application process gets interrupted.

At the conclusion of the application process, the option to download an abbreviated version of the completed application will be provided.

Only complete applications will be processed (completed form with all supporting materials and fees).

- Deficiency notices will be emailed to the applicant, explaining the missing or incomplete documents or information. Once the deficiencies have been corrected, the complete application will be processed by REMSA.

In certain cases, applicants may be required to submit information or documentation in addition to the standard elements described in the “Eligibility” section (above). Applicants will be permitted an extra thirty (30) calendar days to submit the additional materials.

Applications that have been started but remain incomplete will be saved in the credentialing system in an “Initiated” status until completed, or for a maximum of thirty (30) days, whichever is shorter. After thirty (30) days, the application will be considered abandoned, and the credentialing system will automatically withdraw it from the active queue. Once the status of an application is changed to “Withdrawn,” the applicant will need to initiate a new application and pay all related fees again should they wish to continue the certification process.

It is important that the applicant save all uploaded documents and materials for a period of four (4) years in case of State EMS Authority or REMSA audit.

**Certification Fees**
The total fees for EMT Certification in Riverside County range from $169 - 189. Approximate costs are itemized below:

<table>
<thead>
<tr>
<th>Fee Type</th>
<th>Funds Paid To</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live Scan Fingerprinting</td>
<td>“Rolling” Fee</td>
<td>$20 - $40</td>
</tr>
<tr>
<td></td>
<td>3rd Party Servicer</td>
<td></td>
</tr>
<tr>
<td>CA DOJ Analysis Fee</td>
<td>3rd Party Servicer on behalf of the CA DOJ</td>
<td>$32</td>
</tr>
<tr>
<td>FBI Analysis Fee</td>
<td>3rd Party Servicer on behalf of the FBI</td>
<td>$17</td>
</tr>
<tr>
<td>LEMSA certification fee</td>
<td>REMSA</td>
<td>$25</td>
</tr>
<tr>
<td>EMSA Personnel Registry</td>
<td>REMSA (collected on behalf of Cal EMSA)</td>
<td>$75</td>
</tr>
</tbody>
</table>

1 All fees associated with Live Scan Fingerprinting in this table are estimated based on historical pricing. They are assessed and collected by 3rd party servicers and are subject to change without notice or update of this policy. REMSA makes no guarantee of Live Scan Fingerprinting costs; these are simply approximations for financial planning purposes only.

The system will hold, but not process, an application until the required non-refundable fee is paid.

- **All fees paid to REMSA are non-refundable.**

Fees may be paid via debit card (so long as it bears a Visa, MasterCard, or Discover logo) or credit card (all issuers except for AMEX) through the on-line license management system. The payment process is explained on the final (“Acknowledgment”) page of the electronic application.

- Cash, personal checks, money orders, and cashier’s check are not accepted
- REMSA recommends using Chrome or Firefox to process applications.

For applicants whose employer has a voucher system established with REMSA, the voucher payment method is explained on the final (“Acknowledgment”) page.

- **Employer vouchers do NOT cover late fees; applicants are ultimately responsible for timely payment to REMSA. Applications will not be processed until all fees are received.**
Effective and Expiration Dates of Certification

3. The effective date of certification for all applicants will be the date that the certificate is issued.
4. Certification will be valid for two (2) years and will expire on the final day of the same calendar month in which the certification was issued.
PURPOSE
To define the mechanisms and procedures that will be used by the Riverside County EMS Agency (REMSA) to review and investigate actions/inactions that may be cause for disciplinary action against an individual’s EMT or AEMT certificate, and the processes through which such actions will be taken, when necessary.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1798.200.]
California Code of Regulations, Title 22. Social Security, Division 9. Prehospital Emergency Medical Services, Chapter 6
EMSA Publication #134, Recommended Guidelines for Disciplinary Orders and Conditions of Probation for EMT (Basic) and Advanced EMT (4-1-2010)

Introduction
1. Disciplinary actions against a certificate holder include denial, probation, suspension, and revocation of a certificate.

2. Disciplinary actions will be initiated against an applicant or EMT or AEMT certificate holder when it is determined that a disciplinary cause has occurred and a threat to public health and safety exists as defined by the California Health and Safety Code, Section 1798.200 (c).

3. For the purposes of denial, placement on probation, suspension, or revocation of a certificate, pursuant to Section 1798.200(c) of the Health and Safety Code, a crime or act will be considered to be substantially related to the qualifications, functions, or duties of a certificate holder if to a substantial degree it evidences unfitness of a certificate holder to perform the functions authorized by the certificate in that it poses a threat to the public health and safety.

4. When determining the certification action to be imposed or reviewing a petition for reinstatement or reduction of penalty under Section 11522 of the Government Code, REMSA will evaluate the evidence of rehabilitation and present eligibility for certification of the applicant. When the certification action warranted is denial, probation, suspension, or revocation, the following factors may be considered:
   a. Nature and severity of the act(s), offense(s), or crime(s) under consideration;
   b. Actual or potential harm to the public;
   c. Actual or potential harm to any patient;
   d. Prior disciplinary record;
   e. Prior warnings on record or prior remediation;
   f. Number and/or variety of current violations;
   g. Aggravating evidence;
   h. Mitigating evidence;
   i. Rehabilitation evidence;
   j. In the case of a criminal conviction, compliance with terms of the sentence and/or court ordered probation;
   k. Overall criminal record;
   l. Time that has elapsed since the act(s) or offense(s) occurred;
   m. If applicable, evidence of expungement proceedings pursuant to Penal Code 1203.4.
   n. In determining appropriate certification disciplinary action, REMSA may give credit for prior disciplinary action imposed by the respondent’s employer.
Preliminary Inquiry

1. All information received from credible sources, including information obtained from an application, court and/or law enforcement documents, discovery through medical audit, or the routine follow-up of a public complaint, will be evaluated to determine if disciplinary action may be warranted.

2. Evaluation of information
   a. A relevant employer (as defined by Title 22, section 100206), who receives an allegation of misconduct as defined in Health and Safety Code Section 1798.200 will determine its validity and, if found to hold merit, will notify REMSA within three working days, identifying supporting documentation.
   b. If a complaint is received by REMSA, REMSA will determine its validity, and if found to hold merit, will notify the relevant employer, and send supporting documentation within three working days.
   c. The relevant employer will have first right of refusal for full investigation of the allegation.
   d. If the relevant employer declines the investigation or the certificate holder is not an employee of a relevant employer, REMSA will conduct the full investigation to validate allegations for disciplinary cause.
   e. The certificate holder will be notified of the investigation.

3. Prior to the beginning of the investigation, or at any time during the investigation, REMSA, after consultation with the relevant employer, or without consultation when no relevant employer exists, may temporarily suspend, prior to a hearing, a certificate holder upon a determination of the following:
   a. The EMT / AEMT has engaged in acts or omissions that constitute grounds for revocation of the certificate; and
   b. Permitting the EMT / AEMT to continue to engage in certified activity without restriction poses an imminent threat to the public health and safety.

Investigation

1. Investigations involving EMTs or AEMTs employed by a public safety agency as a firefighter will be conducted in accordance with Chapter 9.6, Division 4, of Title 1 of the Government Code, Sections 3250 et. seq., also known as the Firefighters’ Procedural Bill of Rights, when said investigations are for events or circumstances involving the performance of his/her official duties.

2. The investigation and certification action process will be in accordance with Chapter 5 (commencing with Section 11500), Part 1, Division 3, of Title 2 of the Government Code (the California Administrative Procedure Act).

3. All certificate holders or applicants for certification will be permitted to present evidence during the investigation, and mitigating evidence during any hearing or settlement process held.

Determination of Action

1. If the investigation of a complaint or allegation concludes that a violation of Health & Safety Code (H&S Code) 1798.200 has been committed, or documentation of a criminal conviction is determined to meet the conditions of H&S Code 1798.200 and/or Title 22, Section 100214.3, and a threat to public health and safety exists, disciplinary action will be imposed on the applicant or certificate holder. Disciplinary action includes:
   • denial of a certificate
   • placing the certificate holder on probation
   • suspension of the certificate
   • revocation of the certificate
     o If, after conducting the investigation, the relevant employer finds cause for disciplinary action, the relevant employer will create a Disciplinary Action Plan (DAP) and submit it to REMSA.
     o REMSA will review the results of the investigation and the DAP. If REMSA determines that the conduct under investigation warrants disciplinary action, and the relevant employer failed to include disciplinary action in the DAP, or the disciplinary action suggested was not in accordance with the Model Disciplinary Orders (MDOs, EMSA publication #134), REMSA can act to impose appropriate disciplinary action against the certificate holder.
2. Upon determining the disciplinary or certification action to be taken, REMSA will complete and place in the certification file, or any other file used for any personnel purposes by REMSA, a statement certifying the decision made and the date the decision was made. The decision must contain findings of fact and a determination of issues, together with the disciplinary plan and the date the disciplinary plan will take effect.
   • A temporary suspension order will take effect upon the date the notice is mailed to the certificate holder.
   • For all other certification actions, the effective date will be thirty days from the date the notice is mailed to the applicant for, or holder of, the certificate unless another time is specified, or an appeal is made.

3. REMSA will notify the State EMS Authority of the findings of the investigation, and the certification action(s) taken, and will enter said information into the state’s Central Registry.

**Temporary Suspension Order**

1. REMSA may temporarily suspend a certificate prior to a hearing if:
   • The certificate holder was engaged in acts or omissions that constitute grounds for denial or revocation, AND,
   • permitting the certificate holder to continue to engage in certified activity would pose an imminent threat to the public health and safety.

2. Prior to, or concurrent with, initiation of a temporary suspension order, REMSA will notify and consult with the relevant employer (if one is present) of the certificate holder.

3. A notice of temporary suspension pending hearing will be served by certified mail or by personal service to the certificate holder immediately, but no longer than three working days from making the decision to issue the temporary suspension.
   • The notice will include the allegations that allowing the certificate holder to continue to engage in certified activities would pose an imminent threat to the public health and safety.

4. Within three (3) working days of the initiation of the temporary suspension, REMSA and the relevant employer (if one is present) will jointly investigate the allegation in order for REMSA to make a determination of the continuation of the temporary suspension.
   • All investigatory information, not otherwise protected by the law, held by REMSA and the relevant employer will be shared between the parties via facsimile transmission or overnight mail relative to the decision to temporarily suspend.

5. Within 15 calendar days of the initiation of the suspension, REMSA will file an Accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code Administrative Procedure Act).
   • If the certificate holder files a Notice of Defense in response to the Accusation, a hearing before an administrative Law Judge (ALJ) will be held within 30 calendar days of REMSA’s receipt of this Notice of Defense.
   • The temporary suspension order will be deemed vacated if REMSA
     o Fails to serve the Accusation within 15 calendar days, OR
     o Fails to make a final determination within 15 calendar days after receiving a proposed decision from the Administrative Law Judge.

**Probation**

1. REMSA may place a certificate holder on probation any time an infraction or performance deficiency occurs that indicates a need to monitor the certificate holder’s conduct in the EMS system, in order to protect the public health and safety.
   a. The term of the probation and any conditions will be in accordance with the MDOs and its appendices.
   b. The period of probation will run continuous until the conclusion of the probation unless otherwise specified – i.e., under certain conditions probation may only apply when actively practicing as an EMT/AEMT within California.
2. An EMT/AEMT whose certification is placed on probation by REMSA must complete the probationary requirements through REMSA.
   a. If the probation period runs past the expiration date of the certificate, the certificate holder is required to renew the certificate with REMSA prior to its expiration date.

3. Certification will be fully restored upon successful completion of all terms and conditions of probation.

4. REMSA may revoke or suspend certification if the certificate holder fails to successfully complete the terms of probation.

Suspension
1. REMSA may suspend an individual’s EMT / AEMT certificate for a specified period of time for disciplinary cause in order to protect the public health and safety.

2. The term of the suspension and any conditions for reinstatement will be in accordance with the MDOs.

3. When the term of suspension is completed, the certificate will be reinstated only if all conditions for reinstatement have been met. The suspension period will be continued until all conditions have been met.

4. If the suspension period runs past the expiration date of the certificate, the certificate holder is required to renew the certificate with REMSA prior to its expiration date.

Denial or Revocation
1. REMSA is required by Title 22, Section 100214.3, of the California Code of Regulations (CCR) to deny or revoke for disciplinary cause any EMT/AEMT certificate that has been investigated and verified as having met the any one of the criteria below:
   a. Has committed any sexually related offense specified under Section 290 of the Penal Code.
   b. Has been convicted of murder, attempted murder, or murder for hire.
   c. Has been convicted of two or more felonies*.
   d. Is on parole or probation for any felony*.
   e. Has been convicted and released from incarceration for said offense during the preceding 15 years for the crime of manslaughter or involuntary manslaughter.
   f. Has been convicted and released from incarceration for said offense during the preceding 10 years for any offense punishable as a felony*.
   g. Has been convicted of two or more misdemeanors within the preceding five years for any offense relating to the use, sale, possession, or transportation of narcotics or addictive or dangerous drugs.
   h. Has been convicted of two or more misdemeanors within the preceding five years for any offense relating to force, threat, violence, or intimidation.
   i. Has been convicted within the preceding five years of any theft related misdemeanor.

* “felony” or “offense punishable as a felony” refers to an offense for which the law prescribes imprisonment in the state prison as either an alternative or the sole penalty, regardless of the sentence the particular defendant received.

2. REMSA may deny or revoke an EMT/AEMT certificate if any of the following apply to its holder:
   a. Has committed any act involving fraud or intentional dishonesty for personal gain within the preceding seven years.
   b. Is required to register pursuant to Section 11590 of the Health and Safety Code.

3. Items 1 and 2 above:
   a. Apply only to convictions where the applicant/certificate holder was prosecuted as an adult.
   b. Do not apply to convictions that have been pardoned by the Governor.
   c. Do not apply to the convictions of EMTs/AEMTs who obtained their certificates before July 1, 2010, unless they:
i. Committed any sexually related offense specified under Penal Code Section 290.
ii. Failed to disclose prior convictions when completing the application for (re)certification.
iii. Are convicted of any misdemeanor or felony after July 1, 2010.

Appeal Processes
1. An applicant or certificate holder has the right to appeal a disciplinary decision by requesting a review hearing be scheduled before an administrative law judge (ALJ) from the state Office of Administrative Hearings (OAH).
   a. Barring unique circumstances, hearings are scheduled at the convenience of the OAH at their court sites in either downtown San Diego or downtown Los Angeles.
   b. Based on the testimony and evidence presented at the hearing, the ALJ will render an opinion on the disciplinary actions proposed by REMSA. This is an advisory opinion only.
   c. The REMSA Medical Director will review the ALJ’s opinion and render the final decision in the matter.

Notification of Final Decision
1. The REMSA medical director will notify the applicant/certificate holder and his/her relevant employer(s) of the final decision on certification action within 10 working days after making that determination.

2. The notification of final decision will be served by certified mail or personal service and will include the following information:
   • The specific allegations or evidence which resulted in the certification action;
   • The certification action(s) to be taken, and the effective date(s) of the certification action(s), including the duration of the action(s);
   • Which certificate(s) the certification action applies to in cases of holders of multiple certificates;
   • A statement that the certificate holder must report the certification action within 10 working days to any other LEMSA and relevant employer in whose jurisdiction s/he uses the certificate.

General Principles of Disciplinary Actions
1. Disciplinary actions taken by REMSA, or any other certifying entity, are valid statewide and will be honored by all other certifying entities for a period of at least 12 months from the effective date of the certification action.

2. An EMT/AEMT whose application was denied or whose certification was revoked is not eligible to (re)apply, and his/her application will not be honored by any (other) certifying entity for a period of at least 12 months from the effective date of the certification action.

3. Failure to pass a certification examination or to meet any other requirements for certification or continuation of certification will be sufficient grounds for denial of a certificate or denial of the renewal of a certificate without prejudice, and without completing the certificate review process.
PURPOSE
To describe the process of:
- Receiving initial paramedic accreditation
- Reinstating paramedic accreditation after invalidation
- Reverifying paramedic accreditation

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

DEFINITIONS
Local Accreditation
Local accreditation is the authorization that is given to paramedics by REMSA that permits them to perform the standard, and local optional (LOSOP) skill(s), and administer medications within their scope of practice, in Riverside County.

Initial Accreditation
Paramedics who have never practiced in Riverside County for any reason must become REMSA-accredited in order to operate in a paramedic-capacity for an ALS service provider. Additionally, paramedics who experience a lapse in employment from an ALS service provider for 181 days or more, must reapply for initial accreditation. They are not eligible for reverification, or reinstatement, of their accreditation.

Reinstatement of Accreditation
Paramedics who were previously accredited in Riverside County, but their accreditation was invalidated between one (1) day and 180 days, may follow the steps listed in the “Reinstatement of Accreditation After Separation From Employment” section on page 2.

Verification / Reverification of Eligibility
Verification of eligibility occurs when REMSA Credentialing Staff review a paramedic’s application for any type of accreditation, confirming that all licenses and certifications are valid and current.

Eligibility for Accreditation
To practice as a paramedic in Riverside County, an individual must obtain and maintain in good standing, all licenses and certifications described within this policy.

Conditions of Continued Accreditation
1. Accreditation to practice in Riverside County is valid only while working for a REMSA-approved ALS service provider.
2. REMSA will be notified regarding changes in physical and/or mailing address, email address, telephone contact information, and/or employment within thirty (30) calendar days of the change. Notification shall be made by:
   a. Accessing and updating personal profile information in the on-line license management portal, found here: https://ca.emsbridge.com/remsa/public/portal#/login AND
   b. Emailing REMSA at emsapps@rivco.org, notifying that changes / updates have been made in the system.
3. The paramedic will also be responsible for notifying the California EMS Authority (EMSA) in writing within thirty (30) calendar days of any and all changes of their mailing address, giving both the old and the new address, and paramedic license number. This information can also be updated using EMSA’s online Licensing portal, found here: https://emsonline.ems.ca.gov/eGov/Login.aspx?ReturnUrl=%2FeGov%2FLogin
4. Paramedics will comply with all REMSA related requests for information that may include, but are not limited to, medical CQI, incident reviews, arrest inquiries, and disciplinary investigations / reviews.

5. **Temporary assignments**: Riverside County accredited paramedics may take temporary “out of class” assignments, where they operate in a non-paramedic function. These “out of class” assignments are typically administrative in nature and the paramedic’s primary function excludes the provision of direct patient care. So long as the assignment is 365 days or less, accreditation will not be deemed interrupted.

### Accreditation Reverification

Eligibility to maintain paramedic accreditation is verified biannually (every two (2) years) and is based on the expiration date of the paramedic’s current local accreditation in Riverside County.

Paramedics are encouraged to submit their completed accreditation reverification application and required documentation (referenced in *The Application Process*, below) as soon as they have received their renewed state paramedic license.

### Effective and Expiration Dates of Accreditation

1. The effective date of accreditation for all applicants will be the date that the accreditation is issued.
2. The expiration date of accreditation for all applicants will be the date that their state paramedic license expires.
3. Because accreditation is contingent on the paramedic maintaining a valid state paramedic license, paramedics new to Riverside County may not receive a full two (2) year period of accreditation before needing to begin the reverification process.

### Reinstatement of Accreditation After Separation From Employment

If a paramedic’s employment is terminated for any reason (e.g., involuntarily, or voluntarily), their accreditation is invalidated.

**IF A PARAMEDIC IS RE-EMPLOYED WITHIN ONE (1) DAY AND 90 DAYS OF SEPARATION**, the following must be submitted to REMSA to reinstate accreditation:

1. A Paramedic Employment Change form (submitted by the paramedic)
2. Verification of employment (submitted by the employer)

   A reinstatement fee is NOT required if reinstatement of accreditation occurs less than ninety (90) days from the initial date of separation.

**IF A PARAMEDIC IS RE-EMPLOYED BETWEEN NINETY-ONE (91) DAYS BUT LESS THAN ONE-HUNDRED EIGHTY (180) DAYS OF SEPARATION**, the following must be submitted to REMSA to reinstate accreditation:

1. A Paramedic Reverification application (submitted by the paramedic)
2. Verification of employment (submitted by the employer)
3. A fee of $50 for reinstatement of accreditation is required.

**IF A PARAMEDIC IS RE-EMPLOYED AFTER 181 DAYS OF SEPARATION**, THEY ARE NOT ELIGIBLE FOR REINSTATEMENT OF ACCREDITATION. COMPLETION OF THE “PARAMEDIC INITIAL ACCREDITATION” APPLICATION IS REQUIRED.

### Scope of Practice

Once accredited, paramedics:

1. Are responsible, and will be held accountable, for knowing and understanding the skills defined and described in [Title 22 § 100146](http://remsa.us/forums/vb4/forum.php) (Scope of Practice of Paramedic) as well as the REMSA Policy and Protocol manual, found here: [Policy Manual tab → 20XX – Current Manual](http://remsa.us/forums/vb4/forum.php).
2. Are responsible, and will be held accountable, for successfully completing all required didactic training(s) and/or practical skills examinations related to all paramedic scope of practice medications and procedures, basic and LOSOP, specific to Riverside County ([Title 22 § 100166](http://remsa.us/forums/vb4/forum.php)).
3. Must complete all mandatory in-service / skills training sessions as designated by REMSA, including protocol updates and employer, or REMSA, initiated Performance Improvement Plans.
The Application Process

All applications will be submitted through REMSA’s on-line license management portal, found here: https://ca.emsbridge.com/remsa/public/portal#/login. To expedite the certification process, REMSA recommends that applicants scan and export the following documents into PDF format before initiating their application:

- **Photo I.D.**: current, valid, and legal, i.e., state driver’s license, state I.D. card, military I.D. card and/or a passport.
  - Temporary driver’s licenses without a picture and/or military IDs where the applicant is not the primary issuant will not be accepted.
- **Paramedic License**: current and valid in the State of California.
- **CPR Card or REMSA-approved equivalent**: current and valid American Heart Association (AHA), American Red Cross (ARC), or California-approved BCLS/CPR card (“professional” level).
- **ACLS or REMSA-approved equivalent**: current and valid American Heart Association (AHA) Advanced Cardiac Life Support (ACLS) provider card.
- **REMSA ALS SCV form**: proof of successful completion, as evidenced by the ALS SCV form containing names, dates, signatures, etc. in all appropriate fields.

All information on printed cards must be typed. All cards and course completion certificates must be valid for a minimum of thirty (30) days past the accreditation application date.

*REMSA-approved equivalents include, but are not limited to, Riverside County High Performance Resuscitation Training (RheaRT), Advanced Resuscitation Training (ART), Basic Arrhythmia Recognition Training (BART), etc.

After assembling the above materials, the application can be accessed by going directly to the online license management portal, found here: https://ca.emsbridge.com/remsa/public/portal#/login. Once the applicant has logged in, step-by-step instructions will be provided. A brief tutorial will also be available. The system will instruct the applicant to upload / attach required documents to their application when appropriate.

It is not necessary to complete the entire application process in one sitting. The system will save entered data if the application process gets interrupted.

At the conclusion of the application process, the option to download an abbreviated version of the completed application will be provided.

Only complete applications will be processed (completed form with all supporting materials and fees).

- Deficiency notices will be emailed to the applicant, explaining the missing or incomplete documents or information. Once the deficiencies have been corrected, the complete application will be processed by REMSA.

In certain cases, applicants may be required to submit information or documentation in addition to the standard elements described in the “Eligibility” section (above). Applicants will be permitted an extra thirty (30) calendar days to submit the additional materials.

Applications that have been started but remain incomplete will be saved in the license management system in an “Initiated” status until completed, or for a maximum of thirty (30) days, whichever is shorter. After thirty (30) days, the application will be considered abandoned, and the license management system will automatically withdraw it from the active queue. Once the status of an application is changed to “Withdrawn,” the applicant will need to initiate a new application, and pay all related fees again, if they wish to continue the certification process.

It is important that the applicant save all uploaded documents and materials for a period of four (4) years in case of EMSA, or REMSA, audit.
**Initial Accreditation Fee**
The total fee for initial paramedic accreditation in Riverside County is $75:

<table>
<thead>
<tr>
<th>Fee Type</th>
<th>Funds Paid To</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Accreditation - Initial</td>
<td>REMSA</td>
<td>$75</td>
</tr>
<tr>
<td></td>
<td><strong>Total = $75</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Accreditation Reinstatement Fee**
When a lapse in employment occurs and the paramedic is re-employed between 91 days but less than 180 days of separation:

<table>
<thead>
<tr>
<th>Fee Type</th>
<th>Funds Paid To</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Accreditation - Reinstatement</td>
<td>REMSA</td>
<td>$50</td>
</tr>
<tr>
<td></td>
<td><strong>Total = $50</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Accreditation Reverification Fees**

<table>
<thead>
<tr>
<th>When paid</th>
<th>Fee Type</th>
<th>Funds Paid To</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>On time</td>
<td>Local Accreditation - Reverification</td>
<td>REMSA</td>
<td>$50</td>
</tr>
<tr>
<td></td>
<td><strong>Total = $50</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>When paid</th>
<th>Fee Type</th>
<th>Funds Paid To</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>LATE</td>
<td>Local Accreditation - Reverification</td>
<td>REMSA</td>
<td>$50</td>
</tr>
<tr>
<td></td>
<td>Late Fee</td>
<td>REMSA</td>
<td>$25</td>
</tr>
<tr>
<td></td>
<td><strong>Total = $75</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The system will hold, but not process, an application until the required non-refundable fee is paid.

- **All fees paid to REMSA are non-refundable.**

Fees may be paid via debit card (so long as it bears a Visa, MasterCard, or Discover logo) or credit card (all issuers except for AMEX) through the on-line license management system. The payment process is explained on the final ("Acknowledgment") page of the electronic application.

- Cash, personal checks, money orders, and cashier’s check are not accepted
- REMSA recommends using Chrome or Firefox to process applications.

For applicants whose employer has a voucher system established with REMSA, the voucher payment method is explained on the final ("Acknowledgment") page.

- **Employer vouchers do NOT cover late fees; applicants are ultimately responsible for timely payment to REMSA. Applications will not be processed until all fees are received.**
PURPOSE
To describe the authorization requirements to function as a mobile intensive care nurse (MICN) in Riverside county.

APPLICATION
This policy applies to the nurse that is not currently an MICN and is seeking initial authorization.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Minimum eligibility
To be eligible to apply for authorization as an MICN, an individual must:
1. Be licensed by the State of California (CA) as a Registered Nurse (RN) with a status of “Current.”
2. Be employed in an Emergency Department at a base hospital within Riverside county
   a. Current employment is verified by the PLN through the on-line credentialing system.
3. Have successfully completed a REMSA approved MICN course within 365 days of the date of application.
4. Provide proof of participation in an ALS SCV course within 365 days of the date of application.

Authorization Period
MICN authorization will be effective for up to (2) two years from the date of completion of the approved MICN course, provided “Minimum Eligibility” requirements 1 & 2 (above) are maintained.

MICN authorization will expire on the same date as the MICN’s CA RN license.

Application Procedures
1. Nurses applying for authorization as an MICN in Riverside county will use the REMSA approved on-line credentialing system, found here: https://ca.emsbridge.com/remsa/public/portal#/login. To expedite the process, REMSA recommends that applicants scan and export the following documents into PDF format before initiating the application process:
   a. Copy of current CA RN license.
   b. Original documentation that provides proof of meeting all “Minimum Eligibility” requirements (2 – 4, above).
   c. A current legal photo I.D. (i.e., state driver license, state I.D. card, military I.D., or passport). The photo must clearly show the individual’s face. Temporary driver’s licenses without a picture and military IDs where the applicant is not the primary issuant will not be accepted.

2. After navigating to https://ca.emsbridge.com/remsa/public/portal#/login, applicants will click the “Create Account” button to begin. Instructions are available to guide the applicant through each step; a brief tutorial is also available. The system will instruct the applicant to upload / attach their authorization documents to their profile when appropriate.
   • It is not necessary to complete the entire application process in one sitting. The system will save entered data if the application process gets interrupted.
   • At the conclusion of the application process, the option to print an abbreviated version of the completed application will be provided.
3. Only complete applications will be processed (completed form with all supporting materials and fees).
   • Deficiency notices will be emailed to the applicant, explaining the missing or incomplete documents or information. Once the deficiencies have been corrected, the complete application will be processed by REMSA.
     o In certain cases, applicants may be required to submit information or documentation in addition to the standard elements described in the “Minimum Eligibility” section (above). Applicants will be permitted an extra thirty (30) calendar days to submit the additional materials.
   • Applications that have been started but remain incomplete will be saved in the credentialing system in an “Initiated” status until completed, or for a maximum of sixty (60) days, whichever is shorter. After 60 days, the application will be considered abandoned, and the credentialing system will automatically withdraw it from the active queue. Once the status of an application is changed to “Withdrawn,” the applicant will need to initiate a new application if they wish to continue the authorization process.

Authorization Fee
The fee for initial MICN authorization is $75.

The system will hold, but not process, an application until the required non-refundable fee is paid.
   • All fees paid to REMSA are non-refundable. Fees may be paid via debit card (so long as it bears a Visa, MasterCard, or Discover logo) or credit card (all issuers except for AMEX) through the on-line credentialing system. The payment process is explained on the final (“Acknowledgment”) page of the electronic application.
   • Cash, personal checks, money orders, and cashier’s check are not accepted.
   • REMSA recommends using Chrome or Firefox to process applications.

Conditions of Continued Authorization
Loss of employment in an Emergency Department at a base hospital within Riverside county, or a change of employer, will invalidate authorization.
   • Reauthorization may be attempted through the process outlined in policy #1210 (MICN Reauthorization) so long as re-employment is in the Emergency Department at another base hospital in Riverside county.

It is the MICN’s responsibility to keep his / her contact information updated with REMSA via the on-line credentialing system, found here: https://ca.emsbridge.com/remsa/public/portal#/login. Changes in address and/or mailing address, phone number, email address, employment, or any other contact information must be reported to REMSA within thirty (30) days of occurrence.
   • Failure to maintain updated information may result in missed notices, practice updates, or communications regarding formal actions against a license, accreditation, or authorization. Notifications shall be made to REMSA by:
     1. Accessing and updating personal information using the on-line credentialing system AND
     2. Notifying REMSA at emsapps@rivco.org that changes / updates have been made.
PURPOSE
To describe the requirements that must be met to reauthorize as a mobile intensive care nurse (MICN) in Riverside county.

APPLICATION
This policy applies to the nurse that is currently authorized as an MICN and is seeking reauthorization.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Eligibility
To be eligible to apply for reauthorization as an MICN, an individual must:
1. Be licensed by the State of California (CA) as a Registered Nurse (RN) with a status of “Current.”
2. Possess current Riverside county MICN authorization OR have possessed Riverside county MICN authorization that expired less than 180 days from the date of reapplication
   a. MICNs whose authorization expired between 181 days and 365 days from the date of reapplication must complete an additional fifteen (15) hours of approved EMS CE, for a total of forty-five (45) hours
   b. MICNs whose authorization expired more than 365 days from the date of reapplication are not permitted to reauthorize but may challenge the MICN authorization process. Refer to policy #1211 (MICN Challenge) for instruction.
3. Be employed in an Emergency Department at a base hospital within Riverside county
   a. Current employment is verified by the PLN through the on-line credentialing system.
4. Provide proof of completion of the Additional Reauthorization Requirement (see below)
5. Provide proof of continuing education (CE) (see below)

No registered nurse may function as an MICN without current, valid Riverside county authorization.

Additional Reauthorization Requirement
Proof of completion of an ALS skills competency verification (SCV) course OR a PLN coordinated / scheduled ride-out shift with a REMSA approved First Responder agency or transport provider.
1. A maximum of twelve (12) hours of EMS CE may be used for the purposes of reauthorization by participating in a PLN coordinated / scheduled ride-out. CE hours will be awarded by the base hospital and the CE course completion certificate will serve as proof of completion of the additional reauthorization requirement (#4, above).
2. A maximum of eight (8) hours of EMS CE may be used for the purposes of reauthorization by participating in an ALS SCV course. CE hours will be awarded by the provider agency.
   a. To meet the additional reauthorization requirement (#4, above), a completed ALS SCV form must be included in the reauthorization packet.

MICNs are permitted to submit up to twenty (20) hours of the required thirty (30) hours of EMS CEs by participating in both the ALS SCV course as well as a PLN coordinated / scheduled ride-out with a REMSA approved First Responder agency or transporting provider.
Proof of CE
MICNs must provide proof of completion of thirty (30) approved EMS CE hours awarded within the current authorization period, or within the last two (2) years. These may be obtained through paramedic approved courses or national certification courses.

In cases where the initial MICN authorization was issued for a pro-rated period of RN licensure, the following algorithm will be used to determine how many EMS CE hours are required for reauthorization. This applies to MICNs for their first reauthorization cycle only:

- If the initial authorization period was less than 180 days: no additional EMS CE hours are required.
- If the initial authorization period was 181 days up to 365 days: 8 EMS CE hours are required.
- If the initial authorization period was 366 days up to 18 months: 15 EMS CE hours are required.
- If the initial authorization period was 19 months up to 24 months: 30 EMS CE hours are required.

Documentation of CE will be verified by the applicant uploading their EMS Continuing Education certificates to their MICN Reauthorization application in the online credentialing system.

Riverside County EMS Agency will not accept individual CE rosters.

Nationally benchmarked or accredited courses issuing BRN CE credit such as ACLS, ATCN, CEN Review, ENPC, PALS, TCAR, TNCC, may qualify for EMS CE credit. Individual courses will be evaluated on a case-by-case basis, along with course objectives, and a valid BRN-CE certificate and/or copy of course roster.

Any national course not having an EMS CE provider number must be preapproved by REMSA to be accepted for CE credit.

Authorization Period
MICN authorization will be effective for up to (2) two years provided “Eligibility” requirements 1 - 3 (above) are maintained.

MICN authorization will expire on the same date as the MICN’s CA RN license.

Application Procedures
1. Nurses applying for reauthorization as an MICN in Riverside county will use the REMSA approved on-line credentialing system, found here: https://ca.emsbridge.com/remsa/public/portal#/login. To expedite the process, REMSA recommends that applicants scan and export the following documents into PDF format before initiating the application process:
   a. Copy of current CA RN license.
   b. Original documentation that provides proof of meeting all “Eligibility” requirements (2 – 5, above).
   c. A current legal photo I.D. (i.e., state driver license, state I.D. card, military I.D., or passport). The photo must clearly show the individual’s face. Temporary driver’s licenses without a picture and military IDs where the applicant is not the primary issuant will not be accepted.

2. After navigating to https://ca.emsbridge.com/remsa/public/portal#/login, applicants will enter their username and password then click the “Login” button to begin. Instructions are available to guide the applicant through each step; a brief tutorial is also available. The system will instruct the applicant to upload / attach their reauthorization documents to their profile when appropriate.
   • It is not necessary to complete the entire application process in one sitting. The system will save entered data if the application process gets interrupted.
   • At the conclusion of the application process, the option to print an abbreviated version of the completed application will be provided.
3. Only complete applications will be processed (completed form with all supporting materials and fees).
   • Deficiency notices will be emailed to the applicant, explaining the missing or incomplete documents or
     information. Once the deficiencies have been corrected, the complete application will be processed by REMSA.
     o In certain cases, applicants may be required to submit information or documentation in addition to the standard
       elements described in the “Eligibility” section (above). Applicants will be permitted an extra thirty (30) calendar
       days to submit the additional materials.
   • Applications that have been started but remain incomplete will be saved in the credentialing system in an
     “Initiated” status until completed, or for a maximum of sixty (60) days, whichever is shorter. After 60 days, the
     application will be considered abandoned, and the credentialing system will automatically withdraw it from the
     active queue. Once the status of an application is changed to “Withdrawn,” the applicant will need to initiate a
     new application if they wish to continue the authorization process.

    Reauthorization applications must be received a minimum of thirty (30) days in advance of the expiration date
    of the current authorization period to allow sufficient time for correction of any deficiencies, resolution of any
    concerns, verification from the employer, and processing time.

    Reauthorization Fee
    The fee for MICN reauthorization is $50.

    A late fee of $25 will be applied to:
    • All applications submitted after authorization has expired.
    • All applications that have been initiated, but remain incomplete, after authorization has expired.

    The system will hold, but not process, an application until the required non-refundable fee is paid.

    • All fees paid to REMSA are non-refundable.

    Fees may be paid via debit card (so long as it bears a Visa, MasterCard, or Discover logo) or credit card (all
    issuers except for AMEX) through the on-line credentialing system. The payment process is explained on the
    final (“Acknowledgment”) page of the electronic application.
    • Cash, personal checks, money orders, and cashier’s check are not accepted.
    • REMSA recommends using Chrome or Firefox to process applications.

    Conditions of Continued Authorization
    Loss of employment in an Emergency Department at a base hospital within Riverside county, or a change of
    employer, will invalidate authorization.

    • Reauthorization may be attempted through the process outlined above.

    It is the MICN’s responsibility to keep his / her contact information updated with REMSA via the on-line credentialing
    system, found here: https://ca.emsbridge.com/remsa/public/portal#/login. Changes in address and/or mailing
    address, phone number, email address, employment, or any other contact information must be reported to REMSA
    within thirty (30) days of occurrence.
    • Failure to maintain updated information may result in missed notices, practice updates, or communications
      regarding formal actions against a license, accreditation, or authorization. Notifications shall be made to REMSA
      by:
      1. Accessing and updating personal information using the on-line credentialing system AND
      2. Notifying REMSA at emsapps@rivco.org that changes / updates have been made.
PURPOSE
To define the requirements for authorization by challenge as a mobile intensive care nurse (MICN) in Riverside County.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Eligibility
To be eligible to challenge the MICN authorization process, an individual must:

1. Be currently licensed by the State of California as a Registered Nurse (RN).
2. Be currently employed in the Emergency Department (ED) at a Base Hospital within Riverside County AND be approved by the hospital’s Prehospital Liaison Nurse (approval based on internal hospital policies).
3. Possess an MICN authorization from Riverside County which is over one (1+) year, but less than three (3) years expired, OR possess a current, valid MICN authorization from the Inland Counties Emergency Medical Agency (ICEMA) OR an ICEMA authorization that has been expired less than three (3) years.
4. Have successfully completed an MICN orientation process to include a minimum of:
   a. Four (4) hours of protocol review and successful completion of an approved MICN written examination (review hours can include self-paced learning)
   b. Eight (8) hours of precepted Coronary Observation Radio (COR) / EMS radio time.
   c. Twelve (12) shifts of probationary* COR/EMS radio experience.
      i. *During the precepted and probationary time, the RN will be referred to as a MICN Candidate, or “MICN-C”
   d. Eight (8) hours of ride-along time
   e. Two (2) hours of field care audits, with at least three (3) of the audited cases being runs that the individual participated in as a MICN challenge candidate.
   f. Provide proof of participation in an ALS SCV course within 365 days of the date of application.
      i. A REMSA-approved skills verification competency form must be submitted at the time of the challenge.

The MICN orientation process will be completed within a three-month (90 day) period.

Authorization Period
MICN authorization will be valid for a period of two (2) years from the month of completion of the probationary period or the expiration of the State Registered Nurse license, whichever comes first, provided Base Hospital ED employment is maintained.

Authorization expires on the final day of the final month of the authorization period.

Application Procedures
1. Nurses applying for authorization as an MICN via the challenge process will use the REMSA-approved on-line credentialing system, found here: https://ca.emsbridge.com/remsa/public/portal#/login. To expedite the process, REMSA recommends that applicants scan and export the following documents into PDF format before initiating the application process:
   a. A current and valid State of California Registered Nurse license.
   b. A current legal photo I.D. (i.e., state driver license, state I.D. card, military I.D., or passport). The photo must clearly show the individual. Temporary driver’s licenses without a picture and military IDs where the applicant is not the primary issuant will not be accepted.
c. Original documentation from the base hospital Paramedic Liaison Nurse (PLN) of criteria fulfillment as specified in Section 1, b-e (above), must be documented on the REMSA form titled Verification of Eligibility for MICN Challenge, found here: http://remsa.us/policy/MICNCHALLENGEVERIFICATIONOFELIGIBILITYv2.pdf. An original ALS Skills Competency Verification (SCV) form, completed by an approved verifier in accordance with the REMSA Policy for Skills Competency Verification, must also be submitted.

2. After navigating to https://ca.emsbridge.com/remsa/public/portal#/login, applicants will click the “Create Account” button to begin. Instructions are available to guide the applicant through each step; a brief tutorial is also available. The system will instruct the applicant to upload / attach their authorization documents to their profile when appropriate.
   • It is not necessary to complete the entire application process in one sitting. The system will save entered data if the application process gets interrupted.
   • At the conclusion of the application process, the option to print an abbreviated version of the completed application will be provided.

3. Only complete applications will be processed (completed form with all supporting materials and fees).
   • Deficiency notices will be emailed to the applicant, explaining the missing or incomplete documents or information. Once the deficiencies have been corrected, the complete application will be processed by REMSA.
     o In certain cases, applicants may be required to submit information or documentation in addition to the standard elements described in the “Minimum Eligibility” section (above). Applicants will be permitted an extra thirty (30) calendar days to submit the additional materials.
   • Applications that have been started but remain incomplete will be saved in the credentialing system in an “Initiated” status until completed, or for a maximum of sixty (60) days, whichever is shorter. After 60 days, the application will be considered abandoned, and the credentialing system will automatically withdraw it from the active queue. Once the status of an application is changed to “Withdrawn,” the applicant will need to initiate a new application if they wish to continue the authorization process.

Authorization Fee
The fee for MICN authorization is $75.

The system will hold, but not process, an application until the required non-refundable fee is paid.
• All fees paid to REMSA are non-refundable. Fees may be paid via debit card (so long as it bears a Visa, MasterCard, or Discover logo) or credit card (all issuers except for AMEX) through the on-line credentialing system. The payment process is explained on the final (“Acknowledgment”) page of the electronic application.
• Cash, personal checks, money orders, and cashier’s check are not accepted.
• REMSA recommends using Chrome or Firefox to process applications.

Conditions of Continued Authorization
Loss of employment in an Emergency Department at a base hospital within Riverside county, or a change of employer, will invalidate authorization.
• Reauthorization may be attempted through the process outlined in policy #1210 (MICN Reauthorization) so long as re-employment is in the Emergency Department at another base hospital in Riverside county.

It is the MICN’s responsibility to keep his / her contact information updated with REMSA via the on-line credentialing system, found here: https://ca.emsbridge.com/remsa/public/portal#/login. Changes in address and/or mailing address, phone number, email address, employment, or any other contact information must be reported to REMSA within thirty (30) days of occurrence.
• Failure to maintain updated information may result in missed notices, practice updates, or communications regarding formal actions against a license, accreditation, or authorization. Notifications shall be made to REMSA by:
  1. Accessing and updating personal information using the on-line credentialing system AND
  2. Notifying REMSA at emsapps@rivco.org that changes / updates have been made.
PURPOSE
The Out-of-County Certification Acknowledgement extends access to the ePCR platform to those providers who obtained their EMT certification from a California Local Emergency Medical Services Agency (LEMSA) and are employed by Riverside County EMS services. This policy shall:
1. Define who is eligible to apply for the Out-of-County Certification Acknowledgement.
2. Explain the process for application of the Out-of-County Certification Acknowledgement.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.210.]
California Code of Regulations, Title 22, Chapter 2, Sections 100056 – 100064, 100079, & 100083
California Penal Code, Section 11105

Eligibility
To be eligible for the Out-of-County Certification Acknowledgement, applicants must meet the following requirements:
1. Possess current and active EMT certification.
2. EMT certification is issued by a California LEMSA other than Riverside County EMS Agency (REMSA).
3. Applicants must be currently employed by a Riverside County BLS/ALS service provider.

The Application Process
1. All applications will be submitted through REMSA’s online License Management System (LMS).
2. The application can be accessed by going directly to the application portal: https://ca.emsbridge.com/remsa or by accessing it through our website www.rivcoems.org. Once on the website, instructions will guide the applicant through each step. It is not necessary to complete the entire application process at once. The system allows the applicant to save data in progress and to return to complete the application process at another time.
3. There will be no fees assessed or collected for the Out-of-County Certification Acknowledgement.
4. At the conclusion of the application process it will be possible to print an abbreviated version of the completed application should the applicant desire to retain a copy.
5. Only complete applications will be processed. Incomplete applications will remain in the system, and a deficiency notice will be sent to the applicant, explaining the deficiency. Once any deficiencies are corrected, the completed application will be processed by REMSA personnel.
   a. Certification information submitted by applicant will be verified with the State registry to be current and active.
   b. Employment will be verified with the EMS service indicated by applicant.

Effective and Expiration Dates
1. The effective date of Out-of-County Certification Acknowledgement will be the date the application is approved.
2. The expiration date shall match the expiration date of the original out-of-county certification.
PURPOSE
To define the steps and processes used by the Riverside County EMS Agency (REMSA) when initiating, investigating, and adjudicating legal issues involving prehospital personnel.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1863.]
California Government Code Sections 11370 et seq. (Administrative Procedure Act), CCR Title 1, Sections 1000-1050

GUIDELINES
EMSA Recommended Guidelines for Disciplinary Orders and Conditions of Probation for EMT and AEMT (MDOs)
Health and Safety Code 1798.200
California Code of Regulations Denial or Revocation of a Certificate

DEFINITIONS
Accusation
A written statement of charges against a certificate holder, in ordinary and concise language, that explains the acts or omissions with which the respondent is charged. Also referred to as a “charging document.”

Administrative Law Judge
An administrative law judge (ALJ) is a judge and trier of fact who both presides over trials/ Superior Court matters and adjudicates claims or disputes involving administrative law. ALJs can administer oaths, take testimony, rule on questions of evidence, and make factual and legal determinations.

Administrative Procedures Act
Disciplinary proceedings for EMTs and Paramedics will be conducted in accordance with Title 22, Chapter 6 of the California Code of Regulations, which, in addition to specifying certain parameters, requires that due process be assured by using the standards specified in Government Code, Title 2, Division 3, Part 1 Chapter 5 – Administrative Adjudication, which commences with §11500 and continues through §11529. These sections, along with CCR Title 1, §1000 – 1050 are formally called the Administrative Procedures Act (APA).

Certificate / Certification
An umbrella term (used specifically in this policy) to describe Emergency Medical Technician (EMT) and Advanced EMT (AEMT) certifications, Paramedic licenses and local accreditations and/or MICN local authorizations.

Decision and Order
A written statement identifying the respondent’s rights and obligations, as determined by an ALJ via their proposed decision, or the REMSA Medical Director, based on facts and law. A Decision usually includes a brief summary of the facts, a discussion of relevant laws, and the reasoning for the Orders. Orders accompany the Decision; they are written direction(s) that direct the respondent to perform, or refrain from performing, certain acts. Decision and Order (D&O) documents are legal, binding, and are issued by the REMSA Medical Director.

Investigative Review Panel (IRP)
This is similar to that of attending an Administrative Law Hearing expect IRP is typically used for Paramedic and MICN credentials. IRP panels are conducted in similar fashion to that of the ALJ hearing in that the IRP will hear testimony, view evidence, and render a proposed decision to the medical director.
Mitigating Evidence
Evidence furnished by the respondent to prove the existence of extenuating circumstances surrounding the Accusation(s)/Statement of Issues. Examples include explanations, justifications, and/or proof of innocence that might help persuade the California EMS Authority (Cal EMSA) and/or REMSA to decrease the potential discipline that may be issued.

Model Disciplinary Orders (MDO)
Developed by Cal EMSA, in consultation with EMS constituent groups from across the state, MDOs are the accepted guidelines that provide consistent and equitable delivery of discipline in cases dealing with violations of the Health and Safety Code, Division 2.5, Section 1798.200.

Notice of Defense / Notice of Participation
A document that, when signed by or on behalf of the respondent, is returned to Cal EMSA, acknowledging receipt of the Accusation document. This notice also identifies to Cal EMSA that the respondent wishes to participate in their hearing by having their case heard in front of an Administrative Law Judge. Retaining an attorney is not necessary for an ALJ hearing.

Notice of / Request for Discovery
The formal process of exchanging information between the respondent and Cal EMSA and/or REMSA regarding witnesses and evidence that will be presented at trial, should the respondent choose to have their case heard.

Respondent
Any person against whom an Accusation or Statement of Issues is filed.

Statement of Issues
A written statement specifying the statutes and rules that the accused respondent must show compliance with, should they choose to participate in an administrative hearing. A Statement of Issues only against initial applicants for the denial of a certification. Additionally, any particular matters that may have come to the attention of Cal EMSA or REMSA that would authorize the disciplinary action sought against the accused’s certification will be addressed in this statement. Also referred to as a “charging document.”

Statement to Respondent
A written statement that details all documents that were sent to the respondent regarding their case. Should the respondent wish to have their case heard, the Statement to Respondent also provides instructions that include how to file a Notice of Defense and where to mail response documents. It also provides a basic outline of how the Discovery process operates and what to expect during the hearing.

Stipulated Settlement Agreement (Agreement)
A legal document that typically contains admissions of guilt by the respondent to one or more causes for discipline, which automatically trigger the issuance of standardized discipline, based on Cal EMSA’s MDOs. Discipline comes in many forms and, depending on the admission(s) of misconduct, may include probation with terms and conditions, suspension of certification, surrender of certification, or even revocation of certification. When settled, minor violations usually result in remediation through re-education only. Stipulations are negotiated between the respondent, or their attorney, and REMSA. Respondents who choose Agreements over formal hearings waive their rights to further due process procedures and appeals and are legally bound by the terms of the Agreement, but in choosing to settle, save time and money and often end up with the same penalty order that would result after a full administrative hearing.

Investigative Authority
REMSA has the delegated authority to conduct investigations for a variety of reasons, which include but are not limited to, fraud in the procurement of any certificate or license, gross and/or repeated negligent patient care, incompetence, the conviction of any crime which is substantially related to the qualifications, functions, and duties of prehospital personnel, etc. Enforcement guidelines can be found here: https://emsa.ca.gov/enforcement/.
Disciplinary Cause
California Health & Safety Code § 1798.200 specifies the offenses for which REMSA may take disciplinary action against EMS credentialed personnel. When filing an Accusation or a Statement of Issues or other charging documents, REMSA may also cite additional related statutes, codes, regulations, ordinances, policies, and/or protocols. Disciplinary cause applies to any and all provider levels throughout REMSAs jurisdiction in which there was a violation of Health & Safety Code § 1798.200

Specific Causes for Investigation
Criminal Activity
The California Department of Justice (CA DOJ) automatically reports all criminal arrests to REMSA. Additionally, REMSA is provided information from the Federal Bureau of Investigation (FBI) when initial applicants to REMSA submit their LiveScan fingerprints as part of their credentialing packet. The information obtained includes, but is not limited to, convictions in other states, military disciplinary proceedings, including Article 15 disciplinary proceedings, other Uniform Code of Justice (UCMJ) violations, etc.

Unless the certificate holder is charged with a “straight” felony crime or officially convicted of a Felony level offense, those who are detained and charged after their LiveScan fingerprints are received by REMSA (i.e. – mid-cycle) may not be investigated or receive discipline until after a conviction. If convicted, the certification holder will be contacted and all information and documents that must be submitted to REMSA will be communicated although REMSA does not need a conviction to take action or start an investigation. “Straight” felony arrests may be investigated immediately and can result in the issuance of a Temporary Suspension Order (TSO). “Felony” arrests are not wobbler offenses and will be handled in a different matter.

Complaints and Unusual Occurrence Reports
Incidents (“unusual occurrences”), concerns or complaints must be reported using the Policy 7102 Reporting Form, found here: https://forms.office.com/g/yAMDeLNq1S; however, REMSA may be notified by phone if the nature or severity of the incident is particularly egregious or heinous. REMSA policy #7102 (Unusual Occurrence / Occurrence Review Process) explains how reported concerns are processed and how reporting works within the EMS system. REMSA takes all reported concerns seriously, whether or not the official reporting form is used.

When a Policy 7102 Reporting Form is received, REMSA will contact the reporting party to validate and clarify the report then evaluate the preliminary information to determine if any immediate action against the accused’s certification is warranted. In most incidents, the EMS Agency that issued the credential(s) to the involved individual(s) will be responsible for investigating and issuing discipline. In some cases, the EMS Agency that holds jurisdictional authority will perform the investigation and issue discipline. Regardless, the jurisdictional EMS Agency will contact the certifying EMS Agency and discuss how they wish to proceed.

For EMTs whose employer is also their certifying entity, investigative and disciplinary authority rests with the Medical Director of the local EMS Agency (LEMSA) of the county where the entity is headquartered.

INVESTIGATIVE REVIEW PANEL (IRP)
Evaluation of Information
1. The REMSA Medical Director will evaluate information received which may include, but not limited to, information obtained via medical audit, public complaint, or employer concerns that allege or indicate a breach or violation that is egregious, flagrant, demonstrates repeated violations of policy, procedure, or law, or rises to the level of a threat to public health and safety.
2. If the REMSA Medical Director determines, following evaluation of the information, that further inquiry into the circumstance is necessary or that disciplinary action against the certification holder’s local credential may be warranted, they will conduct an investigation into the allegations.
3. Upon conclusion of the investigation, the REMSA Medical Director will determine, in their expert opinion, if the facts support a disciplinary action against the certification holder’s local credential.
Notification of Investigation and Disciplinary Action

1. Upon determination that a complaint, concern, audit finding, or allegation requires investigation that may lead up to and/or include discipline against a local credential, the accused certification holder(s) will receive written notification, by Certified® mail, that an investigation is being conducted.

2. Upon conclusion of the investigation, the REMSA Medical Director will determine what disciplinary action(s), if any, will be taken against the accused certification holder’s local credential.

3. The accused certification holder(s) will be notified in writing, by Certified® mail, of any action to be taken. The notification will include the following information:
   a. The disciplinary action, the basis for the decision, the date it will take effect, and the duration of the action.
   b. A statement that the certification holder is required to report the parameters of the disciplinary action to all employers (paid and volunteer) within REMSA’s geographical jurisdiction within ten (10) days of receipt of the notification.
   c. The certification holder’s right to appeal this decision within fifteen (15) calendar days of receipt by requesting, in writing, the convening of an IRP hearing.
   d. A brief explanation of the IRP process including notification that the certification holder may mutually agree with REMSA on one (1) panel member.

4. If an IRP hearing is requested, notification of the hearing, along with this policy and any other policies or procedures established by REMSA regarding IRPs, will be sent via Certified® mail to the certification holder and their current employer(s) at least fifteen (15) days prior to the IRP hearing. The notice will include the following information:
   a. The purpose of the IRP hearing.
   b. Membership of the IRP and provisions for disqualification of a member.
   c. Date, time, and location of the IRP hearing.
   d. A Request for Discovery form.
   e. The certification holder’s right to be present during any testimony before the IRP.
   f. The certification holder’s right to call witnesses and to cross examine witnesses called by REMSA during the hearing.
   g. The certification holder’s right to be represented by legal counsel at the IRP, or to be accompanied by any other person of their choosing, to provide advice and/or support.
   h. The certification holder’s right to present oral and/or written argument(s) and to present and rebut relevant evidence.
   i. The certification holder’s right to request the hearing be open to the public. If that request is not specifically made, the hearing will be closed to the public.

The Investigative Review Panel

1. Within thirty (30) days of REMSA’s receipt of a request to hold an IRP hearing, an IRP will be convened to review the facts of the case and make its recommendation.

2. The IRP will consist of at least three (3), but no more than five (5), members.

3. One (1) member of the IRP will be mutually agreed upon by the certification holder and REMSA, if the certification holder so requests.

4. The IRP will not include the REMSA Medical Director, any REMSA staff or recent past (within 6 months) employee of REMSA or anyone who submitted allegations against the certification holder or who is directly involved in any incident included in the investigation. Additionally, current or recent past (within 6 months) employers, employees, supervisors, or any first- or second-degree relatives of the certification holder cannot serve as a member of the IRP.

5. IRP members must be knowledgeable in the provision of prehospital emergency medical care, REMSA policies and procedures, the role of accreditation / authorization, and have an understanding of the disciplinary process.

6. An IRP member will voluntarily recuse themselves from any case in which they cannot remain a fair and impartial reviewer.

7. The certification holder may request, in writing, the disqualification of a panel member if they believe the member cannot provide a fair and impartial decision. The request must state the reason(s) upon which the claim is being made and it must be received by REMSA at least seven (7) days prior to the IRP. The REMSA Medical Director will determine within three (3) days of receipt of the request whether the evidence warrants the disqualification of the panel member. Notification of the REMSA Medical Director’s decision will be sent by Certified® mail to the certification holder prior to the date of the IRP hearing.
8. Should the disqualification or recusal of a panel member result in a panel of less than three (3) members, an alternate panel member will be designated. If one cannot be designated prior to the scheduled hearing date, the hearing will be rescheduled with an alternate member no later than fifteen (15) days after the original date.

9. Notification of a rescheduled hearing will be sent by Certified® mail and must be received by the certification holder no less than seven (7) days prior to the rescheduled date.

10. The IRP will consider all relevant evidence on the matter in order to establish the facts of the case and will make a written report of its findings and recommendations to the REMSA Medical Director within fifteen (15) days of the conclusion of the hearing.

Non-Communication with IRP Members
1. Prior to the IRP hearing, the certification holder who is under investigation, or any representative, witness, or agent of the certification holder, is prohibited from contacting any person chosen to serve as a panel member on the IRP regarding any part or portion of the matter under investigation.

2. IRP members are prohibited from contacting the certification holder, or any representative, witness, or agent of the certification holder, regarding any part or portion of the matter under investigation.

3. REMSA employees, its agents and/or witnesses are prohibited from contacting IRP members regarding the substance of the IRP hearing. REMSA communication with IRP members and/or potential IRP members is only permitted for the purposes of explaining procedural aspects of the process, and only enough of the content as to permit panel members to determine if they should recuse themselves from the case. Discussion of arguments, evidence, and/or strategies is not permitted.

IRP Hearing Recording and Open vs. Closed Hearings
1. A recording of the hearing will take place; the means and mechanism to do so is at the discretion of REMSA. Should REMSA decide on an electronic recording, but the certification holder determines that a stenographer is in their best interest, finding a stenographer from a reputable agency, retaining them, and reimbursing them will be the responsibility of the certification holder.

2. The certification holder will notify REMSA that the services of a stenographer have been retained a minimum of three business (3) days prior to the hearing.

3. A member of the IRP, or REMSA, may order closure of all, or any part of the hearing proceedings, for any of the following reasons:
   a. To satisfy the federal or state Constitution, statute, or other law, including but not limited to, laws protecting privileged, confidential, or other protected information.
   b. To conduct the proceedings, including the manner of examining witnesses, in a way that is appropriate to protect a minor witness or a witness with a developmental disability, as defined in Section 45132 of the Welfare and Institutions Code, from intimidation or other harm, taking into account the rights of all persons.

4. If the hearing is open, witnesses will be prohibited from observing until after they have been excused from providing further testimony.

Final Determination and Notification of Disciplinary Action
1. Upon final determination of the disciplinary action to be taken against the certification holder’s local credential, the REMSA Medical Director will complete and place in the certification holder’s record a Final Decision / D&O, certifying the decision that was made, the date the decision was made, the date it will take effect, and the duration of the action. In addition, the statement will contain findings of fact and the determination of issues which led to the decision.
   a. Most disciplinary actions will become effective thirty (30) calendar days from the date the REMSA Medical Director signs the D&O; however, pursuant to Article 13, Chapter 4.5 (commencing with Section 11460.10) of the APA, REMSA may take immediate action to protect the public interest by revoking a certification holder’s credential(s).

2. A notification letter will be sent to the certification holder and will include the above Final Decision/ D&O.

3. The notification letter will indicate that the certification holder is required to report the parameters of the disciplinary action to all employers (paid and volunteer) within REMSA’s geographical jurisdiction within ten (10) days of receipt of the notification letter.

4. The statement and notification letter will be sent to the certification holder via Certified® mail.
5. REMSA will report the disciplinary action to all known employers (paid and volunteer) within its geographical jurisdiction.

6. The certification holder may appeal this final decision by filing a Writ of Mandate and Application for Stay with the Superior Court of California no later than thirty (30) days after receipt of the decision.

7. If the decision is made that no disciplinary action will be taken, a notification letter stating such will be sent to the certification holder.

Types of Formal Discipline
Any formal discipline delivered must be reported to the Cal EMSA/ Central Registry, and in some instances to other national and/or federal entities such as the National Practitioner Data Base.

Denial Due to Discipline
An initial applicant to REMSA (either a new certification holder or a certification holder currently credentialed through another LEMSA but new in Riverside County) may have their application denied for discipline that was received previously. Certification denial by any EMS certifying entity will be respected by all other certifying entities for at least one (1) year.

Denial Due to Qualifications
Any applicant, whether applying initially or renewing their certification, may be “denied without prejudice” for the failure of meeting the required minimum requirements to become certified. “Denial without prejudice” is not based on previous disciplinary action and is not recorded or reported to any other entity. It does not have a one (1) year waiting period to reapply. Reapplication to any EMS credentialing agency may occur as soon as the applicant meets all of the minimum qualifications to become certified as required by the certifying entity.

Probation
Certificate holders whose credentials are placed on probation are still permitted to work at their designated certification level, usually with no restrictions on their scope of practice; however, certain conditions must be satisfied during the probationary time period, or they will be considered in violation of their agreement. Probation conditions may include, but not be limited to, mandatory compliance with all laws and policies, notification to REMSA of changes in employment status, quarterly check-ins (every three (3) months) with REMSA Discipline and Enforcement personnel, which will include the reporting of any negative contact(s) with law enforcement, if applicable, etc. Depending on the reason(s) for probation, maintaining compliance may also require the certification holder to participate in certain classes or therapies and restrict their use of alcohol or drugs. It may also require scheduled medical evaluations, skills competency verifications, or similar requirements. Probation for initial applicants is typically two (2) years and three (3) years for renewing certificate holders. The maximum probationary period allowed by law is five (5) years.

Probation Quarterly Reports
All certificate holders placed on probation are required by Cal EMSA’s MDOs to submit a quarterly (every three (3) months) report to REMSA. This is accomplished electronically, using the ImageTrend License Management System (LMS) portal. The report is a one (1) page form, which is an attestation of compliance (or non-compliance) with the stipulations of probation, with fields to update contact and employer information as needed. While a simple task in itself, it is crucial that probationers complete and return these forms when required. Failure to submit them on time, or at all, is a failure of compliance with probation requirements and may result in the revocation of credentials.

Reports are to be submitted using the following procedure:
2. Under the “Applications” banner that appears, find “Probation Quarterly Report.” Click “Apply Now”
3. On the next screen, review the “Introduction” page and confirm that the submission is being reported for the appropriate quarter. Once reviewed, click “Save and Continue” at the bottom of the screen
4. On the next screen, titled “Probation Quarterly Report”: 

a. Review and confirm that all of the information is correct.
b. Attest to compliance, or non-compliance, with the stipulations of probation.
c. Upload documents as appropriate.
d. Digitally sign and submit.

If successfully submitted, the LMS will send a confirmation email to the email address on file. REMSA recommends saving this email as proof of successful reporting.

**Troubleshooting Probation Quarterly Report Submissions**

If the LMS proves dysfunctional for any reason, the REMSA Help Desk should be contacted as soon as possible at (951) 840-0675.

If submission through the LMS proves to be a nonviable option, a scanned copy of the Quarterly Report should be emailed to EMD-Discipline@rivco.org. In the body of the email, a narrative explaining what issues occurred within the LMS, and the assistance that the Help Desk provided, must be included.

If submission through the LMS proves to be a nonviable option **AND** no response has been received after submitting scanned copies to EMD-Discipline@rivco.org, the EMS Specialist assigned to your case should be contacted in order to schedule an in-person appointment to submit a hard copy of your Quarterly Report.

If all other methods fail, a hard copy of all required documentation should be mailed to the EMS Agency using USPS mail, sent Certified®. REMSA also recommends using the Return Receipt service to prove delivery occurred.

Should the certification holder fail to submit their quarterly report in a timely manner, or at all, the following progressive disciplinary action(s) will take place:
1) **First missed quarterly report** – One (1) final warning of probationary non-compliance will be issued, sent via Certified® Mail and the email on record.
2) **Second missed quarterly report** – Suspension of credentials for fourteen (14) calendar days.
3) **Third missed quarterly report** – Revocation of credentials.

As a courtesy, REMSA may remind probationers of the need to submit their Quarterly Reports; however, it is the ultimate responsibility of the probationer to initiate and submit their reports at the appropriate time and to ensure successful submissions.

**Suspensions**

Suspensions do not affect credential renewal dates, but they may require certain conditions to be met in order to return the credential to an ACTIVE, unrestricted status. Suspension periods may be effective for as little as (14) calendar days to (60) calendar days. When a certification holder’s credential is suspended, they are not permitted to work or volunteer in any capacity in which they would need an active, unrestricted credential to practice medicine. Certification holders who are able to satisfy the conditions of their suspension period should expect a period of probation to follow.

**Suspension Timeframes for Invalid Certifications**

After a thorough investigation, paramedics and MICNs who have worked without a valid credential in Riverside County will be suspended. The suspension period is dependent on the number of days worked while their credential was invalid:

<table>
<thead>
<tr>
<th>Days worked without</th>
<th>0-30 days</th>
<th>30-60 days</th>
<th>60-90 days</th>
<th>120 days or greater</th>
</tr>
</thead>
<tbody>
<tr>
<td>accreditation / authorization</td>
<td>Suspension time</td>
<td>7 days</td>
<td>14 days</td>
<td>21 days</td>
</tr>
</tbody>
</table>

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Temporary Suspension Order (TSO)
A TSO is an immediate suspension of the certification holder’s credential because of the following:
1. The certificate holder has engaged in acts or omissions that constitute grounds for denial or revocation according to Title 22 § Section 100214.3 (c) and (d) AND
2. The opinion of the REMSA Medical Director is that continuing to permit the certificate holder to engage in certified activities would pose an imminent threat to the health and safety of the public.

If challenged, a TSO must be reviewed within thirty (30) days by an ALJ. REMSA may issue a TSO against a state paramedic license; however, the reason(s) for the TSO must be sent immediately to Cal EMSA. Cal EMSA will then review and accept, or reject, the TSO within three business (3) days. If accepted, the thirty (30) day window for a hearing applies.

Revocation
Revocation is the canceling of a certification. Once revoked, providers are no longer a paramedic, EMT or MICN and must meet the standard for a new applicant in order to re-obtain their certification in the future. Certification revocation by any EMS certifying entity will be respected by all other certifying entities for at least one (1) year. If the certification holder is issued a new certification after the revocation period expires, it will be an entirely new number.

Investigation Process
Respondent’s Rights
The respondent is entitled to representation of their choice throughout the investigation and any subsequent prosecution; however, they will be responsible for all associated attorney costs and fees.

The respondent may request “Discovery” up to thirty (30) days after receiving the Accusation. They are encouraged to familiarize themselves with administrative law processes and ask questions to REMSA personnel that pertain to their procedural rights.

DISCLAIMER: The information provided by REMSA personnel to respondents does not, and is not intended to, constitute legal advice; instead, all information provided is for general informational purposes only. Respondents are not required to, but REMSA highly encourages, contacting an attorney to obtain advice with respect to legal matters. Only the respondent’s individual attorney can provide assurances and interpretations of the law based on their particular situation.

Discovery and Preliminary Review
If warranted, REMSA will begin to review circumstances related to the discovered issues and complaints. The review will be conducted under the supervision of the REMSA Medical Director and/or the EMS Agency Administrator. During this phase, REMSA will collect additional information (e.g., ePCRs, CAD data, incident reports, audiotapes, etc.) from the employer, who may or may not be involved in the investigation. Upon review of the circumstances, REMSA will find the complaint to be one (1) of the following:
1. Unsubstantiated – the actions of the certification holder in question do not rise to the level where remediation is a recognized need. The case will be closed.
2. Substantiated – the actions of the certification holder in question rise to the level where remediation is a recognized need, but disciplinary action is not. REMSA will collaborate with the certification holder’s employer to create a remediation / Performance Improvement Plan (PIP).
3. Substantiated and Actionable – the actions of the certification holder in question rise to the level where discipline is a recognized need. Formal disciplinary actions are taken against credentials (suspension, probation, revocation, and/or denial).

Remediation
If education (alone) is offered as a form of remediation, a PIP will be developed to track progress and completion. REMSA may work in cooperation with the certification holder’s employer or other appropriate system resources in the
development and execution of the PIP. Remediation (in the absence of concurrent or subsequent discipline) is considered a quality assurance action; however, failure to complete all required steps outlined in a PIP may result in administrative or disciplinary action.

Interviews
If complaints are found to be substantiated, interviews may be requested to obtain more information. REMSA reserves the right to record interviews using any type of audio and/or visual technology at their disposal.

- REMSA will notify the accused that an investigatory interview is being requested, either by phone, email, or letter.
- If necessary, the accused individual may be requested to participate in interviews on more than one (1) occasion. Compliance is expected.
- REMSA has the legal authority to interview witnesses to the incident / complaint.
- If the accused is a firefighter and the incident / complaint occurred during the course of their active-duty assignment(s), REMSA will provide them with a copy of a Firefighters Bill of Rights Advisement Notification to read and sign prior to the start of the interview.
- If the interview is conducted by telephone and recording of the conversation will occur, REMSA will communicate this to the accused at the beginning of the call, but **AFTER the recording begins**, in order to capture their verbal acknowledgment that recording is taking place.
- Should they choose to, the accused is permitted to utilize their own recording device.
- While the accused may have a legal representative present during an interview, the accused must truthfully answer all questions directed to them.

Formal Disciplinary Review(s) / Action(s)
When the need for a formal investigation is recognized, the respondent and their employer (if applicable) will be notified in writing. A formal disciplinary investigation may consist of, but is not limited to, further collection and review of documents, evidence collection, interviews, etc.

A record of conviction from the court will be considered conclusive evidence of guilt. While REMSA does not relitigate cases, there may be instances when additional information will be requested in the form of specific court and police documents, a written statement from the respondent regarding the incident, and possibly a face-to-face interview, in order to gain a complete understanding of the events that transpired. Any additional materials the respondent wishes to submit will be accepted as a source of mitigating evidence. Disciplinary action will be determined based on the prescribed discipline for the criminal activity per Cal EMSA’s MDOs and a review of the mitigating evidence presented.

Should it be determined by further investigation that disciplinary action will be necessary, or if the court conviction qualifies under regulations as disciplinarily actionable, a legal document ("Accusation") will be written and sent to the respondent. First time applicants to REMSA will be sent a similar document, titled “Statement of Issues.” This document is the formal legal notification to the respondent that REMSA intends to issue disciplinary action. It outlines REMSA’s findings surrounding the events that led up to the decision and what sections of the California Health and safety Code REMSA believes were violated.

The respondent will also be provided with “Statement to Respondent” and “Notice of Defense” documents, which they must complete and return to REMSA should they wish to contest REMSA’s disciplinary decision. The respondent will also receive a “Notice of Discovery” document and a “Stipulated Settlement Agreement” document, which explains in detail the discipline REMSA plans on issuing. Copies of all applicable regulations, statutes, etc. that were violated will be sent to the respondent as well. These documents may be sent concurrently, or shortly after, the Accusation or Statement of Issues is provided.

When a formal accusation is made, the respondent will be informed of their rights in accordance with the applicable regulations. If more than one (1) person is being investigated or is subject to discipline for the same incident or occurrence, each individual will be processed as a separate party.
Investigations & Administrative Hearing Process – EMTs

Decision by Hearing
If the respondent has filed a “Notice of Defense / Notice of Participation,” an administrative hearing is conducted pursuant to the APA. The REMSA Medical Director may choose to participate in the hearing; they also have the authority to delegate the responsibility of hearing testimony, examining evidence, and making a conclusionary decision to an ALJ. The initial appeal is always heard by an ALJ regarding EMT credentials.

If the REMSA Medical Director chooses to delegate the hearing to an ALJ, the ALJ will issue a proposed decision to REMSA within thirty (30) days of the conclusion of the hearing. Thirty (30) days after REMSA receives the proposed decision, a copy will be filed internally by REMSA and will remain public record. A copy will be served by REMSA on each party and their attorney. The REMSA Medical Director has one hundred (100) days from receipt of the proposed decision to make a final decision.

The REMSA Medical Director can:
1. Adopt the decision in its entirety
2. Reduce or otherwise mitigate the proposed discipline and adopt the balance of the proposed decision
3. Make technical or other minor changes and adopt the decision
4. Reject the proposed decision and refer the matter back to the ALJ to take additional evidence OR
5. Reject the proposed decision and decide the case upon the record.

If the REMSA Medical Director fails to make a decision within the one hundred (100) day time period, the proposed decision will be adopted by REMSA as written. The adopted final decision is filed as a public record immediately and is served on the respondent and their attorney. Generally, the final decision becomes effective thirty (30) days after the final decision is delivered or mailed to the respondent.

If a decision issued by REMSA is found to be unfavorable by the respondent, they may file a Writ of Mandate with the California Superior Court, requesting judicial review of the Decision pursuant to Government Code section 11460.80.

Decision by Default
In instances when the respondent fails to return a Notice of Defense / Notice of Participation to REMSA in the appropriate time frame, the REMSA Medical Director has the authority to issue a default D&O that is binding and final. It will align with the maximum penalty allowed by Cal EMSA’s MDOs.

Investigations & Administrative Hearing Process - Paramedics

Certification Denial
When REMSA denies an initial application for local paramedic accreditation, the applicant may appeal based on the rights afforded to them by the APA. They must submit a written request to REMSA which will be met with a charging document for their denial. These charging documents are similar procedurally to a Statement of Issues or Accusation; however, the respondent has the burden of proof to demonstrate that they have satisfied the identified deficiencies communicated in the Statement of Issues.

Investigation and Disciplinary Procedures Specific to Paramedics
REMSA will follow the same investigation and disciplinary procedures as listed for EMTs (above), with the following procedural additions:

- REMSA will notify the paramedic, via Certified Mail if the investigation, and possible disciplinary action, allowing them the opportunity to provide a written statement within ten (10) calendar days.
- During the investigation period, the paramedic’s employer will notify REMSA within three (3) business days of any of the following occurrences:
  - The paramedic was terminated or suspended for a disciplinary cause
  - The paramedic resigned or retired following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause OR
- The paramedic was prohibited from performing paramedic-related duties for a disciplinary cause after the completion of the employer’s investigation.
- REMSA will notify the paramedic in writing of the REMSA Medical Director’s final decision.
- Within fifteen (15) calendar days of receipt of the negative disposition letter from REMSA, the paramedic has the right to file in writing, by Certified® mail, a response regarding the decision; they may also request an Investigative Review Panel (IRP) hearing.

**Actions Against Paramedic Local Accreditation**

Local accreditation may be denied or suspended by the REMSA Medical Director if a paramedic does not maintain current licensure or meet continuous local accreditation requirements. If local accreditation will be denied or suspended:

- The paramedic should be given ample notification of any deadlines and requirements.
- The paramedic must be granted due process in accordance with local policies and procedures.
- Local policies and procedures must provide a process for appeal or reconsideration.

Local accreditation will not be denied based on a paramedic’s accreditation history with another county or their employer affiliation.

Accreditation can be suspended until such time that all identified deficiencies are completed, reviewed, and accepted as complete by REMSA.

- Suspension of local paramedic accreditation privileges means that the certificate holder is not permitted to work in either the basic or optional scope of practice for paramedics in Riverside County. A paramedic may, however, work as an EMT during the accreditation suspension period with prior approval from their employer.

The REMSA Medical Director may suspend or revoke accreditation of a paramedic as part of the quality improvement process when the following conditions have been met:

1. It is determined by the paramedic’s employer, or the REMSA Medical Director, that the paramedic needs additional training, observation, or testing **AND**
2. The employer and the REMSA Medical Director create a specific and targeted program of remediation based upon the needs of the paramedic **AND**
3. The paramedic fails to complete this targeted program or remediation.

If, at any time during the review or investigation, the REMSA Medical Director determines that the facts support suspension or revocation of a paramedic’s local accreditation, they may convene an IRP. With respect to requests for Discovery and/or Motions to Compel, REMSA will follow all lawful procedures with the exception of portions that refer to an ALJ. The responsibilities that are delegated to an ALJ will be performed by the IRP.

If the REMSA Medical Director does not convene an IRP prior to making a final decision to revoke or suspend a paramedic's local accreditation, the paramedic may submit a written request for an IRP within fifteen (15) calendar days of written notification from receiving the REMSA Medical Director’s decision.

**Actions Against Paramedic State Licenses**

When the REMSA Medical Director is advised that a paramedic has committed any act of omission that appears to constitute grounds for disciplinary action against their state license, the information may be evaluated to determine if there is reason to believe that disciplinary action may be necessary. REMSA will notify Cal EMSA of all allegations. Cal EMSA’s Enforcement Division may:

- Determine that they should take over the investigation **OR**
- Suggest that REMSA continue with the preliminary investigation **OR**
- Determine that the allegation does not meet the threshold for investigation and dismiss it.
Investigations & Administrative Hearing Process – Mobil Intensive Care Nurses (MICN)

Negative actions against any MICN authorization may be issued by the REMSA Medical Director based upon findings of an imminent threat to the public’s health and safety.

REMSA will follow the same investigation and disciplinary procedures as listed for EMTs (above), with the following procedural additions:

- REMSA will notify the MICN via Certified Mail, of the investigation, and possible disciplinary action, allowing them the opportunity to provide a written statement within ten (10) calendar days.
- During the investigation period, the MICN’s employer will notify REMSA within three (3) business days of any of the following occurrences:
  - The MICN was terminated or suspended for a disciplinary cause
  - The MICN resigned or retired following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause OR
  - The MICN was prohibited from performing MICN-related duties for a disciplinary cause after the completion of the employer’s investigation
- REMSA will notify the MICN in writing of the REMSA Medical Director’s final decision.
- Within fifteen (15) calendar days of receipt of the negative disposition letter from REMSA, the MICN has the right to file in writing, by Certified® mail, a response regarding the decision; they may also request an Investigative Review Panel (IRP) hearing.

Actions Against MICN Local Authorization

Local authorization may be denied or suspended by the REMSA Medical Director if an MICN does not maintain current licensure or meet continuous local authorization requirements. If local authorization will be denied or suspended:

- The MICN should be given ample notification of any deadlines and requirements.
- The MICN must be granted due process in accordance with local policies and procedures.
- Local policies and procedures must provide a process for appeal or reconsideration.

Local authorization will not be denied based on an MICN’s accreditation history with another county or their employer affiliation.

The REMSA Medical Director may suspend or revoke authorization of an MICN as part of the quality improvement process when the following conditions have been met:

1. It is determined by the MICN’s employer, or the REMSA Medical Director, that the MICN needs additional training, observation, or testing AND
2. The employer and the REMSA Medical Director create a specific and targeted program of remediation based upon the needs of the MICN AND
3. The MICN fails to complete this targeted program or remediation.

If, at any time during the review or investigation, the REMSA Medical Director determines that the facts support suspension or revocation of an MICNs authorization, they may convene an IRP. With respect to requests for Discovery and/or Motions to Compel, REMSA will follow all lawful procedures with the exception of portions that refer to an ALJ. The responsibilities that are delegated to an ALJ will be performed by the IRP regarding rendering proposed decisions, viewing evidence and hearing testimony.

If the REMSA Medical Director does not convene an IRP prior to making a final decision to revoke or suspend an MICN’s authorization, the MICN may submit a written request for an IRP within fifteen (15) calendar days of written notification from receiving the REMSA Medical Director’s decision.

Authorization can be suspended until such time that all identified deficiencies are completed, reviewed, and accepted as complete by REMSA.
• Suspension of local MICN authorization privileges means that RN is not permitted to work in the capacity of an MICN. They may, however, continue working as an RN during the suspension period with prior approval from their employer.
PURPOSE
To outline the process of submitting formal disciplinary complaints to REMSA. Use of the online Policy 1302 Reporting Form (found here: https://docs.google.com/forms/d/1rWJlFX1-S8niwBUJE9etc5rlE6GVITIPyoEO1DTx_4/edit) to submit incidents is mandatory.

NOTE: For CQI issues, clinical occurrences, and/or reportable actions that do not rise to the level of what is described within this policy, please review REMSA policy #7102 (Unusual Occurrence Submission, Process, and Review (Clinical)) for direction.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Health and Safety Code 1798.200

DEFINITIONS
Certificate holder:
An emergency medical technician (EMT-B)

License holder:
A paramedic

Occurrence
An incident or event in which any Federal, State, or local law, or any REMSA policy or protocol was violated, either intentionally or unintentionally. Occurrences are identified by level of severity. For the purposes of this policy, only Level C occurrences, which are considered so egregious that they require formal disciplinary action, are detailed. All other occurrences, which do NOT require formal disciplinary action (Level A and Level B occurrences), are detailed in REMSA Policy #7102.

Reporting Party
The individual, agency, or organization that first discovers, or becomes aware of, an occurrence.

Based on its severity and confounding circumstances, REMSA may choose to assign an occurrence to a higher or lower level than what is described above.

Reporting and Investigation Process
The individual, hospital, department, or agency discovering the occurrence will be considered the Reporting Party.

1. Upon recognition of a Level C occurrence (listed below), the Reporting Party will immediately submit a report using the online Policy 1302 Reporting Form (found here: https://docs.google.com/forms/d/1rWJlFX1-S8niwBUJE9etc5rlE6GVITIPyoEO1DTx_4/edit).
   a. If an occurrence is recognized on a weekend or a holiday, the report must be submitted within seventy-two (72) hours.
   b. The Reporting Party is the only party required to submit an occurrence report. Only one (1) report is necessary.
2. Upon receipt of all required information, REMSA will initiate the investigation process. For information on how REMSA conducts disciplinary investigations, please review REMSA Policy #1301 (Discipline and Enforcement, found here: http://www.remsa.us/policy/1301.pdf).

3. REMSA may contact the Reporting Party for further information.

Examples of reportable actions:
Any immediate threat(s) to public health and safety, defined by California Health and Safety Code (HSC) Section 1798.200. Any of the following actions shall be considered evidence of a threat to the public health and safety and may result in the denial, suspension, or revocation of a certificate or license, or in the placement on probation of a certificate holder or license holder.

1. Fraud in the procurement of any certificate or license:
   • Any individual who falsifies documents, or provides false information, to obtain an EMS certification or license.

2. Gross negligence:
   • Any EMS provider who administers an incorrect medication dosage that results in severe harm to, or the death of, a patient.

3. Repeated negligent acts:
   • Any EMS provider who consistently fails to properly assess and/or monitor patients, which may lead to multiple instances of preventable medical errors or failed Performance Improvement Plans (PIP).

4. Incompetence:
   • Any EMS provider who consistently demonstrates a lack of knowledge and/or the skills required for their role, which may result in substandard patient care or failed Performance Improvement Plans (PIP).

5. The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, and duties of prehospital personnel:
   • Any EMS provider who intentionally alters patient care documentation to cover up a mistake or to falsely represent the level of care provided (i.e., intentional falsification or tampering of legal documents).

6. Conviction of any crime that is substantially related to the qualifications, functions, and duties of prehospital personnel:
   • Any EMS provider who is convicted of ANY CRIME which is directly related to their qualifications, functions, and duties as prehospital personnel.

7. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of any provision of CA HSC or the regulations adopted by the Emergency Medical Services Authority of California pertaining to prehospital personnel:
   • Any EMS provider who knowingly violates protocols and procedures established by the EMS Authority of California and/or REMSA during the course of providing patient care.

8. Violating or attempting to violate any federal or state statute or regulation that regulates narcotics, dangerous drugs, or controlled substances:
   • Any EMS provider who illegally distributes prescription drugs or diverts controlled substances for personal use.

9. Addiction to, the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances:
   • Any EMS provider who develops a substance abuse problem and regularly comes to work under the influence, causing an undue compromise in patient safety.
10. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification:
   • Any EMS provider who operates independently and makes critical medical decisions without first seeking guidance or approval from medical control or the appropriate authorities (e.g., EMTs performing a skill or administering medication(s) outside of their scope of practice, etc.)

11. Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired:
   • Any EMS provider who exhibits erratic behavior, such as shouting at colleagues or displaying signs of severe emotional distress, which raises concerns about their ability to provide safe and effective care.

12. Unprofessional conduct exhibited by any of the following:
   a. Mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of their duties would use if confronted with a similar circumstance:
      • Any EMS provider who uses excessive force while restraining a non-combative patient which may or may not cause unnecessary harm.
   b. Failure to maintain confidentiality of protected patient medical information, except as disclosure is otherwise permitted or required by law:
      • Any EMS provider who shares confidential patient information with unauthorized individuals, violating the patient’s privacy rights.
   c. Commission of any sexually related offense specified under Section 290 of the Penal Code:
      • Any EMS provider who is convicted, or alleged to have engaged in, sexual assault or misconduct, indicating a breach of professional boundaries and trust.

Note: the examples above are provided solely for the purpose of illustrating a general understanding of the concepts conveyed in the relevant section of the health and safety code; they are not intended to be all inclusive or exhaustive. The specific circumstances, actions, and consequences that may constitute a violation of the law can vary depending on the jurisdiction where the action occurred and the particular facts surrounding the case. It is essential to consult the relevant laws, regulations, and legal authorities in your jurisdiction to obtain accurate and up-to-date information.

This disclosure does not constitute legal advice and should not be relied upon as such. If you require legal guidance or have specific questions regarding CA HSCs or any related matters, REMSA recommends consulting a qualified attorney familiar with the laws in your jurisdiction.

Loop Closure
Loop closure/feedback will be provided by REMSA via email, letter and/or phone call to the involved agencies/facilities after the investigative process is complete.
PURPOSE
This policy is part of the system wide EMS Quality Improvement Program (EQIP). It outlines those steps required by any prehospital care provider, approved continuing education (CE) provider, or EMS training program within Riverside County that chooses to perform ALS or EMT skills competency verification (SCV).

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22, Division 9, Chapter 2, Article 5, Section 100080

Qualifications/ Responsibilities of the Skills Verifier and Verifying Agency
1. Any person authorized as a skills competency verifier (SCVr) must:
   a. Be a currently certified or licensed as EMT, EMT-P, registered nurse (RN), physician’s assistant (PA), or physician (MD/DO) employed by a qualifying agency.
   b. Receive approved training from the agency designating them as a SCVr.

2. Skills competency verification will be done by direct observation only.

3. Skills competency verification will be performed only by authorized providers in a setting (time/place) pre-approved by their designating agency.
   a. Approved SCVrs may only observe and validate that level of skills for which they are credentialed, i.e., ALS skills verifiers may only sign off ALS skills, BLS SCVrs may only sign off BLS level skills. However, ALS personnel who attended training for both levels may be credentialed at both levels.

4. Designated skills competency verifiers will:
   a. Use only approved SCV forms.
      i. ALS must be the REMSA-approved SCV form.
      ii. EMT must be the State-approved (07/17) form.
   b. Only sign-off those skills directly observed by them, and that meet the standards as set down by their designated agency's pre-approved skills sheets.
   c. Sign the SCV form in colored ink, preferably blue.
   d. Complete all five areas corresponding to each skill on the form—signature, printed name, state license/certification number, affiliation, and date.
      i. Signature and date MUST be handwritten.
   e. Not complete item 4.d. (above) if sections 1a. and 1b. on the form have not been completed by the individual seeking skills verification.

5. Qualifying agencies who wish to perform skills competency verification will:
   a. For EMT Skills Verification:
      i. Have an approved skills sheet for each of the REMSA-accepted skills in the 10 skills categories defined by the State.
      ii. Use the skills sheets of the National Registry (NR) as the standard for skills competency verification. If no NR skill sheet exists for a particular skill, or if a variation of the NR skill sheet is desired, the skill sheet(s) used for verification will be approved by the EMS Agency prior to implementation.
      iii. Review skills sheets annually and update as appropriate for changes in the standard of care.
      iv. Updated skills sheets must be REMSA reviewed and approved.
b. For ALS Skills Verification:
   i. Utilize the REMSA Performance Standard Validation sheets for each of the REMSA-accepted skills in the 15 skills categories defined by REMSA.

c. For both EMT and ALS Skills Verification:
   i. Provide and document initial training to designated persons on use of the approved skills sheets.
   ii. Submit a limited list of names of persons in their agency who have met the qualifications and training for SCV and who they wish to designate as skills competency verifiers (SCVrs).
   iii. Provide annual update / review training to their designated SCVrs.
      1. Attendees will sign a roster verifying attendance.
   iv. Immediately notify the EMS Agency of any change -- addition or deletion – in their cadre of qualified, trained, and approved SCVrs, supplying the name, level of SCV, and effective date of change.
   v. Submit verification of 5a. – c. v. to the EMS Agency as requested.

Responsibilities of the Individual Seeking Skills Competency Verification

1. Individuals requesting skills competency verification will have the authorized person sign the REMSA ALS Skills Competency Verification Form or State-approved (EMT) skills competency verification form (EMSA-SCV [07/17]) at the time that the skill is observed and verified.
   a. EMTs/ALS Personnel will complete items 1.a. and 1.b. at the top of the SCV form prior to having approved skills verifier (SCVr) sign for skills completion.
   b. It is not required to perform all skills for competency in a singular setting. However, only one SCV form will be utilized by the individual for obtaining signatures verifying skills competency.
   c. Skill 5, "AED and CPR" on the state EMT SCV form, may be verified by an approved skills verifier or the CPR instructor who observed skills performance at the time of CPR renewal.
      i. The signature of an approved CPR instructor on an applicant's SCV form does not negate the requirement to present an approved BLS/CPR card at the time of recertification.

2. EMTs/ALS personnel are required to submit the completed original SCV form at time of recertification, accreditation reverification and renewal of authorization.
PURPOSE
To identify the minimum requirements for an agency to be approved as an emergency medical dispatch (EMD) provider, pursuant to the California Health & Safety Code Section 1797.220 and 1797.223.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

EMD Center Approval Process
Non-EMD provider agencies requesting approval to become an EMD Center in Riverside County must submit a Riverside County Emergency Medical Dispatch Application.

Local provider agencies that plan to utilize contracted EMD services must also submit a REMSA EMD Application. Additionally, the contracted agency that provides EMD services on their behalf must submit an Emergency Medical Dispatch Contracted Provider Agency form.

Both forms (above) can be obtained by sending a request to EmergencyMedicalDispatch@rivco.org.

REMSA will advise of program approval or disapproval in writing within ninety (90) days of receipt of all required application documentation. Identified program deficiencies must be corrected within sixty (60) days of notification. If, after 60 days, the identified deficiencies are not resolved, the application will be considered abandoned and will be withdrawn from consideration. Once an application is withdrawn, the applicant agency will need to initiate a new application if they wish to continue the approval process.

Initial program approval periods expire after two (2) years.

REMSA may audit program materials and/or records as part of the EMD program verification process or for cause.

EMD Center Reapproval Process
EMD Centers must apply for program reapproval a minimum of ninety (90) days prior to the current approval period expiration date. A Riverside County Emergency Medical Dispatch Application Renewal must be obtained and used.

REMSA will advise of program reapproval or disapproval in writing within sixty (60) days of receipt of all required application documentation.

Program reapproval periods expire after four (4) years.

EMD Center Staffing Requirements
Program Administration - Local
EMD Centers operating in Riverside County will employ an EMD Program Coordinator, who will be International Academies of Emergency Dispatch (IAED) certified and qualified by education and experience in the EMD and Quality Management program process. Nothing in this section prohibits the same individual from being responsible for more than one (1) function, so long as they meet the qualifications of each position that they hold.
Duties of the Program Coordinator will include but not be limited to:
1. Administering the EMD program
2. Coordinating all clinical and field activities related to the EMD program
3. Ensuring that all emergency medical dispatchers meet all continuing education and update requirements as needed to maintain continuous certification.
4. Assuring that all aspects of the EMD program comply with state and county laws and policies
5. Administration of the EMD Quality Management program (i.e., quality improvement and quality assurance program).
6. Work to assure uninterrupted function and regular maintenance of the MPDS
7. Be the authorized point of contact for all matters relating to the agency’s EMD program
8. Review the EMD program (CDE, Training, Orientation, QM activities, etc.) at least annually, retaining all applicable records for a period of four (4) years or as required by IAED whichever is longer.

Program Administration - Contracted
EMD provider agencies contracting EMD services will employ an EMD Liaison, who will function as a point of contact between their EMD contracted agency and REMSA. Nothing in this section prohibits the same individual from being responsible for more than one (1) function, so long as they meet the qualifications of each position that they hold.

Medical Direction and Oversight
EMD Centers will designate a current employee who is a licensed physician, or contract the services of a licensed physician, who will serve as a Medical Advisor. The EMD Center Medical Advisor will provide medical oversight for all medical aspects of the EMD program. This will include, but not be limited to:
1. The Emergency Medical Dispatch Protocol Reference System (EMDPRS) excluding protocols that pertains to Local Medical Control review and approval. Local Medical Control review and approval is deferred to REMSA and its Medical Director
2. The EMD training program
3. The CDE program
4. Compliance standards
5. Policies and procedures
6. The Quality Management program
7. Risk management functions
8. Records management

The EMD Medical Advisor will have medical management and accountability for the:
1. Approval of the EMD Center’s training program. They will participate in the ongoing evaluation and review of their agency’s program
2. Approval of their agency’s CDE program
3. Design of the medical aspects of their agency’s EMD orientation and performance evaluation methods
4. Approval of the EMDPRS utilized by their agency excluding protocols that pertains to Local Medical Control review and approval. Local Medical Control review and approval is deferred to REMSA and its Medical Director
5. Review of the Quality Management program, training, and risk management functions in their agency’s Continuous Quality Improvement (CQI) plan, including the establishment and monitoring of programs designed to correct identified medical quality issues
6. Participation in REMSA’s system CQI process

The EMD Medical Advisor will:
1. Be licensed in California and hold board certification in, or have verifiable experience practicing, Emergency Medicine
2. Possess knowledge of EMS systems in California and Riverside County
3. Be familiar with dispatching systems and methodologies

The EMD Medical Advisor will be responsible for ensuring that the provider agency’s EMD Program is established following state and local guidelines and policies.
Training and Certification
The scope of practice for EMD Center dispatch personnel will be consistent with the role and responsibility of the
Emergency Medical Dispatcher, as described in the current version of the IAED’s Emergency Medical Dispatch Course
Manual.

EMD centers will ensure that their dispatchers continuously maintain IAED and cardiopulmonary resuscitation (CPR)
certifications. CPR training programs approved for EMD dispatchers in Riverside County include the American Heart
Association (AHA), American Red Cross (ARC) and the IAED (Dispatcher Directed CPR).
Provider agencies and/or provider agency dispatch personnel are not permitted to medically triage or give prearrival, or
post-dispatch, instructions to any 9-1-1 caller unless they have IAED MPDS certification AND current approval from
REMSA.

EMD Center Operations
Only provider agencies with written approval from the Riverside County EMS Agency (REMSA) may operate as an EMD
center.

Agencies that provide EMD will operate twenty-four (24) hours a day, seven (7) days a week, except under certain
circumstances such as infrequent dispatcher work overload or under disaster conditions as specified by the State of
California Government Code, California Emergency Services Act, Chapter 7, Division 1, Title 2, Section 8558.

Provider agencies that utilize contracted EMD services from another EMD Center must ensure the following:
1. The contracted EMD Center is an (IAED) certified EMD center.
2. The contracted EMD Center is in good standing with, and has unrestricted approval from, their local EMS Agency
   (LEMSA).
3. The contracted EMD Center meets and/or exceeds the requirements of this policy and REMSA Policy #7101 (CQI
   System).
4. The contracted EMD Center adopts REMSA local medical control criteria for Medical Priority Dispatch System
   (MPDS) protocols 9, 10, 14, 18, 24, 28, 33, 34, 36 & 37 and any other protocols that may apply in the future.
5. The contracted EMD Center establishes a liaison for both agencies that will serve to communicate and coordinate
   with REMSA.

The EMD Center’s Program Coordinator, or the provider agency’s contracted agency EMD Liaison, must notify REMSA in
writing of any EMD program operational change(s), which may include but not be limited to:
1. Modifications in the MPDS
2. Changes to policies and/or procedures
3. Substantial program or administrative changes not previously submitted during the last approval period
4. Termination of the use of a contracted EMD provider agency or substantial changes in the contracted EMD services
   provider’s EMD program.

EMD Centers should make every effort to provide notification to REMSA within twenty-four (24) hours but no less than
seventy-two (72) hours.

REMSA recommends that all EMD Centers strive to attain the Accredited Center of Excellence (ACE) designation by the
IAED.

EMD Center CAD Requirements
EMD Centers that utilize the Riverside County contracted 9-1-1 ambulance transport provider will establish a real-time
data link, capable of transmitting emergency response information, which will include but not be limited to EMD MPDS
response determinants (e.g., 9-E-1, 26-Ω-2, etc.) and geographical location of the emergency response. For the purposes
of this section, a “real-time data link” refers to either a direct Computer-Aided Dispatch (CAD)-to-CAD transmission or an
indirect connection, which may include but not be limited to, a ring down line, intercom, radio, or other electronic
means to achieve timely notification of caller data in accordance with California Health and Safety Code 1797.223.
All EMD Centers will utilize Priority Dispatch Corporation’s ProQA™ dispatching software for the purposes of call-taking and dispatching, and AQUA™ for the purposes of case review and quality management. EMD Centers will, within ninety (90) days from the release date, update their CAD system to the newest version of ProQA™ and/or AQUA™.

**EMD Center Quality Management**

REMSA will establish an EMD Quality Review Taskforce (EQRT) and conduct meetings on a predetermined basis. EQRTs will, at minimum, be comprised of each EMD Center’s EMD Program Coordinator or their designee. EQRTs will provide a forum for:

1. The exchange of best practices, ideas and information between EMD Centers to improve overall system performance.
2. The discussion and resolution of inter-organizational issues related to EMD operations and the EMS system.
3. EMD advisories throughout the EMS system.
4. Identifying system-level EMD training needs or procedural changes as they relate to this policy.
5. Providing feedback on EMD and reporting to the PMAC (Prehospital Medical Advisory Committee) as needed / requested.

EMD Quality Management programs will be incorporated into the provider agency’s overall system CQI program.

EMD Centers will establish policies and procedures through their Quality Management program, to include but not be limited to:

1. Implementation and application of MPDS
2. Local medical control approval of all current and future applicable protocols (e.g., protocols 9, 10, 14, 18, 24, 28, 33, 34, 36 & 37)
3. Protocol compliance
   - i. Agency and individual protocol compliance
   - ii. Emergency Rule procedures
   - iii. Quality Assurance / Improvement
   - iv. Continuing Dispatch Education (CDE) requirements
   - v. Performance management and remediation
   - vi. Customer service
   - vii. Language translation processes
4. Call taking by authorized emergency dispatchers only and processes for EDs with expired, suspended, or revoked IAED certification.

EMD Centers will assure that call acuity (i.e., ProQA Response Determinants) is integrated into their ePCR platform.

EMD Centers will utilize AQUA™ software for quality improvement / assurance evaluation.

EMD Quality Management programs will, at a minimum, evaluate protocol compliance and conduct random case reviews for both individual emergency dispatchers and the agency.

**EMD Center Reporting Requirements**

REMSA will collect and analyze activity data from EMD Centers to assist with system overview, improvement, development, and policy priorities. Reports will be submitted quarterly to REMSA and will be due by the end of the following month after the end of each quarter (April, July, October, and January).

EMD Centers will review the following reports monthly. This list is not exhaustive and only includes the mandatory minimum:

1. EMD Determinant Drift Report
2. EMD Time Analysis by Dispatch Level
3. EMD Performance Report
EMD Center Record Management Requirements

EMD Centers will maintain copies of their basic training program course completion records, “in-house” EMD CDE topics (methodologies, dates, times, locations, and the number of CDE hours awarded for each session) and copies of EMD CDE course completion records according to IAED standards.

Each EMD Center will retain Compliance-to-Protocol reports, as required by law.
PURPOSE
For Emergency Medical Dispatch centers to implement enhanced screening of 9-1-1 callers who are suspected of Emerging Infectious Disease (EID) and to provide responding personnel with early notification of symptomatic patients so that proper personal protective equipment (PPE) can be utilized while providing care to patients.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

EIDS Tool Utilization
1. When this policy is activated by Riverside County Emergency Medical Services Agency (REMSA) Medical Director, all Emergency Medical Dispatch (EMD) ProQA Medical Priority Dispatch System (MPDS) centers shall utilize the Emerging Infectious Disease Surveillance (EIDS) Tool to collect information from patients experiencing flu like symptoms and to provide confidential notification to responding crew of PPE utilization.
   a. For EIDS v6.0.0 the following are further defined:
      i. There is currently no additional “Physician Advisor-approved questions:” to be asked other than the default questions listed in the EIDS v6.0.0.
      ii. The “hot” areas are affected areas defined as geographic regions where sustained community transmission has been identified. In addition to several foreign countries, this also includes domestic areas (i.e., Seattle, WA, San Francisco, CA & New York, NY). Relevant affected areas will be defined as a country with at least a CDC level 2 Travel Health Notice. Current list of countries is available in CDC’s COVID-19 Travel Health Notices. [https://www.cdc.gov/coronavirus/2019-ncov/travelers](https://www.cdc.gov/coronavirus/2019-ncov/travelers)
      iii. Under “Special Instruction” section, the following instruction can be given upon the discretion of the call taker if s/he determines the instruction would be beneficial to the person.
         1. If you have a surgical mask and if it does not impede your breathing, you can place a surgical mask on patient.
         2. If it’s safe to do so, please have the patient step outside to meet the responders once they arrive.
   2. For Emergency Medical Service (EMS) dispatch centers and Public Safety Answering Point (PSAP) that are not authorized EMD centers, REMSA policy 3307 Emerging Viruses can be referenced for procedures regarding highly pathogenic emerging viruses that are suspected during emergency call taking and response.
   3. For EMD ProQA MPDS-user agencies that implement medical dispatch enhanced screening procedures, the IAED recommends using the EIDS Tool for the following Chief Complaints:
      a. Sick Person (Protocol 26)
      b. Breathing Problems (Protocol 6)
   4. EIDS Tool should be used for other Chief Complaints when the caller offers information that would lead the dispatcher to suspect a respiratory-type illness.
   5. It is recommended that EMD dispatchers utilize the EIDS Tool upon completion of Key Questions and Determinant Code selection as to not delay any response.

EMD center actions for Positive EIDS Tool Findings
1. EMD centers will confidentially notify the responding unit(s) of the “PPE Alert” and must receive confirmation that they received the message.
PURPOSE
For Non-Emergency Medical Dispatch centers to implement enhanced screening of 9-1-1 callers who are suspected of Emerging Infectious Disease (EID) and to provide responding personnel with early notification of symptomatic patients so that proper personal protective equipment (PPE) can be utilized while providing care to patients.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Non-EMD REMSA EIDS Tool Utilization
1. When this policy is activated by the Riverside County Emergency Medical Services Agency (REMSA) Medical Director, all PSAP call centers, IFT call centers, or EMS System Provider call centers should utilize the REMSA Emerging Infectious Disease Surveillance (REMSA EIDS) Tool to collect information from callers arranging for patient transfer or patients experiencing flu like symptoms and to provide confidential notification to responding crew of PPE utilization.
2. For Emergency Medical Service (EMS) dispatch centers and Public Safety Answering Point (PSAP) that are not authorized EMD centers, REMSA policy 3307 Emerging Viruses, and associated annexes can be referenced for procedures regarding highly pathogenic emerging viruses that are suspected during emergency call taking and response.
3. REMSDA EIDS Tool should be used for other Chief Complaints when the caller offers information that would lead the dispatcher to suspect a respiratory-type illness.

Call center actions for Positive REMSA EIDS Tool Findings
1. Non-EMD centers, IFT call centers or EMS System Provider call centers will confidentially notify the responding unit(s) of the “PPE Alert” and must receive confirmation that they received the message.
2. Data from these call types will be submitted to public health partners or REMSA
During routine call questioning, if the patient's complaint is categorized as a **breathing problem** or **sick person**, follow the flow chart below.

**Is the patient complaining of fever OR cough OR shortness of breath?**

**YES**

Ask the patient if, in the last 14 days, they have come in contact with a person known to be infected with COVID-19 or who is currently undergoing testing for COVID-19.

**YES**

Notify responding personnel of the need to don the appropriate level of contact PPE.

**NO**

Ask the patient if, in the last 14 days, they have come in contact with a person known to be infected with COVID-19 or who is currently undergoing testing for COVID-19.

**NO**

No further action is required. Standard PPE is acceptable and treatment/transport to the closest, most appropriate receiving center is acceptable.
INTERIM 2019 NOVEL CORONAVIRUS (2019-nCoV) PATIENT UNDER INVESTIGATION (PUI) FORM

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<td>Gender □ M □ F □ Other</td>
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**PUI Criteria**

**Approximate date of symptom onset ____________**

*Does the patient have any of the following signs and symptoms (check all that apply)?*

- □ Fever
- □ Cough
- □ Sore throat
- □ Shortness of breath
- □ Chills
- □ Headache
- □ Muscle aches
- □ Vomiting
- □ Abdominal pain
- □ Diarrhea
- □ Other, specify__________________________

**In the 14 days before symptom onset, did the patient:**

*Have close contact with, or provide care for, a 2019-nCov PUI? □ Yes □ No □ Unknown*

*Have close contact with a laboratory-confirmed 2019-nCov case? □ Yes □ No □ Unknown*

- Was the case ill at the time of contact? □ Yes □ No □ Unknown
- Did the case originate in the United States? □ Yes □ No □ Unknown
- Did the case originate OUTSIDE of the United States? □ Yes □ No □ Unknown

**If yes to the question above: in which country was the case diagnosed?**

- □ China
- □ Iran
- □ Italy
- □ Japan
- □ South Korea
- □ Other ______________________

**Additional patient information**

*Is the patient a healthcare worker, or in a congregate living situation with, someone who has been in a healthcare facility (as a patient, worker or visitor) in any of the international areas with sustained (ongoing) transmission? □ Yes □ No □ Unknown*

**If yes to the question above, in which country did this occur?**

- □ China
- □ Iran
- □ Italy
- □ Japan
- □ South Korea

*Is the patient a member of a cluster of patients with severe acute respiratory illness (e.g., fever and pneumonia requiring hospitalization) of unknown etiology in which 2019-nCov is being evaluated? □ Yes □ No □ Unknown*

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If the patient complains of any of the symptoms identified at the beginning of this form, or if any of the questions with * next to them were answered affirmatively, be sure to advise all responding personnel to don the appropriate level of PPE prior to making patient contact.

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*Updated: 4/7/2020 8:23 AM*
PURPOSE
To define the procedures for the utilization of the closest, most appropriate ALS ambulance, in accordance with Emergency Medical Dispatch (EMD) and Medical Priority Dispatch System (MPDS). This policy shall apply to all 9-1-1 medical emergencies within the Mountain Plateau non-exclusive operating area (NEOA) including Idyllwild Fire Protection District (IFPD) exclusive operating area (EOA).

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22, Social Security, Division 9. Prehospital Emergency Medical Services
Riverside County Ambulance Ordinance 756

Nothing in this policy is intended to waive any rights the participating providers may have under the EMS Act, including any grandfathered rights IFPD has within their jurisdictional boundaries under Section 1797.201.

Ambulance Providers
Ambulance providers must adhere to all REMSA ordinances, policies, protocols, and procedures. The status and location of all ALS ambulances must be tracked utilizing a digital Computer Aided Dispatch (CAD) system with fully integrated automated vehicle locator (AVL)/global positioning system (GPS).

Prioritization and Allocation
The Riverside County Emergency Command Center (ECC) will utilize and comply with EMD and MPDS protocols for response prioritization and resource allocation within the Mountain Plateau NEOA including IFPD EOA.

Ambulance Staffing and Availability
ALS ambulances must be staffed with a minimum of one (1) certified EMT and one (1) Riverside County accredited paramedic at all times during the response. Ambulances will not be considered available for response if the minimum staffing level is not met at the time of dispatch.

Reporting and Continuous Quality Improvement (CQI)
Ambulance providers must provide a monthly performance report in the format specified by REMSA. This report shall be submitted to REMSA within the first 15 business days of the following calendar month.

Procedure for Closest Ambulance Response
1. When a 9-1-1 request for emergency medical response is received, the closest authorized ALS ambulance(s) will be identified by the CAD utilizing AVL/GPS.
2. The closest authorized ALS ambulance(s) will be assigned to the response.
3. The assigned ambulance(s) shall acknowledge the assignment and respond to the call.
4. The responding ambulance shall notify the Emergency Command Center (ECC)/Dispatch Center of all of the following:
   a. Unit En Route (eTimes.05)
   b. Unit Arrived on Scene (eTimes.06)
   c. Unit Left Scene (Transporting)(eTimes.09)
   d. Arrival at destination –Landing Zone (eTimes.10)
   e. Patient Arrived at Destination-Hospital (eTimes.11)
   f. Unit Cancelled (eTimes.14)
   g. Unit Back at Home Location (eTimes.15)
5. Patient Care Reports shall be completed pursuant to REMSA requirements.
PURPOSE
To facilitate radio communication interoperability, define the standard of radio frequencies for Emergency Medical Service (EMS) providers and describe the guidelines to be observed by prehospital and hospital emergency medical personnel operating in Riverside County.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Radio Etiquette
Radio traffic is expected to be professional at all times and to conform to the rules and regulations of the Federal Communications Commission (FCC). Use of frequencies for other than intra-agency or interagency communication or as authorized by those agencies during a specific incident is prohibited.
1. Clear text communication will be utilized during radio communications.
2. Use of the complete radio call sign is important in all radio communication and is particularly essential when interfacing with other agencies and on larger incidents.
   a. Call signs for private ambulance units will coincide with the respective unit or assignment preceded by resource type, e.g.:
      i. BLS units - “Permitted Provider 110”, “BLS Provider 22”
      ii. ALS units - “Permitted Provider Medic 345”
   b. First response agency units will use the assigned call signs designated by their respective agencies.

Radio Communication Procedures
All ambulance resources within the Riverside County operating area must maintain radio communications capability as specified in this policy at all times.
1. Two-way communications between EMS/ambulance dispatch centers and the responsible first response agency will occur for all emergency medical responses requiring a joint response.

2. The responsible first response agency will designate the response frequencies for use by the responding public safety resources and should include them as part of the initial dispatch information communicated to the EMS/ambulance dispatch center.

3. EMS/ambulance dispatch centers will inform the appropriate responsible first response agency of the responding unit’s identifier upon receipt of all dispatch information. This can happen concurrently with acknowledgement of receipt of the call.

4. The permitted provider dispatch center will notify the responding ambulance units of assigned frequencies and responding units will initiate communication and monitor the assigned public safety frequency throughout the response, during staging and while on-scene.

5. Two-way communication between on-scene incident command and ambulance units will occur as needed to facilitate a timely, safe, and effective emergency medical response.

6. All communications initiated by the on-scene Incident Commander to the responding ambulance unit will be acknowledged by the unit.
**Provider Responsibilities**
Permitted providers upon receipt of the current year radio programming plan provided by REMSA, must have all radios reprogrammed no later than 30 calendar days.

All permitted providers will have a VHF radio in, or immediately accessible to for the purpose of providing patient information to receiving facilities.

All permitted providers will have printed documents of the current programming available in the EMS resource list. Inspection of these documents include the current First response repeater map provided by County Fire every year the programming is published.

All permitted providers will be required to train on curriculum developed by the EMS Communications working group through the Riverside County Association of Fire Chiefs. This will include an initial training, and annual updates thereafter.

**Hospital Responsibilities**
Base hospitals will ensure that their medical control VHF radio and prehospital dedicated recorded telephone lines are fully functional and operational at all times to include regular checks of all systems.

Radio communication disruptions must be reported to surrounding hospitals and EMS dispatch centers, so that field resources may contact alternate hospitals. Additionally, the Riverside County EMS Agency will be notified of all communication disruptions.

All receiving hospitals will have a VHF radio in, or immediately accessible to, the emergency department for the purpose of receiving patient information from inbound ambulances.

All hospitals will have a ReddiNet terminal for interfacility and/or inter-county emergency / disaster communication. Hospitals will assure appropriate placement and operation of ReddiNet terminals to facilitate their readiness and usage. All essential information regarding hospital status and bed availability must be updated on a continuous basis for the rapid and efficient coordination of patient destinations in the event of a multi-patient incident.

**Specific Frequency Requirements**
All ambulance resources will be capable of communicating with the Emergency Communications Center (ECC) of the Riverside County Fire Department, EMS providers at the scene, local fire agencies, and with designated receiving hospitals in Riverside County.

All permitted ambulance providers must maintain applicable frequency use agreements with respective first response agencies that facilitate interoperable communications for 911, and potential disaster response.

All EMS vehicles will have immediate access to all frequencies listed in the Riverside County Radio Frequency Annex. EMS providers that need or require additional frequency coordination will contact Riverside County Information Technology Department, PSEC division for assistance.

The following are descriptions of the County and State licensed radio frequencies utilized within the Riverside County EMS System and their specified usage.

1. **The Riverside County Information Systems, Radio Division is responsible for the following frequencies:**
   a. **MEDNET 1 (155.2650, PL 110.9 hz, Encode/Decode)**
      This frequency is to be used by ambulances to advise hospital emergency departments (EDs) of inbound patients. Applicable DTMF Tones are included in the resource list to contact the appropriate receiving facilities.
b. **MEDNET 2** (155.2950, PL 110.9 Hz, Encode/Decode)
   This frequency is to be used by Ambulance Contractor to dispatch and coordinate emergency ALS ambulances within western Riverside county.
   i. North (Box Springs)
      Receive: 155.2950MHz 110.9Hz
      Transmit: 155.9100MHz D532N (Max Power 45-Watts)

2. Ambulance Contractor is responsible for the following frequencies, with permission given to first responder agencies to utilize them:
   a. **MEDNET 3** (155.3550, PL 110.9 Hz, Encode/Decode)
      This frequency is to be used by Ambulance Contractor (to include Hemet and Pass areas) to dispatch emergency ALS ambulances in the western section of the county. Repeater frequency information for MedNet 3 as listed below:
      i. South (Elsinore Peak)
         Receive: 155.3550MHz 110.9Hz
         Transmit: 155.9850MHz 118.8Hz

b. **MEDNET 4** (155.2050, PL 110.9 Hz, Encode/Decode)
   This frequency is to be used by Ambulance Contractor to dispatch emergency ALS ambulances in the eastern section of the county (desert cities). Repeater frequency information for MedNet 4 as listed below:
   i. Desert West (Whitewater)
      155.2050MHz 110.9Hz
      151.1150MHz 88.5Hz
   ii. Desert Indio (Indio Hill)
      155.2050MHz 110.9Hz
      151.1150MHz D114N
   iii. Desert Center (Chuckwalla)
      155.2050MHz 110.9Hz
      151.1150MHz D532N

3. The California State Office of Emergency Services (OES) is responsible for the following frequency:
   a. **CALCORD** (156.0750, Tone 6)
      CALCORD is a California Coordination frequency, provided by the California State Office of Emergency Services, which is a unit-to-unit frequency for on-scene coordination during Health Department declared emergencies and for medical management of multi-casualty / patient incidents. This frequency is often used for ground to air communication. The Riverside County Fire Department and the Riverside County Health Services Agency have permits to operate on this frequency.

4. **Public Safety Enterprise Communication** (700MHz Digital Trunk Radio System)
   The Public Safety Enterprise Communications System is a countywide digital trucked radio system used in Riverside County. It provides interoperable communications between county and city stakeholders. The system has been a cooperative effort between Riverside County Sheriff, Riverside County Fire, Riverside County, Economic Development Agency, the County Executive office, and Riverside County Information Technology Department.

5. The Riverside County Sheriff’s Office (S.O.) is responsible for the following frequencies. These frequencies are to be used by emergency medical services personnel to patch in and communicate with S.O. at the scene (S.O. utilizes a 700 MHz system).
   a. Riverside Sheriff VHF West (trans 154.8900, PL 110.9 Hz Enc/Decode, rvc 158.8500 carrier squelch)
   b. Riverside Sheriff VHF Desert (trans 158.7600, PL 110.9 Hz Encode/Decode, rvc 159.0900 carrier squelch)
   c. Riverside Sheriff VHF Blythe (trans 154.8900, PL 192.8 Hz Enc/Decode rvc 158.8500 carrier squelch)
6. The Hospital Association of Southern California (H.A.S.C.) is responsible for the following service: ReddiNet. This is a satellite and internet communications system linking hospitals, providers, and public health officials. It is used in the management of EMS daily operations (e.g., diversion status, MCI/MPI coordination) as well as being the major interfacility disaster communications system.

7. All ALS units will have the capacity to make base hospital contact for medical direction. Primary means of communication with the hospital will be either cellphone or VHF radio.

Waiver
The Riverside County EMS Agency reserves the right to grant waivers to the requirements of this policy on an as needed basis. The request for waiver must stipulate the reasons for the request and a statement as to the alternative method proposed for meeting the communications requirements being waived.

Communication Failure
This policy does not in any way modify requirements for notification procedures of receiving facilities or treatment modalities. Any communication failure with both online medical direction, or any other unusual event resulting in radio communication failure, must be reported to REMSA via the online communication failure reporting form, found here: https://forms.office.com/g/zFLpbDYHGh.
PURPOSE
To describe the capabilities of the ReddiNet, the responsibilities associated with its use, and its operation.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

ReddiNet Capabilities
The ReddiNet is used by the EMS system for operational communications, including: ambulance diversion status, multiple casualty / patient incident (MCI/MPI) management, disaster and public health assessment, system wide operational messaging / alerts / emergency communications, and bed capacity reporting. Other uses are not authorized.

ReddiNet Responsibilities
Each authorized dispatch and/or receiving center’s administrative staff and end users must understand the ReddiNet’s capabilities and be skilled in its operation as an operational and emergency communications tool.

Each center will maintain a ReddiNet system including:
1. Required hardware, software, and licensing
   a. Hardware must be dedicated to ReddiNet operations
2. Continuously online
   a. Problems reported/corrected immediately
      i. Center’s own information technology (IT) staff
      ii. ReddiNet Technical Support: (800) 440-7808
      iii. County of Riverside EMS Agency (REMSA) Duty Officer: (951) 712-3342
3. Noticeable
   a. Visual and audible alerts maintained appropriately
      i. Assigned staff must be able to see and hear alerts from work area
4. Accessible
   a. Dispatch center terminal: within the dispatch center
   b. Emergency department (ED) terminal: within or in close proximity to the ED
   c. Base hospital (BH) terminal: within or in close proximity to the radio room
   d. Additional and/or backup terminals: distributed appropriately
5. Continuously staffed
   a. At minimum, one skilled operator will be on duty and ready to man the ReddiNet at all times
   b. A ReddiNet terminal will be manned by an operator throughout major incidents and disasters

Each center will ensure that staff is trained in ReddiNet capabilities, responsibilities, and operations through:
1. Initial training
2. Annual refresher training
3. Frequent in-service training
4. Drills
   a. System-wide or regional drills must have REMSA approval
   b. All centers will participate in drills approved or conducted by REMSA
Operation of the ReddiNet

Typical uses of the ReddiNet are described below; sectioned by the major tabs appearing in the ReddiNet interface.

Please refer to the most current training ([https://www.reddinet.net/support/Home/Videos](https://www.reddinet.net/support/Home/Videos)) and/or the applicable user guide ([https://www.reddinet.net/support/Home/UserGuides](https://www.reddinet.net/support/Home/UserGuides)) for instructions. NOTE: you will need the specific username and password for your facility to access these materials.

1. Logging into the ReddiNet
   a. The ReddiNet will be accessed from both the dedicated terminal and additional/backup terminals

2. STATUS Tab
   a. The STATUS tab will be used as described in REMSA Policy #6103 (Ambulance Diversion)

3. MCI/MPI Tab
   a. During a Multi-Casualty / Patient Incident (MCI/MPI), the contacted base hospital will initiate the MCI/MPI and communicate with other authorized receiving centers by means of the ReddiNet
   b. All receiving centers will respond promptly to polls
   c. Receiving centers will complete data entry for all patients received from an MCI/MPI
   d. The base hospital initiating an MCI/MPI will end the MCI/MPI once all patients have arrived at a receiving center
   e. When necessary, REMSA may take over responsibility for managing an MCI/MPI
      i. The base hospital and the receiving centers will be notified via the ReddiNet

4. ASSESSMENT Tab
   a. The Riverside County Department of Public Health (DOPH) will initiate assessment polls related to:
      i. Surveillance for syndromes such as influenza like illness (ILI), severe acute respiratory syndrome (SARS), or organophosphate exposure
      ii. The impact of wildfires, earthquakes, and other major incidents on the healthcare and EMS systems
      iii. Other public health issues
   b. Both dispatch and receiving centers will promptly respond to assessment polls
      i. Initial responses may include estimates
      ii. These responses will be updated as more accurate information becomes available
   c. Responding to these polls does not relieve the center from the requirements of the California Code of Regulations (CCR), Title 17, Division 1, Chapter 4, Subchapter 1, Article 1, Section 2500.

5. MESSAGES Tab
   a. Both dispatch and receiving centers will use the email like ReddiNet messaging system for system wide operational messaging, alerts, and emergency communications; especially during major incidents and disasters.
      i. ReddiNet operators must, at minimum, be familiar with initiating and replying to messages

6. BED CAPACITY Tab
   a. Authorized receiving centers will update the HAvBED (Hospital Available Beds for Emergencies and Disasters) sub-tab as requested by REMSA and/or the DOPH
      i. ReddiNet operators at receiving centers must, at minimum, be familiar with completing the HAvBED update

7. DASHBOARD Tab
   a. The DASHBOARD tab will be consulted as necessary
<table>
<thead>
<tr>
<th>BED TYPE</th>
<th>BED / ROOM / WARD / FLOOR DEFINITION</th>
<th>PATIENT CENSUS INFORMATION NEEDED</th>
<th>HABED INFORMATION NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical / Surgical (MED/S)</td>
<td>MED/S beds / rooms / wards / floors include surge / expansion beds / rooms as well as any TELE beds / rooms temporarily assigned to a MED/S ward or floor. They are occupied by any patient who is waiting for, or is recovering from surgery, or who is currently being treated for any type of illness that requires no specialty monitoring. Patient to RN ratio is typically 5:1.</td>
<td>The total number of currently admitted patients occupying a bed in an area that meets the MED/S bed / room / ward / floor definition</td>
<td>The total number of unoccupied, staffed beds / rooms in an area that meets the MED/S bed / room / ward / floor definition</td>
</tr>
<tr>
<td>Telemetry (TELE)</td>
<td>TELE beds / rooms / wards / floors are commonly reserved for patients who are medically stable but require continuous cardiac monitoring. They are usually received as either a step-down / PCU or direct admit patient due to any number of acute and/or chronic cardiac issues. Patient to RN ratio is typically 4:1.</td>
<td>The total number of currently admitted patients occupying a bed in an area that meets the TELE bed / room / ward / floor definition</td>
<td>The total number of unoccupied, staffed beds / rooms in an area that meets the TELE bed / room / ward / floor definition</td>
</tr>
<tr>
<td>Adult Intensive Care or Adult Critical Care Unit (ICU / CCU)</td>
<td>ICU / CCU beds / rooms / wards / floors allow for intensive patient observation, usually utilizing a ratio of 1:1 but sometimes 2:1. Patients admitted to, and observed in, these beds / rooms / wards are typically critically ill, require significant levels of acute care and are 18 years of age or older. These patients may or may not be on a ventilator. NOTE: An ICU / CCU bed / room / ward / floor excludes nursing areas that provide step-down, intermediate care or telemetry only. Specialty care areas are also excluded (Examples include post-op areas, areas reserved for patients in need of acute dialysis services, areas where 1:1 care is not needed, etc.).</td>
<td>The total number of currently admitted patients occupying a bed in an area that meets the ICU / CCU bed / room / ward / floor definition</td>
<td>The total number of unoccupied, staffed beds / rooms in an area that meets the ICU / CCU bed / room / ward / floor definition</td>
</tr>
<tr>
<td>Pediatric Intensive Care Unit (PICU)</td>
<td>PICU beds / rooms / wards / floors allow for intensive patient observation, usually utilizing a ratio of 1:1 but sometimes 2:1. Patients admitted to, and observed in, these beds / rooms / wards are typically critically ill, require significant levels of acute care and are usually 32 weeks to 17 years old. These patients may or may not be on a ventilator. NOTE: PICU beds / rooms / wards / floors may include nursing areas that provide step-down or intermediate care only.</td>
<td>The total number of currently admitted patients occupying a bed in an area that meets the PICU bed / room / ward / floor definition</td>
<td>The total number of unoccupied, staffed beds / rooms in an area that meets the PICU bed / room / ward / floor definition</td>
</tr>
<tr>
<td>(Neonatal Intensive Care Unit (NICU)</td>
<td>NICU beds / rooms / wards / floors allow for intensive patient observation, usually utilizing a ratio of 2:1. Patients admitted to, and observed in, these beds / rooms / wards are typically critically ill, require significant levels of acute care and are usually younger than 32 weeks old. These patients may or may not be on a ventilator. Occasionally, these wards will also include well-baby nursery beds. NOTE: NICU beds / rooms / wards / floors may include nursing areas that provide step-down or intermediate care only.</td>
<td>The total number of currently admitted patients occupying a bed in an area that meets the NICU bed / room / ward / floor definition</td>
<td>The total number of unoccupied, staffed beds / rooms in an area that meets the NICU bed / room / ward / floor definition</td>
</tr>
<tr>
<td>Pediatrics (PEDS)</td>
<td>Peds beds / rooms / wards / floors are occupied by any patient who is waiting for, or is recovering from surgery, who is currently being treated for any type of illness that requires no specialty monitoring, is medically stable and is between the ages of 32 weeks and 17 years. Continuous cardiac monitoring may take place. Patient to RN ratio is typically 5:1.</td>
<td>The total number of currently admitted patients occupying a bed in an area that meets the PEDS bed / room / ward / floor definition</td>
<td>The total number of unoccupied, staffed beds / rooms in an area that meets the PEDS bed / room / ward / floor definition</td>
</tr>
<tr>
<td>Obstetrics and Gynecological (OB/GYN)</td>
<td>OB/GYN beds / rooms / wards / floors are occupied by any patient needing or requiring prenatal care who is ≥ 20 weeks pregnant, or who needs or requires peri- and/or post-partum care. These beds / rooms / wards / floors may be identified as Labor and Delivery (L&amp;D) units, L&amp;D delivery rooms / suites (private or otherwise), well-baby nurseries (not otherwise included in a separate NICU) or any combination of these terms.</td>
<td>The total number of currently admitted patients occupying a bed in an area that meets the OB/GYN bed / room / ward / floor definition</td>
<td>The total number of unoccupied, staffed beds / rooms in an area that meets the OB/GYN bed / room / ward / floor definition</td>
</tr>
<tr>
<td>Trauma</td>
<td>Trauma beds / rooms / wards / floors are typically reserved for and occupied by any admitted patient who has suffered from complex traumatic injuries including multiple fractures, traumatic brain injuries, internal injuries and/or lacerations. NOTE: This does not include patients being treated or held in an ED trauma bed / bay prior to transfer, inpatient admission or emergent surgery</td>
<td>The total number of currently admitted patients occupying a bed in an area that meets the Trauma bed / room / ward / floor definition</td>
<td>The total number of unoccupied, staffed beds / rooms in an area that meets the Trauma bed / room / ward / floor definition</td>
</tr>
<tr>
<td>Category</td>
<td>Description</td>
<td>The total number of currently admitted patients occupying a bed in an area that meets the <strong>Burn</strong> bed / room / ward / floor definition</td>
<td>The total number of unoccupied, staffed beds / rooms in an area that meets the <strong>Burn</strong> bed / room / ward / floor definition</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Burn</td>
<td>Burn beds / rooms / wards / floors are typically reserved for and occupied by any patient whose primary injury is burn related. Injuries may affect any body system but are usually dermatological, respiratory, musculoskeletal, ocular or ENT in nature. <strong>NOTE:</strong> This does not include patients being treated or held in an ED trauma bed / bay prior to transfer, inpatient admission or emergent surgery.</td>
<td>The total number of currently admitted patients occupying a bed in a room that meets the <em>Isolation</em> room-type definition</td>
<td>The total number of unoccupied, staffed rooms that meet the <em>Isolation</em> room-type definition</td>
</tr>
<tr>
<td>Isolation (ISO)</td>
<td>Isolation beds are located in rooms that are able to provide a negative pressure environment for patients with highly contagious airborne illnesses. Other room types (MED/S, ICU, etc.) may be converted into, and counted as, isolation rooms; however, to be defined as such they must have the ability to provide a negative pressure environment. Private rooms with portable HEPA filters, rooms with doors that are not self-closing and/or don’t provide an adequate seal and/or use common HVAC ducts are not examples of isolation rooms.</td>
<td>The total number of currently admitted patients occupying a bed in an area that meets the <strong>Psych</strong> bed / room / ward / floor definition</td>
<td>The total number of unoccupied, staffed beds / rooms in an area that meets the Isolation room-type definition</td>
</tr>
<tr>
<td>Psychiatric (Psych)</td>
<td>Psych beds / rooms / wards / floors are typically reserved for and occupied by any <strong>admitted</strong> patient whose primary complaint is behavioral, emotional and/or psychiatric in nature. These patients may or may not be on an involuntary psychiatric hold at any time during their stay. <strong>NOTE:</strong> This does not include patients being held the ED prior to transfer.</td>
<td>The total number of currently admitted patients occupying a bed in an area that meets the Psych bed / room / ward / floor definition</td>
<td>The total number of unoccupied, staffed beds / rooms in an area that meets the Psych bed / room / ward / floor definition</td>
</tr>
<tr>
<td>Operating Rooms (OR)</td>
<td>OR beds / suites / areas include any location in the facility where pre-, peri- and post-operation care and/or services occur. If applicable, this may also include ASC / outpatient surgery centers.</td>
<td>The total number of patients occupying a bed in a location that meets the OR bed / suite / area definition</td>
<td>The total number of unoccupied, staffed beds in a location that meets the OR bed / suite / area definition</td>
</tr>
<tr>
<td>Emergency Department (ED) Admission Hold</td>
<td>An ED Admission Hold is defined as a patient who is occupying a bed in the ED, or equivalent, on a temporary basis due to a lack of available beds in / on the floor / unit where they require definitive care services. Admission orders have already been written and movement out of the ED occurs as soon as an inpatient bed is available.</td>
<td>The total number of patients occupying a bed in the ED that meet the ED Admission Hold patient-type definition</td>
<td>N/A</td>
</tr>
<tr>
<td>Ventilators Available</td>
<td>Ventilators are defined as any anesthesia machine or portable/transport ventilator that can be used to support, assist or control respirations (inclusive of the weaning period) through the application of positive pressure to the airway when delivered via an artificial airway, specifically an oral/nasal endotracheal or tracheostomy tube. <strong>Note:</strong> Any ventilation or lung expansion device that delivers positive pressure to the airway via non-invasive means is not considered a ventilator unless positive pressure is delivered via an artificial airway.</td>
<td>N/A</td>
<td>Ventilators Available should include all units in all departments (including NICU and PICU) as well as any unit that is currently not being used due to malfunction or that is in need of repair / PM before being placed back into service.</td>
</tr>
</tbody>
</table>

Citations:

PURPOSE
To provide definitions and response time standards for data collection and reporting pursuant to the California Health & Safety Code Section 1797.227.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

STANDARDS

Definitions
NEMSIS eTimes:
eTimes.01 - PSAP Call Date/Time
eTimes.02 - Dispatch Notified Date/Time
eTimes.03 - Unit Notified by Dispatch Date/Time
eTimes.04 - Dispatch Acknowledged by Unit Date/Time
eTimes.05 - Unit En Route Date/Time
eTimes.06 - Unit Arrived on Scene Date/Time
eTimes.07 - Unit Arrived at Patient Date/Time
eTimes.08 - Transfer of EMS Patient Care Date/Time
eTimes.09 – Unit Left Scene Date/Time
eTimes.10 – Arrived at Destination Landing Area Date/Time
eTimes.11 – Patient Arrived at Destination Date/Time
eTimes.12 – Destination Patient Transfer of Care Date/Time
eTimes.13 – Unit Back in-Service Date/Time
eTimes.14 – Unit Cancelled Date/Time
eTimes.15 – Unit Back at Home Location Date/Time
eTimes.16 – EMS Call Completed Date/Time

Prehospital Response Time Intervals (see Prehospital Patient Time Continuum Chart below):
Alarm Answering Time – eTimes.01 to eTimes.02
Alarm Transfer Time – eTimes.01 to eTimes.02 (when the call is transferred to another designated entity)
Alarm Handling Time – eTimes.01 to eTimes.03
Alarm Processing Time – eTimes.02 to eTimes.03
Turnout Time – eTimes.03 to eTimes.05
Travel Time – eTimes.05 to eTimes.06
Intervention Time – eTimes.06 to eTimes.07
Total Response Time – eTimes.01 to eTimes.07

2203 — Response Time Standard
EMS Providers
All EMS providers are required to submit to REMSA verifiable NEMSIS compliant response time data through electronic Patient Care Reports (ePCR). Please refer to REMSA Patient Care Records Policy and REMSIS Authorization and Security Policies for further information on data utilization / security and ePCR management.

Response Time Data Utilization
REMSA will collect and use response time data for monitoring system performance, research, and quality improvement. The uniform and consistent use of system performance data will provide the strength and validity needed to make system improvements. Aggregate reports will be generated by REMSA and will be shared with EMS system stakeholders and the State EMS Authority.
PURPOSE
To outline the responsibilities of emergency medical service (EMS) first response agencies and their personnel operating within the purview of the Riverside County EMS Agency (REMSA).

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22, Social Security, Division 9, Prehospital Emergency Medical Services

First Response Agencies

First Response Agency
1. An agency responsible for providing EMS first response services including: emergency response, scene management, primary assessment, emergency stabilization, secondary assessment, patient disposition, patient management, re-assessment, and documentation.

2. The responsible local public safety agency, typically fire/rescue, is designated as the primary EMS “First Response Agency” within its jurisdiction.

3. The responsible local agency will ensure that EMS first response services are dispatched as needed within its jurisdiction.

4. The responsible local public safety agency will ensure that all necessary response information is transmitted to the appropriate REMSA authorized ALS transport service’s dispatch center.

First Response Personnel

1. Any paid or volunteer first response agency staff that are REMSA authorized as any of the following:
   a. CAL FIRE’s “First Responder” (FR)
   b. Emergency medical technician (EMT)
   c. Advanced emergency medical technician (AEMT)
   d. Paramedic (EMT-P)

Medical Management and Patient Care

1. The highest level of REMSA authorized first response personnel at scene (FR, EMT, AEMT, or EMT-P) are responsible for the medical management of an individual from patient contact / accepting transfer of care until transferring care to an EMS provider of an equal or higher REMSA authorized level.

2. The first response personnel will perform scene management, primary assessment, emergency stabilization, secondary assessment, patient disposition, patient management, re-assessment, and documentation as specified by the REMSA Treatment Protocols and Operational Policies.

3. The scope of practice and standard of care are set by the:
   a. California Code of Regulations, Title 22, Division 9
   b. REMSA Policy Manual
4. Meeting the standard of care requires a thorough knowledge of the principles taught in the following courses:
   a. Approved initial training program
      i. Proof of course completion required for REMSA authorization at all levels
   b. Cardio-Pulmonary Resuscitation (CPR) for the Professional Rescuer or Healthcare Provider
      i. Current proof of course completion required for REMSA authorization at all levels
   c. Pre-Hospital Trauma Life Support (PHTLS) or International Trauma Life Support (ITLS)
      i. Current proof of course completion required for REMSA authorization as an AEMT, or paramedic
   d. Advanced Cardiac Life Support (ACLS)
      i. Current proof of course completion required for REMSA authorization as a paramedic
   e. Pediatric Advanced Life Support (PALS) or Pediatric Education for Prehospital Professionals (PEPP)
      i. Current proof of course completion required for REMSA authorization as a paramedic
PURPOSE
To define occasions when a BLS ambulance may be used to transport a critical patient due to delayed arrival of the primary ambulance provider.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Use of Alternative Ambulance
1. Use of a BLS ambulance will be exercised only when expeditious transport is deemed critical for the survival of the patient and only when both the patient status and time criteria defined below are met.
   a. The on-scene ALS crew will provide ALS personnel and equipment to care for patient transports in BLS ambulance.
2. The initial responding ALS provider will perform a patient assessment and begin initial treatment(s). Expeditious transport of the patient is deemed critical if the initial assessment determines the patient to meet any of the following criteria:
   a. Persons suffering from a fragile or unmanageable airway / airway compromise. (e.g., foreign body airway obstruction (FBAO), bag-valve-mask (BVM)-assisted respirations, continuous suctioning)
   b. Persons experiencing an acute myocardial infarction (AMI) as confirmed by diagnostic changes on a 12-lead EKG.
   c. Persons showing rapidly deteriorating vital sign and/or deteriorating mental status.
   d. Persons meeting critical trauma patient (CTP) criteria AND who show signs of respiratory, circulatory, or neurological compromise as defined in 2.c. above.
3. If the patient meets one of the above criteria, AND the ALS transport unit has yet to arrive on scene, the on-scene ALS provider will query for an ETA of the responding ALS transport unit.
   a. If the response time given for a responding ALS transport unit falls outside the response time frame established by contract (time varies by location), the ALS transport dispatch center will query the availability and ETA of the closest approved BLS ambulance(s).
   b. If the initial responding ALS transport unit has an ETA greater than 10 minutes longer than the ETA of the BLS ambulance, the BLS ambulance will be dispatched by the ALS Transport Unit’s dispatch center and will respond Code 3.
   c. The ALS transporting unit will continue its response. Both transporting units will respond to the incident. Upon arrival of the first unit, the Incident Commander should consider canceling the ambulance still in route.
4. Acceptable BLS backup response ambulances are those of permitted providers who meet the requirements established by Riverside County Ordinance 756 and who have an EMS Agency approved subcontract with the approved ALS provider in the coverage area.
5. The EMS Agency will conduct a quality assurance review on all incidents utilizing this protocol. The review will include patient care concerns, scene management, and transport times. Additional QA/QI reviews will be conducted:
   a. By the EMS Provider agency that initiated the protocol.
   b. By the ALS Transport Agency that dispatched the BLS Transport unit.
   c. Through the County-wide CQI process.
PURPOSE
To establish the role, duties, and required equipment for fire personnel to operate in the capacity of Fireline Emergency Medical Technician (FEMT) or Fireline Emergency Medical Paramedic (FEMP) rendering care to assigned fireline personnel, either within Riverside County or, when requested through the mutual aid system, outside of the county. This policy is intended to integrate with FEMP ICS 223-11 (ICS Position Manual, Fireline Emergency Medical Technician Paramedic) and CICCS (California Incident Command Certification System) Qualification Guide.

AUTHORITY
- California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.204.]
- California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.220.]
- California Code of Regulations, Title 22, Division 9, Chapter 4, Article 5
- California Fire Service and Rescue Emergency Mutual Aid System, Mutual Aid Plan (2-12)

GUIDELINES
- California Incident Command Certification System (CICCS) Qualification Guide

Fireline
1. Emergency medical personnel are authorized to render care within their scope of practice as a designated FEMT or FEMP during wildland fires as long as they meet all of the following requirements:
   a. Currently certified EMT, or AEMT; or state licensed paramedic.
   b. Locally certified or accredited by the County of Riverside EMS Agency (REMSA).
   c. Authorized to function as a FEMT or FEMP by the employing fire agency.
   d. Assigned to perform as a FEMT or FEMP by the appropriate incident command.
2. Fireline agencies will adhere to the training required by FEMP ICS 223-11 and the CICCS Qualification Guide.
3. FEMT or FEMP personnel must adhere to REMSA policies and procedures. At no time may a FEMT or FEMP function outside of REMSA medical control as provided through written standing orders or base hospital orders.
4. Riverside County authorized FEMTs or FEMPs may carry medical equipment and supplies consistent with FEMP ICS 223-11 and listed in the REMSA Drug and Equipment List under the heading “Light Response”.
   a. It is not always possible to maintain standard minimum levels of drugs and equipment while on the fireline. The Drug and Equipment List heading “Light Response” reduces the minimum requirements based on non-vehicular and small vehicle operations.
   b. Reasonable variations may occur with consideration to weight, length of assignment, anticipated needs, and access to additional supplies.
5. REMSA authorized FEMTs or FEMPs must adhere to the following procedures, and out-of-area personnel operating within Riverside County should also be briefed on these procedures:
   a. The FEMT or FEMP must check in and obtain a briefing from the Logistics Section Chief or the Medical Unit Leader (MEDL) at the wildfire.
   b. Patient care documentation must be completed per REMSA policy.
   c. A copy of the Patient Care Report (PCR) or Patient Information Worksheet (PIW) will be provided to the MEDL and submitted as part of the incident archive.
   d. A copy of the PCR will also be provided to REMSA.
   e. Continuous quality improvement activities will be performed according to REMSA policy and the provider agency’s CQI procedures.
   f. Management of controlled substances must be performed per REMSA or, in the case of out-of-area personnel operating within Riverside County, the originating local EMS agency (LEMSA) policy.
PURPOSE
To establish criteria for permitting ambulance operations within Riverside County.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.200.]
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.222.]
County of Riverside Ordinance 756 (Ambulance Ordinance)

Initial Permit Application
To receive an ambulance service permit, the applicant must:
1. Complete and submit an interest letter in the form of an ambulance permit pre-application form. The form can be found here: https://rivcoems.org/Programs/Ambulance-Permits
2. Complete the Riverside County Emergency Medical Services Agency (REMSA) ambulance permit application.
3. Initial ambulance permit applications are accepted from July 1 thru September 30 each year. Completed application must be submitted to REMSA no later than September 30.
4. Each ambulance will utilize two-way communications equipment, as specified by REMSA, capable of direct two-way voice communications with the first response agencies and ALS transport services operating within the Riverside County EMS system; and with REMSA.
5. Each ground ambulance service must establish at least one ambulance station within Riverside County.
   a. Each ambulance based at that location must be available as a disaster resource within one hour of REMSA request.
   b. Each ambulance station will comply with all applicable zoning, building, and occupational health and safety regulations and will be sufficient for all personnel in accordance with all local, state, and federal regulations.
   c. Each ambulance station will be adequate to house the ambulance crews required for the ambulance(s) based at that location.
   d. Ambulance stations are subject to unannounced REMSA inspection.
6. Provide proof of current Commission on Accreditation of Ambulance Services (CAAS) accreditation.
   a. Private ambulance services that hold/held a current permit on April 1, 2015, must meet this requirement by April 1, 2017 (this grandfather clause will be removed at that time).
   b. Private ground ambulance services that also provide air ambulance services may accredit the service’s ground ambulances with the Commission on Accreditation of Medical Transport Systems (CAMTS) as a substitute for CAAS accreditation (CAAS does not accredit air ambulances).
   c. Public ambulance services are exempt from CAAS accreditation but are encouraged to obtain it.
7. Pass REMSA inspection of ambulance equipment and supplies.
8. Pay ambulance permit and unit fees as directed by County of Riverside Ordinance 756.
9. Meet all requirements identified in the ambulance permit application.
10. Comply with all rules and regulations.

Conditions of Permit
1. An ambulance service permit is valid from the date of issue and expires on June 30 each year.
2. All BLS services must establish an EMT AED program which meets or exceeds the requirements of REMSA Policy #5101 (EMT AED Service Provider).
3. Comply with all applicable provisions of Ambulance Ordinance 756; and with all regulations, policies and protocols established to carry out its provisions.
4. All permitted providers will meet operating standards as may be established by REMSA.
5. Maintain an EMT AED program which meets or exceeds the requirements of REMSA Policy #5101 (EMT AED Service Provider).
6. Maintain fully operational two-way communication equipment in each ambulance as specified by REMSA.
7. Maintain at least one ambulance station within Riverside County.
   a. Private ambulance services that hold/held a current permit on April 1, 2015, must meet this requirement by April 1, 2017 (this grandfather clause will be removed at that time).
   b. Private ground ambulance services that also provide air ambulance services may accredit the service’s ground ambulances with the Commission on Accreditation of Medical Transport Systems (CAMTS) as a substitute for CAAS accreditation (CAAS does not accredit air ambulances).
   c. Public ambulance services are exempt from CAAS accreditation but are encouraged to obtain it.
9. Comply with all requirements of the County of Riverside Ordinance 756 Section H.
10. The permit officer may deny the renewal of, suspend, or revoke a provider permit issued under the provisions of the County of Riverside Ordinance 756 when it has been found that the permit holder has violated one or more of the conditions set forth in Section M of the ordinance. This is based upon such facts or circumstances as may be known to the permit officer or discovered upon his or her conducting an investigation.
11. During mass casualty / patient incidents (MCI/MPI), the capability of the 911 ambulance providers to provide necessary prehospital emergency care and transportation may be insufficient for the number of casualties / patients. Therefore, it is necessary that all non-911 ambulances permitted in Riverside County be available to assist during an MCI/MPI. For this reason, each permitted provider will make available, and place into service, all available permitted units upon REMSA request. All permitted ambulance providers, in the event of an MCI/MPI, will:
   a. Provide immediate ambulance resource availability within Riverside County when requested by REMSA.
   b. Have an emergency response plan which includes a personnel call-back plan.
   c. Have trained all management and field personnel for compliance with any REMSA approved MCI/MPI Plan.
   d. Provide, within reason, immediate response to any polls or surveys from REMSA.
   e. Provide, within reason, equipment, facilities, and personnel as requested by REMSA.
   f. When disaster relief funding is available, the County of Riverside may assist the participating providers in seeking reimbursement for costs associated with any disaster. The County of Riverside will have no financial responsibility for these costs or charges.
12. When requested by REMSA the permitted agency or service will assign at least one fully staffed ambulance to participate in Riverside County organized disaster exercises. The request for participation will be provided in writing at least 30 days in advance. All costs associated with participation in disaster exercises will be the sole responsibility of the permitted agency or service.

Permit Renewal

1. Applications for renewal of an ambulance permit must be submitted to REMSA at least 60 days prior to expiration.
   a. Any application for renewal submitted less than 60 days prior to expiration is subject to a renewal fee increased by 20 percent.
PURPOSE
To outline the responsibilities of emergency medical service (EMS) transport services and their personnel operating within the purview of the Riverside County EMS Agency (REMSA).

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22, Social Security, Division 9. Prehospital Emergency Medical Services

Transport Services
Transport Service
1. Any REMSA authorized agency or service responsible for providing EMS transport services, including: emergency response, scene management, primary assessment, emergency stabilization, secondary assessment, patient disposition, transport, patient management, re-assessment, and documentation.

2. The transport service will ensure that EMS transport services are dispatched as requested by the responsible local public safety agencies.

Transport Personnel
1. Any paid or volunteer transport agency or service staff that are REMSA authorized as any of the following:
   a. Emergency medical technician (EMT)
   b. Advanced emergency medical technician (AEMT)
   c. Paramedic (EMT-P)

Medical Management and Patient Care
1. The highest level of REMSA authorized transport personnel at scene (EMT, AEMT, or EMT-P) are responsible for the medical management of an individual from patient contact / accepting the transfer of care until transferring care to an EMS provider of an equal or higher REMSA authorized level or arriving at an authorized receiving center.

2. Transport person will perform scene management, primary assessment, emergency stabilization, secondary assessment, patient disposition, transport, patient management, re-assessment, and documentation as specified by the REMSA Treatment Protocols and Operational Policies.

3. The scope of practice and standard of care are set by the:
   a. California Code of Regulations, Title 22, Division 9
   b. REMSA Policy Manual

4. Meeting the standard of care requires a thorough knowledge of the principles taught in the following courses:
   a. Approved initial training program
      i. Proof of course completion required for REMSA authorization at all levels
   b. Cardio-Pulmonary Resuscitation (CPR) for the Professional Rescuer or Healthcare Provider
      i. Current proof of course completion required for REMSA authorization at all levels
   c. Pre-Hospital Trauma Life Support (PHTLS) or International Trauma Life Support (ITLS)
      i. Current proof of course completion required for REMSA authorization as an AEMT, or paramedic
   d. Advanced Cardiac Life Support (ACLS)
      i. Current proof of course completion required for REMSA authorization as a paramedic
   e. Pediatric Advanced Life Support (PALS) or Pediatric Education for Prehospital Professionals (PEPP)
      i. Current proof of course completion required for REMSA authorization as a paramedic
PURPOSE
To define and establish criteria for permitting Advanced Life Support Interfacility Transport (ALS IFT) service providers within Riverside County.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.206.]
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.208.]
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.214.]
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.218.]
County of Riverside Ordinance 756 (Ambulance Ordinance)

Procedures
1. Application of Policy
   a. Authorization as an ALS IFT service provider is in addition to a Riverside County Emergency Medical Services Agency (REMSA) ambulance permit.
   b. ALS IFT service providers are authorized to conduct advanced life support (ALS) interfacility transports (IFT) that are requested by medical order of a California licensed physician or licensed medical provider representing a California authorized healthcare provider organization or agency.
   c. ALS IFT is those that can be conducted within the scope of practice of California licensed and REMSA accredited paramedic.
   d. Any ambulance provider agency that wishes to obtain authorization must submit ALS IFT ambulance permit application that addresses items of sections below to REMSA.

2. Criteria - General
   a. Agreement to provide ALS IFT service response on an uninterrupted daily, continuous 24-hour basis.
   b. Other than still alarms, ALS IFT service providers are not authorized to respond to Public Safety Answering Point (PSAP) generated 9-1-1 calls unless it is through a mutual aid request from a Riverside County Exclusive Operating Area (EOA) ambulance provider.
   c. No ALS IFT service provider shall advertise a seven (7) or (10) digit or 800 number to replace a request for a 9-1-1 emergency response.
   d. ALS IFT service provider shall, without delay, notify REMSA in advance any known or foreseeable interruptions, suspensions, delays in services or significant operational changes.
   e. ALS IFT service providers who choose to provide event medical services shall notify REMSA of scheduled event coverage and submit Incident Action Plan (IAP) within 30 days prior to the event or as soon as possible if the provider was requested for service less than 30 days from the event.
   f. ALS IFT service provider shall identify the number of ALS IFT ambulances in service and identify a geographical zone area (Northwest, Southwest, Central, San Jacinto, Pass, Desert, Mountain Plateau, and Palo Verde) for proposed ALS IFT services. (Reference Attachment A for zone areas)
   g. ALS IFT service providers shall participate and be available as a mutual aid backup 9-1-1 emergency and/or medical disaster resource for the Riverside County emergency medical services system.
   h. Comply with all applicable federal/state/local laws.

3. Criteria – Operational
   a. ALS IFT service providers shall develop and update policies and procedures manuals or standard operating procedures (SOP) that cover all aspects of ALS IFT service program.
   b. Medical Oversight
i. Comply with REMSA policies and procedures including but not limited to policy #6401 (Interfacility Transfer).
ii. ALS IFT service providers shall employ full or part-time (or per diem) physician advisor for medical oversight.
   1. ALS IFT service providers shall designate a physician advisor to conduct medical oversight over the ALS IFT service provider program.
   2. The physician advisor shall be a full or part-time physician licensed in the State of California and qualified by training and experience with recent, within last five (5) years, practice in an emergency or acute critical care medicine.
iii. ALS IFT service providers shall designate an ALS coordinator to oversee and manage the ALS IFT service provider program.
   1. ALS coordinator shall at minimum possess a valid CA State paramedic license or valid CA State Registered Nursing License and minimum of three years of prehospital and/or interfacility transport experience.
   2. The duties of an ALS coordinator shall at minimum perform the following but not limited to:
      a. ALS coordinator shall oversee initial and ongoing education and training for all medical personnel involved in the ALS IFT program.
      b. Develop and maintain a REMSA approved ALS IFT CQI plan as defined by REMSA policies and procedures.
      c. Assure that ALS IFT personnel adhere to BLS and ALS IFT Standing Orders approved by the REMSA Medical Director.
      d. Assure that ALS IFT personnel adhere to REMSA protocols, policies and procedures.
      e. Paramedics
         i. Maintain all necessary licenses and certification as identified by REMSA.
         ii. Maintain Riverside County paramedic accreditation as identified in REMSA policies.
         iii. ALS IFT service providers shall assure staff’s current paramedic license, accreditation, and certification as described in REMSA policy #3202 (Transport Services), through its maintenance program.
         iv. ALS IFT service providers shall submit for approval a paramedic accreditation program.
      d. Emergency Medical Technicians (EMT)
         i. All EMTs staffing ALS IFT ambulance shall complete “EMT Out-of-County Acknowledgment” application within Riverside County EMS Credentialing process if they obtained EMT certification outside of Riverside County.
         ii. ALS IFT service providers shall assure staff’s current EMT certification, license, and certification through its maintenance program.
      e. ALS IFT ambulance staffing
         i. Ambulance performing services under this policy shall be staffed according to Riverside County Ambulance Ordinance 756 – ALS Ambulance, REMSA policies, and REMSA EMS Plan.
      f. Employee health and wellness
         i. All training and education required by the Occupational Safety and Health Administration (OSHA) for EMS field personnel shall be adhered to at initial hire and annually thereafter.
      g. Facilities
         i. ALS IFT service providers shall deploy and operate its ambulances from a physical location within Riverside County. This facility will be sufficient to provide crew housing and vehicle re-supply.
      h. Development of required reporting policies
         i. Upon discovery, the ALS IFT service provider shall report to REMSA, or the REMSA Duty Officer if outside of business hours/days, immediately any instance in which:
            1. A patient dies, is injured, or is otherwise harmed due to actions of commission or omission by a member of the ALS IFT service provider;
            2. An authorized EMS response vehicle operated by the ALS IFT service provider is involved in a motor vehicle crash in which a patient, member of the crew or other person is killed or injured to the extent requiring hospitalization or care by a physician;
            3. EMS personnel are killed, or injured to the extent requiring hospitalization or care evaluation by a physician, while on duty;
            4. Patient care equipment fails while in use, causing patient harm;
            5. It is alleged that any member of the service has responded to an incident or treated a patient while under the influence of alcohol or drugs;
6. Any changes to the geographic area coverage for ALS IFT service provider.
7. The timely reporting of infectious disease exposures to other healthcare providers and facilities possibly exposed and methods for timely care and prophylaxis, as appropriate, for ALS IFT service provider and other service provider personnel.
8. ALS IFT service provider shall notify REMSA immediately of any expiration, suspensions or revocation of Commission on Accreditation of Ambulance Services (CAAS) accreditation.

4. Criteria - Communications
   a. Communication Center
      i. ALS IFT service providers shall operate a dispatch center and maintain all hardware and software necessary to receive and fulfill requests for ALS IFT services. ALS service providers shall be capable of receiving and replying to requests for ALS IFT service by voice and by Computer Aided Dispatch (CAD). ALS IFT service provider’s dispatch center shall be capable of dispatching all ambulance units to provide ALS IFT services.
      ii. ALS IFT service provider’s communication center shall operate uninterrupted daily, continuous 24-hour basis.
      iii. Radio communication
           1. ALS service providers shall be compliant with REMSA Policy #2201 (Radio Communication Standard).
           2. Unit Mobile Radios – ALS IFT service providers are responsible for the communications equipment on ambulances used in the performance of mutual aid back up of ALS 9-1-1 emergency and ALS IFT ambulance services.
           3. REMSA approved radio equipment shall be installed in conformance with existing REMSA policies prior to assignment.
           4. ALS IFT service providers shall operate communications equipment in conformance with all applicable rules and regulations of the Federal Communication Commission, and in conformance with all applicable REMSA policies and operating procedures.
           5. Base hospital/paramedic receiving hospital - Communications equipment used for an ambulance to hospital communication shall be configured so that personnel providing patient care are able to directly communicate with a base hospital or receiving hospital staff regarding the patient.
      vi. ALS IFT service provider shall conduct initial and ongoing training of ALS IFT personnel on the use of mutual aid radios including but not limited to:
           a. Accessing proper radio channels for mutual aid responses
           b. Training of annual update of VHF Radio Dot frequencies
           c. Proper radio etiquette
      iv. ALS IFT service provider must use criteria-based dispatch protocols approved by REMSA that determine the appropriate level for dispatching of incoming calls, including BLS level, ALS level, CCT level and referral to the 9-1-1 system for emergency medical service requests.
      v. ALS IFT service provider shall have and enforce written policies concerning authorization and protocols for an ALS IFT communication center to send a referral service when the service cannot respond.

5. Criteria – Continuous Quality Improvement
   a. Standard of care – ALS IFT service providers shall cooperate with REMSA and collaborate with EMS System participants to develop, implement and continuously improve clinical standards of care that optimize patient outcomes. ALS IFT service providers agree to continuously maintain the optimal effort to improve core indicators of quality service as established by REMSA with the goal to consistently provide excellent patient care and patient satisfaction.
   b. ALS IFT service providers shall comply with REMSA policy #7101 (CQI System) and #7102 (Unusual Occurrence / Incident Review Process).
   c. Maintain ALS medical equipment and supplies as defined in REMSA policy #3303 (Drug and Equipment List).

6. Criteria – Training and Education
   a. ALS IFT service providers shall develop and implement a clinical education and training program that is linked to its CQI plan and is congruent with REMSA EMS Quality Improvement Program (EQIP).
b. New hire/reclassification training requirements: Prior to a field assignment, all newly hired/reclassified EMT and paramedic employees shall complete an orientation that is designed to prepare them to be fully functioning EMTs or paramedics in Riverside County. This orientation shall be approved by REMSA and will include, but not be limited to:
   i. A review of all REMSA plans, programs, policies, protocols, and procedures as appropriate for the individual’s level of credentialing and job duties
   ii. Demonstration of skills proficiency as identified in REMSA policies, protocols, procedures, performance standards and EQIP
   iii. Geography and maps of Riverside County
   iv. Prehospital Receiving center (PRC), trauma centers and specialty care centers including designated patient catchment areas
   v. Mandated reporting and associated documentation
   vi. ICS 100, 200, 700 and 800 within 6 months of hire date.

c. On-going training requirements: Paramedics – required training may be modified by changes in REMSA plans, programs, policies, protocols, and procedures. Education/training required for paramedics include:
   i. Advanced Cardiac Life Support (ACLS) or equivalent as determined by REMSA.
   ii. Pediatric Advanced Life Support (PALS) or equivalent as determined by REMSA.
   iii. Prehospital Trauma Life Support (PHTLS) or equivalent as determined by REMSA.
   iv. CPR for the professional rescuer.
   v. Demonstration of skills proficiency as identified in REMSA policies, protocols, procedures, performance standards and EQIP
   vi. Quarterly 9-1-1 patient assessment ride-a-longs: ALS IFT service provider will partner/enter into agreement with ALS 9-1-1 emergency service provider to obtain paramedic(s) employed by ALS IFT service provider the necessary 9-1-1 patient contact experience (non-treatment) for paramedics employed by ALS IFT service provider. A minimum of 5 ALS patient contacts will be required per quarter per paramedic assigned to an ALS IFT service provider. Records of each ALS IFT’s paramedic ride-a-longs will be kept in personnel training files. The ride-a-long log should have at minimum a date of ride-along, hours of ride-along, 9-1-1 emergency service provider name and number of ALS patient contacts, and signature of authorized 9-1-1 emergency service provider’s paramedic provider. These records will be kept up to four years. Records will be subject to inspection upon REMSA’s request.

d. On-going training requirements: EMT - Required training may be modified by changes in REMSA plans, programs, policies, protocols, and procedures. Education/training required for EMTs include:
   i. CPR for the Professional Rescuer
   ii. Demonstration of skills proficiency as identified in REMSA policies, protocols, procedures, performance standards and EQIP
   iii. Training to support ALS IFT ambulance operations
      e. Driver’s Training/Safety
         i. All field personnel that operates emergency vehicles shall complete the following:
            1. Driver’s training that meets all of the components and requirements of CAAS accreditation.

7. Data Collection
   a. ALS IFT service providers shall comply with REMSA policy #7101 (CQI System) #7703 (REMSIS Authorization and Security).

   a. ALS IFT service provider ambulance permit will be concurrent with the Riverside County Ambulance permit cycle.
   b. ALS IFT service provider ambulance permit renewal shall be made within the Riverside County Ambulance permit renewal application process.
   c. All components set forth in the Riverside County Ambulance Ordinance 756 and its approval process shall apply to the ALS IFT service provider ambulance permit process.
d. Annual Evaluation – REMSA reserves the right to evaluate the performance of the ALS IFT service providers on an annual basis which may be done by a site visit, annual report submissions or any other methods deemed necessary by REMSA.

e. Ambulance service rates – ALS IFT service rates shall not be less than Centers for Medicare & Medicaid Services (CMS) allowable rates.

f. Observation and Inspections – REMSA may, at any time, and without notification, directly observe and/or inspect all aspects of the operations of the ALS IFT service providers.

g. ALS IFT service provider shall maintain current Commission on Accreditation of Ambulance Services (CAAS) in order to maintain the current status of ALS IFT service provider in Riverside County.

h. The REMSA medical director shall discontinue approval of ALS IFT service provider if that provider presents a threat to community health and safety.
DEFINITION
Nationally recognized supply limitation:
Nationally recognized supply limitations are determined by the Food and Drug Administration (FDA) and the status of any applicable medication will be listed as “Currently in Shortage” in their electronic portal (found here: https://www.accessdata.fda.gov/scripts/drugshortages/default.cfm). Before submitting a waiver request, their website should be referenced; waivers to operate outside of REMSA policy will not be approved if the medication in question is not listed.

PURPOSE
To permit and regulate the use of alternative medications and/or concentrations when the REMSA authorized “Standard” medications and/or concentrations cannot be obtained due to nationally recognized supply limitations.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Procedure
If REMSA-approved standard medications and/or concentrations (as documented on pages 16 – 18 of REMSA Policy #3303 (Drug and Equipment List)) cannot be obtained due to nationally recognized supply limitations and an alternative medication and/or concentration must be used, then:

1. REMSA must be notified by utilizing the REMSA Medication Waiver form, found here: https://forms.office.com/g/ZRPuzthLhM.
   a. Reliance on the inventory of only one (1) vendor is not a legitimate reason for approval to operate outside of compliance. Live links must be included in the submitted waiver for verification purposes.

2. Once verified and approved, agencies / organizations may then obtain the needed medication(s) in an alternative concentration and/or volume, as outlined in the REMSA policy #4102 (“Alternative Medications / Dosages”).

3. Should additional education regarding storage, handling, pre-administration mixing, proper administration techniques, side effects, medication disposal, etc. be required, it must be approved by the REMSA Medical Director prior to deployment.

4. As an additional safety measure, agencies / organizations should consider placing a high-visibility red sticker on each alternative medication vial and/or ampule.

5. Internal agency / organization policy must be followed for alternative medication distribution, notification of staff, and field calculation of volumes.

6. 100% continuous quality improvement (CQI) review of each use of an alternative medication is expected.

7. Notification of each use of an alternative medication must be reported to REMSA within seventy-two (72) hours, using the form found here: https://forms.office.com/g/ACStXc1FnA.
   a. Epinephrine diluted and administered at the point of care must be reports using this form: https://forms.office.com/g/2iYVT4Jf3Y
PURPOSE
To establish minimum requirements for compliance with the Controlled Substances Act and Title 22 by County of Riverside EMS Agency (REMSA) authorized or permitted first response agencies and/or transport services.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Controlled Substances
Approved Drug Enforcement Administration (DEA) Schedule II controlled substances for paramedic staffed first response agencies and/or transport services include:
1. Fentanyl (Sublimaze)
2. Morphine Sulfate

Approved DEA Schedule III-N controlled substances for paramedic staffed first response agencies and/or transport services include:
1. Ketamine (Ketalar)

Approved DEA Schedule IV controlled substances for paramedic staffed first response agencies and/or transport services include:
1. Diazepam (Valium)
2. Lorazepam (Ativan)
3. Midazolam (Versed)

All paramedic staffed first response agencies and/or transport services will have a formal agreement with a DEA registrant who is accountable for the agency or service’s compliance with the Controlled Substances Act. The DEA registrant will maintain a separate DEA registration number for each agency or service that they affiliate with, which will also be separate from the DEA registrant’s own practice and separate from any other legal entity. The DEA registrant will establish policies and procedures, compliant with this policy, for each agency or service they serve.

Security Mechanisms and Procedures
Ordering and Order Tracking
Each agency or service will order controlled substances from an authorized drug wholesaler or pharmacy. Schedule II controlled substances require use of the DEA Form 222 or the Controlled Substance Ordering System (CSOS). These orders will be delivered to the agency or service’s facility found at the single physical location and address noted on the DEA registrant’s license for that agency or service. Each order must be tracked in a manner that documents the parties requesting, ordering, and receiving controlled substances.

Receipt and Accountability
Controlled substances must be received at the agency or service’s facility found at the single physical location and address noted on the DEA registrant’s license for that agency or service. Personnel receiving controlled substances must be authorized by the DEA registrant and included on the agency or service’s roster of personnel authorized to manage controlled substances. A witness, also included on the roster of personnel authorized to manage controlled substances, must participate in the receipt and documentation of the controlled substance(s).
The receipt of controlled substances will be documented in the master supply log(s). The information documented will include: the date and time, the name of the medication, the strength, the quantity, the expiration date, the manufacturer, and the lot number. Signatures of the receiving party and the witness will be included as well.

**Master Supply Storage, Security and Documentation**

The master supply storage of controlled substances will be at the agency or service’s facility found at the single physical location and address noted on the DEA registrant’s license for that agency or service.

Follow the manufacturer’s guidelines regarding storage of each controlled substance:
1. Store within the required temperature range
   a. Lorazepam must be classified as “damaged” after 90 days of non-temperature-controlled storage
2. Protect from light as required

Master supply security measures will include:
1. Tamper evident containers
2. Storage under double lock
3. Witnessed counting, no less than once (1x) each month

Personnel handling and/or counting controlled substances at the master supply must be authorized by the DEA registrant and included on the agency or service’s roster of personnel authorized to manage controlled substances. A witness, included on the roster of personnel authorized to count controlled substances, must also participate in each count and its documentation.

Master supply documentation will include:
1. The agency or service’s roster(s) naming personnel authorized to:
   a. Manage controlled substances
   b. Count controlled substances
   c. Administer controlled substances
   d. Audit controlled substances
2. Copies of each DEA Form 222, including voided forms; purchase records; a log(s) of all controlled substances ordered, received, stored, damaged during storage, placed into service, damaged while in service, administered, wasted, restocked, returned to master supply, reverse distributed, and/or transferred or exchanged between agencies and/or services; and a patient care record / electronic patient care record (PCR/ePCR) or other appropriate report corresponding to each administration, waste, damage, or expiration
3. These records will be:
   a. Maintained at and/or electronically accessible from the master supply location
   b. Available for inspection within twenty-four (24) hours
   c. Retained for a period of no less than three (3) years

**Controlled Substance Labeling and Tracking**

Controlled substances must remain in the original manufacturer’s containers, Food and Drug Administration (FDA) compliant labels remaining intact and unaltered, until the time of administration.

Tracking of controlled substances will include documentation in the log(s) as described throughout this policy; including: the date and time of each transaction, the name of the medication, the strength, the quantity, the expiration date, the manufacturer, the lot number, and the party / parties involved, including signature(s). Additional methods of tracking are encouraged.
Vehicle Storage and Security
Make every reasonable attempt to follow the manufacturer’s guidelines regarding vehicle storage of each controlled substance while in service:
1. Avoid exposure to temperature extremes
   a. Lorazepam must be classified as “damaged” after ninety (90) days of non-temperature-controlled storage
2. Protect from light as required

Vehicle storage security measures will include:
1. Tamper evident containers
2. Storage under double lock
3. Witnessed counting with each change in personnel or change of shift but no less than once (1x) each day

Personnel handling and/or counting controlled substances while in service must be authorized by the DEA registrant and included on the agency or service’s roster of personnel authorized to administer controlled substances. A witness, preferably included on that same roster, but, at minimum, included on the roster of personnel authorized to count controlled substances, must also participate in each transaction and its documentation.

Documentation while in service will include:
1. A log(s) of all controlled substances accepted into service, counted, damaged while in service, received as re-stock, and/or returned to master supply
2. These records will be:
   a. Maintained with the medications until submitted to and/or electronically accessible from the master supply location
   b. Available for inspection within twenty-four (24) hours
   c. Submitted to master supply at least once (1x) per month
      i. Maintained as master supply documentation for a period of no less than three (3) years

Usage Procedures and Documentation
Controlled substances will be administered by paramedics only as authorized in the REMSA policy manual currently in effect at the time of the use. Personnel administering controlled substances must be authorized by the DEA registrant and included on the agency or service’s roster of personnel.

Usage documentation will include:
1. A log(s) of all controlled substances administered
2. A PCR/ePCR corresponding to each administration
3. These records will be:
   a. Maintained with the medications until submitted to and/or electronically accessible from the master supply location
   b. Available for inspection within twenty-four (24) hours
   c. Submitted to master supply at least once (1x) per month
      i. Maintained as master supply documentation for a period of no less than three (3) years

Reverse Distribution
Each agency or service will send expired and/or damaged controlled substances to an authorized reverse distributor. Schedule II controlled substances must be transferred using the DEA’s Form 222 or the Controlled Substance Ordering System (CSOS), while Schedule III – V controlled substances may be transferred by invoice. These reverse distributions will be sent to the reverse distributor’s facility found at the single physical location and address noted on the reverse distributor’s DEA license. Each reverse distribution must be tracked in a manner that documents the parties sending and receiving the expired and/or damaged controlled substances.
Personnel sending controlled substances for reverse distribution must be authorized by the DEA registrant and included on the agency or service’s roster of personnel authorized to manage controlled substances. A witness, also included on the roster of personnel authorized to manage controlled substances, must participate in the shipment and its documentation.

All reverse distribution will be documented in the master supply log(s) including: the date and time, the name of the medication, the strength, the quantity, the expiration date, the manufacturer, the lot number, and the sending party and the witness, including their signatures.

**Disposal**

Disposal of expired and/or damaged controlled substances will be performed as described above under “Reverse Distribution”.

Disposal of controlled substances residual to patient administration (“wasting”) will be performed following the agency or service’s internal policy.

Personnel wasting controlled substances must be authorized by the DEA registrant and included on the agency or service’s roster of personnel authorized to administer controlled substances. A witness, preferably included on that same roster, but, at minimum, included on the roster of personnel authorized to count controlled substances, must also participate in each waste and its documentation.

Wasting documentation will include:
1. A log(s) of all controlled substances wasted
2. A PCR/ePCR corresponding to each waste
3. These records will be:
   a. Maintained with the medications until submitted to and/or electronically accessible from the master supply location
   b. Available for inspection within twenty-four (24) hours
   c. Submitted to master supply at least once (1x) per month
      i. Maintained as master supply documentation for a period of no less than three (3) years

**Restocking Procedures**

Restocking of controlled substances will be performed following the agency or service’s internal policy that will include, at minimum, verification of administration, waste, damage, and/or expiration. If an agency or service chooses to require the retention and transport of used and/or damaged containers and/or sharps for restock purposes, internal policies will include the use of appropriate sharps containers.

Personnel providing restock of controlled substances must be authorized by the DEA registrant and included on the agency / service’s roster of personnel authorized to manage controlled substances. Personnel receiving restocked controlled substances must be authorized by the DEA registrant and included on the agency / service’s roster of personnel authorized to administer controlled substances. Both parties must participate in and document the restocking.

Restocking documentation will include:
1. A log(s) of all controlled substances restocked
2. A PCR/ePCR or other appropriate report corresponding to each administration, waste, damage, or expiration
3. These records will be:
   a. Maintained at and/or electronically accessible from the master supply location
   b. Available for inspection within twenty-four (24) hours
   c. Retained for a period of no less than three (3) years

**Transfer or Exchange Between Agencies and/or Services**

The transfer or exchange of controlled substances between agencies and/or services is discouraged.
If such a transfer or exchange is required, it must be:
1. Approved by the DEA registrants of both the supplying and the receiving agencies and/or services
2. Conducted between personnel included on each agency and/or service’s roster of personnel authorized to manage controlled substances; one (1) supplying and one (1) receiving
3. Witnessed by additional personnel included on each agency and/or service’s roster of personnel authorized to manage controlled substances; one (1) supplying and one (1) receiving
4. Documented by both the supplying and the receiving agencies and/or services, using the DEA Form 222 for Schedule II controlled substances and an invoice for Schedule III – V controlled substances, and a log(s) of all controlled substances transferred or exchanged

Transfer or exchange documentation will include:
1. Copies of each agency and/or service’s DEA Form 222 for Schedule II controlled substances
2. Copies of each agency and/or service’s invoice for Schedule III – V controlled substances
3. Each agency and/or service’s log(s) of all controlled substances transferred or exchanged
4. These records will be:
   a. Maintained at and/or electronically accessible from agency and/or service’s master supply location
   b. Available for inspection within twenty-four (24) hours
   c. Retained for a period of no less than three (3) years

Investigation and Mitigation of Suspected Tampering or Diversion
Drug inventories and all related records are subject to inspection by REMSA, the California EMS Authority (EMSA), the California State Board of Pharmacy, the DEA, and the Justice Department’s Bureau of Narcotic Enforcement.

Controlled Substance Testing
Testing personnel for controlled substances may be performed following the agency or service’s internal policy. Such policies may provide for controlled substance testing that is random, routine, or in response to suspected tampering and/or diversion. Any such policy should be developed in consultation with the DEA registrant and legal counsel.

Discrepancy Reporting
Each agency or service will follow its internal policy for reporting discrepancies including tampering, theft, loss, or diversion of controlled substances. This policy will be established by the DEA registrant and must include immediate verbal reporting followed by written reports and investigation. The DEA registrant must notify the DEA of the discrepancy within one (1) business day of discovery, using either the paper form #106, "Report of Theft or Loss of Controlled Substances," or online, here: https://apps2.deadiversion.usdoj.gov/TLR/login.xhtml;jsessionid=xEDfDcJ9E1ldndP_302gftqC9j1i_%ycYhvAJSF2.web2

Tampering, Theft and Diversion Prevention and Detection
Each agency or service’s internal policy regarding controlled substances will comply with this policy, with the intent to prevent and detect the tampering, theft, loss, and/or diversion of controlled substances. Areas to be addressed will include:
- Ordering and order tracking
- Receipt and accountability
- Master supply storage, security, and documentation
- Labeling and tracking
- Vehicle storage and security
- Usage procedures and documentation
- Restocking procedures
- Reverse distribution and disposal
- Transferring or exchange of controlled substances between agencies and/or services
- Discrepancy reporting, tampering, theft and diversion prevention and detection
- Controlled substance testing
- Usage audits
Additionally, reporting the suspected tampering, theft, and/or diversion of controlled substances to local law enforcement is encouraged. If the tampering, theft, and/or diversion of controlled substances is substantiated, written reports must be made within seventy-two (72) hours to REMSA and EMSA for action against the responsible party’s certification, license, or accreditation.

Usage Audits
Each agency or service will follow its internal policy for usage audits. These audits will:
1. Be conducted by the DEA registrant or designee
   a. Any such designee must be authorized by the DEA registrant and included on the agency or service’s roster of personnel authorized to audit controlled substances
2. Account for the current disposition of all controlled substances
   a. Include review of forms, purchase records, logs, and PCRs/ePCRs
   b. Identify and report discrepancies as required
3. Identify and investigate unusually high rates of administration
   a. Establish a baseline rate of controlled substance administration among all individuals authorized to administer controlled substances during the time period being audited
   b. Identify high outliers (i.e. - individuals with high rates of controlled substance administration)
   c. Review each administration of controlled substances performed by these high outliers for accountability and clinical appropriateness
4. Be performed at least quarterly. Records of these audits will be:
   a. Maintained at and/or electronically accessible from the agency or service’s quality assurance location
   b. Available for inspection within twenty-four (24) hours
   c. Retained for a period of no less than three (3) years
PURPOSE
To set equipment requirements for Riverside County EMS Agency (REMSA) authorized PSP, EMT, AEMT or EMT-P staffed light response, first response and ground transport operations.

APPLICATION
This policy applies to public safety personnel (PSP), emergency medical technicians (EMTs), advanced emergency medical technicians (AEMTs), paramedics (EMT-Ps), first response agencies and transport services that constitute the organized EMS system in Riverside County.

Drug and Equipment List
This policy lists the required and optional equipment, along with corresponding minimum quantities, to be carried by each EMS light response unit*, first response vehicle or ground transport vehicle operating in Riverside County. Operational needs should be met by carrying more than the minimum quantities. Any omitted equipment is not authorized except as required by law. Equipment trials must be authorized by the EMS Agency.

*Light response operations include authorized non-vehicular and small vehicle programs which access patients primarily by foot, bicycle, motorcycle, all-terrain vehicle, personal watercraft, or similar means.

Equipment:
- Optional equipment is identified by an “O”.
  - Any agency desiring to carry and/or utilize glucometers for their BLS personnel must submit the “Optional Equipment Authorization Application” (Found here) and receive approval by REMSA prior to purchase
  - Any agency desiring to carry and/or utilize mechanical CPR device with associated supplies must submit the “Optional Equipment Authorization Application” (Found here) and receive approval by REMSA prior to purchase
- Unauthorized equipment is identified by an “X”.

Medications:
- Alternative medications and/or concentrations are identified by an “A”.

Personal Documents
Personal documents are listed per staff person. These documents must be current and valid; and carried as originals, photocopies, or as digital reproductions.

<table>
<thead>
<tr>
<th>Personal Documents</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>First Responder/PSP Certificate</td>
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<td>CA EMT Certificate</td>
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</tr>
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<td>CA EMT-P License</td>
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<tr>
<td>CPR for the “Professional Rescuer” or “Healthcare Provider” Card</td>
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</tr>
</tbody>
</table>
### Personal Protective Equipment (PPE)

PPE is listed per individual and must be appropriately sized and fitted. All PPE must comply with OSHA/Cal OSHA regulations. Additionally:

1. Respiratory protection requires a P100 Mask or PAPR; or a SCBA with Cal OSHA variance. Requirements for respiratory protection include [Cal OSHA Title 8 Section 5144 Respiratory Protection](https://www.osha.gov/pls/oshaweb/owadisp.show_content?c=standard&p=sgndt000254), [Cal OSHA Title 8 Section 5199 Aerosol Transmissible Diseases](https://www.osha.gov/pls/oshaweb/owadisp.show_content?c=standard&p=sgndt000254), and 42 CFR 84; also refer to [NIOSH Respirator Selection Logic 2004](https://www.first-responder.com/respiratorselectionlogic.php) and [Selection and Use of Particulate Respirators Certified Under 42 CFR 84](https://www.osha.gov/pls/oshaweb/owadisp.show_content?c=standard&p=sgndt000254).

PPE for light response units is mainly left unspecified as it must be selected based on the environment and type of operation.

The standards for first response PPE will defer to the more stringent standards for firefighting operations.

PPE for ground transport personnel must meet the NFPA 1999 EMS Standards and/or these requirements:

1. Helmets for ground transport personnel must meet ANSI Z89.1-1986 (Class B) standards.
2. Eye protection for ground transport personnel must meet ANSI Z87.1, or the equivalent.
3. Multiple use footwear for ground transport personnel must meet ANSI Z41-1991, or the equivalent.

<table>
<thead>
<tr>
<th>Personal Protective Equipment</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
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<td>EMT-P</td>
</tr>
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</tr>
<tr>
<td>Hearing Protection</td>
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<tr>
<td>Multiple-Use Eye Protection</td>
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</tr>
<tr>
<td>Respiratory Protection</td>
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<td>1</td>
</tr>
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<td>Uniform Shirt/Pant or Jumpsuit</td>
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<td>Uniform Cold Weather Outerwear</td>
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<tr>
<td>High Visibility Garment</td>
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</tr>
<tr>
<td>Barrier Garment</td>
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<td>Medical Exam Glove</td>
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<td>Personal Equipment</td>
<td>Light Response</td>
<td>First Response</td>
<td>Ground Transport</td>
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<td>Work Glove</td>
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<td>Multiple-Use Footwear</td>
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<td>Pocket Mask</td>
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<tr>
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**Personal Equipment**

Personal equipment is listed per individual.

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<thead>
<tr>
<th>Personal Equipment</th>
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<th>Ground Transport</th>
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</thead>
<tbody>
<tr>
<td>Flashlight</td>
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<td>Trauma Shears</td>
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</table>

**Incident Command System**

Incident Command System (ICS) equipment is listed per unit or vehicle. Each item must be the most current revision.

<table>
<thead>
<tr>
<th>Incident Command System</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
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<tr>
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<td>Triage Tags</td>
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<td>Field Operations Guide (ICS 420-1)</td>
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<td>Packet of ICS Forms including:</td>
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### Cervical Spine Stabilization & Splinting

Cervical spine stabilization and splinting equipment is listed per unit or vehicle.

<table>
<thead>
<tr>
<th>Stabilization &amp; Splinting</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
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<tbody>
<tr>
<td></td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
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<td>Adjustable Pediatric C-Collar</td>
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<td>Adjustable Adult C-Collar</td>
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<td>Disposable Head Stabilizer</td>
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<td>Long Spine Board</td>
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<tr>
<td>15’ D-Ring Spine Board Strap</td>
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<tr>
<td>8 Point Plus Hook &amp; Loop Spine Board Strap (Spider Strap)</td>
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<td>Speed Clip Spine Board Straps (4 Speed Clip Straps per Board)</td>
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<td>Medical Duct Tape</td>
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<td>KED Type Extrication Device</td>
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<td>Pediatric Stabilization Device</td>
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<td>Scoop or “Special” Stretcher</td>
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<td>Vacuum Mattress, Pump, and Supplies</td>
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<td>Leg Splint</td>
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<td>Traction Splint(s) with Pediatric and Adult Capabilities</td>
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</table>

### Assessment

Assessment equipment is listed per unit or vehicle. Length based pediatric resuscitation tapes must be commercially available and standardized. For consistency and accuracy, colors / kgs should correspond to REMSA’s Pediatric Medication Dosing Resource.

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
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<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>Penlight</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Trauma Shears</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Stethoscope</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Infant BP Cuff</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Suction equipment is listed per unit or vehicle.

<table>
<thead>
<tr>
<th>Suction</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>Manually Powered Portable Suction Unit</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>with Collection Container and Supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Battery Powered Portable Suction Unit</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>with Collection Container, Battery/Batteries, and Supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wall Mount Suction with Collection Container and Supplies</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Suction Tubing</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rigid or Semi-Rigid Suction Tip</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bulb Syringe</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Suction Catheter 6 Fr.</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Suction Catheter 8 Fr.</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Suction Catheter 10 Fr.</td>
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</tbody>
</table>
BLS Airway

BLS airway equipment is listed per unit or vehicle.

<table>
<thead>
<tr>
<th>BLS Airway</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>Size 0 (50 mm) Oropharyngeal Airway (OPA)</td>
<td>0</td>
<td>0</td>
<td>O</td>
</tr>
<tr>
<td>Size 1 (60 mm) Oropharyngeal Airway (OPA)</td>
<td>0</td>
<td>0</td>
<td>O</td>
</tr>
<tr>
<td>Size 2 (70 mm) Oropharyngeal Airway (OPA)</td>
<td>0</td>
<td>0</td>
<td>O</td>
</tr>
<tr>
<td>Size 3 (80 mm) Oropharyngeal Airway (OPA)</td>
<td>0</td>
<td>0</td>
<td>O</td>
</tr>
<tr>
<td>Size 4 (90 mm) Oropharyngeal Airway (OPA)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Size 5 (100 mm) Oropharyngeal Airway (OPA)</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>14 Fr. Nasopharyngeal Airway (NPA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>16 Fr. Nasopharyngeal Airway (NPA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>18 Fr. Nasopharyngeal Airway (NPA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>20 Fr. Nasopharyngeal Airway (NPA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>22 Fr. Nasopharyngeal Airway (NPA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>24 Fr. Nasopharyngeal Airway (NPA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>26 Fr. Nasopharyngeal Airway (NPA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>28 Fr. Nasopharyngeal Airway (NPA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>30 Fr. Nasopharyngeal Airway (NPA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>32 Fr. Nasopharyngeal Airway (NPA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>34 Fr. Nasopharyngeal Airway (NPA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>36 Fr. Nasopharyngeal Airway (NPA)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lubricating Jelly Packets</td>
<td>0</td>
<td>0</td>
<td>0</td>
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</table>
**Laryngoscopy**
Laryngoscopy equipment is listed per unit or vehicle.

<table>
<thead>
<tr>
<th>Laryngoscopy</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>Laryngoscope Handle with Batteries</td>
<td>X</td>
<td>X</td>
<td>1</td>
</tr>
<tr>
<td>Extra Batteries</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>0 Straight Blade</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>1 Straight Blade</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>2 Straight Blade</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>3 Straight Blade</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>4 Straight Blade</td>
<td>X</td>
<td>X</td>
<td>1</td>
</tr>
<tr>
<td>1 Curved Blade</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>2 Curved Blade</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>3 Curved Blade</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>4 Curved Blade</td>
<td>X</td>
<td>X</td>
<td>1</td>
</tr>
<tr>
<td>Extra Bulbs (if applicable to device)</td>
<td>X</td>
<td>X</td>
<td>2</td>
</tr>
<tr>
<td>Video Laryngoscope and Supplies</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>Pediatric Magill Forceps</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>Adult Magill Forceps</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
</tbody>
</table>

**ALS Airway**
ALS airway equipment is listed per unit or vehicle.

<table>
<thead>
<tr>
<th>ALS Airway</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>6 mm Cuffed Endotracheal Tube</td>
<td>X</td>
<td>X</td>
<td>1</td>
</tr>
<tr>
<td>6.5 mm Cuffed Endotracheal Tube</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>7 mm Cuffed Endotracheal Tube</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>7.5 mm Cuffed Endotracheal Tube</td>
<td>X</td>
<td>X</td>
<td>1</td>
</tr>
<tr>
<td>8 mm Cuffed Endotracheal Tube</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
</tbody>
</table>
**Ventilation**

Ventilation equipment is listed per unit or vehicle. PSP equipment requirements apply to REMSA authorized providers.

<table>
<thead>
<tr>
<th>Ventilation</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>Neonate Resuscitator Mask</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Infant Resuscitator Mask</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pediatric Bag Valve Mask (BVM) Resuscitator Mask with O2 Reservoir</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adult Bag Valve Mask (BVM) Resuscitator Mask with O2 Reservoir</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Manometer for BVM</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pediatric Colorimetric CO2 Detector</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adult Colorimetric CO2 Detector</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>O2-RESQ™ CPAP Device with Flow Generator and Circuit, one (1) Medium Bi-Trac ED Mask, Head Strap and one (1) each 5 / 7.5 / 10 cmH2O Variable Valves</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>O2-RESQ™ Large Bi-Trac ED Mask</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>O2-RESQ™ 12.5 cmH2O Valve</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
</tbody>
</table>
### AED

AED equipment is listed per unit or vehicle. PSP equipment requirements apply to REMSA authorized PSP providers.

<table>
<thead>
<tr>
<th>AED</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>AED with Cables, Battery/Batteries, and Supplies</td>
<td>1 1 1</td>
<td>1 1 1</td>
<td>1 1 0</td>
</tr>
<tr>
<td>Adult AED Pads</td>
<td>2 2 2</td>
<td>2 2 2</td>
<td>2 2 0</td>
</tr>
<tr>
<td>Pediatric AED Pads (or Pediatric Capability</td>
<td>0 0 0</td>
<td>1 1 1</td>
<td>2 2 0</td>
</tr>
<tr>
<td>with Adult Pads)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disposable Prep Razor</td>
<td>1 1 1</td>
<td>1 1 1</td>
<td>1 1 0</td>
</tr>
</tbody>
</table>

### Resuscitation

Resuscitation equipment is listed per unit or vehicle.

<table>
<thead>
<tr>
<th>Resuscitation</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mechanical CPR Device with Supplies</td>
<td>0 0 0</td>
<td>X 0 0</td>
<td>0 0 0</td>
</tr>
</tbody>
</table>

### ECG

ECG equipment is listed per unit or vehicle.

<table>
<thead>
<tr>
<th>ECG</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECG Monitor with the following capabilities:</td>
<td>X X O</td>
<td>X X X</td>
<td>X X 1</td>
</tr>
<tr>
<td>• 12-Lead Acquisition &amp; Transmission</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Biphasic Defibrillation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cardioversion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Real-time CPR Feedback</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Transcutaneous Pacing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Waveform Capnography</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Must also have the following accessories:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cables, Battery / Batteries, and Supplies</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Oxygen (O₂)

O₂ equipment is listed per unit or vehicle. PSP equipment requirements apply to REMSA authorized PSP providers. Required O₂ must be carried in sufficient amounts:

**Portable O₂**
O₂ for at least 20 minutes @ 10 LPM, approximately:
- D Tank @ 1450 PSI
- Jumbo-D Tank @ 1000 PSI
- E Tank @ 925 PSI

**Mounted O₂**
O₂ for at least 60 minutes @ 10 LPM, approximately:
- M Tank @ 600 PSI
- G Tank @ 450 PSI
- H Tank @ 400 PSI

<table>
<thead>
<tr>
<th>Oxygen</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>Portable Oxygen System with O₂ Key, Liter Flow Regulator and Diameter Index Safety System Male (DISS-M) Connector</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Spare Portable O₂ Tank</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Wall Mount O₂ Regulator</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mounted Main O₂ Tank</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>O₂ Supply Hoses, Adaptors and Connectors</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Infant Non-Rebreather (NRB) O₂ Mask</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pediatric Non-Rebreather (NRB) O₂ Mask</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adult Non-Rebreather (NRB) O₂ Mask</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Infant Nasal Cannula</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pediatric Nasal Cannula</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Adult Nasal Cannula</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
## Wound Care

Wound care equipment is listed per unit or vehicle. PSP equipment requirements apply to REMSA authorized PSP Providers. REMSA approved tourniquets include those recommended by the Co-TCCC and the SWAT-T.

<table>
<thead>
<tr>
<th>Wound Care</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>3X3 Sterile Gauze Sponge</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4X4 Sterile Gauze Sponge</td>
<td>6</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Gauze Sponge</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rigid Eye Shield (<a href="#">Example</a>)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Eye Pad</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Abdominal Pad</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Trauma Dressing</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Occlusive Dressing</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Roller Gauze Bandage</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Triangular Bandage</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Hemostatic Dressing (<a href="#">EMSA approved only</a>)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Combat-Application-Tourniquet (C-A-T) ®</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Tourniquet</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Non-Adherent Dressing</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Self-Adherent Wrap</td>
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<td>2</td>
</tr>
<tr>
<td>Elastic Wrap</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transpore™ Tape</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cloth Tape</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Silk Tape</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposable Cold Pack</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Sterile Burn Sheet</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>1 Liter Normal Saline for Irrigation</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Eye Wash, Bottle</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Disposable OB Kit with Receiving Blanket and Head Cover</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
### Vascular Access

Vascular access equipment is listed per unit or vehicle.

<table>
<thead>
<tr>
<th>Vascular Access</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>Constricting Band</td>
<td>X</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>IV Start Kit</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Adhesive Band-Aid</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>IV Stabilization Dressing</td>
<td>X</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>IV Stabilization Splint</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Alcohol Swab</td>
<td>X</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Povidone Iodine Swab</td>
<td>X</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Chloraprep Swab</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>24 ga IV Catheter</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>22 ga IV Catheter</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>20 ga IV Catheter</td>
<td>X</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>18 ga IV Catheter</td>
<td>X</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>16 ga IV Catheter</td>
<td>X</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>14 ga IV Catheter</td>
<td>X</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Powered IO Device with Pediatric Capability</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Powered IO Device with Adult Capability</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>EZ-IO Power Driver</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>EZ-IO 15 ga / 15 mm – Pink Needle Set</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>EZ-IO 15 ga / 25 mm – Blue Needle Set</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>EZ-IO 15 ga / 45 mm – Yellow Needle Set</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>B.I.G. 18 ga – Red Pediatric IO Device</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>B.I.G. 15 ga – Blue Adult IO Device</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>Blood Collection Needle</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Blood Collection Needle Holder</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
**Medication Administration**

Medication administration equipment is listed per unit or vehicle.

<table>
<thead>
<tr>
<th>Medication Administration</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>Handheld Nebulizer with Mouthpiece, Reservoir, and Supply Tubing</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Pediatric Nebulizer Mask</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Adult Nebulizer Mask</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Nebulizer Tee with Adaptors</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Holding Chamber for MDI</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>MAD® Nasal-Mucosal Atomization Device</td>
<td>X</td>
<td>X</td>
<td>O</td>
</tr>
<tr>
<td>18 - 19 ga Hypodermic Needle</td>
<td>X</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>18 - 19 ga Filter Needle</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Blunt IV Injection Cannula for Needleless System</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>21 ga X 1 - 1.5” Hypodermic Needle</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>23 ga X 1 - 1.5” Hypodermic Needle</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>25 ga X 1” Hypodermic Needle</td>
<td>X</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>1 mL TB Syringe</td>
<td>X</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3 mL Syringe</td>
<td>X</td>
<td>0</td>
<td>O</td>
</tr>
<tr>
<td>5 mL Syringe</td>
<td>X</td>
<td>0</td>
<td>O</td>
</tr>
<tr>
<td>10 mL Syringe</td>
<td>X</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>20 mL Syringe</td>
<td>X</td>
<td>0</td>
<td>O</td>
</tr>
<tr>
<td>30 mL Syringe</td>
<td>X</td>
<td>0</td>
<td>O</td>
</tr>
<tr>
<td>or 60 mL Syringe</td>
<td>X</td>
<td>0</td>
<td>O</td>
</tr>
<tr>
<td>Carpuject® Holder</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Saline Lock Extension Set</td>
<td>X</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>
Transportation equipment is listed per vehicle. Restraints must be constructed of neoprene over nylon webbing with double hook and loop closure.

### Transportation

<table>
<thead>
<tr>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transportation</strong></td>
<td><strong>EMT</strong></td>
<td><strong>AEMT</strong></td>
</tr>
<tr>
<td>Ambulance Cot with 8+ Point Seat Belts</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cot Securing System</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Commercial Child Restraint System</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Collapsible (Folding) Stretcher</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Stair Chair</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rescue Basket / Litter / Stretcher / Similar Device</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Wrist Restraint</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Ankle Restraint</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Spit Sock (Patient Hood)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Waste Disposal

Waste disposal equipment is listed per unit or vehicle. PSP equipment requirements apply to REMSA authorized PSP Providers.

<table>
<thead>
<tr>
<th>Waste Disposal</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Waste Disposal</strong></td>
<td><strong>EMT</strong></td>
<td><strong>AEMT</strong></td>
<td><strong>EMT-P</strong></td>
</tr>
<tr>
<td>Mounted Sharps Container</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
### Drug and Equipment List

<table>
<thead>
<tr>
<th>Linen</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>Portable Sharps Container</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Covered Waste Container</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Waste Bag</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Biohazard Bag</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Emesis Basin</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Bed Pan</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Urinal</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Linen

Linen is listed per unit or vehicle. PSP equipment requirements apply to REMSA authorized PSP Providers.

### Documentation

Documentation equipment is listed per unit or vehicle. PSP equipment requirements apply to REMSA authorized PSP providers.

<table>
<thead>
<tr>
<th>Documentation</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>Mobile ePCR System with:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Portable Touchscreen Computer</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Magnetic Strips / Barcode Reader</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ECG Monitor Connectivity</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mobile Internet Access</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Clipboard</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pen</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Paper Release Forms</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Pencil</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Medications
Medications are listed per unit or vehicle. Of the authorized options, the preferred medication is in **bold** print.

<table>
<thead>
<tr>
<th>Medications</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adenosine</strong> — 12 mg / 4 mL Prefilled Syringe or Vial</td>
<td>X X O</td>
<td>X X X X 2</td>
<td>X X 2</td>
</tr>
<tr>
<td><strong>or</strong> Adenosine — 6 mg / 2 mL Prefilled Syringe or Vial</td>
<td>X X O</td>
<td>X X X 4</td>
<td>X X 4</td>
</tr>
<tr>
<td><strong>Albuterol 0.083%</strong> — 2.5 mg / 3 mL Vial</td>
<td>X O O</td>
<td>X X 3 3</td>
<td>X 3 3</td>
</tr>
<tr>
<td><strong>or</strong> Albuterol — 90 mcg / 1 Dose Metered Dose Inhaler / May substitute vials &amp; equipment</td>
<td>X 1 1</td>
<td>X X O O O</td>
<td>X O O</td>
</tr>
<tr>
<td><strong>or</strong> Levalbuterol — 1.25 mg / 0.5 mL Vial</td>
<td>X X (3)</td>
<td>X X (3)</td>
<td>X X (3)</td>
</tr>
<tr>
<td><strong>or</strong> Levalbuterol — 1.25 mg / 3 mL Vial</td>
<td>X X (3)</td>
<td>X X (3)</td>
<td>X X (3)</td>
</tr>
<tr>
<td><strong>or</strong> Levalbuterol — 0.63 mg / 3 mL Vial</td>
<td>X X (3)</td>
<td>X X (3)</td>
<td>X X (3)</td>
</tr>
<tr>
<td><strong>or</strong> Levalbuterol — 0.31 mg / 3 mL Vial</td>
<td>X X (6)</td>
<td>X X (6)</td>
<td>X X (6)</td>
</tr>
<tr>
<td><strong>or</strong> Albuterol with Ipratropium Bromide — 3 mg and 0.5 mg / 3 mL Vial</td>
<td>X X (A)</td>
<td>X X (A)</td>
<td>X X (A)</td>
</tr>
<tr>
<td><strong>Amiodarone</strong> — 150 mg / 3 mL Vial</td>
<td>X X 2</td>
<td>X X X 3</td>
<td>X X 3</td>
</tr>
<tr>
<td><strong>or</strong> Amiodarone — 900 mg / 18 mL Vial</td>
<td>X X 1</td>
<td>X X X 1</td>
<td>X X 1</td>
</tr>
<tr>
<td><strong>Aspirin</strong> — 81 mg / 1 Tablet, Chewable Tablet in Packet</td>
<td>X 4 4</td>
<td>X X 8 8</td>
<td>X 8 8</td>
</tr>
<tr>
<td><strong>or</strong> Aspirin — 81 mg / 1 Tablet Multi-dose Chewable Tab. Bottle</td>
<td>X 1 1</td>
<td>X X 1 1</td>
<td>X 1 1</td>
</tr>
<tr>
<td><strong>Atropine</strong> — 1 mg / 10 mL Prefilled Syringe</td>
<td>X X 1</td>
<td>X X X 1</td>
<td>X X 1</td>
</tr>
<tr>
<td><strong>or</strong> Atropine — 0.5 mg / 5 mL Prefilled Syringe</td>
<td>X X 2</td>
<td>X X X 2</td>
<td>X X 2</td>
</tr>
<tr>
<td><strong>or</strong> Atropine — 1 mg / 1 mL Ampule or Vial</td>
<td>X X 1</td>
<td>X X X 1</td>
<td>X X 1</td>
</tr>
<tr>
<td><strong>Atropine</strong> — 8 mg / 20 mL Vial</td>
<td>X X O</td>
<td>X X X 1</td>
<td>X X 1</td>
</tr>
<tr>
<td><strong>or</strong> Atropine — 1 mg / 1 mL Ampule or Vial</td>
<td>X X O</td>
<td>X X X 8</td>
<td>X X 8</td>
</tr>
<tr>
<td><strong>Calcium Chloride 10%</strong> — 1 g / 10 mL Prefilled Syringe</td>
<td>X X O</td>
<td>X X X 1</td>
<td>X X 1</td>
</tr>
<tr>
<td><strong>Dextrose 10%</strong> — 25 g / 250 mL IV Bag</td>
<td>X 1 1</td>
<td>X X 2 2</td>
<td>X 2 2</td>
</tr>
<tr>
<td><strong>or</strong> Dextrose 50% — 25 g / 50 mL Prefilled Syringe or Vial</td>
<td>X 1 1</td>
<td>X X 2 2</td>
<td>X 2 2</td>
</tr>
<tr>
<td>Drug</td>
<td>Quantity</td>
<td>Format</td>
<td>Amount</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>or Dextrose 25% — 2.5 g / 10 mL Prefilled Syringe</td>
<td>X 10</td>
<td>10</td>
<td>X</td>
</tr>
<tr>
<td>or Dextrose 10% — 1 g / 10 mL Prefilled Syringe</td>
<td>X 25</td>
<td>25</td>
<td>X</td>
</tr>
<tr>
<td>Diphenhydramine — 50 mg / 1 mL Vial or Carpuject®</td>
<td>X X 1</td>
<td>X X X</td>
<td>X 1</td>
</tr>
<tr>
<td>Epinephrine 1:1,000 — 1 mg / 1 mL Vial or Ampule</td>
<td>X 1</td>
<td>1</td>
<td>X X 1</td>
</tr>
<tr>
<td>or Epi. 1:1,000 — 30 mg / 30 mL Vial or “EpiPen” / Auto-Injector. — 0.3 mg / 0.3 mL</td>
<td>X 1</td>
<td>1</td>
<td>X X 1</td>
</tr>
<tr>
<td>or Epi. 1:10,000 — 1 mg / 10 mL Prefilled Syringe with Carpuject®</td>
<td>X X 2</td>
<td>X X X</td>
<td>X 3</td>
</tr>
<tr>
<td>Glucagon / Glucagen — 1 mg / 1 mL, Vial of Glucagon Powder + Vial of Diluent</td>
<td>X 1</td>
<td>1</td>
<td>X X 1</td>
</tr>
<tr>
<td>Glucose Gel — 1 Container</td>
<td>1 1</td>
<td>X 1</td>
<td>1 1</td>
</tr>
<tr>
<td>Ipratropium Br. — 0.5 mg / 2.5 mL Vial</td>
<td>X X 0</td>
<td>X X X</td>
<td>X 1</td>
</tr>
<tr>
<td>Lidocaine 2% — 100 mg / 5 mL Prefilled Syringe</td>
<td>X X 0</td>
<td>X X X</td>
<td>X 1</td>
</tr>
<tr>
<td>or Lidocaine 2% — 400 mg / 20 mL Vial</td>
<td>X X 0</td>
<td>X X X</td>
<td>X 1</td>
</tr>
<tr>
<td>Magnesium Sulfate — 5 g / 10 mL Prefilled Syringe or Vial</td>
<td>X X 0</td>
<td>X X X</td>
<td>X 1</td>
</tr>
<tr>
<td>or Magnesium Sulfate — 1 g / 2 mL Vial</td>
<td>X X 0</td>
<td>X X X</td>
<td>X 5</td>
</tr>
<tr>
<td>or Magnesium Sulfate - 4 g / 100 mL IV Bag</td>
<td>X X 0</td>
<td>X X X</td>
<td>X 1</td>
</tr>
<tr>
<td>Naloxone — 2 mg / 2 mL Prefilled Syringe or Vial</td>
<td>X 1</td>
<td>1</td>
<td>X LOSOP</td>
</tr>
<tr>
<td>or Naloxone — 4 mg / 10 mL Vial</td>
<td>X 1</td>
<td>1</td>
<td>X X 2</td>
</tr>
<tr>
<td>or Naloxone — 0.4 mg / 1 mL Prefilled Syringe, Vial or Carpuject®</td>
<td>X 5</td>
<td>5</td>
<td>X X 20</td>
</tr>
<tr>
<td>or Naloxone — 4 mg / 0.1 mL, REMSA Approved Intranasal Delivery Device</td>
<td>X X X</td>
<td>LOSOP</td>
<td>X X X</td>
</tr>
<tr>
<td>Nitroglycerin — 0.4 mg / 1 Dose, Multidose Spray or Bottle of Tab.</td>
<td>X 1</td>
<td>1</td>
<td>X X 1</td>
</tr>
<tr>
<td>Nitro. Paste 2% — 1 g / 1 Inch, Packet with Paper Applicators</td>
<td>X X 0</td>
<td>X X X</td>
<td>X 2</td>
</tr>
<tr>
<td>or Nitro. Paste 2% — 30 g / 1 Tube, with Paper Applicators</td>
<td>X X 1</td>
<td>X X 1</td>
<td></td>
</tr>
<tr>
<td>or Nitro. Paste 2% — 60 g / 1 Tube, with Paper Applicators</td>
<td>X X 1</td>
<td>X X 1</td>
<td></td>
</tr>
<tr>
<td>Normal Saline 0.9% — 1000 mL IV Bag</td>
<td>X 1</td>
<td>1</td>
<td>X X 2</td>
</tr>
<tr>
<td>or Normal Saline 0.9% — 500 mL IV Bag</td>
<td>X 2</td>
<td>2</td>
<td>X X 4</td>
</tr>
<tr>
<td>or Normal Saline 0.9% — 250 mL IV Bag</td>
<td>X 4</td>
<td>4</td>
<td>X X 8</td>
</tr>
</tbody>
</table>
Normal Saline 0.9% — 50 mL IV Bag | X | X | O | X | X | X | 1 | X | X | 1
Normal Saline 0.9% — 10 mL Prefilled Syringe or Vial | X | X | O | X | X | X | 2 | X | X | 2
*or Normal Saline 0.9% — 5 mL Prefilled Syringe or Vial | X | X | O | X | X | X | 4 | X | X | 4
Ondansetron — 4 mg / 2 mL Prefilled Syringe or Vial | X | X | O | X | X | X | 1 | X | X | 1
*or Ondansetron — 40 mg / 20 mL Vial | X | X | O | X | X | X | 1 | X | X | 1
Ondansetron — 4 mg / 1 Oral Disintegrating Tablet (ODT) | X | X | O | X | X | X | 1 | X | X | 1
Sodium Bicarbonate 8.4% - 50 mEq / 50 mL Prefilled Syringe or Vial | X | X | O | X | X | X | 1 | X | X | 1
*or Sodium Bicarbonate 8.4% - 10 mEq / 10 mL Prefilled Syringe or Vial | X | X | O | X | X | X | 5 | X | X | 5
Tranexamic Acid 1 gram/10 mL Vial | X | X | O | X | X | X | 1 | X | X | 1

*5 mL NS prefilled syringes are not permitted for use when medication administration is required. They must be drawn into a 10 mL syringe first.

**Controlled Substances**

Controlled substances are listed per unit or vehicle. Of the authorized options, the preferred medication is in **bold** print. Minimum par levels required at all times:

<table>
<thead>
<tr>
<th>Controlled Substances</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Fentanyl</strong> — 100 mcg / 2 mL Ampule, Vial, or Carpuject®</td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>or Fentanyl — 100 mcg / 5 mL Ampule, Vial, or Carpuject®</td>
<td>X</td>
<td>X</td>
<td>1</td>
</tr>
<tr>
<td>or Fentanyl — 100 mcg / 10 mL Ampule, Vial, or Carpuject®</td>
<td>X</td>
<td>X</td>
<td>1</td>
</tr>
<tr>
<td><strong>Ketamine</strong> — 500 mg / 10 mL Ampule, Vial or Carpuject®</td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>or Ketamine — 50 mg / 1 mL Ampule, Vial, or Carpuject®</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>or Ketamine — 200 mg / 20 mL Ampule, Vial, or Carpuject®</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td>or Ketamine — 500 mg / 5 mL Ampule, Vial, or Carpuject®</td>
<td>X</td>
<td>X</td>
<td>0</td>
</tr>
<tr>
<td><strong>Midazolam</strong> — 5 mg / 1 mL Ampule, Vial or Carpuject®</td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>or Midazolam — 10 mg / 2 mL Ampule, Vial, or Carpuject®</td>
<td>X</td>
<td>X</td>
<td>2</td>
</tr>
<tr>
<td>or Midazolam — 5 mg / 5 mL Ampule or Vial</td>
<td>X</td>
<td>X</td>
<td>2</td>
</tr>
<tr>
<td>or Lorazepam — 4 mg / 1 mL Ampule, Vial, or Carpuject®</td>
<td>X</td>
<td>X</td>
<td>A</td>
</tr>
<tr>
<td>or Lorazepam — 2 mg / 1 mL Ampule, Vial, or Carpuject®</td>
<td>X</td>
<td>X</td>
<td>A</td>
</tr>
<tr>
<td>or Diazepam — 10 mg / 2 mL Ampule, Vial, or Carpuject®</td>
<td>X</td>
<td>X</td>
<td>A</td>
</tr>
<tr>
<td><strong>Morphine Sulfate</strong> — 10 mg / 1 mL Ampule, Vial or Carpuject®</td>
<td>X</td>
<td>X</td>
<td>A</td>
</tr>
</tbody>
</table>
CDC Medications

CDC medications are listed per unit or vehicle. Of the authorized options, the preferred medication is in **bold** print. Note that these medications are for administration to patients; and that these same medications when listed under Personal Protective Equipment are for personal use.

<table>
<thead>
<tr>
<th>CDC Medications</th>
<th>Light Response</th>
<th>First Response</th>
<th>Ground Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
</tr>
<tr>
<td>DuoDote Nerve Agent Antidote Kit</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>or Mark I Nerve Agent Antidote Kit</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

Cardiac Monitor Specification

Attributes/capabilities for Cardiac Monitor, Pacemaker, Defibrillator


Physical Attributes

<table>
<thead>
<tr>
<th>Feature</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six (6) foot lead set with removable precordial lead connection</td>
<td></td>
</tr>
<tr>
<td>Multifunction cable with hands-free MFP capability</td>
<td></td>
</tr>
<tr>
<td>CPR diagnostic qualitative and quantitative feedback and reporting capability (*not optional – additional specification below)</td>
<td></td>
</tr>
<tr>
<td>A/C power adapter/battery charger</td>
<td>Full functionality should be present while device is functioning with A/C power</td>
</tr>
<tr>
<td>Lithium-ion batteries, two/device, must be smart batteries lasting minimum of 3 hours each</td>
<td></td>
</tr>
<tr>
<td>Battery charging device, minimum of 2 bay/bank charger.</td>
<td>Charging support systems must recalibrate and test batteries in addition to charging.</td>
</tr>
<tr>
<td>Minimum one (1) year EMS warranty</td>
<td></td>
</tr>
<tr>
<td>Biphasic waveform with hands-free defibrillation functionality with adult and pediatric capability.</td>
<td>Energy setting options must be compatible with applicable REMSA protocols.</td>
</tr>
<tr>
<td>Functionality to operate in Automated External Defibrillator or Semi-Automated External defibrillator mode</td>
<td></td>
</tr>
<tr>
<td>Functionality to provide synchronized cardioversion at multiple age-appropriate energy levels.</td>
<td>Energy setting options must be compatible with applicable REMSA protocols.</td>
</tr>
<tr>
<td>Adjustable and controllable amperage and rate for transthoracic pacing with adult and pediatric capability</td>
<td></td>
</tr>
<tr>
<td>Ability to operate in fixed, demand, and overdrive modes</td>
<td></td>
</tr>
<tr>
<td>Capability to detect and indicate presence of internal pacemaker</td>
<td></td>
</tr>
<tr>
<td>Capability to print field user machine test/internal diagnostic test results</td>
<td></td>
</tr>
<tr>
<td>Display, select and/or cascade multiple waveforms simultaneously (e.g.: paddles/MFP, Lead I, Lead II, Lead III, capnography, SpO2 Photoplethysmograph (pleth) – all are required as options for display)</td>
<td></td>
</tr>
<tr>
<td>Programmable audio and visual alert systems for fatal arrhythmias, VF/VT at a minimum</td>
<td></td>
</tr>
<tr>
<td>Separate programmable alerts for biometric parameters of NIBP, heart rate, respiratory rate, etCO2, SpO2</td>
<td></td>
</tr>
<tr>
<td>Record, display, and import into the REMSA ePCR system: the etCO2 value – waveform and quantitative measure. In-line and Side-Stream capabilities are required, capability for use on the intubated and non-intubated patient.</td>
<td></td>
</tr>
<tr>
<td>Record, display, and import into the REMSA ePCR system: SpO2 value – waveform and quantitative measure. All patient age ranges must be accommodated in disposable/hard wired probes, and diagnostic feedback</td>
<td></td>
</tr>
</tbody>
</table>
Drug and Equipment List

### Physical Attributes

- **Record, display, and import into the REMSA ePCR system:** Non-invasive blood pressure measure accounting for vibration resistance both at vehicle rest and vehicle motion. All patient age ranges must be accommodated in disposable/hard wired cuffs. Cuff sizes must meet REMSA Policy for Drug and Equipment List. (*NIBP is an optional component and, if purchased, specification must be met)

- **Calculate and display Mean Arterial Pressure reading**

- **Record, display, and import temperature* readings into the REMSA ePCR system.** Device must have a minimum of one (1) temperature channel and must be able to monitor skin and/or ambient temperature, esophageal temperature, and rectal temperature.
  - Temperature must measure from 25°C to 45°C at minimum
    - Temperature monitoring is an optional component and, if purchased, specification above must be met.

- **Record, display, and import into the REMSA ePCR system: Non-invasive carbon monoxide* waveform and quantitative measure (spCO).**
  - Display, print, and mark in events and/or code summary carbon monoxide waveforms and quantitative values. Probe for measurement shall cover adult and pediatric patients. Precision and accuracy must be at least within three (3) digits (+/-) when spCO is 0-10%.
    - Carbon monoxide (spCO) monitoring is an optional component and, if purchased, specification above must be met.

- **Record, display, and import into the REMSA ePCR system: Non-invasive methemoglobin* quantitative levels (spMet).**
  - Display, print, and mark in events and/or code summary methemoglobin quantitative value. Probe for measurement shall cover adult and pediatric patients. Precision and accuracy must be at least within one (1) digit (+/-) when spMet is 0-10%.
    - Methemoglobin (spMet) level monitoring is an optional component and, if purchased, specification above must be met.

### Physical Attributes continued

- **Record, print and have capability to import customizable Code Summary records from individual patient contacts into REMSA ePCR system.**
- **Display that is color capable, subject to wide angle viewing, and adaptable to changes in brightness.**
- **Customizable audio/visual alerts (configurable w/o vendor involvement) of biometric parameters (at minimum NiBP, HR, RR)**
- **Capability for users to adjust automatically performed vital sign intervals**
- **Capability to mark events in Code Summary recording**
- **Patient biometric trending is automatically engaged with device use, and can be viewed on screen and/or printed**
- **Safe user-driven discharge of electricity, outside of therapeutic energy delivery**
- **Audio/visual alerts for detached leads**
- **Device vendor must facilitate data integrations with REMSA ePCR vendor**
- **Device, including any add-on features must be upgradeable as technological advances and research permit. Including but not limited to, CPR qualitative and quantitative feedback, 12 lead ECG algorithms, capnography diagnostics, temperature monitoring.**

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### 12 Lead Functionalities

- **Acquire, interpret, transmit and print diagnostic quality 12 lead ECGs**
  1. The unit shall be capable of diagnostic 12-lead monitoring in leads I, II, III, aVR, aVL, aVF, V1, V2, V3, V4, V5 and V6
  2. Vendor must provide data regarding the maintenance / update of specificity and sensitivity of algorithms utilized for STEMI interpretation. Data must be provided annually and at any maintenance or update periods.
  3. Transmitted data shall be secured in a HIPAA compliant manner, and meet current applicable REMSA Information Security policies / standards

- **12 lead ECG print capability shall include configuration to print interval measurements, interpretation, axes measurements, and clinician entered patient demographic variables of name, age and gender at minimum**
- **Continually monitor and trend 12 lead ECG when leads are attached, without requirement of obtaining a specific 12 lead ECG**
- **Acquired 12 lead ECGs must be chronologically and numerically ordered as obtained during individual patient contact (serial 12 lead ECG capability)**
- **Device must be able to transmit 12 lead ECGs, to any / all REMSA designated STEMI receiving center (at minimum).**
  1. ECG transmissions shall generate an electronic notification, which will provide an alert to the facility, and can include multiple facility designated personnel.
  2. Reports regarding 12 lead ECG transmissions – success, failure, aggregate frequency, shall be available to the service provider, STEMI receiving center, and REMSA.
  3. ECG transmission shall be field-user feasible with mobile gateways, hot spots, cellular / data services, or the like.
  4. ECG transmission must not require any software / server purchase, or proprietary service to view, distribute.
### Cardiopulmonary Resuscitation (CPR) diagnostics/feedback device must:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure / gauge depth, rate and chest recoil of each compression / cycle of compressions during active CPR, in both static patient situations and dynamic movement of the patient</td>
<td>Provide for synchronous and asynchronous CPR qualitative and quantitative feedback.</td>
</tr>
<tr>
<td>Provide audio and/or visual feedback to correct cadence, depth of compressions, and chest recoil/release, whether patient is static or dynamically moving</td>
<td>Provide real time visual and auditory feedback to clinicians.</td>
</tr>
<tr>
<td>Provide an inactivity timer, indicating time duration of no chest compressions</td>
<td>Provide an inactivity timer, indicating time duration of no chest compressions.</td>
</tr>
<tr>
<td>Provide synchronous and asynchronous CPR qualitative and quantitative feedback</td>
<td>Provide synchronous and asynchronous CPR qualitative and quantitative feedback.</td>
</tr>
<tr>
<td>Be able to transmit from device via cable or WIFI connection, into reportable software or database accessible by individual EMS Providers and REMSA.</td>
<td>Be stored by individual patient encounters and provide a minimum of two (2) unique identifiers (such as date of service, time of service, patient demographics or combinations to enable accuracy in data collection and reporting).</td>
</tr>
<tr>
<td>Be stored by individual patient encounters and provide a minimum of two (2) unique identifiers (such as date of service, time of service, patient demographics or combinations to enable accuracy in data collection and reporting).</td>
<td>As with ePCR technology, CPR diagnostics/feedback/summary must import into the REMSA ePCR system.</td>
</tr>
</tbody>
</table>

### Data Integration and Management:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Device automatically stores patient information on internal memory per device application. Data stored must include at least two unique identifiers (incident number, date of service, time of service, patient information or combination), clinician entered events, therapies delivered.</td>
<td>Archived patient records must be able to be transmitted, printed and deleted by staff without vendor involvement.</td>
</tr>
<tr>
<td>Device must provide for the option of a USB cell modem for the wireless transmission of biometric parameters, CPR diagnostic feedback and 12 lead ECG.</td>
<td>Device must be capable of transferring data (including 12 Lead ECG, historical patient trends, event/code summary, CPR feedback and biometric parameters) into the REMSA ePCR system utilizing a directly connected cable or WIFI connection.</td>
</tr>
<tr>
<td>Data Integration and Management continued:</td>
<td>1. All applicable REMSA Information Security policies and procedures must be followed during data transmissions, imports or other sharing methodologies.</td>
</tr>
<tr>
<td>Device must be capable of transferring data (including 12 Lead ECG, historical patient trends, event/code summary, CPR feedback and biometric parameters) into the REMSA ePCR system utilizing a directly connected cable or WIFI connection.</td>
<td>1. All applicable REMSA Information Security policies and procedures must be followed during data transmissions, imports or other sharing methodologies.</td>
</tr>
</tbody>
</table>

### DEFINITIONS


### REFERENCES

California Code of Regulations - Division 2.5: Emergency Medical Services
California Code of Regulations, Title 13. Motor Vehicles, Section 1103.2
California Vehicle Code Section 2418.5 Resuscitator Requirements for Ambulances
California Code of Regulations, Title 8. Industrial Relations
Occupational Safety and Health Administration (OSHA), Occupational Safety and Health Standards, Standard 1910
California Fire Service and Rescue Emergency Mutual Aid System, Mutual Aid Plan (2-12)
American National Standards Institute (ANSI)
British Standards Institution (BSI)
Canadian Standards Association (CSA)
Commission on Accreditation of Medical Transport Services (CAMTS)
National Fire Protection Association (NFPA)
National Institute for Occupational Safety and Health (NIOSH)
EMSA #216: Minimum Personal Protective Equipment (PPE)
Extending the Shelf Life of Critical Chemical Biological, Nuclear and Radiological (CBRN) Medical Materiel Using the FDA/DOD Shelf Life Extension Program
EMSC Guidelines for Equipment on Ambulances
California Incident Command Certification System (CICCS) Qualification Guide
PURPOSE
To clarify the local application of Section 1798 of the Health and Safety Code as it relates to scene management and the related responsibilities of emergency medical service (EMS) first response agencies, transport services, and base hospitals.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Authority for Scene Management
As stated in the California Health and Safety Code Section 1798.6, “Authority for the management of the scene of an emergency” is “vested in the appropriate public safety agency having primary investigative authority”, ordinarily law enforcement or fire suppression. Scene management at this highest level includes not only the safety of the EMS team and its patient(s) but “other persons who may be exposed to the risks”, the public. While “public safety officials shall consult emergency medical services personnel . . . in the determination of relevant risks”, they retain the authority for scene management and incident command.

Responsibility to mitigate criminal activities and environmental hazards lies with the appropriately trained and equipped public safety agency. EMS providers without these responsibilities will not knowingly enter a crime scene or an environmentally hazardous scene until the appropriate public safety agency has arrived, secured the scene, and deemed it reasonably ‘safe to enter’.

The appropriate public safety agency is responsible for the non-medical aspects of scene management. In the exceptional situation when private EMS personnel have arrived first, there is no apparent hazard, and private EMS personnel are managing the non-medical aspects of the scene; the responsibility for scene management will immediately pass to public safety personnel upon their arrival.

Authority for Patient Health Care Management
As stated in the California Health and Safety Code Section 1798.6, “Authority for patient health care management in an emergency” is “vested in . . . any paramedic or other prehospital emergency personnel, at the scene of the emergency who is most medically qualified”. Authority to provide EMS lies with the emergency medical technician (EMT), Advanced emergency medical technician (AEMT), or paramedic (EMT-P) who arrives first and initiates patient health care management. In the absence of these “licensed or certified health care” personnel “authority shall be vested in the most appropriate medically qualified representative of public safety”; perhaps someone trained as a First Responder (FR). All personnel will immediately handoff authority for patient health care management to any arriving EMS provider who is REMSA authorized at a higher level.

Having accepted authority for patient health care management, first response personnel (REMSA Policy 3101 – First Response Agencies) authorized at the same level as transport personnel (REMSA Policy 3202 – Transport Services) will handoff individual patients as soon as possible when medically appropriate. The authority for each patient passes with completion of the handoff report and acceptance of the transfer of care, while the authority for management of the multi-patient scene is not typically passed to transport service personnel.

In the exceptional situation when transport service personnel have accepted authority for management of the multi-patient scene, they will immediately pass this authority to any arriving first response personnel who are REMSA authorized at an equal or higher level, and then resume the transport role as soon as possible.
Authority for Patient Disposition
Ordinarily the two primary components of patient disposition, destination and mode of transport, are indicated by patient’s preference, clinical needs, and operational requirements. In all cases, EMS personnel, and base hospitals when included, are responsible to collaboratively determine the medically appropriate patient disposition and to advise the incident commander (IC) of this conclusion. However, when there is disagreement, destination is primarily a medical decision. As such, EMS personnel will comply with medical direction regarding destination, whether by protocol or base hospital order. Similarly, when there is disagreement, mode of transport is primarily an operational decision. As such, EMS personnel will comply with operational direction from the IC regarding mode of transport.
PURPOSE
To establish a flexible medical management and documentation strategy for multiple patient incidents (MPI) and multiple casualty incidents (MCIs) to improve patient outcomes and decrease patient scene time.
Management should include focus on triage of the patients, utilizing REMSA Trauma Triage Indicators and transport to the appropriate receiving facility for the patient’s injuries. An MCI may be activated when there are ten (10) or more patients requiring transport or if deemed necessary by Incident Command.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Multiple Patient Incident (MPI) Management
1. Multiple Patient Incidents (MPI) are incidents where more than one (1) patient, but less than ten (10) patients, require transport. Incidents with multiple patients that are not determined to be a Multiple Casualty Incident (MCI) by the Incident Commander are also defined as an MPI.
2. MPI incidents shall be named using a naming convention consistent with the incident’s geographic location.
3. MPI incidents shall be managed with an Incident Commander and a designated Medical Communication (MedCom) Coordinator role.

COMMUNICATIONS:
 a. Early trauma base hospital notification is essential to managing MPI incidents fluidly.
 b. All base hospital communications must be done by the designated MedCom personnel member.
   i. MedCom role must be filled by a paramedic whenever possible.
 c. The assigned Medical Communications Coordinator (MedCom) shall initiate contact as soon as possible with the closest most appropriate trauma BH.
   i. MedCom’s initial contact shall include:
      1. Identifying self as MedCom.
      2. Name and location of the MPI Incident.
      3. ETA to closest hospital and trauma center to establish a point of reference.
      4. Scene description including any special circumstances.
      5. Number of patients that will likely require transport.
   ii. MedCom’s second contact to the trauma BH shall include:
      1. Current patient count by patient status (Immediate, Delayed, or Minor).
      2. Transportation destination considerations: pediatrics, burn, trauma.
         a. The trauma BH will coordinate patient destination with MedCom.
         b. Receiving centers should be determined utilizing REMSA Trauma Triage Indicators as the primary determinant for destination. Wherever possible patients meeting trauma triage criteria should be transported to trauma receiving centers.
   d. Transporting ambulances shall notify the receiving hospital as soon as possible, and shall include:
      i. Incident Name/Location Incident
      ii. Patient number from patient count at incident location
      iii. Patient Status (Immediate, Delayed, or Minor)
      iv. Chief Complaint/Major Injury
      v. Mechanism of Injury
      vi. Glasgow Coma Scale (GCS)
      vii. Patient’s Vital Signs
      viii. Estimated Time of Arrival
PATIENT TRANSPORTATION:

a. Treatment and transportation should be according to the seriousness of the patients’ injuries whenever possible.
b. Receiving centers should be determined utilizing REMSA Trauma Triage Indicators as the primary determinant for destination. Wherever possible patients meeting trauma triage criteria should be transported to trauma receiving centers.

DOCUMENTATION:

a. A REMSA Approved ePCR must be completed for each patient involved in the response.

Multiple Casualty Incident (MCI) Scene Management

1. The Incident Command System (ICS) as defined by FIRESCOPE will be utilized at all MCIs. Its Multi-Casualty organizational module is designed to provide for the necessary supervision and control of essential functions required during an MCI. The primary functions will be directed by the Medical Group Supervisor, if activated (otherwise Operations), who reports to the Multi-Casualty Branch Director, if activated, or directly to the Incident Commander (IC). Resources having direct involvement with patients are supervised or coordinated by one of the functional leaders or coordinators. The required functional positions under the Medical Group Supervisor (Operations) are:

   a. **Triage Unit Leader:** Supervises triage personnel, who perform the actual triage of patients. Once triaged, directs movement of patients to the Treatment Area, usually via backboard or litter carried by litter bearers. Once all initial triage is complete, secondary patient assessment utilizing a comprehensive physical exam (e.g. PHTLS/ITLS trauma assessment) shall continue until all patients have been transported from the incident.

   b. **Medical Communication (MedCom) Coordinator:** Maintains communications with the Base Hospital (BH)/Coordinating Facility. Responsible for reporting location, mechanism, and approximate number of immediate, delayed, and minor patients, requesting hospital availability and determining patient transportation and destination decisions.

   c. **Treatment Unit Leader:** Supervises personnel assigned to treat patients in the three treatment areas. Assumes responsibility for treatment, preparation for transport, coordination of patient treatment and directs movement of patients to the loading area. Responsible for the continued triage and assessment of patients as the incident evolves.

   d. **Ambulance Coordinator:** The Ambulance Coordinator reports to the Patient Transportation Unit Leader, manages the Ambulance Staging Area(s), and dispatches ambulances as requested.

   e. **Patient Transportation Unit Leader:** The Patient Transportation Unit Leader is responsible for the coordination of patient transportation and the maintenance of records relating to the patient’s identification, condition, and destination.

   

   

   More than one functional position may be assigned to a single responder

2. **S.T.A.R.T.:** This system allows first responders to triage patients in sixty (60) seconds or less, based on three (3) physical assessments: ventilation, perfusion, and mental status.

   - **Deceased:** No ventilation present even after attempting to position airway.
   - **Immediate:** Ventilation is present only after positioning the airway.
   - **Delayed:** Any patient who does not fit the Immediate or Minor categories.
   - **Minor:** These patients are separated from the general group at the start of the triage by requesting those who can walk to go to an assigned area.

RESPONSE

The first on-scene responder unit will complete a rapid size-up of the incident, declare the incident an MCI by notifying their dispatch agency of this, request additional personnel and equipment as necessary, initiate the ICS, and begin triage of victims using the START system and approved triage tags.
a. Incident Command will be established by the appropriate jurisdictional public safety agency. In the absence of public safety agency on scene, the transport provider agency should institute ICS as necessary.
   i. Incident Command will be responsible for the management of all incident operations.
   ii. The IC will assign the MedCom Coordinator position as soon as feasible in the incident, preferably to a paramedic.
b. Prior to arrival at scene, all responding personnel/units will contact the IC or his/her designee on the assigned radio channel to request assignment or staging instructions. All personnel shall remain with their vehicles until otherwise assigned.
c. The IC has the authority to change assignments as he/she sees fit.
d. All on-scene providers will follow legal orders of/from the IC.

COMMUNICATIONS

a. All responding units will be informed of the channel and will use it for all incident radio communications.
b. Responding units will not contact a BH prior to arrival on-scene.
c. The assigned MedCom Coordinator shall initiate contact as soon as possible with the closest most appropriate Trauma BH.
   i. MedCom’s initial contact shall include:
      1. Identifying self as MedCom.
      2. Name and location of the MCI Incident.
      3. ETA to closest hospital and trauma center to establish a point of reference.
      4. Scene description including any special circumstances.
      5. Number of patients and request for MCI bed availability.
         a. The Trauma BH will use the ReddiNet to notify other hospitals of MCI by sending a general notification and initiating an MCI. (Consider out-of-county hospital(s) for receiving facilities based upon incident location.)
         b. For MCI’s with greater than 10 patients: ReddiNet polling for bed availability should be initiated by the Trauma BH.
         c. Receiving hospitals will acknowledge the MCI notification and respond with bed availability promptly as needed.
   ii. MedCom’s second contact to the Trauma BH shall include:
      1. Receiving bed availability from the BH using the ICS-MC-308 form.
      2. Current patient count by patient status (Immediate, Delayed, or Minor).
      3. Transportation destination considerations: pediatrics, burn, trauma.
         a. The Trauma BH will coordinate patient destination with MedCom.
         b. Receiving centers should be determined utilizing REMSA Trauma Triage Indicators as the primary determinant for destination. Wherever possible patients meeting trauma triage criteria should be transported to trauma receiving centers.
         c. Receiving hospitals will monitor and use the ReddiNet.
   iii. MedCom’s subsequent contacts to the Trauma BH shall be consistent with the ICS-MC-306 form.
      1. Patient Triage Tag Number
      2. Patient Status (Immediate, Delayed, or Minor)
      3. Chief Complaint
      4. Patient Info: Age/Sex
      5. Hospital Destination
      6. Ambulance Company & Unit ID Number
      7. Off Scene Time
         a. The BH will track patient destinations via use of the ReddiNet or ICS-MC-306 form
         b. Receiving hospital will “Arrive” each patient via ReddiNet when each arrives in the ED and add all pertinent patient information as appropriate.
d. Transporting ambulances shall notify the receiving hospital as soon as possible, and shall include:
   i. Incident Name/Location Incident
   ii. Triage Tag Number
   iii. Patient Status (Immediate, Delayed, or Minor)
   iv. Chief Complaint/Major Injury
   v. Mechanism of Injury
vi. Glasgow Coma Scale (GCS)

vii. Patient’s Vital Signs

viii. Estimated Time of Arrival

e. Base and receiving hospitals shall utilize the ReddiNet to manage patient destination assignments from all MCIs.

**PATIENT TRANSPORTATION**

a. The IC or his/her designee will designate an ambulance staging area.

b. Prior to arrival at MCI scene, each ambulance will contact the IC or his/her designee on assigned radio channel and request assignment or staging instructions.

c. Treatment and transportation should be according to the seriousness of the patients’ injuries whenever possible.

d. Receiving centers should be determined utilizing REMSA Trauma Triage Indicators as the primary determinant for destination. Wherever possible patients meeting trauma triage criteria should be transported to trauma receiving centers.

e. The Transportation Unit Leader will notify the MedCom of departing units.

f. The Transportation Unit Leader will copy the information from the triage tag onto the ICS-MC-306 Form and confirm the destination with the ambulance crew.

g. During large MCIs where patient transport demands tax ALS ambulance availability and/or negatively affect the operation and continuity of the EMS system, patients may be transported by Basic Life Support (BLS) ambulance.

i. Patients should be prioritized with higher acuity patients going via ALS ambulance and lower acuity patients going via BLS ambulance transports whenever possible.

ii. Based upon available personnel, a non-transport paramedic (ALS First Responder) should be considered for the provision of care to patients triaged as immediate during transport in a BLS ambulance.

iii. Once the decision to utilize BLS ambulance has been made by the IC, those BLS ambulances that present the best estimated time of arrival (ETA) to the scene will be used.

h. During extreme circumstances where ambulance resources are exhausted or where alternative transportation resources, such as buses, will provide the most expedient transport or enhance patient safety, use of those resources are authorized as determined by the IC.

i. The IC is responsible for assuring patient safety when alternative transportation options are utilized.

ii. Minimum staffing shall be two (2) emergency medical technicians (EMTs), supplied with radios and BLS equipment if vehicles, such as buses, are used to transport patients triaged as Minor.

**DOCUMENTATION**

Patient identification, assessment, treatment, and disposition will be documented on the triage tags. Only the Cal Chiefs-approved triage tags shall be used. The triage tag will be handled as follows:

*NOTE: For non-contaminated incidents, remove the “contaminated” portion of the triage tag. If a contamination hazard exists, all EMS personnel shall coordinate with the IC or his/her designee for briefing.*

a. As patients are triaged, one half of the appropriate triage category (immediate, delayed, and minor) will be removed from the tag and retained by the triage personnel.

b. Once the triage is complete, triage personnel will deliver the retained category halves of the triage tags to the Triage Unit Leader to retain accountability.

c. The category half remaining on the triage tag must remain with the patient for the identification of the individual patient triage category.

d. The transport portion affixed to the top of the triage tag (below the Personal Property Receipt) will be removed by the Transportation Unit Leader and documented with transport destination and mode of transportation with appropriate unit identifier.

e. Following the conclusion or resolution of the incident, the IC will be responsible for completion of all MCI documentation. Documentation should be attached to the ePCR for the incident, which may include:

i. ICS-214 (For each personnel assigned to a functional position)

ii. ICS-MC-305 form (Multiple Casualty Branch Worksheet)

iii. ICS-MC-306 form draft version (Multiple-Casualty Recorder Worksheet)

iv. ICS-MC-308 form draft version (Multiple-Casualty Hospital Resource)
v. ICS-MC-310 form draft version (Multiple-Casualty Ambulance Resource Status)
vi. ICS-MC-312 form (Medical Supply Receipt and Inventory Form)

***All documentation will be turned into the provider’s continuous quality improvement (CQI) department***

**TRAINING**
The Riverside County EMS Agency approved MCI Training Program for initial and biennial recurrent training is required for all:
- ALS Providers
- BLS Providers
- Base Hospitals
PURPOSE
To set parameters for the use of physical restraint and transport of the restrained.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Welfare and Institutions Code - Division 5: Community Mental Health Services [5150]

Physical Restraint and Transport
Physical restraint is to be used only when necessary:
1. When a patient is a danger to others, or to him or herself.
   a. Use the minimum restraint necessary to ensure safety.

2. When the patient is transported under California Code Section 5150:
   a. Use four-point wrist and ankle restraints.
      i. Take the original, completed, and signed 5150 form, if it is available. If it is not, a copy/facsimile of the original “shall be treated as the original” (WIC 5150(e)) for the purposes of this policy.
   b. Transport the patient as clinically indicated by REMSA Policy.
      i. Law enforcement may elect to meet the ambulance, follow in tandem, or ride in the patient compartment.
      ii. Law enforcement remains legally responsible for the patient during transport.

3. When the patient is transported under arrest.
   a. If restrained, but not handcuffed, law enforcement may follow the ambulance in tandem.
   b. If handcuffed, law enforcement must ride in the patient compartment of the ambulance.
      i. Do not allow handcuffing to the ambulance cot.

When wrist and/or ankle restraints are used:
1. Use only REMSA approved neoprene over nylon webbing with Velcro closure wrist and/or ankle restraints.

2. Distal circulation must be assessed at least every 15 minutes.

3. Restraint may not interfere with assessment or care of the patient.
   a. Transport the restrained patient on the ambulance cot in low to high Fowler’s position.
   b. Never restrain supine or prone.
      i. Clinically indicated mechanical spinal immobilization is an exception for supine restraint.
   c. Never restrain a patient on a spine board or lifting appliance to the ambulance cot.
      i. Restrain to the spine board or lifting appliance only.
   d. Never “hog-tie” or “backboard sandwich” a patient.

PURPOSE
To specify the procedures to be followed when highly pathogenic emerging viruses are suspected during emergency call taking and response; or confirmed prior to interfacility transport.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Procedures for Call-takers
Emergency Medical Service (EMS) dispatch centers and Public Safety Answering Points (PSAPs) shall consider screening callers for symptoms and risk factors of emerging viruses.

- If call takers suspect a caller is reporting symptoms of an emerging virus, they shall screen callers for risk factors.
- If call takers have information alerting them to a person with a possible emerging virus, they shall make sure any first responders and EMS personnel are made confidentially aware of the potential for an emerging virus before the responders arrive on scene.
- If responding at an airport or other port of entry to the United States, call-takers shall notify:
  - The Centers for Disease Control and Prevention (CDC) Los Angeles Quarantine Station at (310) 215-2365 (24-hour access).
  - The Riverside County Disease Control Branch through the EMS Agency Duty Officer.

Note that approved emergency medical dispatch (EMD) providers using ProQA software are authorized to use the Emerging Infectious Disease Surveillance Tool (EID Tool) if the patient has symptoms consistent with an emerging virus.

Procedures for First Response and Transport Personnel

Patient Assessment
Address scene safety:

- If the dispatch center or PSAP advises that the patient is suspected of having an emerging virus, first response and transport personnel shall put on the personal protective equipment (PPE) appropriate for suspected cases of an emerging virus (described below) before entering the scene.
- Keep the patient separated from other persons as much as possible.
- Use caution when approaching a patient with an emerging virus.

During patient assessment and management, first response and transport personnel shall consider the symptoms and risk factors of the suspected emerging virus:

- All patients shall be assessed for symptoms of the emerging virus. If the patient has symptoms of the emerging virus, then ask the patient about risk factors before the onset of symptoms.
- Based on the presence of symptoms and risk factors, put on or continue to wear appropriate PPE and follow the scene safety guidelines for any suspected case of an emerging virus.
- If there are no risk factors, proceed with normal EMS care.

Transfer to a Receiving Facility
Transport personnel shall notify the receiving healthcare facility when transporting a suspected emerging virus patient, so that appropriate infection control precautions may be prepared prior to patient arrival. Any U.S. hospital that is following CDC's infection control recommendations and can isolate a patient in a private room is capable of safely managing a patient with an emerging virus.
Interfacility Transport
Personnel involved in the air or ground interfacility transfer of patients with a suspected or confirmed emerging virus shall wear recommended PPE (described below).

Infection Control
First response and transport personnel can safely manage a patient with a suspected or confirmed emerging virus by following recommended isolation and infection control procedures, including standard, contact, and droplet precautions. Particular attention shall be paid to protecting mucous membranes of the eyes, nose, and mouth from splashes of infectious material, or self-inoculation from soiled gloves. Early recognition and identification of patients with a potential emerging virus is critical. First response and transport providers managing a suspected emerging virus patient shall follow these CDC recommendations:

- Limit activities, especially during transport that can increase the risk of exposure to infectious material (e.g., airway management, cardiopulmonary resuscitation, use of needles).
- Limit the use of needles and other sharps as much as possible. All needles and sharps shall be handled with extreme care and disposed in puncture-proof, sealed containers.
- Phlebotomy, procedures, and laboratory testing shall be limited to the minimum necessary for essential diagnostic evaluation and medical care.

Personal Protective Equipment (PPE)
Use of standard, contact, and droplet precautions is sufficient for most situations when treating a patient with a suspected case of an emerging virus. Personnel shall wear:

- Gloves
- Gown (fluid resistant or impermeable)
- Eye protection (goggles or face shield that fully covers the front and sides of the face)
- Facemask
- Additional PPE might be required in certain situations (e.g., large amounts of blood and body fluids present in the environment), including but not limited to double gloving, disposable shoe covers, and leg coverings.

Pre-hospital resuscitation procedures such as endotracheal intubation, open suctioning of airways, and cardiopulmonary resuscitation frequently result in a large amount of body fluids, such as saliva and vomit. Performing these procedures in a less controlled environment (e.g., moving vehicle) increases risk of exposure. If conducted, perform these procedures under safer circumstances (e.g., stopped vehicle, hospital destination).

During pre-hospital resuscitation procedures (intubation, open suctioning of airways, cardiopulmonary resuscitation):

- In addition to recommended PPE, respiratory protection is required; providers should wear an N95 or equivalent or higher-level respirator.
- Additional PPE must be considered for these situations due to the potential increased risk for contact with blood and body fluids including, but not limited to, double gloving, disposable shoe covers, and leg coverings.

If blood, body fluids, secretions, or excretions from a patient with a suspected emerging virus come into direct contact with the provider’s skin or mucous membranes, then the provider shall immediately stop working. They shall wash the affected skin surfaces with soap and water and report exposure to a supervisor for follow-up.

Recommended PPE shall be used by first response and transport personnel as follows:

- PPE shall be worn upon entry into the scene and continued to be worn until personnel are no longer in contact with the patient.
- PPE shall be carefully removed without contaminating one’s eyes, mucous membranes, or clothing with potentially infectious materials.
- PPE shall be placed into a medical waste container at the hospital or double bagged and held in a secure location.
- Re-useable PPE shall be cleaned and disinfected according to the manufacturer’s reprocessing instructions and the first response agency or transport service’s policies.
- Instructions for putting on and removing PPE have been published online at https://www.cdc.gov/niosh/ppe/
- Hand hygiene is critical and shall be performed effectively and immediately after removal of PPE.
Environmental Infection Control
Environmental cleaning and disinfection, and safe handling of potentially contaminated materials is essential to reduce the risk of contact with blood, saliva, feces, and other body fluids that can soil the patient care environment. Personnel shall always practice standard environmental infection control procedures, including vehicle/equipment decontamination, hand hygiene, cough and respiratory hygiene, and proper use of U.S. Food and Drug Administration (FDA) cleared or authorized medical PPE.

Personnel performing environmental cleaning and disinfection shall:
• Wear recommended PPE (described above) and consider use of additional barriers (e.g., shoe and leg coverings) if needed.
• Wear face protection (facemask with goggles or face shield) when performing tasks such as liquid waste disposal that can generate splashes.
• Use an EPA-registered hospital disinfectant with a label claim for viruses that share some technical similarities to the emerging virus to disinfect environmental surfaces. Disinfectant shall be available in spray bottles or as commercially prepared wipes for use during transport.
• Spray and wipe clean any surface that becomes potentially contaminated during transport. These surfaces shall be immediately sprayed and wiped clean (if using a commercially prepared disinfectant wipe) and the process repeated to limit environmental contamination.

Cleaning Equipment and Transport Vehicles
The following are general guidelines for cleaning or maintaining equipment and transport vehicles after contact with a patient with a suspected or confirmed emerging virus:
• Personnel performing cleaning and disinfection shall wear recommended PPE (described above) and consider use of additional barriers (e.g., rubber boots or shoe and leg coverings) if needed. Face protection (facemask with goggles or face shield) shall be worn since tasks such as liquid waste disposal can generate splashes.
• A blood spill or spill of other body fluid or substance (e.g., feces or vomit) shall be managed through removal of bulk spill matter, cleaning the site, and then disinfecting the site. For large spills, a chemical disinfectant with sufficient potency is needed to overcome the tendency of proteins in blood and other body substances to neutralize the disinfectant’s active ingredient.
• An EPA-registered hospital disinfectant with label claims for viruses that share some technical similarities to the emerging virus and instructions for cleaning and decontaminating surfaces or objects soiled with blood or body fluids shall be used according to those instructions. After the bulk waste is wiped up, the surface shall be disinfected as described in the bullet above.
• Contaminated reusable patient care equipment shall be placed in biohazard bags and labeled for cleaning and disinfection according to agency policies. Reusable equipment shall be cleaned and disinfected according to manufacturer’s instructions by trained personnel wearing correct PPE. Avoid contamination of reusable porous surfaces that cannot be made single use.
• Patient-care surfaces (including stretchers, railings, medical equipment control panels, and adjacent flooring, walls and work surfaces) are likely to become contaminated and shall be cleaned and disinfected after transport.
• Use only a mattress and pillow with plastic or other covering that fluids cannot get through. To reduce exposure among staff to potentially contaminated textiles (cloth products) while laundering, discard all linens, non-fluid-impermeable pillows, or mattresses as appropriate.

An emerging virus may be a Category A infectious substance regulated by the U.S. Department of Transportation’s (DOT) Hazardous Materials Regulations (HMR, 49 C.F.R., Parts 171-180). Any item transported for disposal that is contaminated or suspected of being contaminated with a Category A infectious substance must be packaged and transported in accordance with the HMR. This includes medical equipment, sharps, linens, and used health care products (such as soiled absorbent pads or dressings, kidney-shaped emesis pans, portable toilets, used PPE [e.g., gowns, masks, gloves, goggles, face shields, respirators, booties] or byproducts of cleaning) contaminated or suspected of being contaminated with a Category A infectious substance.
Follow-up and/or Reporting Measures

- First response and transport personnel shall be aware of the follow-up and/or reporting measures they shall take after caring for a suspected or confirmed emerging virus patient.
- First response agencies and transport services shall develop policies for monitoring and management of personnel potentially exposed to an emerging virus.
- First response agencies and transport services shall develop sick leave policies for personnel that are non-punitive, flexible, and consistent with public health guidance.
- First response agencies and transport services shall ensure that all personnel are aware of the sick leave policies.
- Personnel with exposure to blood, bodily fluids, secretions, or excretions from a patient with a suspected or confirmed emerging virus shall immediately:
  - Stop working and wash the affected skin surfaces with soap and water. Mucous membranes (e.g., conjunctiva) shall be irrigated with a large amount of water or eyewash solution;
  - Contact their supervisor for assessment and access to post-exposure management services; and
  - Supervision / Designated Officer shall notify, via phones, the Riverside County Disease Control Branch through the Riverside County EMS Duty Officer.
  - Supervision / Designated Officer shall report exposure to the Riverside County Disease Control Branch using the Communicable Disease Exposure Reporting Form: [https://www.rivco-diseasecontrol.org/Portals/12/documents/E-3_attachment_2_CD-145_Exposure_Reporting_Form_09-12.pdf](https://www.rivco-diseasecontrol.org/Portals/12/documents/E-3_attachment_2_CD-145_Exposure_Reporting_Form_09-12.pdf)
  - Receive medical evaluation and follow-up care. They may continue to work based upon the first response agency or transport service’s policy and discussion with the County of Riverside Department of Public Health.
- Personnel who develop symptoms after an unprotected exposure (i.e., not wearing recommended PPE at the time of contact with a suspected or confirmed emerging virus patient shall:
  - Not report to work or immediately stop working and isolate themselves;
  - Notify their supervisor, who shall notify the Riverside County Disease Control Branch through the Riverside County EMS Duty Officer.
  - Contact their supervisor for assessment and access to post-exposure management services; and
  - Comply with work exclusions until they are deemed no longer infectious to others.
PURPOSE
To specify the procedures to be followed when contacting a suspected person under investigation for 2019-novel Coronavirus (COVID-19). This policy is applied secondarily to REMSA 3307 Emerging Virus and has adjacent dependency on REMSA 2102 Emerging Infectious Disease Screening that applies to Emergency Medical Dispatch Providers.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

2019 novel Coronavirus (COVID-19), suspected person under investigation (PUI)
Patients in the United States who meet the following criteria should be evaluated as a PUI for 2019-nCoV/COVID-19. These criteria are a guideline only and clinical judgement must be utilized. The CDC clinical criteria for a 2019-nCoV/COVID-19 suspected person under investigation (PUI) have been developed based on what is known about COVID-19 and are subject to change as additional information becomes available.

<table>
<thead>
<tr>
<th>Clinical Features</th>
<th>&amp;</th>
<th>Epidemiologic Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever or signs/symptoms of lower respiratory illness (e.g. cough or shortness of breath) or new onset fatigue, muscle aches, sore throat, loss of sense of smell or taste</td>
<td>AND</td>
<td>Any person, including health care workers, who has had close contact with a laboratory-confirmed 2019-nCoV patient within fourteen (14) days of symptom onset</td>
</tr>
<tr>
<td>Fever and signs/symptoms of a lower respiratory illness (e.g., cough or shortness of breath)</td>
<td>AND</td>
<td>A history of travel from an affected country within fourteen (14) days of symptom onset</td>
</tr>
<tr>
<td>Patients with severe respiratory illness (e.g. pneumonia, ARDS) requiring hospitalization, with unknown etiology</td>
<td>AND</td>
<td>No known alternate etiology or diagnosis identified.</td>
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</tbody>
</table>

Fever – can be subjective or confirmed
Close contact is defined as—
- a) being within approximately six (6) feet of a 2019-nCoV/COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a health care waiting area or room with a COVID-19 case – or –
- b) having direct contact with infectious secretions of a 2019-nCoV/COVID-19 case (e.g., being coughed on).
- c) If such contact occurs while not wearing recommended personal protective equipment or PPE (e.g., gowns, gloves, NIOSH-certified disposable N95 respirator, eye protection), criteria for PUI consideration are met.

Procedures for First Response and Transport Personnel
1. Due to the degree of community spread of COVID-19, source control of patients is necessary to limit contact during the patient encounter. Source control can be achieved by having the patient don a facial covering (i.e. cloth face mask, neck gaiter, surgical mask). Healthcare providers must also use the appropriate medical grade face mask when interacting with patients (ranging from surgical mask to the appropriate respirator based on patient presentation and procedures needed for patient treatment).
2. Wear eye protection during activities where prolonged face-to-face or close contact with a potentially infectious patient is unavoidable. Also, during care activities where splashes and sprays are anticipated, which includes aerosol...
generating procedures. Eye protection should not have gaps between the glasses and the face which do not fully protect the eyes.

3. If the patient’s travel / social history is consistent with suspected PUI criteria or patient has a known COVID-19 diagnosis:
   a. Initiate standard contact and airborne precautions by donning a single pair of gloves, isolation gown, N95 respirator, and eye protection.
   b. Keep the patient separated from other persons as much as possible and ensure all clinical care providers have donned the appropriate PPE.
   c. Implement appropriate treatment protocols.
      1. If aerosolized medical procedures (BVM use, CPR, suctioning, nebulizer use, or advanced airway placement) are clinically indicated then an N95 or equivalent or higher-level respirator should be utilized.
   d. Contact the closest most appropriate receiving center utilizing the REMSA Universal Patient reporting format, including details about suspected PUI status or known COVID-19 diagnosis.
   e. During transport of the patient, If the transport vehicle does not have an isolated driver’s compartment, the driver should remove the face shield or goggles, gown and gloves and perform hand hygiene. A respirator should continue to be used during transport.
      1. If aerosolized medical procedures (BVM use, CPR, suctioning, nebulizer use, or advanced airway placement) are clinically indicated then an N95 or equivalent or higher-level respirator should be utilized.
   f. Contact the closest most appropriate receiving center utilizing the REMSA Universal Patient reporting format, including details about suspected PUI status or known COVID-19 diagnosis.
   g. During transport of the patient, If the transport vehicle does not have an isolated driver’s compartment, the driver should remove the face shield or goggles, gown and gloves and perform hand hygiene. A respirator should continue to be used during transport.
      1. Family members and other contacts of patients with possible COVID-19 should not ride in the transport vehicle, if possible. If riding in the transport vehicle, they should wear a facemask.
      2. Utilize the exhaust fan functionality during the transport and allow to run while offloading the patient.
      3. During transport, vehicle ventilation in both compartments should be on non-recirculated mode to maximize air changes that reduce potentially infectious particles in the vehicle.

4. Following conclusion of patient care, transfer of patient care:
   a. As needed, contact your agency supervisor to report possible exposure to suspected COVID-19.
   b. Agency supervisor should contact the REMSA EMS Duty Officer (951) 830-8041 (24/7/365 coverage) for reporting of a suspected PUI as soon as possible.
   c. REMSA Duty Officer will initiate contact with RUHS Public Health - Disease Control Branch for appropriate follow-up.

5. PPE Removal and Disposal recommendations:
   a. PPE should be appropriately doffed following manufacturer recommendations and REMSA policy #3307 (Emerging Viruses) procedures.
   b. Reusable PPE (i.e. turnouts, etc.) should be cleaned utilizing manufacturer recommendations.
   c. For PPE disposal at healthcare destination: utilize appropriate waste containers, doff PPE appropriately per policy and perform hand hygiene.
   d. For PPE disposal at non-healthcare locations: make efforts to place appropriately doffed PPE in external trash can. Perform hand hygiene after PPE disposal. Standard biohazard waste processes apply for COVID-19.
PURPOSE
To establish criteria for downgrading from an advanced life support (ALS) level of care to a basic life support (BLS) level of care in the pre-hospital setting.

APPLICATION
The intent of this policy is to permit first response agencies to downgrade the level of care a patient will receive during transport so that the maximum number of ALS transport ambulances and/or ALS first response apparatus are able to remain in service, and available, to respond to other medical aid requests. If / when an ALS transport ambulance arrives on scene before a first response agency apparatus, and the ALS transport paramedic determines that additional ALS assistance is not required AND the patient’s condition meets the criteria below, the patient should be transported by that ambulance. Excluding patients that have met Assess and Refer criteria related to behavioral health emergencies who have been referred out of the 911 system, it is not appropriate for an ALS transporting unit to wait at the scene for a BLS transporting unit when the paramedic is able to provide a BLS level of care.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.204.]
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.206.]
California Code of Regulations, Title 22, Chapter 4, Article 8, and Section 100170

ALS to BLS DOWNGRADE ELIGIBILITY – PRIMARY / SECONDARY IMPRESSION
If at any point during the ALS assessment or in the presence of an ALS scene provider the patient exhibits any of the following conditions, the patient is no longer considered eligible for ALS to BLS transition and care must be provided by an ALS provider.
1. Acute altered mental status (excluding patients whose mentation is GCS 14 or lower as their baseline)
2. Acute cardiac dysrhythmias
3. Any patient requiring specialty care services (Trauma, Stroke, STEMI)
4. Airway obstruction
5. Hypoglycemia that persists after oral glucose administration
6. Influenza-like illness which falls outside of the vital sign eligibility criteria listed below
7. Overdose, poisoning, or ingestion
8. Pregnancy / OB delivery-related complications
9. Seizures (active and/or presenting as postictal)
10. Suspected cardiac chest pain
11. Water-related submersion incidents

ALS to BLS DOWNGRADE ELIGIBILITY – VITAL SIGN ELIGIBILITY
If at any point during the ALS assessment, or in the presence of an ALS scene provider, the trend of the patient’s vital signs falls OUTSIDE of the parameters listed below, the patient cannot be downgraded to a BLS level of care. Trending vital signs require A MINIMUM OF TWO SETS during the patient encounter.
1. Blood glucose (BGL) is less than 60 mg/dl OR
   a. Glucometer reads “LO” OR
   b. The patient presents with symptomatic hypoglycemia, a BGL less than 80 mg/dl, AND a persistent, acute, altered mental status (excluding patients whose mentation is GCS 14 or lower as their baseline)
2. Blood glucose (BGL) is greater than 250 mg/dl OR
   a. Glucometer reads “HI” OR
   b. The patient presents with signs / symptoms of diabetic ketoacidosis (DKA): polydipsia, polyuria, generalized weakness, fatigue, nausea / vomiting, Kussmaul respirations, fruity odor on their breath, dry / flushed skin, etc.
3. Pulse oximetry (SpO2) of 93% saturation or below
4. Pulse rate is less than 60 beats per minute
5. Pulse rate is greater than 120 beats per minute
6. Respiratory rate of 10 breaths a minute or below
7. Respiratory rate of 24 breaths a minute or more
8. Sustained systolic blood pressure greater than 180 mmHg
9. Sustained systolic blood pressure less than 90 mmHg
10. Sustained diastolic blood pressure greater than 100 mmHg
11. Temperature is less than 93.2°F
12. Temperature is greater than 101°F

ALS to BLS DOWNGRADE ELIGIBILITY – PEDIATRIC PATIENTS
If at any point during the ALS assessment of a pediatric patient, or in the presence of an ALS scene provider, the patient’s vital signs fall OUTSIDE of the parameters listed below, the patient cannot be downgraded to a BLS level of care.

1. Acute altered mental status (altered for the patient)
2. Acute cardiac dysrhythmias
3. Apparent life-threatening event / brief resolved unexplained event (ALTE / BRUE) in the pediatric population
4. Evidence of poor perfusion and/or cyanosis
5. Severe respiratory distress
6. Status epilepticus
7. HYPOTENSION:
   a. In neonates (1 day to 28 days) = SBP less than 60 mmHg
   b. In infants (1 to 12 months) = SBP less than 70 mmHg
   c. In pediatrics (1 to 10 years) = SBP less than [70 + (age x2)]
   d. In adolescents (11 to 14 years) = SBP less than 90 mmHg

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 intervention(s), 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
In addition to the minimum NEMSIS requirements, the following must be documented in the ePCR:
- After selecting 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)
- Treatments provided, if any
- All pertinent findings and observations

CONTINUOUS QUALITY IMPROVEMENT
All patient dispositions where the level of care was downgraded from ALS to BLS will undergo a minimum of 50% CQI by the ALS service provider who initiated the downgrade.
PURPOSE
To establish the processes and procedures to allow for approved public safety personnel (PSP) to provide intranasal naloxone to patients with suspected acute narcotic overdose.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22. Social Security, Division 9. Ch. 1.5 Prehospital Emergency Medical Services

Training Standards
1. Agencies that employ PSPs in Riverside County seeking to utilize naloxone to manage patients with suspected narcotic overdose shall be authorized and approved by REMSA in accordance with state laws, regulations and REMSA policies. Authorized agencies shall administer naloxone in accordance with this policy.
2. PSPs must be trained to the Public Safety Personnel First Aid and CPR standard as outlined in Title 22, Division 9, Chapter 1.5, Section 100017 (found here: https://govt.westlaw.com/calregs/Document/I64A10E20B55D11E4BD3CC9706BA5168A?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)&bhcp=1) and maintain ongoing competencies and proficiencies as outlined by Section 100022 (found here: https://govt.westlaw.com/calregs/Document/I654EB340B55D11E4BD3CC9706BA5168A?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default).
3. Ongoing competency for the administration of intranasal naloxone must be maintained every two (2) years, training for ongoing competency must be approved by REMSA.
4. Each authorized agency that employs PSPs that is requesting authorization will submit:
   a. A formal request for approval of intranasal naloxone use.
   b. A designated point of contact for the program and provide contact information for the individual in the formal request letter above.

Performance Standards
1. PSPs working for agencies authorized to administer intranasal naloxone by REMSA may provide 4 mg intranasal naloxone following procedure outlined in this policy and in REMSA approved training.
2. Intranasal Naloxone Administration:
   a. Identify the victim of possible narcotic overdose.
   b. Ensure paramedic response has been requested.
   c. Maintain standard blood and body fluid precautions and use appropriate personal protective equipment.
   d. Check victim for responsiveness.
   e. Ensure an open airway using Basic Life Support Techniques. Perform CPR if patient is in cardiac arrest.
   f. As clinically indicated, provide rescue breathing using a bag-valve-mask or face shield.
   g. Administer intranasal naloxone, using procedure from training.
   i. Repeat dose if respiratory depression persists (breathing < 8 breaths/minute).
   h. Continue CPR, rescue breathing, or other first aid as clinically indicated.
   i. Prepare for possible reversal behavior or withdrawal symptoms such as agitation/aggression, combativeness, vomiting, etc.
   j. Notify the responding agency’s paramedic of the administration of naloxone.
   k. Replace the used naloxone device with another intranasal naloxone administration device.
3. Responding EMS providers shall document the intranasal naloxone use as “prior to arrival” and assign the administration to the administering public safety agency.
4. Participating public safety agencies will report all cases of naloxone administration to REMSA via the Naloxone use for Public Safety Personnel form, found here: https://forms.office.com/g/CaDY22ycFA
PURPOSE
To authorize and describe procedures for EMS personnel to distribute “Leave Behind Naloxone” kits to individuals who are at risk for experiencing an opioid overdose. “Leave Behind Naloxone” kits may also be distributed to individuals who may come in contact with individuals who are at risk for experiencing an opioid overdose.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Civil Code Section 1714.22

BACKGROUND
The Naloxone Distribution Project (NDP) is a federally funded “Leave Behind Naloxone” initiative administered by the Department of Health Care Services (DHCS) in California to combat opioid overdose-related deaths through the free distribution of Naloxone to qualifying entities for the purpose of distribution to persons at risk for opioid overdose and those in a position to assist those persons at risk. EMS agencies in California are qualified entities to participate in this program. The NDP program is currently active in Riverside County through other community-based organizations; this program will now be extended to include distribution by EMS personnel who come in contact with high-risk individuals through the EMS system.

RESOURCES
https://www.dhcs.ca.gov/individuals/Pages/Naloxone_Distribution_Project.aspx
https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/Naloxone-Standing-Order.aspx

REQUIREMENTS
- All patients treated for an opioid overdose shall be assessed and managed in accordance with REMSA Policy #4601 (Overdose / Adverse Reaction).
- All patients treated for an opioid overdose who refuse transport shall be managed in accordance with REMSA Policy #4107 (Refusal of Treatment and/or Transport).
- This policy applies only to “Leave Behind Naloxone” kits intended for laypersons’ use.
- This policy does not refer to any Naloxone in the responding units’ required medication inventory, as outlined in REMSA Policy #3303 (Drug and Equipment List).
- EMS personnel shall document distribution of “Leave Behind Naloxone” kits in compliance with local and state reporting as required.
APPLICATION
This policy applies only to transport providers that are enrolled in the Centers for Medicare and Medicaid Services (CMS) Emergency Triage, Treat, and Transport (ET3) program.

PURPOSE
To memorialize the program for ET3 approved transport providers in Riverside county.

Definitions
1. **Non-Acute Care Facility**
   A medical facility that has entered into a business contract with a transport provider to receive patients that have been referred out of the 911 system. The facility will have access to receive electronic records on behalf of the patient from the transport provider.

2. **Transport Provider**
   An ambulance transport provider that is part of the CMS ET3 pilot project.

3. **Virtual Visit**
   A telemedicine option employed by a transport provider that facilitates remote access to physician services.

Non-Acute Care Facilities

<table>
<thead>
<tr>
<th>Location</th>
<th>Facility Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lake Elsinore</td>
<td>A Plus Urgent Care</td>
<td>31571 Canyon Estates Drive, Suite 100 Lake Elsinore, CA 92532</td>
</tr>
<tr>
<td>Menifee</td>
<td>A Plus Urgent Care</td>
<td>29821 Antelope Road, Suite 102 Menifee, CA 92584</td>
</tr>
<tr>
<td>Murrieta</td>
<td>A Plus Urgent Care</td>
<td>29955 Technology Drive, Suite 111 Murrieta, CA 92563</td>
</tr>
<tr>
<td>Murrieta</td>
<td>A Plus Urgent Care</td>
<td>41880 Kalmia Street, Suite 100 Murrieta, CA 92562</td>
</tr>
<tr>
<td>Moreno Valley</td>
<td>Riverside Medical Clinic</td>
<td>6405 Day St, Riverside, CA 92507</td>
</tr>
<tr>
<td>Riverside</td>
<td>Riverside Medical Clinic</td>
<td>7117 Brockton Ave, Riverside, CA 92506</td>
</tr>
<tr>
<td>Temescal Canyon / Corona</td>
<td>Riverside Medical Clinic</td>
<td>21634 Retreat Pkwy, Temescal Valley, CA 92883</td>
</tr>
</tbody>
</table>

Data Collection and Access
- All data will be collected using the REMSIS ePCR system.
- All non-acute care facilities will be given access to Hospital Hub to access specific patient contact records.

CQI
All ePCRs associated with patients who were transported to non-acute care facilities, as well as those who participated in Virtual Visits, will be reviewed by the transport provider for CQI purposes.
PURPOSE
To establish standards for the identification of patients whose condition does not require transport by 9-1-1 emergency ambulance to an emergency department. All 9-1-1 calls for EMS will receive an appropriate response, timely assessment, and appropriate patient care. If it is determined that the patient is stable and does not require emergency department services, EMS field personnel will assess all patients and provide an appropriate recommendation to a non-acute care facility.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

GENERAL CONSIDERATIONS
• Patients who require immediate medical attention will be transported to the closest most appropriate hospital.
• Patients who refuse referral to a non-acute care facility will be transported to the closest most appropriate hospital.
• Patients who accept a referral to a non-acute care facility are not required to sign Refusal of Treatment / Transport documentation on the electronic Patient Care Record (ePCR).

PARAMEDIC ASSESS AND REFER DECISION MAKING PRINCIPLES
• Does the patient, guardian, or parent have decision making capacity?
• Are EMS field personnel concerned with the patient’s current medical condition?
• How likely is the patient to successfully navigate the provided referral?

ASSESS AND REFER CRITERIA
The patient, guardian, or parent must meet all the following criteria:
• Is an adult (18 years of age or over), or is legally emancipated if under 18 years of age?
• Has a Glasgow Coma Scale (GCS) of 15 or GCS is at patient’s baseline?
• Exhibits no clinical evidence of:
  o Altered level of consciousness
  o Alcohol or drug ingestion that impairs decision making capacity
  o Abnormal or labored breathing or shortness of breath
  o Chest pain or discomfort of any kind
  o Hypoxia as indicated by low oxygen saturation of less than 94%
  o Significant tachycardia
  o Serious hemorrhage
• Exhibits evidence of decision-making capacity sufficient to understand the nature of the medical condition as well as the risks and potential consequences of not seeking additional medical care from the provided recommendation.
• The patient would benefit from the provided recommendation.
• The patient is likely to successfully navigate the provided recommendation.

   If the patient presents with clinical evidence of a viral illness, in addition to the criteria above, they must also:
• Be older than two (2), but younger than sixty-five (65), years of age.
• Not have an underlying medical history.

For the COVID+ or PUI patient, assess for a referral to stay home, self-isolate, and seek follow-up treatment with a physician.
ASSESS AND REFER RECOMMENDATIONS TO THE PATIENT

If the patient’s condition meets all criteria listed above, EMS field personnel will provide the following recommendation:

“Our assessment indicates no evidence of any medical condition that requires immediate care in an emergency department. You should seek care with your regular healthcare provider or visit a local urgent care or clinic. If your symptoms persist or progress, you should seek medical help immediately or re-contact 9-1-1.”

DOCUMENTATION REQUIREMENTS

In addition to the minimum NEMSIS requirements, the following must be documented in the ePCR:

- Utilize “REMSA Assess and Refer” disposition in the ePCR.
- Physical exam.
- Treatment provided.
- Patient, parent, or guardian is alert, oriented, and acting appropriately for their age.
- Indications that there were no signs of significant impairment due to drugs, alcohol, organic causes, or mental illness.
- Any other observations that indicate that the patient, guardian, or parent had unimpaired decision-making capacity.
- Recommendation / referrals shall be documented utilizing the following four (4) step process:
  1. That a recommendation / referral was offered.
  2. What the recommendation / referral was that EMS field personnel provided.
  3. The patient’s understanding of the recommendation / referral.
  4. The patient’s plan based on the recommendation / referral of the EMS field personnel.
- The person(s), if any, who remained to look after the patient (the patient’s "support system").
- The name of the interpreter utilized, if applicable.
- EMS field personnel will leave a referral card containing relevant community referral information with the patient.

CONTINUOUS QUALITY IMPROVEMENT

All assess and refer cases will undergo 100% CQI by the service providers.
PURPOSE
To introduce the County of Riverside Emergency Medical Services (EMS) Agency (REMSA) treatment protocols, and the REMSA Approved Policies and Procedures Manual. These policies must be observed within the full context of the REMSA Policy Manual, which establishes the REMSA approved Public Safety Personnel, Emergency Medical Technician, Advanced Emergency Medical Technician, and paramedic scope of practice as specified in Title 22 of the California Code of Regulations.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

APPLICATION
The REMSA treatment protocols must be adhered to by each part of the EMS System including the following personnel:
- Public Safety Personnel (PSP)
- Emergency Medical Technician (EMT)
- Advanced Emergency Medical Technician (AEMT)
- Paramedic (EMT-P)
- Mobile Intensive Care Nurse (MICN)
- Base Hospital Physician (BHP)

PSPs are non-EMT firefighters, peace officers and/or lifeguards functioning in the Riverside County EMS System. PSPs who have completed either Cal Fire’s PSP First Aid and CPR Training Course, or a REMSA Approved PSP First Aid and CPR course, must follow the REMSA treatment protocols as they were trained at the PSP level and may not operate beyond the REMSA approved PSP scope of practice.

All REMSA treatment protocols were developed to be consistent with pre-hospital provider primary impressions, as approved by the California EMS Authority. The foundations for these treatment protocols are the EMT and EMT-P scope of practice, medical research, and community standards in medical practice.

Patients with the same disease may have differing symptoms and presentations, and conversely, patients with similar signs and symptoms may have very different diagnoses. As such, the treatment protocols contained in this series of the REMSA policy manual were created to provide treatment guidance of “classic” presentations based on the most common patient complaints, based on evidence-based practice.

These protocols were not developed with the intent that all therapies will be performed on scene, or that at any therapy contained in a specific treatment protocol will be performed simply because of a provided complaint. EMTs, EMT-Ps, MICNs and BHPs must utilize their medical knowledge, expertise, and critical thinking to determine appropriate treatment(s), if any, for each patient. Additionally, transport of patients with treatment(s) en route is left to the discretion of the provider and the base hospital.

REMSA treatment protocols, as approved, allow EMTs and EMT-Ps the latitude to provide treatments and perform procedures based on a thorough assessment of the patient’s complaint as well as their clinical presentation. It is incumbent upon the individual provider to know and understand their scope of practice based on their level of certification.
Introduction to the Treatment Protocols
Each REMSA treatment protocol included in this series constitutes medical control by the REMSA Medical Director, as specified in Section 1798 of the California Health and Safety Code, so long as it bears the following:

• A “Last Reviewed” date, indicating the most recent date that the protocol was reviewed in its entirety AND
• A “Last Revised” date, indicating the most recent date that a change was made to the protocol. These changes may include but not be limited to grammar, syntax, spelling formatting and/or content.

These protocols must be observed within the full context of the REMSA Policy Manual, which establishes the REMSA approved PSP, EMT, AEMT, or EMT-P scope of practice as specified in Title 22 of the California Code of Regulations.

Format of the Treatment Protocols
All REMSA treatment protocols follow a consistent format, where BLS patient management medications and procedures are contained in the first column (left) and ALS patient management medications and procedures are contained in the second column (right).

In general, most patients will be transported to the closest, most appropriate receiving center without issue. For all other patients, and if the section is present at the end of the individual treatment protocol, refer to “Patient Disposition” for specific instructions or suggestions regarding treatment and transport considerations.

Understanding the Treatment Protocols
• Medical Direction
Medical direction is provided through standing orders written into the REMSA treatment protocols, and through base hospital orders given during online / verbal base hospital contact. At no time may any REMSA authorized personnel operate beyond, or direct another to operate beyond, their REMSA approved scope of practice as established by the REMSA Policy Manual.

• Standing orders
REMSA treatment protocols include standing orders for medications, procedures, and dosages and/or dosing formulas, which apply to both adult and pediatric patients. Medications, concentrations, dosages, volumes, energy settings and advanced airway sizes for pediatric patients can be found in the REMSA Pediatric Medication Dosing Resource, located here: http://remsa.us/policy/PMDRCOMPLETE.pdf. Adult medication dosing and energy settings are embedded in each associated treatment protocol.

Standing orders are to be utilized as clinically indicated. Not every standing order in a treatment protocol must be carried out on every patient treated under that treatment protocol. A thorough assessment of the patient’s complaint, their clinical presentation, and sound judgment are required.

• Base hospital orders and contact
Base hospital contact is required when any clinically indicated medication or procedure is not included in the applicable standing orders, when directed by protocol, or when the EMT, AEMT, or EMT-P encounters any atypical presentation, circumstance, or is uncertain of any of the following:

1. The differential diagnosis and field impression
2. What therapeutic interventions are indicated
3. What patient disposition is indicated
Base hospital contact will be performed by the highest level of REMSA authorized provider at scene: EMT, AEMT, or paramedic. Orders issued by the base hospital may not exceed the scope of practice of the person making contact. BHOs are not provided to PSPs.

BHOs are given during base hospital contact: radio or phone voice communications with the MICN or BHP of a REMSA authorized base hospital. The MICN or BHP may also assume the base hospital role at any time while receiving notification.

**Using the Treatment protocols**

Pre-hospital Providers: After completing a thorough assessment of the patient’s complaint, condition and clinical presentation, the primary care provider at the scene will determine his / her primary impression. REMSA treatment protocols are categorized according to body systems, mechanisms of injury and natures of illness, with each impression corresponding to a specific treatment protocol in that category:

- 4100 – Key Policies
- 4200 – General Medical
- 4300 – Trauma
- 4400 – Cardiovascular / Pulmonary
- 4500 – Neurological
- 4600 – Toxicological
- 4700 – Environmental
- 4800 – Pregnancy and Childbirth

The primary care provider will determine the treatment protocol that most closely aligns with the patient’s complaint, condition and clinical presentation and begin providing care as outlined in the BLS Patient Management column. After all BLS treatments have been rendered, and if the patient’s condition warrants, continuation of treatment(s) as outlined in the ALS Patient Management column should be rendered. If a patient presents with multiple complaints and appropriate medications and/or procedures are contained in multiple treatment protocols, treatment of the most life-threatening conditions must occur first, before providing any other treatments.

**EX:**

*A patient complains of chest discomfort with associated nausea and vomiting. This patient should be treated utilizing BLS and ALS Patient Management strategies as outlined in REMSA Policy #4401 (Suspected Acute Coronary Syndrome) before administering Ondansetron / Zofran, as outlined in Policy #4203 (Nausea and/or Vomiting).*

Not all treatments, as outlined in each column, need to be provided to each patient. Additionally, treatments, as outlined in each column, do not need to be provided or performed in the order in which they are presented. A thorough assessment of the patient’s complaint, their clinical presentation, and the providers sound judgment are required to determine clinical necessity and appropriateness as well as the order in which they are rendered.

**Should the patient require immediate intervention(s) due to life threatening conditions, ALS Patient Management should be provided before BLS Patient Management is provided.**

MICNs / BHPs: The MICN or BHP may provide orders for further assessment, clarification, monitoring, procedures, medications, patient disposition and destination. MICNs and/or BHPs may not order medications, routes or procedures that are outside the EMT, AEMT, or EMT-P scope of practice. **FURTHERMORE, PREHOSPITAL PERSONNEL ARE NOT PERMITTED TO FOLLOW ORDERS THAT ARE GIVEN OUTSIDE OF THEIR SCOPE OF PRACTICE.**
PURPOSE: To identify all medications, concentrations, and dosing formulas for medications determined to be “alternative” or that are permitted for use in the event of a mass exposure to nerve agents, organophosphates, or carbamates (“CDC Medications”). In the event that a medication cannot be purchased in a concentration already approved by REMSA (see Policy #3303 (Drug and Equipment List)), a medication waiver must be submitted and approved by the REMSA Medical Director prior to purchase and deployment.

<table>
<thead>
<tr>
<th>Alternative Medications</th>
<th>Formula</th>
<th>CDC Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Albuterol MDI</strong></td>
<td>Adults: 2 metered doses (2 puffs)</td>
<td><strong>Atropine Autoinjector</strong></td>
</tr>
</tbody>
</table>
| *90 mcg / 1 puff*       | Pediatrics:  
  • Weight = 14 kg (=31 lbs) or less: **NOT PERMITTED**.  
  • Weight = 15 kg (=33 lbs) or more: 2 metered doses (2 puffs). | 2 mg / 0.7 mL  
  **MAY REPEAT PRN.** |
| **Atropine Autoinjector** | Adults: 2 mg (1 injection) IM. **MAY REPEAT PRN.** | Pediatrics: **NOT PERMITTED.** |
| *2 mg / 0.7 mL*         | Pediatrics: **NOT PERMITTED.** | **Atropine Autoinjector** |
| **Atropine Autoinjector** | Adults: 2 mg (2 injections) IM. **MAY REPEAT PRN.** | 1 mg / 0.7 mL  
  **MAY REPEAT PRN.** |
| *1 mg / 0.7 mL*         | Pediatrics:  
  • Weight = 14 kg (=31 lbs) or less: **NOT PERMITTED.**  
  • Weight = 15 kg (=33 lbs) or more: 1 mg IM. **MAY REPEAT PRN.** | **Atropine Autoinjector** |
| **Atropine Autoinjector** | Adults: 2 mg (4 injections) IM. **MAY REPEAT PRN.** | 0.5 mg / 0.7 mL  
  **MAY REPEAT PRN.** |
| *1 mg / 0.7 mL*         | Pediatrics: 0.5 mg IM x2. **MAY REPEAT PRN.** | **Atropine Autoinjector** |
| **Atropine Autoinjector** | Adults: 2 mg (1 injection) IM. **MAY REPEAT PRN.** | 2 mg / 0.7 mL  
  **MAY REPEAT PRN.** |
<table>
<thead>
<tr>
<th>Medication &amp; Concentration</th>
<th>Formula</th>
<th>Medication &amp; Concentration</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atropine Autoinjector</td>
<td>Adults: 2 mg (4 injections) IM. <strong>MAY REPEAT PRN.</strong>&lt;br&gt;Pediatrics: 0.5 mg IM x2. <strong>MAY REPEAT PRN.</strong></td>
<td>Diazepam - IM 10 mg / 2 mL</td>
<td>Adults: 5 mg (1 mL) IM</td>
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<td>0.5 mg / 0.7 mL</td>
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<td>Pediatrics: 0.1 mg / kg IM</td>
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<td></td>
<td>• Patients weighing 14 kg or less (=31 lbs): Preferred injection site is the lateral thigh. <strong>MAX VOLUME PER INJECTION IS 3 mL.</strong></td>
</tr>
<tr>
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<td>• Patients weighing 15 kg or more (=33 lbs): Preferred injection site is the deltoid. <strong>MAX VOLUME PER INJECTION IS 1 mL.</strong></td>
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<td><strong>ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER.</strong></td>
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<td>Pediatrics: <strong>NOT PERMITTED.</strong></td>
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<td></td>
<td><strong>Diazepam – IV</strong> 10 mg / 2 mL</td>
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<td>Adults: 2.5 mg (0.5 mL) IV</td>
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<td>Pediatrics: 0.05 mg / kg IV</td>
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<td></td>
<td><strong>Diazepam - IM</strong> 10 mg / 2 mL</td>
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<td></td>
<td><strong>Diazepam – IV</strong> 10 mg / 2 mL</td>
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<td></td>
<td>Adults: 2.5 mg (0.5 mL) IV</td>
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<td>Pediatrics: 0.05 mg / kg IV</td>
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<td></td>
<td><strong>Diazepam – IV</strong> Related to CPAP Mask 10 mg / 2 mL</td>
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<td>Adults: 1 mg / 0.2 mL IV.</td>
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<td></td>
<td></td>
<td>Pediatrics: <strong>NOT PERMITTED.</strong></td>
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<td></td>
<td><strong>Diazepam Autoinjector</strong> 10 mg / 2 mL</td>
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<td></td>
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<td>Adults: 10 mg (1 injection) IM. <strong>MAY REPEAT TWICE AT 15 MINUTE INTERVALS.</strong> <strong>ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER.</strong></td>
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<td>Pediatrics: <strong>NOT PERMITTED.</strong></td>
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<td></td>
<td><strong>Midazolam (Seizalam) – IV</strong> 5 mg / 1 mL OR 50 mg / 10 mL</td>
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<td></td>
<td>Adults: 2.5 mg (0.5 mL) IV</td>
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<td>Pediatrics: 0.05 mg / kg IV</td>
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<td></td>
<td><strong>DuoDote (NAAK) Autoinjector</strong> Atropine 2.1 mg / 0.7 mL &amp; Pralidoxime 600 mg / 2 mL</td>
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<td></td>
<td>Adults: 1 injection (both syringes) IM. <strong>MAY REPEAT TWICE.</strong></td>
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<td>Pediatrics: <strong>NOT PERMITTED.</strong></td>
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<td></td>
<td><strong>Mark I (NAAK) Autoinjector</strong> Atropine 2 mg / 0.7 mL &amp; Pralidoxime 600 mg / 2 mL</td>
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<td>Adults: 1 injection (both syringes) IM. <strong>MAY REPEAT TWICE.</strong></td>
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<td>Pediatrics: <strong>NOT PERMITTED.</strong></td>
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<td><strong>DuoDote (NAAK) Autoinjector</strong> Atropine 2.1 mg / 0.7 mL &amp; Pralidoxime 600 mg / 2 mL</td>
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<td>Adults: 1 injection (both syringes) IM. <strong>MAY REPEAT TWICE.</strong></td>
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<td></td>
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<td>Pediatrics: <strong>NOT PERMITTED.</strong></td>
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<tr>
<td>Medication &amp; Concentration</td>
<td>Formula</td>
<td>Medication &amp; Concentration</td>
<td>Formula</td>
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<tr>
<td><strong>Ketamine - IVPB</strong>&lt;br&gt;100 mg / 1 mL OR&lt;br&gt;10 mg / 1 mL</td>
<td>Adults: 0.3 mg / kg. Infuse in 50-100 mL Normal Saline, administer over 5 minutes. <strong>MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). MAX SINGLE DOSE IS 30 MG.</strong>&lt;br&gt;Pediatrics: <strong>NOT PERMITTED.</strong></td>
<td>Midazolam (Seizalam) - IM/IN&lt;br&gt;5 mg / 1 mL OR&lt;br&gt;50 mg / 10 mL</td>
<td>Adults: 5 mg (1 mL) IM/IN.&lt;br&gt;Pediatrics: 0.1 mg / kg IM/IN</td>
</tr>
<tr>
<td><strong>Ketamine - IN</strong>&lt;br&gt;100 mg / 1 mL OR&lt;br&gt;10 mg / 1 mL</td>
<td>Adults: 0.5 mg / kg IN. <strong>MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). MAX SINGLE DOSE IS 30 MG.</strong>&lt;br&gt;Pediatrics: <strong>NOT PERMITTED.</strong></td>
<td>Pralidoxime - IM&lt;br&gt;1000 mg / 5 mL (in 20 mL vial)</td>
<td>Adults: 600 mg (3 mL) IM. <strong>MAY REPEAT TWICE.</strong> Preferred injection site is the lateral thigh. <strong>MAX VOLUME PER INJECTION IS 3 mL AT THIS SITE.</strong>&lt;br&gt;Pediatrics: 20 mg / kg IM. <strong>MAY REPEAT TWICE.</strong>&lt;br&gt;• Patients weighing 14 kg or less (=31 lbs): Preferred injection site is the lateral thigh. <strong>MAX VOLUME PER INJECTION IS 3 mL AT THIS SITE.</strong>&lt;br&gt;• Patients weighing 15 kg or more (=33 lbs): Preferred injection site is the deltoid. <strong>MAX VOLUME PER INJECTION IS 1 mL AT THIS SITE.</strong></td>
</tr>
<tr>
<td><strong>Lorazepam – IV/IN</strong>&lt;br&gt;4 mg / 1 mL</td>
<td>Adults: 2.4 mg / 0.6 mL IV/IN.&lt;br&gt;Pediatrics: 0.05 mg / kg IV/IN.</td>
<td>Pralidoxime - IVPB&lt;br&gt;1000 mg / 20 mL</td>
<td>Adults: 600 mg (12 mL) IVPB.&lt;br&gt;Pediatrics: 20 mg / kg IVPB.</td>
</tr>
<tr>
<td><strong>Lorazepam - IM</strong>&lt;br&gt;4 mg / 1 mL</td>
<td>Adults: 5.2 mg / 1.3 mL IM.&lt;br&gt;Pediatrics: 0.1 mg / kg IM.&lt;br&gt;• Patients weighing 14 kg or less (=31 lbs): Preferred injection site is the lateral thigh.&lt;br&gt;• Patients weighing 15 kg or more (=33 lbs): Preferred injection site is the deltoid.</td>
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</tr>
<tr>
<td><strong>Lorazepam Related to CPAP Mask</strong>&lt;br&gt;4 mg / 1 mL</td>
<td>Adults: 1.2 mg (0.3 mL) slow IV/IO push or IM/IN.&lt;br&gt;Pediatrics: <strong>NOT PERMITTED.</strong></td>
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<tr>
<td>Medication &amp; Concentration</td>
<td>Formula</td>
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<td>----------------------------</td>
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</tbody>
</table>
| **Lorazepam – IV/IN**  
2 mg / 1 mL | Adults: 2.6 mg (1.3 mL) IV.  
Pediatrics: 0.05 mg / kg IV. |
| **Lorazepam - IM**  
2 mg / 1 mL | Adults: 5 mg (2.5 mL) IM.  
Pediatrics: 0.1 mg / kg IM.  
- Patients weighing 14 kg or less (≈31 lbs): Preferred injection site is the lateral thigh. **MAX VOLUME PER INJECTION IS 3 mL AT THIS SITE.**  
- Patients weighing 15 kg or more (≈33 lbs): Preferred injection site is the deltoid. **MAX VOLUME PER INJECTION IS 1 mL AT THIS SITE.** |
| **Lorazepam Related to CPAP Mask**  
2 mg / 1 mL | Adults: 1 mg (0.5 mL) slow IV/IO push or IM/IN.  
Pediatrics: **NOT PERMITTED.** |
| **Magnesium Sulfate**  
4 g / 100 mL (IV Bag) | Adults: 2 gm (50 mL) IV/IO.  
Pediatrics: 0.05 gm / kg IV/IO. |
| **Mark I (NAAK) Autoinjector**  
Atropine 2 mg / 0.7 mL & Pralidoxime 600 mg / 2 mL | Adults: 1 injection (both syringes) IM. **MAY REPEAT TWICE.**  
Pediatrics: **NOT PERMITTED.** |
| **Morphine Sulfate – IV/IM**  
10 mg / 1 mL | Adults: 5 mg (0.5 mL) IV/IM.  
Pediatrics: 0.1 mg / kg IV/IM.  
- Patients weighing 14 kg or less (≈31 lbs): Preferred injection site is the lateral thigh.  
- Patients weighing 15 kg or more (≈33 lbs): Preferred injection site is the deltoid. |
| **Morphine Sulfate – IV**  
10 mg / 10 mL | Adults: 5 mg (5 mL) IV.  
Pediatrics: 0.1 mg / kg IV. |
<table>
<thead>
<tr>
<th>Medication &amp; Concentration</th>
<th>Formula</th>
</tr>
</thead>
</table>
| **Morphine Sulfate - IM** 10 mg / 10 mL | Adults: 2.5 mg (2.5 mL) IM x2.  
Pediatrics: 0.1 mg / kg IM.  
• Patients weighing 14 kg or less (≈31 lbs): Preferred injection site is the lateral thigh. **MAX VOLUME PER INJECTION IS 3 mL AT THIS SITE.**  
• Patients weighing 15 kg or more (≈33 lbs): Preferred injection site is the deltoid. **MAX VOLUME PER INJECTION IS 1 mL AT THIS SITE.** |
| **Naloxone – IV/IM** 4 mg / 10 mL OR 0.4 mg / 1 mL | Adults: 0.5 mg (1.25 mL) IV/IM. **MAY REPEAT PRN.**  
Pediatrics: 0.1 mg / kg IV/IM. **MAX SINGLE DOSE IS 0.5 MG. MAY REPEAT PRN.** |
| **Naloxone - IN** 4 mg / 10 mL OR 0.4 mg / 1 mL | Adults: 0.4 mg (1 mL) IN. **MAY REPEAT PRN.**  
Pediatrics: 0.2 mg (0.5 mL) IN x2. **MAY REPEAT PRN.** |
| **Ondansetron – IM/IV** 40 mg / 20 mL | Adults: 4 mg (2 mL) IM/IV. **MAY REPEAT TWICE TO MAX 12 MG.**  
Pediatrics: 0.1 mg / kg IV/IM.  
• Patients weighing 14 kg or less (≈31 lbs): Preferred injection site is the lateral thigh. **MAX VOLUME PER INJECTION IS 3 mL AT THIS SITE.**  
• Patients weighing 15 kg or more (≈33 lbs): Preferred injection site is the deltoid. **MAX VOLUME PER INJECTION IS 1 mL AT THIS SITE.** |
<table>
<thead>
<tr>
<th>Medication &amp; Concentration</th>
<th>Formula</th>
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</thead>
<tbody>
<tr>
<td><strong>Pralidoxime - IM</strong>&lt;br&gt;1000 mg / 5 mL (in 20 mL vial)</td>
<td><strong>Adults</strong>: 600 mg (3 mL) IM. <strong>MAY REPEAT TWICE.</strong> Preferred injection site is the lateral thigh. <strong>MAX VOLUME PER INJECTION IS 3 mL AT THIS SITE.</strong>&lt;br&gt;&lt;br&gt;<strong>Pediatrics</strong>: 20 mg / kg IM. <strong>MAY REPEAT TWICE.</strong>&lt;br&gt;- Patients weighing 14 kg or less (≈31 lbs): Preferred injection site is the lateral thigh. <strong>MAX VOLUME PER INJECTION IS 3 mL AT THIS SITE.</strong>&lt;br&gt;- Patients weighing 15 kg or more (≈33 lbs): Preferred injection site is the deltoid. <strong>MAX VOLUME PER INJECTION IS 1 mL AT THIS SITE.</strong></td>
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<tr>
<td><strong>Pralidoxime - IVPB</strong>&lt;br&gt;1000 mg / 20 mL</td>
<td><strong>Adults</strong>: 600 mg (12 mL) IVPB.&lt;br&gt;&lt;br&gt;<strong>Pediatrics</strong>: 20 mg / kg IVPB.</td>
</tr>
<tr>
<td>Grey</td>
<td>Pink</td>
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<tr>
<td>4-5 kg</td>
<td>5-7 kg</td>
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<tr>
<th>50 kg</th>
<th>52 kg</th>
<th>54 kg</th>
<th>57 kg</th>
<th>59 kg</th>
<th>61 kg</th>
<th>64 kg</th>
<th>66 kg</th>
<th>68 kg</th>
<th>70 kg</th>
<th>73 kg</th>
<th>75 kg</th>
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<tbody>
<tr>
<td>110 lbs</td>
<td>115 lbs</td>
<td>120 lbs</td>
<td>125 lbs</td>
<td>130 lbs</td>
<td>135 lbs</td>
<td>140 lbs</td>
<td>145 lbs</td>
<td>150 lbs</td>
<td>155 lbs</td>
<td>160 lbs</td>
<td>165 lbs</td>
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<tr>
<th>77 kg</th>
<th>79 kg</th>
<th>82 kg</th>
<th>84 kg</th>
<th>86 kg</th>
<th>88 kg</th>
<th>91 kg</th>
<th>93 kg</th>
<th>95 kg</th>
<th>98 kg</th>
<th>100 kg</th>
<th>102 kg</th>
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<tr>
<td>170 lbs</td>
<td>175 lbs</td>
<td>180 lbs</td>
<td>185 lbs</td>
<td>190 lbs</td>
<td>195 lbs</td>
<td>200 lbs</td>
<td>205 lbs</td>
<td>210 lbs</td>
<td>215 lbs</td>
<td>220 lbs</td>
<td>225 lbs</td>
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## GENERAL MEDICAL SKILLS

### BLOOD GLUCOSE (BG) MONITORING
- Symptomatic hypoglycemia
- Neurological dysfunction
- History of diabetes
- Vague or general symptoms or complaints
- Need to reassess unusual and/or unexpected measurement(s)
- Need to reassess following treatment of hypoglycemia
- EMT, AEMT or EMT-P judgment
- At the request of a base hospital (BHO)

### INDICATION(S)
- Reassess patient's symptoms and prompt EMT, AEMT, or EMT-P to reassess if it is uncertain whether hypoglycemia has resolved.

### EXPECTATIONS
- None

Repeat as clinically indicated. BG should always be evaluated and documented prior to allowing the patient to refuse treatment and/or transport.
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<tr>
<th>SKILL</th>
<th>INDICATION(S)</th>
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<th>EMT</th>
<th>AEMT</th>
<th>EMT-P</th>
<th>CONTRAINDICATIONS</th>
<th>EXPECTATIONS</th>
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<tbody>
<tr>
<td>ECG APPLICATION AND MONITORING</td>
<td>Patients that present with the following signs and/or symptoms:</td>
<td>BLS Patient Management</td>
<td>ALS Patient Management</td>
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<td>Relative:</td>
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<td></td>
<td>• ACS (Chest pain, discomfort, pressure or tightness radiating to the jaw, shoulders, or arms)</td>
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<td>• Uncooperative patient</td>
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<td></td>
<td>• Known history of ACS</td>
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<td></td>
<td>• Life-threatening conditions</td>
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<tr>
<td></td>
<td>• Palpitations</td>
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<td></td>
<td></td>
<td></td>
<td>• Applying ECG leads</td>
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<td></td>
<td>• Unexplained diaphoresis</td>
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<td></td>
<td></td>
<td>will impede immediate patient care needs</td>
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<tr>
<td></td>
<td>• Dyspnea</td>
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<td></td>
<td>• Syncope, near syncope, or dizziness</td>
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<td></td>
<td>• Altered mental status</td>
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<td></td>
<td>• Epigastric pain</td>
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<tr>
<td></td>
<td>• General weakness</td>
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<tr>
<td></td>
<td>• Congenital heart problems</td>
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<tr>
<td>SKILL</td>
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<td>EMT-P</td>
<td>CONTRAINDICATIONS</td>
<td>EXPECTATIONS</td>
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|-----------------------------|-------------------------------------------------------------------------------|----------------------------|------------------------|------------------------|--------------------------------|----------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|--
| ECG APPLICATION AND MONITORING - 12-LEAD | Patients that present with the following signs and/or symptoms:  
- ACS (Chest pain, discomfort, pressure or tightness radiating to the jaw, shoulders, or arms)  
- Known history of ACS  
- New onset cardiac dysrhythmias (including adult cardiac arrest, if return of spontaneous circulation occurs)  
- Palpitations  
- Unexplained diaphoresis  
- Dyspnea  
- Syncope, near syncope, or dizziness  
- Altered mental status  
- Epigastric pain  
- General weakness  
- Congenital heart problems  
- Any patient the EMT-P feels would benefit from a 12-lead ECG assessment | BLS Patient Management | ALS Patient Management | MAY ASSIST WITH PLACEMENT OF LEADS BUT MAY NOT INTERPRET | MAY ASSIST WITH PLACEMENT OF LEADS BUT MAY NOT INTERPRET | Relative:  
- Uncooperative patient  
- Life-threatening conditions  
- Applying and performing 12-lead will impede immediate patient care needs | 12-lead ECGs should be transmitted to a STEMI Receiving Center when:  
- A STEMI is suspected  
- A STEMI is ECG-monitor identified or  
- The patient’s cardiac rhythm is atypical or difficult to interpret  
Serial 12-lead ECGs should be performed on patients when acute MI is suspected |
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<tr>
<th>SKILL</th>
<th>INDICATION(S)</th>
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<th>CONTRAINDICATIONS</th>
<th>EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>INDWELLING DEVICE ACCESS</td>
<td>• When fluid resuscitation or medications need to be provided and peripheral IV access and IO access is unobtainable</td>
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<td></td>
<td>NOT PERMITTED IN RIVERSIDE COUNTY</td>
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<tr>
<td></td>
<td>BLS Patient Management</td>
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<td></td>
<td>ALS Patient Management</td>
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<tr>
<td>INTRAMUSCULAR INJECTION</td>
<td>• When unable to establish peripheral IV access for medication administration</td>
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<td>MAY ONLY ASSIST</td>
<td>• The preferred site in patients greater than or equal to 3 years of age is the deltoid (maximum of 1 ml volume)</td>
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<td>• When the desired route for administration of a medication is IM</td>
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<td>WITH THE USE OF PATIENT’S RXd EPI-PEN</td>
<td>• The preferred site in patients less than or equal to 3 years of age is the vastus lateralis (maximum of 3 ml volume)</td>
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<tr>
<td>INTRANASAL NALOXONE (IN) ADMINISTRATION BY PUBLIC SAFETY PERSONNEL</td>
<td>• Respiratory depression / arrest with suspected narcotic overdose</td>
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<td>REQUIRE RSMA APPROVAL</td>
<td>• PSPs working for agencies that are REMSA authorized to administer intranasal naloxone may provide 4 mg IN following procedures outlined in policy #3309 and in REMSA approved training</td>
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<td>INTRANASAL MEDICATION ADMINISTRATION</td>
<td>• When unable to establish peripheral IV access for medication administration</td>
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<td>• Significant nasal trauma • Significant amount of blood or dried mucous discharge present in the nare(s)</td>
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<td>• When the desired route for administration of a medication is IN</td>
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<td>Volumes over 1 ml per nostril are likely too large and may result in runoff out of the nostril. Attempt to administer less, if possible</td>
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<td>SKILL</td>
<td>INDICATION(S)</td>
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<td>AEMT</td>
<td>EMT-P</td>
<td>CONTRAINDICATIONS</td>
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<tr>
<td>INTRAOSSEOUS (IO) ACCESS</td>
<td>• When unable to establish peripheral IV access for medication administration</td>
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<td>IO access is considered the primary vascular access route in patients eight (8) years of age and younger</td>
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<td></td>
<td>AEMTs may use:</td>
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<td>• the Waismed Bone Injection Gun (B.I.G.) at the proximal tibia in pediatrics only</td>
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<td>Any clinically indicated insertion site may be used by EMT-Ps in any patient following discussion with the base hospital physician (BHPO) concerning the risks and benefits, the operator’s training and experience, and limitations of the available device</td>
</tr>
<tr>
<td>Skill</td>
<td>Indication(s)</td>
<td>PSP</td>
<td>EMT</td>
<td>AEMT</td>
<td>EMT-P</td>
<td>Contraindications</td>
<td>Expectations</td>
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<tr>
<td><strong>Intraosseous (IO) Access: LIDOCAINE Administration for Pain During IO Infusion in the Conscious Patient</strong></td>
<td>Standing order: Pain during IO infusion in the conscious patient</td>
<td>Red</td>
<td>Red</td>
<td>Green</td>
<td>None</td>
<td>Adults: 50 mg (2.5 mL) slow IO push over 1 minute. Additional administrations require a base hospital order (BHO). Pediatrics: 0.5 mg / kg slow IO push over 1 minute. Additional administrations require a base hospital order (BHO). For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
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<tr>
<td><strong>Intraosseous Access - External Jugular</strong></td>
<td>When unable to establish peripheral IV access, or IO access, when medication administration or fluid resuscitation is required</td>
<td>Red</td>
<td>Red</td>
<td>Red</td>
<td>Red</td>
<td>Patients who: • Are eight (8) years of age or younger • Cannot tolerate lying supine • Are actively vomiting • Have a neck mass or evidence of infection at or near the intended insertion site • Have a VP shunt on the side of the intended insertion Have obscured landmarks Avoid using large bore catheters</td>
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<tr>
<td><strong>Intraosseous Access - Peripheral</strong></td>
<td>Administration of medication(s), the need for fluid replenishment and/or anticipation of administration of either</td>
<td>Red</td>
<td>Red</td>
<td>Green</td>
<td>None; however, care should be taken in patients with coagulopathy and in the presence of local infection, burns, or compromised skin at the intended site of insertion When the administration of medication(s) or the need for fluid replenishment is not indicated but is anticipated, placement of a saline lock ONLY is appropriate. Administration of IV fluids should always be clinically indicated and given as a bolus, not at a TKO rate.</td>
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<td>SKILL</td>
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<td>CONTRAINDICATIONS</td>
<td>EXPECTATIONS</td>
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<td>BLS Patient Management</td>
<td>ALS Patient Management</td>
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<tr>
<td>PAIN MANAGEMENT</td>
<td>• When a patient complains of pain greater than 5 / 10 on the pain scale and would benefit from the administration of analgesics</td>
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<td><strong>NOTE:</strong> the administration of Fentanyl to its max dose followed by the administration of Ketamine – or vice versa – is a standing order.</td>
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<td>Fentanyl:</td>
<td>REPETITION OF ANY ANALGESIC AFTER ALL MAX DOSES HAVE BEEN ADMINISTERED REQUIRES A BASE HOSPITAL ORDER (BHO)</td>
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<td></td>
<td>• Sensitivity to opioids</td>
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<td>• Hypotension / systolic BP less than 90 mmHg</td>
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<td></td>
<td>Ketamine:</td>
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<td>• Patients less than 15 years of age</td>
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<td>• Sensitivity to Ketamine</td>
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<td>• Pain / discomfort of suspected cardiac origin</td>
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<tr>
<td>SUPPLEMENTAL OXYGEN</td>
<td>• Pulse oximetry reading of less than 94% in the presence of shortness of breath</td>
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<tr>
<td>THERAPY</td>
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<tr>
<td>VENOUS BLOOD SAMPLING</td>
<td>• Obtaining IV access for the purpose of taking a venous blood sample at the request of law enforcement</td>
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<td>NOT PERMITTED IN RIVERSIDE COUNTY</td>
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<td>SKILL</td>
<td>INDICATION(S)</td>
<td>PSP</td>
<td>EMT</td>
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<td>CONTRAINDICATIONS</td>
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<td>AIRWAY MANAGEMENT</td>
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</table>
| ADJUNCT – NASOPHARYNGEAL (NPA) | • Inadequate / ineffective positive pressure ventilations  
• Conscious patients who cannot tolerate an OPA |     |     |      |       | • Signs of basilar skull fractures, facial trauma, and any disruption of the midface, nasopharynx or roof of the mouth  
• Patients with suspected epiglottitis  
• Coagulopathic patients (including those taking anti-coagulants) due to the risk of hemorrhage  
• Patients with large nasal polyps  
• Patients who have had recent nasal surgery |     |     |      |       | Nasopharyngeal airways (NPAs) are the preferred BLS adjunct                      |                                                                               |
| ADJUNCT – OROPHARYNGEAL (OPA) | • Inadequate / ineffective positive pressure ventilations |     |     |      |       | • Patients with an intact gag reflex  
• Patients with a foreign body obstructing the airway | Nasopharyngeal airways (NPAs) are the preferred BLS adjunct |
| SUCTIONING            | • Mucus, blood or foreign body obstruction in the airway  
• Low SpO₂ with audible gurgling sounds  
• Cyanosis associated with airway compromise  
• Difficulty in ventilating patient due to high airway pressures  
• Request by the conscious patient: The patient may be familiar with their own airway status and need for suctioning  
• Significant increase in stridor or changes in breathing sounds associated with audible gurgling sounds |     |     |      |       | • None                                                                              | 3 mL of normal saline may be introduced during suctioning to loosen thickened secretions. **MAY REPEAT PRN.** |
<table>
<thead>
<tr>
<th>SKILL</th>
<th>INDICATION(S)</th>
<th>PSP</th>
<th>EMT</th>
<th>AEMT</th>
<th>EMT-P</th>
<th>CONTRAINDICATIONS</th>
<th>EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BAG VALVE MASK (BVM) / POSITIVE PRESSURE</td>
<td>• Inadequate / ineffective respirations REQUIRES REMSA APPROVAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
<td>• All ALS provider agencies MUST use waveform / digital capnography when providing rescue ventilations via BVM</td>
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<tr>
<td>VENTILATIONS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Nasopharyngeal airways (NPAs) are the preferred BLS airway when providing rescue ventilations via BVM</td>
</tr>
<tr>
<td>CAPNOGRAPHY - COLOMETERS</td>
<td>• For use immediately after orotracheal intubation to confirm correct placement of the ETT, prior to use of waveform / digital capnography</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
<td>• A colormetric device may be used in conjunction with waveform / digital capnography but it does not take the place of waveform / digital capnography use</td>
</tr>
<tr>
<td>CAPNOGRAPHY - WAVEFORM / DIGITAL</td>
<td>• To identify ETT dislodgement • To assist in monitoring the effectiveness of ventilations and perfusion in any patient • To monitor the quality of chest compressions in cardiac arrest patients • To confirm ROSC • To monitor the status of asthmatic, CHF, COPD and/or PE patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>None</td>
<td>• In the event of waveform / digital capnography failure, the use of a colormetric device is mandatory</td>
</tr>
</tbody>
</table>

Waveform / digital capnography utilization, interpretation and documentation is mandatory:

- Immediately following orotracheal intubation
- After every patient movement
- Prior to transfer of care to hospital staff
- With any change in patient condition
- When providing positive pressure ventilations via BVM when EMT-Ps are present
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<tr>
<th>SKILL</th>
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</tr>
</thead>
</table>
| CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP) | An awake, alert patient who can maintain their own airway and complains of severe respiratory distress suggestive of:  
- CHF exacerbation  
- COPD exacerbation  
- Asthma Exacerbation  
- Non-fatal drowning | MAY ONLY ASSIST WITH APPLICATION IN THE PRESENCE OF AN EMT-P | MAY ONLY ASSIST WITH APPLICATION IN THE PRESENCE OF AN EMT-P | | | Apnea  
Unconsciousness  
Pediatric patients (appearing to be 14 years of age or less)  
Suspected pneumothorax  
Vomiting  
Pump failure due to severe bradycardia or non-compensatory tachycardia (treat rate first)  
Systolic blood pressure of 90 mmHg or less | Begin at 5 cmH2O and increase pressure in 2.5 – 5 cmH2O increments, to max 15 cmH2O. TITRATE TO RELIEF OF DYSPNEA.  
INCREASING PRESSURE TO 20 cmH2O REQUIRES A BASE HOSPITAL ORDER (BHO). |
| CRICO - THYROIDOTOMY, NEEDLE | • When airway management is required for a patient in severe respiratory distress in whom less invasive techniques (e.g., BLS airway management and OTI) have failed or are not likely to be successful | NOT PERMITTED IN RIVERSIDE COUNTY | | | | |
| CRICO - THYROIDOTOMY, SURGICAL | • When airway management is required for a patient in severe respiratory distress in whom less invasive techniques (e.g., BLS airway management and OTI) have failed or are not likely to be successful | NOT PERMITTED IN RIVERSIDE COUNTY | | | | |
| DIRECT LARYNGOSCOPY WITH MAGILL FORCEPS | • When the need to visualize the airway exists due to inadequate ventilations and/or signs of hypoxia in the presence of a suspected, or confirmed, foreign body airway obstruction (FBAO) | | | | | None  
Suction and oxygenate as clinically indicated |
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<th>SKILL</th>
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<th>EXPECTATIONS</th>
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</thead>
</table>
| INDIRECT LARYNGOSCOPY USING VIDEO DEVICES | • To assist with visualization of the airway due to inadequate ventilations and/or signs of hypoxia in the presence of a suspected, or confirmed, foreign body airway obstruction (FBAO)  
• To assist with visualization of the trachea during orotracheal intubation | **BLS Patient Management** | **ALS Patient Management** | | | | • Presence of facial trauma |
| NASOGASTRIC TUBE PLACEMENT | • To facilitate passive gastric decompression | | | | | **NOT PERMITTED IN RIVERSIDE COUNTY** | |
| OROGASTRIC TUBE PLACEMENT | • To facilitate passive gastric decompression after orotracheal intubation (OTI) or the insertion of an i-gel supraglottic airway device. | | | | | | • After successful OTI, insertion of an appropriately sized OG tube is **highly recommended.**  
• After successful placement of the i-gel, insertion of an appropriately sized OG tube is **mandatory.**  
Determine appropriately sized OG tube based on:  
1. The available tube size, post-OTI OR  
2. The size of the i-gel supraglottic airway device being inserted  
Use the appropriate measuring technique to ensure proper placement.  
Confirm proper placement then secure to the airway device or the patient’s face. | • Pediatric patients (appearing, or known to be, 14 years of age or less)  
• The patient’s airway is **NOT** being managed with an ETT or i-gel supraglottic airway device.  
• Adult patients weighing less than 36 kg / 79.2 lbs. **AND** whose length (measured from crown to heel) falls within the range of any commercially available, standardized length-based pediatric resuscitation tape. |
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<thead>
<tr>
<th>SKILL</th>
<th>INDICATION(S)</th>
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<tbody>
<tr>
<td>INTUBATION - NASAL</td>
<td>• When BLS airway management is inadequate and/or ineffective and orotracheal intubation is contraindicated or not possible</td>
</tr>
<tr>
<td>INTUBATION – OROTRACHEAL (OTI), ADULT</td>
<td>• When BLS airway management is inadequate and/or ineffective</td>
</tr>
</tbody>
</table>

**BLS Patient Management**

**NOT PERMITTED IN RIVERSIDE COUNTY**

**EMT**

**EMT-P**

**CONTRAINDICATIONS**

**EXPECTATIONS**

- When BLS airway management **is inadequate and/or ineffective**
- Patients weighing less than 36 kg / 79.2 lbs. **AND** whose length (measured from crown to heel) falls within the range of any commercially available, standardized length-based pediatric resuscitation tape.
- Utilize a colormetric device immediately after OTI to confirm correct placement of the ETT THEN utilize waveform / digital capnography to:
  - Identify ETT dislodgement
  - Assist in monitoring the effectiveness of ventilations and perfusion in the intubated patient
  - Monitor the quality of chest compressions in cardiac arrest patients
  - Confirm ROSC

- Remove the ETT immediately if esophageal placement is suspected.

- In the event of waveform / digital capnography failure, the use of a colormetric device is mandatory.

- The appropriate depth of an ETT is ½ - 1 inch beyond the vocal cords, usually between the 22 - 23 cm marking at the teeth.

- The target range for ETCO₂ levels is between 30 – 45 mmHg if ROSC is present. The target range for ETCO₂ levels is between 15 mmHg – 45 mmHg during CPR.

- After successful OTI, insertion of an appropriately sized OG tube is highly recommended.
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<th>SKILL</th>
<th>INDICATION(S)</th>
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<td></td>
<td></td>
<td>BLS Patient Management</td>
<td>ALS Patient Management</td>
<td></td>
<td>None</td>
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<tr>
<td>INTUBATION – OROTRAQUEAL (OTI), ADULT WITH INTRODUCER / BOUGIE</td>
<td>• When ETT placement / orotracheal intubation assistance is needed due to a difficult airway</td>
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<td>The introducer is correctly placed when:</td>
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<td>• It can be seen going through the vocal cords</td>
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<td>• Ratcheting of the tip can be felt on the tracheal rings as it is introduced and/or</td>
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<td>• When resistance is met after it has been advanced (the tip is at the carina).</td>
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<td></td>
<td>If no resistance is encountered and the entire length of the introducer is inserted, the device is in the esophagus</td>
<td></td>
</tr>
<tr>
<td>INTUBATION - OROTRAQUEAL, PEDIATRIC / NEONATE</td>
<td>• When BLS airway management is inadequate and/or ineffective in the pediatric and/or neonate patient</td>
<td>NOT PERMITTED IN RIVERSIDE COUNTY</td>
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<tr>
<td>INTUBATION - OROTRAQUEAL, RAPID SEQUENCE (RSI)</td>
<td>• When BLS airway management is inadequate and/or ineffective and rapid airway management is necessary through the use of induction, and paralytic, medications</td>
<td>NOT PERMITTED IN RIVERSIDE COUNTY</td>
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<tr>
<td>INTUBATION - STOMAL</td>
<td>• When BLS airway management is inadequate and/or ineffective and an ETT is used to control a patient’s airway through a pre-existing tracheal stoma</td>
<td>NOT PERMITTED IN RIVERSIDE COUNTY</td>
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</table>
| i-gel / SUPRAGLOTTIC AIRWAY DEVICE | When airway management is required for a patient that is apneic in whom:  
  • Less invasive techniques (BLS airway management) have failed AND  
  • OTI has failed  
  Patients must meet ALL of the following criteria:  
  1. Apnea or inadequate respirations (usually less than eight (8) breaths per minute)  
  2. Unresponsive to verbal and/or tactile stimuli  
  3. Absence of a gag reflex  
  4. Airway management is unsuccessful using BLS maneuvers (BVM with oral / nasal adjuncts)  
  5. Airway management is unsuccessful after oral endotracheal intubation (OTI)  
  6. An appropriately sized airway is available | BLS Patient Management | ALS Patient Management | Introduction of the i-gel is contraindicated if ANY of the criteria below exist:  
  • The patient appears, or is known to be, 14 years of age or younger (pediatric)  
  • The patient is an adult but weighs less than 36 kg / 79.2 lbs. AND their length (measured from crown to heel) falls within the range of any commercially available, standardized length-based pediatric resuscitation tape.  
  • The patient is conscious and has an intact gag reflex  
  • Known ingestion of caustic substances  
  • Unresolved upper foreign body airway obstruction (FBAO)  
  • Severe facial or esophageal trauma, bleeding or swelling of the airway or an unstable jaw fracture  
  • The patient has a known esophageal disease or diseases (e.g., cancer, varices, surgery, etc.)  
  • The patient’s airway can be maintained using less invasive methods (i.e., BVM with oral / nasal adjuncts)  
  Determine appropriately sized i-gel device based on the patient’s estimated weight  
  Apply appropriate, clinically required technique to manually position the head and mandible of the unconscious patient to open the upper airway  
  Insert the i-gel supraglottic airway device into the patient’s mouth, directing it towards the hard palate. The cuff outlet should be facing the patient’s chin.  
  Advance the i-gel supraglottic airway device with gentle but continuous pressure until definitive resistance is felt. The integral bite block should rest at the incisors.  
  After successful placement of the i-gel, insertion of an appropriately sized OG tube is mandatory. |
| PULSE OXIMETRY (SpO₂) | When the patient has:  
  • A chief complaint of respiratory, cardiovascular and neurological complications  
  • Abnormal vital signs  
  • Any sign or symptom that indicates that they would benefit from SpO₂ monitoring | | | | | Oxygen administration should be titrated to maintain, or increase, SpO₂ to a minimum of 94%.  
  A range of 88-92% is acceptable for patients with a history of COPD | | | None |
<table>
<thead>
<tr>
<th>SKILL</th>
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<th>EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AUTOMATED EXTERNAL DEFIBRILLATOR (AED)</strong></td>
<td>• Cardiac arrest</td>
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<td></td>
<td>AED patches should not be placed over implanted medical devices, jewelry or transdermal medication patches</td>
</tr>
<tr>
<td><strong>MANUAL DEFIBRILLATION</strong></td>
<td>• Ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT) in the cardiac arrest patient</td>
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<td></td>
<td>Settings: Adults: Use manufacturer recommended joule settings Peds: Initial = 2 J / kg. Subsequent = 4 J / kg.</td>
</tr>
<tr>
<td><strong>MECHANICAL CPR DEVICE</strong></td>
<td>• Patients in cardiac arrest</td>
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<td></td>
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<td></td>
<td>Application and use requires provider agency training Patients not in cardiac arrest</td>
</tr>
</tbody>
</table>

**CARDIAC CARE SKILLS**

**The presence of:**
- Palpable pulses
- Spontaneous respirations
- A DNR
- A POLST

**Settings:**
- Adults: Use manufacturer recommended joule settings
- Peds: Initial = 2 J / kg. Subsequent = 4 J / kg.

- Anterior-posterior placement of defibrillation pads is recommended to minimize pain and maximize current conduction.

- Patients who are being monitored and have a perfusing rhythm that develops into VF or VT (i.e. witnessed arrest) should be treated with stacked defibrillation attempts, at escalating energy dosages, per the manufacturer’s recommended energy dose.

- Chest compressions should be applied between stacked defibrillation attempts

- Stacked defibrillation attempts should not exceed three (3) attempts.
<table>
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<tr>
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<td></td>
<td>BLS Patient Management</td>
<td>ALS Patient Management</td>
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**SYNCHRONIZED CARDIOVERSION**

Patients experiencing symptomatic supraventricular tachycardia (SVT) or VT with pulses who are exhibiting the following signs and symptoms of systemic poor perfusion:

- Hypotension
- Altered mental status
- Chest pain
- Dyspnea / tachypnea
- Diaphoresis
- Pale / cool skin

**AND**

- Have a heart rate greater than 150 in adults
- Have a heart rate greater than 180 in children
- Have a heart rate greater than 220 in infants

**SYNCHRONIZED CARDIOVERSION OF PEDIATRIC PATIENTS REQUIRES A BASE HOSPITAL ORDER (BHO)**

- Patients not experiencing symptomatic SVT or VT with pulses

**CONTRAINDICATIONS**

- Adults:
  - Initial 100j
  - Second 150j
  - Subsequent 200j

- Peds:
  - Initial = 1 j / kg.
  - Subsequent = 2 j / kg.

- Anterior-posterior placement of defibrillation pads is recommended to minimize pain and maximize current conduction.

- An ECG strip of Lead II should always be printed prior to, during and after performing any electrical therapy. Wide complex rhythms may appear to be cardiac dysrhythmias when, in fact, they are paced rhythms (some monitors do not show pacer spikes).

- Perform a 12-lead ECG prior to cardioversion only if such a delay does not cause harm to the patient.

- Strongly consider Versed for amnesic effects while preparing cardioversion equipment. Use IN/IM administration if IV access is poor.

- Do not delay cardioversion in an unstable patient presenting with signs and symptoms of poor perfusion.
<table>
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<tr>
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<th>EXPECTATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TRANSCUTANEOUS CARDIAC PACING (TCP)</td>
<td>Patients experiencing symptomatic bradycardia who are exhibiting the following signs and symptoms of systemic poor perfusion:</td>
<td></td>
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<td>Begin at 20 mA and 70 bpm. Titrate in 5 mA increments to find the minimum current required to maintain electrical and mechanical capture. Increase in 10 bpm increments, up to 100 bpm maximum, to gain adequate cardiac output and tissue perfusion.</td>
</tr>
<tr>
<td></td>
<td>• Hypotension</td>
<td></td>
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<td></td>
<td></td>
<td>• Anterior-posterior placement of pacer pads is recommended to minimize pain and maximize current conduction.</td>
</tr>
<tr>
<td></td>
<td>• Altered mental status</td>
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<td></td>
<td>• An ECG strip of Lead II should always be printed prior to performing any electrical therapy. Wide complex rhythms may appear to be cardiac dysrhythmias when, in fact, they are paced rhythms (some monitors do not show pacer spikes).</td>
</tr>
<tr>
<td></td>
<td>• Chest pain</td>
<td></td>
<td></td>
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<td></td>
<td>• Perform a 12-lead ECG prior to TCP only if such a delay does not cause harm to the patient.</td>
</tr>
<tr>
<td></td>
<td>• Dyspnea / tachypnea</td>
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<td></td>
<td></td>
<td>• Use IN/IM administration for Versed administration if warranted and if IV access is poor.</td>
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<tr>
<td></td>
<td>• Diaphoresis</td>
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<td>• Do not delay TCP in patients with poor peripheral vasculature or in patients experiencing high-degree blocks (2nd degree Type II or 3rd degree)</td>
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<tr>
<td></td>
<td>• Pale / cool skin</td>
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<td></td>
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<td></td>
<td>• Have a heart rate less than 60</td>
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<tr>
<td></td>
<td><strong>TRANSCUTANEOUS CARDIAC PACING OF PEDIATRIC PATIENTS REQUIRES A BASE HOSPITAL ORDER (BHO)</strong></td>
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<tr>
<td>VAGAL</td>
<td>Patients experiencing symptomatic supraventricular tachycardia (SVT) who are</td>
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<td>• An ECG strip of Lead II should always be printed prior to, during and</td>
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<tr>
<td>MANEUVERS</td>
<td>exhibiting the following signs and symptoms of systemic poor perfusion:</td>
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<td>immediately after to a vagal maneuver in order to capture any potential</td>
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<tr>
<td></td>
<td>• Hypotension</td>
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<td></td>
<td>rhythm change(s)</td>
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<tr>
<td></td>
<td>• Altered mental status</td>
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<td></td>
<td>• Perform a 12-lead ECG prior to the patient attempting a vagal maneuver</td>
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<td></td>
<td>• Chest pain</td>
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<td>only if such a delay does not cause harm to the patient.</td>
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<tr>
<td></td>
<td>• Dyspnea / tachypnea</td>
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<td></td>
<td>• Do not delay cardioversion in an unstable patient presenting with signs</td>
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<tr>
<td></td>
<td>• Diaphoresis</td>
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<td>and symptoms of poor perfusion.</td>
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<td>• Pale / cool skin</td>
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<td></td>
<td>• Have a heart rate greater than 150 in adults</td>
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<td>• Have a heart rate greater than 180 in children</td>
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<td>• Have a heart rate greater than 220 in infants</td>
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### CERVICAL SPINE IMMOBILIZATION

The patient complains of:

- Spinal pain after a confirmed, or suspected, traumatic injury
- Acute neurological deficit following a confirmed, or suspected, traumatic injury

**THEN**

Establish, maintain, and ensure cervical spine stabilization when NSAID criteria is met:

- Neuro deficits
- Spinal Tenderness
- Altered Mental Status
- Intoxication
- Distracting Injury

**CONTRAINDICATIONS**

- Victims of any penetrating trauma to the head, neck, and/or torso should not have a rigid cervical spine immobilization device applied unless one of the following are present:
  - Acute neurological deficit
  - Priapism
  - Anatomic deformity to the spine secondary to injury

**EXPECTATIONS**

- The long backboard (LBB) is an extrication tool and should only be used to facilitate patient transfer to the stretcher. It is not intended, or appropriate, to use a LBB to achieve or maintain spinal stabilization. Judicious application of the LBB for purposes other than extrication require that the benefits outweigh the risks of application. If the LBB is used, patients should be removed as soon as soon as is safe and practical***

---

### HEMOSTATIC AGENTS

- Life-threatening hemorrhage when a tourniquet cannot be used
- When bleeding remains uncontrolled after application of a tourniquet

**CONTRAINDICATIONS**

- None

**EXPECTATIONS**

- Acceptable hemostatic dressings for use in California include the following:
  - QuikClot® Combat Gauze™.
  - HemCon® ChitoFlex® PRO Dressing.
  - Celox™ Gauze

---

### JOINT REDUCTION

- When manual manipulation of a dislocated joint is required to return it to its proper anatomical alignment.

**CONTRAINDICATIONS**

- NOT PERMITTED IN RIVERSIDE COUNTY
<table>
<thead>
<tr>
<th>SKILL</th>
<th>INDICATION(S)</th>
<th>PSP</th>
<th>EMT</th>
<th>AEMT</th>
<th>EMT-P</th>
<th>CONTRAINDICATIONS</th>
<th>EXPECTATIONS</th>
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</thead>
<tbody>
<tr>
<td>NEEDLE DECOMPRESSION / THORACOSTOMY</td>
<td>Signs and symptoms of tension pneumothorax:</td>
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<td>• Elevated hemithorax without respiratory movement</td>
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<td>• Hypotension</td>
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<td>• Respiratory distress</td>
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<td>• Unilateral absence of breath sounds</td>
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<td>• Cyanosis (late sign)</td>
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<td>• Tracheal deviation away from the side of the injury (late sign)</td>
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<td>For unilateral decompression:</td>
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<td>• Signs and symptoms of tension pneumothorax with compromised cardiac output</td>
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<td>AND rapidly progressing respiratory distress unrelieved by less invasive means</td>
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<td>For bilateral decompression</td>
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<td>• Cardiac arrest with known/suspected torso trauma</td>
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<td>• Cardiac arrest with a presentation suggesting spontaneous pneumothorax</td>
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<td>Anterior approach:</td>
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<td>the third (3rd) rib (2 ICS @ MCL)</td>
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<td>the fourth (4th) rib (3 ICS @ MCL)</td>
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<td>• When unable to positively identify the appropriate anatomical landmarks</td>
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<td>• When none of the listed indications are present</td>
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<td>• Fourth (4th) intercostal space at the anterior axillary line immediately</td>
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<td>above the fifth (5th) rib (4 ICS @ AAL)</td>
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<td>above the sixth (6th) rib (5 ICS @ AAL)</td>
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<td>• Four lateral thoracostomy</td>
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<td>the fifth (5th) rib (4 ICS @ MAL)</td>
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<td>CONTRAINDICATIONS</td>
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<tr>
<td>TOURNIQUET</td>
<td>• Life-threatening hemorrhage when bleeding is uncontrolled after direct pressure has been applied</td>
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<td>• When bleeding is controlled after direct pressure has been applied</td>
<td>• Tourniquets must be approved for use by the Co-TCCC and the SWAT-T</td>
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<td>APPLICATION</td>
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<td>• Do not delay tourniquet application to extricate / load patient, establish IVs, or other treatments</td>
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<td>• If the patient’s condition allows, use of a tourniquet prior to TXA administration is recommended</td>
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<td>• Pain management should be considered unless clinically contraindicated</td>
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<td>Drug Name</td>
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<td>CALCIUM CHLORIDE</td>
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<td>DIPHENHYDRAMINE (BENADRYL)</td>
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<td>EPINEPHRINE</td>
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<td>GLUCAGON</td>
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<td>GLUCOSE (ORAL)</td>
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<td>IPRATROPIUM BROMIDE (ATROVENT)</td>
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<td>KETAMINE (KETALAR)</td>
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<td>MAGNESIUM SULFATE</td>
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<td>MIDAZOLAM (VERSED)</td>
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<td>NALOXONE (NARCAN)</td>
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<td>SODIUM BICARBONATE</td>
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<td>TRANEXAMIC ACID (TXA)</td>
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</table>
**ADENOSINE (ADENOCARD)**

**CLASS:**
- Endogenous nucleoside (occurs naturally in all cells of the body)

**ACTION:**
- Slows electrical conduction through AV node, and inhibits re-entry pathway, converting SVT to NSR
- ONSET = within 15 seconds
- DURATION= 1-2 minutes

<table>
<thead>
<tr>
<th>INDICATION</th>
<th>DOSAGE/ROUTE</th>
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<tbody>
<tr>
<td>Symptomatic supraventricular tachycardia (SVT) with Pulses (4403)</td>
<td>Adults: Adenosine 12 mg (4 mL) rapid IV/IO push. Follow immediately with 20 mL normal saline rapid IV/IO push. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
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<tr>
<td></td>
<td>Pediatrics: Adenosine 0.2 mg / kg rapid IV/IO push. Follow immediately with 20 mL normal saline rapid IV/IO push. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
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</tbody>
</table>

**CONTRAINDICATIONS:**
- 2nd and 3rd degree AV heart blocks
- Sick sinus syndrome (without pacemaker)

**USE WITH CAUTION:**
- Patients with a history of COPD, asthma, or bronchospasm; Adenosine has been found to stimulate vagal nerve fibers in the lungs, causing an acute onset of difficulty breathing, asthma attacks and/or bronchospasm.

**SIDE EFFECTS:**
- SOB / Dyspnea
- Chest pressure / palpitations; may be acute in some patients for brief period
- Mild hypotension due to decreased peripheral vascular resistance
- Dizziness / lightheadedness / headache
- Nausea
- Transient arrhythmias; (bradycardia, AV blocks, ventricular ectopy). These are generally not treated and are quickly self-limiting

**SPECIAL INFORMATION:**
1. Effective in treating Wolff-Parkinson-White syndrome in adults and pediatrics.
2. Rapid IV/IO push of Adenosine is necessary because it is metabolized very quickly. Use a large bore IV in a proximal large vein, if able, to assist administration of the rapid IV push.
3. Obtain ECG documentation before, during, and after giving Adenosine.
4. Transient arrhythmias (PVC's, PAC's, sinus bradycardia, AV block, sinus tach and possibly asystole) may be witnessed after administration
5. Discontinue administration if 2nd or 3rd degree block develops.
6. Adenosine will only convert SVT; it will not convert A-Fib or A-Flutter.
7. Caffeine and Theophylline act as antagonists; maximum doses may be required.
ALBUTEROL

CLASS:
- Sympathomimetic

ACTION:
- Activates the beta-2 adrenergic receptors to relax bronchial smooth muscles.
- Bronchodilation, relieves bronchospasms, and reduces airway resistance.
- ONSET = 5 minutes
- PEAK = 1 hour
- DURATION = 3-4 hours

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>DOSAGE/ROUTE</th>
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<tbody>
<tr>
<td>Suspected hyperkalemia associated with crush injuries (4302)</td>
<td>INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)</td>
</tr>
<tr>
<td>Suspected hyperkalemia associated with heat illness / hyperthermia (4702)</td>
<td>Adults and pediatrics: 2.5 mg / 3 mL (one pouch), nebulized.</td>
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<tr>
<td>Bronchospasm (4406)</td>
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<tr>
<td>Bronchospasm associated with suspected toxic inhalation (4603)</td>
<td>Adults and pediatrics: 2.5 mg / 3 mL (one pouch), nebulized. MAY REPEAT PRN.</td>
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<tr>
<td>Bronchospasm associated with allergy and/or anaphylaxis (4704)</td>
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</tbody>
</table>

CONTRAINDICATIONS:
- None

SIDE EFFECTS:
- Tachycardia / palpitations
- Dizziness, headache
- Tremors, nervousness

SPECIAL INFORMATION:
1. One (1) DuoNeb treatment may be given standing order; repeat administration of Albuterol is a standing order.
   REPEAT ADMINISTRATION OF IPRATROPIUM IS A BASE HOSPITAL ORDER (BHO).
2. Albuterol becomes unstable in moderate to high temperatures. If it appears discolored (it is normally clear) or is precipitated, discard it immediately.
3. Causes minimal cardiac stimulation (tachycardia); monitor ECG & heart rate.
4. Use with caution in pregnancy.
5. Check lung sounds, SpO₂, capnography wave forms and respiratory rate before and after administration of Albuterol to determine effectiveness.
AMIODARONE

CLASS:
- Anti-dysrhythmic

ACTION:
- Reduces the maximum rate of depolarization via sodium channel blocking (class I action).
- Raises the threshold for VF by inhibiting sympathetic stimulation via alpha- and beta-blocking properties (class II action).
- Increases the duration of the action potential by blocking potassium channels (class III action).
- Slows AV conduction by blocking calcium channels (class IV action).
- Prolongs the action potential duration and the refractory period of the myocardial electrical conduction system thereby facilitating the termination of sustained VT or VF.
- ONSET = 1-3 minutes
- DURATION = 15-140 days

INDICATIONS  | DOSAGE/ROUTE
-------------|-------------------
Symptomatic Tachycardia with Pulses (4403) | INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)  
Adults: Amiodarone 150 mg (3 mL) IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes.
Pediatrics: Amiodarone 5 mg / kg IVPB. MAX SINGLE DOSE TO INFUSE IS 150 MG. Infuse in 50-100 mL normal saline, administer over 10 minutes. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

Cardiac arrest with VF or VT (4405) | Adults: 300 mg (6 mL) IV/IO. MAY REPEAT ONCE AT 150 MG (3 ML) 5 MINUTES AFTER FIRST (1ST) DOSE, TO A MAX OF 450 MG. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).  
INITIAL AND REPEAT PEDIATRIC ADMINISTRATION REQUIRES A BASE HOSPITAL ORDER (BHO).  
Pediatrics: 5 mg / kg IV/IO. MAX SINGLE DOSE IS 150 MG. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

CONTRAINDICATIONS:
- Previous history of liver disease
- Hypersensitivity to iodine
- Cardiogenic shock
- Sinus bradycardia
- 2nd / 3rd degree AV blocks

SIDE EFFECTS:
- Hypotension
- Bradycardia
- May increase the effects of anti-coagulants as well as Digoxin and Dilantin

SPECIAL INFORMATION:
1. Large bore catheter is recommended in case of hypotension following administration.
2. Fluid resuscitation should be anticipated during the post resuscitation phase.
ASPIRIN

CLASS:
- Salicylate

ACTIONS:
- Inhibits the normal tendency for platelets to accumulate inside injured or occluded cardiac arteries thereby promoting better blood flow through vessels to better perfuse the heart.
- ONSET = 15-30 minutes
- DURATION = days (antiplatelet effects)

INDICATIONS | DOSAGE/ROUTE
--- | ---
Acute Coronary Syndrome (ACS) (4401) | Adults: 324 mg (four 81 mg chewable tablets) PO. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). ADMINISTRATION OF ASPIRIN TO PEDIATRIC PATIENTS IS NOT PERMITTED.

CONTRAINDICATIONS:
- Administer with caution to pts with Hx of bleeding ulcers / GI bleeds (upper and/or lower)
- Patients with VADs

SIDE EFFECTS:
- GI upset (indigestion, nausea/vomiting, epigastric pain, heartburn)
- Occult bleeding

SPECIAL INFORMATION:
1. Aspirin decomposes at high temperatures or with high humidity / moisture. Pills may crumble or have a "vinegar" smell that may be detected when it has deteriorated. If either of these are noted, discard immediately.
ATROPINE SULFATE

CLASS:
• Anticholinergic

ACTION:
• Competes with acetylcholine for receptor sites blocking the PNS response at SA & AV nodes.
• Increases heart rate by increasing electrical conduction through the heart.
• Inhibits secretions by decreasing PNS effect on bronchial, salivary, sweat and GI glands.
• ONSET = 2-4 minutes
• DURATION = 2-6 hours

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>DOSAGE/ROUTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Symptomatic bradycardia with pulses (4404)</td>
<td>Adults: 1 mg (10 mL) IV/IO. MAY REPEAT EVERY 3-5 MINUTES TO A MAX OF 3 MG (30 mL).</td>
</tr>
<tr>
<td>Cardiac Arrest (4405)</td>
<td>INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td>Nerve agent, organophosphate and carbamate poisoning (4604)</td>
<td>Adults: 1 mg (10 mL) IV/IO. MAY REPEAT PRN.</td>
</tr>
<tr>
<td></td>
<td><strong>OR</strong> 1 mg (2.5 mL of MDV) IM x2. MAY REPEAT PRN.</td>
</tr>
<tr>
<td></td>
<td>Pediatrics: 0.02 mg / kg IV/IO push. MAX SINGLE DOSE IS 0.5 MG. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
<tr>
<td></td>
<td><strong>OR</strong> 0.05 mg / kg IM x2. MAX SINGLE DOSE IS 1 MG. MAY REPEAT PRN. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
</tbody>
</table>

CONTRAINDICATIONS:
• None

SIDE EFFECTS:
• Tachycardia / palpitations
• Dry mouth / nausea / vomiting
• Pupil dilation / blurred vision
• Flushed / hot / dry skin
SPECIAL INFORMATION:
1. In true OPP poisonings, multiple doses of Atropine will be needed
2. Assessing the effectiveness of Atropine administration:
   - Unstable Bradycardia—check ECG for increase in HR, palpate pulse and obtain a BP
   - OPP—watch for decreased secretions
CALCIUM CHLORIDE (CaCl₂)

**CLASS:**
- Electrolyte

**ACTION:**
- Necessary for the proper function of the nervous, muscular, skeletal, digestive and endocrine systems
- Positive inotropic activity increases the strength of myocardial contractions
- Increases ventricularautomaticity
- ONSET = 2-10 mins
- DURATION = 30-60 mins

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<tr>
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<tbody>
<tr>
<td>Suspected hyperkalemia associated with crush injuries (4302)</td>
<td>INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td>Suspected beta blocker or calcium channel blocker overdose (4601)</td>
<td>Adults: 1 gm (10 mL) IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes.</td>
</tr>
<tr>
<td>Cardiac dysrhythmias associated with toxic exposure, inhalation, or ingestion (4603)</td>
<td>Pediatrics: 20 mg / kg IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
<tr>
<td>Suspected hyperkalemia associated with heat illness / hyperthermia (4702)</td>
<td>INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td>Cardiac arrest with suspected hypocalcemia, hyperkalemia, hypermagnesemia, or calcium channel blocker overdose (4405)</td>
<td>Adults: 1 gm (10 mL) IV/IO.</td>
</tr>
<tr>
<td>Cardiac arrest in a known / suspected dialysis patient (4405)</td>
<td>Adults: 1 gm (10 mL) IV/IO. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
</tbody>
</table>

**CONTRAINDICATIONS:**
- Digitalis toxicity
- Hypercalcemia
- VF
- Impaired kidney function (suspension contains aluminum which may cause aluminum toxemia)

**SIDE EFFECTS:**
- Hypotension
- Cardiac arrest
- Syncope
- Tingling sensation in the extremities
- Metallic taste in the mouth
- Facial flushing
DEXTROSE

CLASS:
- Carbohydrate

ACTION:
- Increases blood glucose by introducing free sugar directly into the blood stream
- ONSET approximately 1 minute
- DURATION is dependent on the degree of hypoglycemia

<table>
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<tr>
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<tbody>
<tr>
<td>Symptomatic hypoglycemia with blood glucose less than 80 mg/dL in adults or 70 mg/dL in pediatrics and neonates (4201)</td>
<td>Adults: 25 gm (D10%) IV/IO bolus or drip. MAY REPEAT PRN. Pediatrics and neonates: 5 mL / kg (D10%) IV/IO bolus or drip. MAY REPEAT PRN. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
<tr>
<td>Neonatal resuscitation (4801)</td>
<td>INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO) D10% IV/IO bolus or drip.</td>
</tr>
</tbody>
</table>

CONTRAINDICATIONS:
- Hyperglycemia

SIDE EFFECTS:
- Local venous irritation / infection
- Hyperglycemia

SPECIAL INFORMATION:
1. Tissue necrosis may occur with infiltration; to ensure patency, aspirate before and halfway through administration.
2. Repeat blood sugar if patient is signing AMA
3. Assess the effectiveness of D50W administration:
   - Altered LOC- reassess LOC and skins; recheck BGL if there is no improvement in symptoms
**DIPHENHYDRAMINE (BENADRYL)**

**CLASS:**
- Antihistamine

**ACTION:**
- Binds to histamine receptor sites, suppressing histamine induced allergic symptoms. Does not prevent histamine release.
- **ONSET = 15-30 minutes**
- **DURATION = 6-12 hours**

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<tr>
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</thead>
</table>
| Nausea and/or Vomiting (4203) | ***INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).***  
Adults: 25-50 mg (0.5 – 1 mL) IM or slow IV/IO push.  
Pediatrics: 1 mg / kg slow IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.  
**OR**  
2 mg / kg IM. **MAX SINGLE DOSE IS 50 MG.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app. |

| Overdose / Adverse Reaction: suspected dystonic reaction (4601) | Adults: 50 mg (1 mL) IM or slow IV/IO push.  
**ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**  
Pediatrics: 1 mg / kg slow IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.  
**OR**  
2 mg / kg IM. **MAX SINGLE DOSE IS 50 MG.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** |

| Allergy and/or Anaphylaxis (4704) | Adults: 50 mg (1 mL) IM or slow IV/IO push.  
**ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**  
Pediatrics: 1 mg / kg slow IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.  
**OR**  
2 mg / kg IM. **MAX SINGLE DOSE IS 50 MG.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** |

**CONTRAINDICATIONS:**
- None

**SIDE EFFECTS:**
- Drowsiness / sedation (excitement in children)
- Palpitations / tachycardia
- Hypotension
- Dry mouth / thickened bronchial secretions
- Seizures

**SPECIAL INFORMATION:**
1. Cumulative depressant effects occur in the presence of alcohol and or other sedatives.
2. Use with caution when administering to children with history of asthma who weigh less than 20 lbs (9 kg) due to thickened bronchial secretions.
3. Common drugs which may cause extrapyramidal reactions: Haldol, Compazine, Thorazine, Stelazine, Prolixin
4. Extrapyramidal reaction may be seen up to 7-10 days after ingestion of medication
5. Assessing effectiveness of Benadryl administration:
   - Anaphylaxis and allergic reaction - observe for a decrease in erythema and itching.
   - Extrapyramidal reactions - observe for a decrease in facial and neck spasm
EPINEPHRINE

CLASS:
- Sympathomimetic (both alpha and beta effects)

ACTION
- On the bronchi: bronchodilation (beta-2).
- On the peripheral vasculature: vasoconstriction (alpha).
- On the heart:
  > increased heart rate (beta-1) / chronotropic
  > increased contractility / inotropic
  > increased AV conduction / dromotropic
  > increased automaticity / dromotropic
- ONSET = IV/IO: 1-2 minutes, IM: 5-10 minutes
- DURATION = 5-10 minutes

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<tr>
<td>Shock UNRELATED TO TRAUMA (4202)</td>
<td>Adults and pediatrics: 0.01 mg (1 mL, 0.01 mg / mL concentration, Push Dose Epinephrine) IV/IO. MAY REPEAT PRN EVERY 1-5 MINUTES TO MAINTAIN A SYSTOLIC BP GREATER THAN:</td>
</tr>
<tr>
<td>Shock following ROSC (4405)</td>
<td>90 mmHg - adults</td>
</tr>
<tr>
<td>Shock associated with allergy and/or anaphylaxis (4704)</td>
<td>70 mmHg - pediatrics</td>
</tr>
<tr>
<td>Shock associated with snakebite (4705)</td>
<td>Adults: 1 mg (10 mL, 0.1 mg / mL concentration) IV/IO. MAY REPEAT EVERY 5 MINUTES TO A MAX OF 5 MG (50 mL). ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td>Cardiac Arrest (4405)</td>
<td>Pediatrics: 0.01 mg / kg (0.1 mg / mL concentration) IV/IO. MAY REPEAT EVERY 5 MINUTES TO A MAX OF FIVE (5) ADMINISTRATIONS. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
</tbody>
</table>
**Shock following ROSC WHEN PATIENT’S SYSTOLIC BP IS LESS THAN 90 MMHG (4405)**

Adults: 0.4 mg (0.4 mL, 1 mg / mL concentration) IVPB, infused in 100 mL normal saline

**OR**

0.2 mg (0.2 mL, 1 mg / mL concentration) IVPB, infused in 50 mL normal saline.

**RATE WILL BE CONTROLLED VIA DIAL-A-FLOW. INCREASE DOsing EVERY 2-3 MINUTES, TO MAX 10 MCG/MIN, TO ACHIEVE OR MAINTAIN SYSTOLIC BP OF 90 MMHG OR GREATER**

- Begin infusion at 1 mcg/min (15 ml/hr) then increase to
- 2 mcg/min (30 ml/hr) then increase to
- 4 mcg/min (60 ml/hr) then increase to
- 10 mcg/min (150 ml/hr)

**IF MAX DOSING HAS BEEN REACHED AND A SYSTOLIC BP OF 90 MMHG HAS NOT BEEN ACHIEVED, BEGIN ADMINISTERING 0.01 MG (1 mL) 1:100,000 (PUSH DOSE EPINEPHRINE) PRN EVERY 1-5 MINUTES IN ADDITION TO THE DRIP UNTIL A SYSTOLIC BP OF 90 MMHG OR GREATER IS ATTAINED**

**ADMINISTRATION OF EPINEPHRINE BY IVPB DRIP TO PEDIATRIC PATIENTS IS NOT PERMITTED**

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**Respiratory distress (4406)**

Adults: 0.3 mg (0.3 mL, 1 mg / mL concentration) IM.

Pediatrics: 0.01 mg / kg (1 mg / mL concentration) IM. **MAX SINGLE DOSE IS 0.3 MG.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

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**Suspected Anaphylaxis (4704)**

Adults: 0.3 mg (0.3 mL, 1 mg / mL concentration) IM. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

Pediatrics: 0.01 mg / kg (1 mg / mL concentration) IM. **MAX SINGLE DOSE IS 0.3 MG. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
### Neonatal Resuscitation (4801)

0.1 mg / mL concentration IV/IO. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

### Shock associated with postpartum hemorrhage (4803)

0.01 mg (1 mL, 0.01 mg / mL concentration, Push Dose Epinephrine) IV/IO. **MAY REPEAT PRN EVERY 1-5 MINUTES TO MAINTAIN A SYSTOLIC BP GREATER THAN 90 MMHG.**

#### CONTRAINDICATIONS
- (Relative) tachycardia

#### CONTRAINDICATIONS (DRIP)
- Administration via IO route
- Patients 14 years of age or younger
- Shock due to trauma
- Unable to obtain a systolic BP
- Unable to use a Dial-a-Flow

#### CONTRAINDICATIONS (PUSH DOSE EPI)
- Shock due to trauma

#### SIDE EFFECTS:
- Anxiety / restlessness
- Palpitations / tachyarrhythmias
- Ventricular irritability
- Hypertension
- Angina
- Headache
- Nausea

### SPECIAL INFORMATION:
1. Continuously monitor ECG during any Epinephrine administration
2. Alkalosis or acidosis may decrease the effectiveness of Epinephrine. Flush tubing between Sodium Bicarbonate and Epinephrine administrations.
3. Assessing the effectiveness of epinephrine administration:
   - Arrhythmias - monitor ECG, pulses, and BP.
   - Allergies / anaphylaxis - monitor ECG, pulses, BP, respiratory rate, lung sounds and O2 saturation
   - Respiratory distress--monitor lung sounds, respiratory rate, SpO2, capnography, ECG and pulse
FENTANYL

CLASS:
- Opioid (Synthetic)

ACTION:
- Binds with stereospecific receptors at many sites within the CNS.
- Increases pain thresholds and alters pain reception.
- ONSET = IV/IO: within seconds, IM/IN: 7-8 minutes
- DURATION = IV/IO: 30-60 minutes, IM/IN: 1-2 hours

<table>
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<tr>
<th>INDICATIONS</th>
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</table>
| Pain associated with:  
  - Acute abdominal / flank pain, sickle cell crisis or cancer pain (4204)  
  - Acute traumatic injury or injuries (4302)  
  - Suspected ACS with persistent chest discomfort unresponsive to Nitroglycerin (4401)  
  - Burns (4701)  
  - Frostbite (4703)  
  - Snakebite (4705) | Adults: 50 mcg (1 mL) slow IV/IO push or IM/IN. Patient’s systolic BP must be greater than or equal to 90 mmHg at the time of administration. MAY REPEAT ONCE, IN 5-10 MINUTES, DEPENDENT ON PAIN SEVERITY, TO A MAX OF 100 MCG. ADDITIONAL ADMINISTRATIONS AFTER 100 MCG REQUIRE A BASE HOSPITAL ORDER (BHO).  
Pediatrics: 1 mcg / kg slow IV/IO push or IM/IN. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app. |

Discomfort associated with transcutaneous cardiac pacing: TCP (4404) | Adults: 50 mcg (1 mL) slow IV/IO push or IM/IN. Patient’s systolic BP must be greater than or equal to 90 mmHg at the time of administration. MAY REPEAT ONCE, IN 5-10 MINUTES, DEPENDENT ON PAIN SEVERITY, TO A MAX OF 100 MCG. ADDITIONAL ADMINISTRATIONS AFTER 100 MCG REQUIRE A BASE HOSPITAL ORDER (BHO).  
INITIAL AND REPEAT PEDIATRIC ADMINISTRATION REQUIRES A BASE HOSPITAL ORDER (BHO).  
Pediatrics: 1 mcg / kg slow IV/IO push or IM/IN. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app. |

Pain following ROSC (4405) | INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)  
Adults: slow IV/IO push or IM/IN with dosing dependent on pain. Patient’s systolic BP must be greater than or equal to 90 mmHg at the time of administration.  
ADMINISTRATION OF FENTANYL TO PEDIATRIC PATIENTS FOR POST-ROSC PAIN IS NOT PERMITTED. |
CONTRAINDICATIONS:
• Sensitivity to Fentanyl or other opioids
• Systolic BP less than 90 mmHg

Use with Caution:
• in patients with a known history of opioid abuse. Ketamine is the preferred pain management medication for this population.
• in the elderly and in patients with known hepatic insufficiency. Slow / poor metabolization may results in unintended, exacerbated analgesia and an increase in untoward effects

SIDE EFFECTS:
• Respiratory depression / arrest
• Decreased LOC
• Transient hypotension
• Palpitations / Arrhythmias
• Nausea / Vomiting
• Pinpoint pupils

SPECIAL INFORMATION:
1. The administration of Fentanyl to its max dose followed by the administration of Ketamine – or vice versa – is a standing order. **REPETITION OF ANY ANALGESIC AFTER ALL MAX DOSES HAVE BEEN ADMINISTERED REQUIRES A BASE HOSPITAL ORDER (BHO)**
2. Vitals signs (ECG, SpO2 and waveform / digital capnography) must be monitored throughout BLS and ALS interventions for pain management
GLUCAGON

CLASS:
- Pancreatic hormone

ACTION:
- Increases blood glucose by converting glycogen stored in the liver to free glucose.
- ONSET = 20 minutes
- DURATION = 60-90 minutes

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<tr>
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<tbody>
<tr>
<td>Symptomatic hypoglycemia with blood glucose less than 80 mg/dL in adults or 70 mg/dL in pediatrics and neonates WHEN UNABLE TO ADMINISTER IV/IO DEXTROSE (4201)</td>
<td>Adults: 1 mg (1 mL) IM. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). Pediatrics and neonates: Weight = 21 kg (=46 lbs) or less: 0.5 mg (0.5 mL) IM. Weight = 22 kg (=48 lbs) or more: 1 mg (1 mL) IM. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td>Suspected esophageal food impaction (4406)</td>
<td>INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO). Adults: 1 mg (1 mL) IV/IO/IM. Pediatrics: Weight = 21 kg (=46 lbs) or less: 0.5 mg (0.5 mL) IV/IM. Weight = 22 kg (=48 lbs) or more: 1 mg (1 mL) IV/IM.</td>
</tr>
<tr>
<td>Suspected beta blocker or calcium channel blocker overdose (4601)</td>
<td>INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO). Adults: 1 mg (1 mL) IV/IO/IM. Pediatrics: 50 mcg / kg, IV/IO/IM. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
</tbody>
</table>

CONTRAINDICATIONS: 
- Hyperglycemia

SIDE EFFECTS: 
- Nausea / Vomiting
- Tachycardia
- Hyperglycemia

SPECIAL INFORMATION:
1. Glucagon will not work appropriately if a patient's glycogen stores in the liver are depleted (severe hypoglycemia, malnutrition, adrenal insufficiency).
2. To assess the effectiveness of glucagon administration:
   - Reassess the patient's level of consciousness, skins, and BG level
GLUCOSE (ORAL)

**CLASS:**
- Carbohydrate

**ACTION:**
- Increases blood glucose by introducing free sugar directly into the blood stream.
- ONSET approximately 5 minutes
- DURATION is dependent on the degree of hypoglycemia

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| BLS care providers:  
Symptomatic hypoglycemia with blood glucose less than 80 mg/dL in adults or 70 mg/dL in pediatrics (4201)  
ALS care providers:  
Symptomatic hypoglycemia with blood glucose less than 80 mg/dL in adults or 70 mg/dL in pediatrics WHEN UNABLE TO ADMINISTER DEXTROSE OR GLUCAGON (4201)  
**MAY ONLY BE ADMINISTERED TO ALERT, COOPERATIVE PATIENTS WITH AN INTACT GAG REFLEX.** | Adults: 15 gm (1 tube) PO. **MAY REPEAT PRN.**  
**Pediatrics:**  
- **ADMINISTRATION OF GLUCOSE (ORAL) TO PATIENTS WEIGHING LESS THAN 10 KG (=22 LBS) IS NOT PERMITTED.**  
- Weight is between 10–29 kg (=22-64 lbs): as tolerated, PO. **MAY REPEAT PRN.**  
- Weight = 30 kg or greater (=66 lbs+): 15 gm (1 tube) PO. **MAY REPEAT PRN.** |

**CONTRAINDICATIONS:**
- Hyperglycemia
- Lack of gag reflex / inability to swallow

**SIDE EFFECTS:**
- Hyperglycemia
**IPRATROPIUM BROMIDE (ATROVENT)**

**CLASS:**
- Anticholinergic

**ACTION:**
- Antagonizes the action of acetylcholine, preventing the interaction of acetylcholine with muscarinic receptors in bronchial smooth muscle causing bronchodilation
- Bronchodilation, site specific (in lung - not systemic)
- ONSET = 15-30 minutes
- PEAK = 1-2 hours
- DURATION = 4-5 hours

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<tbody>
<tr>
<td>Bronchospasm (4406)</td>
<td>Adults and pediatrics: 0.5 mg / 2.5 mL (one pouch), mixed with one (1) pouch of Albuterol, then nebulized. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
</tbody>
</table>

**CONTRAINDICATIONS:**
- Hypersensitivity to Atropine
- Allergies to peanuts / soybeans

**SIDE EFFECTS:**
- Blurred vision / eye irritation (with direct contact of mist)
- GI distress
- Headache
- Nausea
- Nervous / dizziness
- Palpitations

**SPECIAL INFORMATION:**
1. One (1) DuoNeb treatment may be given standing order; repeat administration of Albuterol is a standing order. **REPEAT ADMINISTRATION OF IPRATROPIUM IS A BASE HOSPITAL ORDER (BHO).**
2. Ipratropium becomes unstable in moderate to high temperatures. If it appears discolored (it is normally clear) or is precipitated, discard it immediately.
3. Causes minimal cardiac stimulation (tachycardia); monitor ECG & heart rate.
4. Check lung sounds, SpO₂, capnography wave forms and respiratory rate before and after administration of Ipratropium to determine effectiveness.
**KETAMINE (KETALAR)**

**CLASS:**
- Anesthetic / dissociative

**ACTION:**
- Noncompetitively antagonizes NMDA receptors, blocking glutamate, producing a cataleptic-like state.
- **ONSET = IVPB:** within 30 seconds, **IN:** 5-10 minutes
- **DURATION = IVPB:** approximately 10 minutes, **IN:** 30-60 minutes

<table>
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<tbody>
<tr>
<td>Pain associated with:</td>
<td>Adults: 0.3 mg / kg IVPB. Infuse in 50-100 mL Normal Saline, administer over 5 minutes. <strong>MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</strong></td>
</tr>
<tr>
<td>• Acute abdominal / flank pain, sickle cell crisis or cancer pain (4204)</td>
<td>**<strong>OR</strong> **</td>
</tr>
<tr>
<td>• Acute traumatic injury or injuries (4302)</td>
<td>0.5 mg / kg IN. <strong>MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</strong></td>
</tr>
<tr>
<td>• Burns (4701)</td>
<td>THE MAX SINGLE DOSE FOR EITHER ROUTE IS 30 MG.</td>
</tr>
<tr>
<td>• Frostbite (4703)</td>
<td><strong>ADMINISTRATION OF KETAMINE TO PEDIATRIC PATIENTS IS NOT PERMITTED.</strong></td>
</tr>
<tr>
<td>• Snakebite (4705)</td>
<td></td>
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</tbody>
</table>

**CONTRAINDICATIONS:**
- Patients less than 15 years of age
- Sensitivity to Ketamine
- Pain or discomfort of suspected cardiac origin (ACS)

**SIDE EFFECTS:**
- Nausea and/or vomiting

**SPECIAL INFORMATION:**
1. **PEDIATRIC ADMINISTRATION IS NOT PERMITTED.**
2. Ketamine use in some patients has been known to cause dream-like states, delusions, hallucinations and/or confusion, acute onset excitement / anxiety / aggression, etc. If your patient presents with any of these behaviors, monitor them closely and, if necessary, discontinue administration. The response to Ketamine is transient and usually resolves within minutes of the infusion being stopped.
3. The administration of Ketamine to its max dose followed by the administration of Fentanyl — or vice versa — is a standing order. **REPETITION OF ANY ANALGESIC AFTER ALL MAX DOSES HAVE BEEN ADMINISTERED REQUIRES A BASE HOSPITAL ORDER (BHO).**
4. Vitals signs (ECG, SpO₂ and waveform / digital capnography) must be monitored throughout BLS and ALS interventions for pain management.
5. The max single dose for Ketamine is 30 mg regardless of the route.
LIDOCAINE (2% XYLOCAINE)

CLASS:
- Amide Derivative

ACTION:
- Decreases ventricular excitability by suppressing automaticity in the His-Purkinje system
- ONSET = 1-2 minutes
- DURATION = 10-20 minutes

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<tr>
<td>Pain during IO infusion in the conscious patient</td>
<td>Adults: 50 mg (2.5 mL) slow IO push over 1 minute. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td>Pediatrics: 0.5 mg / kg slow IO push over 1 minute. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
<td></td>
</tr>
<tr>
<td>Symptomatic tachycardia with pulses (4403)</td>
<td>Adults: 1 mg / kg slow IV/IO push followed by the second dose (0.5 mg / kg) 8-10 minutes later, to a max of 3 mg / kg.</td>
</tr>
<tr>
<td>Cardiac arrest with VF or VT WHEN AMIODARONE IS UNAVAILABLE (4405)</td>
<td>Pediatrics: 1 mg / kg slow IV/IO push followed by the second dose (1 mg / kg) 8-10 minutes later. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
</tbody>
</table>

CONTRAINDICATIONS:
- 2nd & 3rd degree heart blocks
- Idioventricular rhythms

SIDE EFFECTS: (TOXICITY)
EARLY SIGNS
- Combative
- Anxiety
- Nausea
- Numbness
- Euphoria
- Twitching

LATE SIGNS
- Decreased BP
- Prolonged PRI
- Widening QRS
- VF
- Seizures
- Coma

SPECIAL INFORMATION:
1. Do not push faster than 50 mg / minute in an awake patient.
2. Toxicity and delayed effects are more likely in the elderly and patients with CHF / liver disease due to a reduced ability to metabolize Lidocaine. Repeat doses in this patient population should be given at 10-minute intervals.
3. Use with caution in AV blocks (suppressing automaticity may cause further block).
4. Assess effectiveness of Lidocaine:
   - conversion from ventricular rhythms
   - improvement in cardiac output, improved BP, skins, cap refill and LOC
   - reduced or eliminated cardiac discomfort / palpitations
MAGNESIUM SULFATE

**CLASS:**
- Electrolyte / anti-convulsant

**ACTION:**
- Reduces striated muscle contractions and blocks peripheral neuromuscular transmission by reducing acetylcholine release at the myoneural junction
- Central nervous system depressant
- Onset = immediate
- Peak = 30 mins
- Duration = 3-4 hours

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>DOSAGE/ROUTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac arrest with VF or VT WHEN ASSOCIATED WITH TORSADES DE POINTES / POLYMORPHIC VT (4405)</td>
<td>INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td>Adults: 2 gm (4 mL) slow IV/IO push.</td>
<td><strong>Pediatrics:</strong> 50 mg / kg slow IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
<tr>
<td>Asthma exacerbation unresponsive to Albuterol and Ipratropium breathing treatments (4406)</td>
<td>INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td>Adults: 2 gm (4 mL) slow IV/IO push.</td>
<td><strong>Pediatrics:</strong> 50 mg / kg IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
<tr>
<td>Cardiac dysrhythmias associated with toxic exposure, inhalation, or ingestion (4603)</td>
<td>5 gm (10 mL) IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes. <strong>ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</strong></td>
</tr>
<tr>
<td>Suspected pre-eclampsia or eclampsia (4802)</td>
<td><strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>2.5 gm (5 mL) IM x2. <strong>ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</strong></td>
</tr>
</tbody>
</table>
CONTRAINDICATIONS:
- Heart block
- Recent myocardial infarction

SIDE EFFECTS:
- Constipation
- Flushing
- General Muscle Weakness
- Headache
- Lethargy
- Nausea/Vomiting
- Palpitations

SPECIAL INFORMATION:
1. Magnesium IVPB may be given prophylactically for suspected eclampsia
2. With IVPB administration, the onset of anticonvulsant action is immediate and lasts about 30 minutes
3. With IM administration, the onset of action occurs in about one (1) hour and persists for three to four (3-4) hours.
### MIDAZOLAM (VERSED)

**CLASS:**
- Benzodiazepine

**ACTION:**
- CNS depressant
- Produces retrograde amnesia then sedation
- Stops and prevents seizures
- **ONSET = IV / IO / IN:** 2-5 minutes, **IM:** 15 minutes
- **DURATION = 1-4 hours**

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>DOSAGE/ROUTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amnesic effect in the conscious VAD patient prior to synchronized cardioversion (4402)</td>
<td><strong>CONSIDER:</strong> 2.5 mg (0.5 mL) slow IV/IO push. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). <strong>OR</strong> 5 mg (1 mL) IM/IN. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td>Amnesic effect prior to synchronized cardioversion (4403)</td>
<td>Adults: 2.5 mg (0.5 mL) slow IV/IO push. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). <strong>OR</strong> 5 mg (1 mL) IM/IN. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td>Amnesic effect prior to Transcutaneous Cardiac Pacing (TCP) (4404)</td>
<td>INITIAL AND REPEAT PEDIATRIC ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). Pediatrics: 0.1 mg / kg slow IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app. <strong>OR</strong> 0.2 mg / kg IM/IN. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
<tr>
<td>Anxiety following ROSC (4405)</td>
<td>INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)</td>
</tr>
<tr>
<td>Shivering associated with heat illness / hyperthermia (4703)</td>
<td>Adults: 1 mg (0.2 mL) slow IV/IO push or IM/IN. ADMINISTRATION OF MIDAZOLAM TO PEDIATRIC PATIENTS FOR POST-ROSC ANXIETY OR HEAT ILLNESS-RELATED SHIVERING IS NOT PERMITTED.</td>
</tr>
</tbody>
</table>
| **Anxiety related to the use of CPAP (4406)** | Adults: 1 mg (0.2 mL) slow IV/IO push or IM/IN. Patient’s systolic BP must be greater than or equal to 90 mmHg at the time of administration. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**  
**ADMINISTRATION OF MIDAZOLAM TO PEDIATRIC PATIENTS FOR ANXIETY RELATED TO THE USE OF CPAP IS NOT PERMITTED.** |
|---|---|
| **Continuous or recurrent tonic-clonic seizures unrelated to eclampsia (4501)** | Adults: 2.5 mg (0.5 mL) slow IV/IO push. **MAY REPEAT ONCE.** ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).  
**OR**  
5 mg (1 mL) IM/IN. **MAY REPEAT ONCE.** ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).  
**Pediatrics:** 0.1 mg / kg slow IV/IO push. **MAY REPEAT ONCE.** ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.  
**OR**  
0.2 mg / kg IM/IN. **MAY REPEAT ONCE.** ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app. |
| **Eclampsia unresponsive to Magnesium Sulfate administration (4802)** | **INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**  
2.5 mg (0.5 mL) slow IV/IO push  
**OR**  
5 mg (1 mL) IM/IN. |

**CONTRAINDICATIONS:**  
- Anxiety related to CPAP: systolic blood pressure of 90 mmHg or less  

**SIDE EFFECTS:**  
- Respiratory depression / apnea  
- Drowsiness / confusion  
- Hypotension  

**SPECIAL INFORMATION:**  
1. Carefully monitor adequacy of respiratory status and SpO₂ during administration  
2. Versed induced respiratory depression may be potentiated when combined with the use of ETOH, other sedative hypnotics and other CNS depressants.  
3. When used for cardioversion, amnesia is the desired effect, not sedation. The dosage administered may produce lethargy even though it is not the intended effect.
NALOXONE (NARCAN)

**CLASS:**
• Opioid Antagonist

**ACTION:**
• Reverses respiratory depression, sedation, and hypotensive effects of opioid overdose by occupying opiate receptor sites
• ONSET = IV / IN: 1-2 minutes, IM: 2-5 minutes
• DURATION = IV / IN: 30-60 minutes, IM: longer

<table>
<thead>
<tr>
<th>INDICATION</th>
<th>DOSAGE/ROUTE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REMSA Authorized Public Safety Personnel AND first response agency BLS providers in the absence of ALS providers – LOSOP Approval Required</strong> Respiratory depression / respiratory arrest with suspected narcotic overdose (4601)</td>
<td>MAY REPEAT ONCE. Use REMSA approved intranasal administration device with REMSA approved pre-loaded dose</td>
</tr>
<tr>
<td><strong>Agency LOSOP Approval Required for BLS Providers</strong> Respiratory depression / respiratory arrest with suspected narcotic overdose (4601)</td>
<td>Adults: 0.5 mg (0.5 mL) IV/IO/IM/IN. MAY REPEAT PRN. TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS</td>
</tr>
<tr>
<td>Neonatal resuscitation (4801)</td>
<td>Pediatrics: 0.1 mg / kg IV/IO/IM/IN. MAX SINGLE DOSE IS 0.5 MG. MAY REPEAT PRN. TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
<tr>
<td></td>
<td>INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td></td>
<td>IV/IO/IM/IN. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
</tbody>
</table>

**CONTRAINDICATIONS:**
• None

**SIDE EFFECTS:**
• Acute withdrawal symptoms, may be severe
• Nausea / vomiting
• Tachycardia / hypertension

**SPECIAL INFORMATION:**
1. The duration of Narcan is generally less than any opioid. Watch for relapse as long as opioid is still in the patient’s system and be prepared to continue administrations
2. Assessing effectiveness of Narcan:
   - increase in LOC, respiratory status, SpO2 and pupil response
   - Effective against:
     - Codeine
     - Darvon
     - Demerol
     - Dilaudid
     - Fentanyl
     - Heroin
     - Lomotil
     - Methadone
     - Morphine
     - Nubain
     - Oxycontin
     - Paragoric
     - Percodan
     - Stadol
     - Talwin
     - Vicodin

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NITROGLYCERIN (NTG, NITRO)

CLASS:
• Nitrate

ACTION:
• Relaxes systemic venous & arterial vessels causing vasodilatation thereby:
  ➢ Decreases preload & afterload
  ➢ Decreases myocardial workload.
  ➢ Decreases myocardial O₂ consumption.
• Dilates coronary arteries
• ONSET = 2 minutes
• DURATION = 30-60 minutes

<table>
<thead>
<tr>
<th>INDICATIONS</th>
<th>DOSAGE/ROUTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suspected ACS (4401)</td>
<td>0.4 mg (1 tablet or 1 metered spray) SL when the patient’s systolic BP is greater than 90 mmHg. May repeat twice at 3-5 minute intervals. Additional administrations require a base hospital order (BHO).</td>
</tr>
<tr>
<td>Dyspnea with suspected CHF (4406)</td>
<td>1 gm (1 inch) transdermal paste when the patient’s systolic BP is greater than 90 mmHg. If systolic BP falls below 90 mmHg, wipe away paste. Additional administrations require a base hospital order (BHO). Administration following the patient’s use of a PDE5 inhibitor (ex: Cialis / tadalafil, Levitra / vardenafil, Stendra / avanafil or Viagra / sildenafil) requires a base hospital physician order (BHPO).</td>
</tr>
</tbody>
</table>

CONTRAINDICATIONS:
• Suspected intracranial bleed
• Patient who has taken a sexual performance enhancing medication (Viagra® / Cialis® / Levitra® / Stendra®) within the last 48 hours
• Patients with VADs

SIDE EFFECTS:
• Facial flushing
• Orthostatic hypotension (can be profound)
• Reflex tachycardia
• Dizziness / syncope
• Temporary pulsating headache
NORMAL SALINE (0.9% SODIUM CHLORIDE SOLUTION, NS)

CLASS:
- Electrolyte / Isotonic crystalloid

ACTION:
- Electrolyte solution which is osmotically equivalent to blood.
- Increases the circulating volume of the vascular system (2/3 of infused volume leaves vascular space within 1 hour)

<table>
<thead>
<tr>
<th>INDICATIONS</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Loosen thickened secretions during suctioning (4104)</td>
<td>3 mL. MAY REPEAT PRN.</td>
</tr>
<tr>
<td>Shock unrelated to Trauma (4202 / 4403 / 4405 / 4701 / 4702 / 4802)</td>
<td></td>
</tr>
<tr>
<td>Shock due to Trauma (4301)</td>
<td>Adults: 250 mL IV/IO bolus. MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.</td>
</tr>
<tr>
<td>Suspected hyperkalemia associated with crush injuries (4302)</td>
<td>Pediatrics: 20 mL / kg IV/IO bolus. Use a volume control administration set for accurate dosing. MAY REPEAT AS CLINICALLY INDICATED. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
<tr>
<td>Hyperthermia or heat illness symptoms related to severe agitation / aggression / distress (4602)</td>
<td></td>
</tr>
<tr>
<td>Significant burns (4701)</td>
<td></td>
</tr>
<tr>
<td>Heat illness / hyperthermia (4702)</td>
<td></td>
</tr>
<tr>
<td>Hypothermia (4703)</td>
<td></td>
</tr>
<tr>
<td>Hemodynamically unstable VAD patient (4402)</td>
<td>CONSIDER: 250 mL IV/IO bolus. MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.</td>
</tr>
</tbody>
</table>

CONTRAINDICATIONS:
- Fluid challenges in patients with rales

SIDE EFFECTS:
- None

SPECIAL INFORMATION:
1. When the administration of medication(s) or the need for fluid replenishment is not indicated but is anticipated, placement of a saline lock ONLY is appropriate. Administration of IV fluids should always be clinically indicated and given as a bolus, not at a TKO rate.
2. In the absence of 10 mL Normal Saline prefilled syringes and 10 mL Normal Saline vials, or when 50 mL or 100 mL Normal Saline IV bags are unavailable for use as multi-dose medication reservoirs, two (2) 5 mL Normal Saline prefilled syringes will be drawn into an empty 10 mL syringe which may then be used for medication administration. Single 5 mL Normal Saline prefilled syringes are not permitted for use when medication administration is required.
   a. Direct dilution of Epinephrine to concentrations of 0.1 mg / 1 mL and/or 0.01 mg / 1 mL from a 5 mL NS prefilled syringe is not permitted.
ONDANSETRON (ZOFRAN)

**CLASS:**
- Serotonin 5-HT3 receptor antagonist / anti-emetic

**ACTION:**
- Reduces activity of the vagus nerve, deactivating the vomiting center in the medulla oblongata.
- Blocks serotonin receptors in the chemoreceptor trigger zone.
- **ONSET =** IV: 2-3 minutes, IM: 10-15 minutes, PO: 20 -30 minutes
- **DURATION =** 1.5 – 2 hours

<table>
<thead>
<tr>
<th>INDICATIONS</th>
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</tr>
</thead>
</table>
| Nausea and/or vomiting (4203) | Adults: 4 mg PO (1 ODT). MAY REPEAT TWICE TO MAX 12 MG. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).  
**OR** 4 mg (2 mL) IV solution slow IV/IO push or IM. MAY REPEAT TWICE TO MAX 12 MG. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).  
**OR** 0.1 mg / kg IV solution slow IV/IO push or IM. **MAX SINGLE DOSE IS 4 MG. MAY REPEAT TWICE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.  |
| Pediatrics: ADMINISTRATION OF ONDANSETRON ODT TO PATIENTS WEIGHING LESS THAN 10 KG (=22 LBS) IS NOT PERMITTED.  
Weight = 10 kg or greater: 4 mg PO (1 ODT). MAY REPEAT TWICE TO MAX 12 MG. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).  
**OR** 0.1 mg / kg IV solution slow IV/IO push or IM. **MAX SINGLE DOSE IS 4 MG. MAY REPEAT TWICE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.  |

**USE WITH CAUTION:**
- in patients with a history of congenital long QT syndrome
- in patients with a history of hepatic injury or impairment

**SIDE EFFECTS:**
- Headache
- Dizziness

**SPECIAL INFORMATION:**
1. Use with caution in patients with a history of congenital long QT syndrome; studies have shown that these patients are at higher risk for spontaneous episodes of Torsades de Pointes at very high doses (16 mg at a time or higher)
2. Zofran is heavily metabolized in the liver, use with caution in patients with a significant history or hepatic impairment.
SODIUM BICARBONATE (BICARB, NaHC03)

CLASS:
• Electrolyte

ACTION:
• Reduces acidosis or causes alkalosis by direct release of bicarbonate ions into the blood stream
• ONSET = 2-10 minutes
• DURATION = 30-60 minutes

### INDICATIONS

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Suspected hyperkalemia associated with crush injuries (4302)</td>
<td>INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td>Altered mental status and/or dysrhythmia with suspected cyclic antidepressant overdose (4601)</td>
<td>Adults: 50 mEq (50 mL) IV/IO push.</td>
</tr>
<tr>
<td>Suspected hyperkalemia associated with heat illness / hyperthermia (4602 / 4702)</td>
<td>Pediatrics: 1 mEq / kg IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
<tr>
<td>Cardiac arrest with suspected metabolic acidosis, hyperkalemia, or tricyclic antidepressant overdose (4405)</td>
<td>Adults: 50 mEq (50 mL) IV/IO push. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td>Neonatal resuscitation (4801)</td>
<td>INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td></td>
<td>IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
</tbody>
</table>

### CONTRAINDICATIONS:
• Metabolic / respiratory alkalosis
• Hypocalcemia

### SIDE EFFECTS:
• Electrolyte / Ph imbalances

### SPECIAL INFORMATION:
1. Alkalosis or acidosis may decrease the effectiveness of Epinephrine. Flush tubing between Sodium Bicarbonate and Epinephrine administrations.
TRANEXAMIC ACID (TXA)

CLASS:
- Antifibrinolytic agent / amino acid derivative (synthetic)

ACTION:
- Competitively inhibits the activation of plasminogen to plasmin, resulting in inhibition of fibrinolysis
- ONSET = approximately 10 minutes
- DURATION approximately 2-4 hours

INDICATIONS

<table>
<thead>
<tr>
<th>Traumatic injuries within three (3) hours with signs and symptoms of hemorrhagic shock with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Systolic BP less than 90 mmHg</td>
</tr>
<tr>
<td><strong>OR</strong></td>
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<tr>
<td>Significant hemorrhage with heart rate greater than or equal to 120</td>
</tr>
<tr>
<td><strong>OR</strong></td>
</tr>
<tr>
<td>Uncontrolled bleeding despite tourniquet application (4301 / 4302)</td>
</tr>
</tbody>
</table>

DOSAGE/ROUTE

- Adults: 1 gm (10 mL) IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes.
- **ADMINISTRATION OF TRANEXAMIC ACID (TXA) TO PEDIATRIC PATIENTS IS NOT PERMITTED.**

CONTRAINDICATIONS:
- Shock that is **unrelated** to trauma (post-partum hemorrhage, GI bleeding, etc.)
- Traumatic injuries that occurred **more than** three (3) hours prior
- Signs and symptoms of hemorrhagic shock but systolic BP is greater than 90 mmHg
- Significant hemorrhage but heart rate is less than or equal to 120
- Bleeding that is controlled after the application of a tourniquet
- Patients less than 15 years of age

SIDE EFFECTS:
- Nausea / vomiting / diarrhea
- Dizziness / light-headedness
- Mild itching or rash

SPECIAL INFORMATION:
1. If the patient's condition allows, application of a tourniquet prior to TXA administration is recommended
2. TXA is a synthetic hemostatic agent that contains no blood products. It is safe to use in patients that are practicing Jehovah's Witnesses
On-Scene Physician Wishing to Assume Responsibility

When an on-scene physician wishes to assume responsibility for prehospital emergency care, they must do the following:

1. State that they are a physician and that they wish to assume responsibility for prehospital emergency patient care
2. Present a valid photo ID and California medical license

When an on-scene physician wishes to assume responsibility for prehospital emergency care, the prehospital provider must do the following:

1. Inform the on-scene physician that:
   a. She / he must directly request that the base hospital physician (BHP) relinquish the responsibility to give medical direction
   b. If the base hospital physician (BHP) agrees, the on-scene physician may direct medical care
   c. The on-scene physician must accompany the patient during ambulance transport

2. Contact a single REMSA authorized base hospital (BH):
   a. Provide the on-scene physician’s name and license number
   b. The on-scene physician must request directly, on a recorded line, that the base hospital physician (BHP) relinquish the responsibility to give medical direction
   c. Confirm with the base hospital physician (BHP) that they have relinquished the responsibility to give medical direction

3. If the base hospital physician (BHP) has relinquished the responsibility to give medical direction:
   a. Assist the on-scene physician as directed, within REMSA authorized scope of practice
   b. Maintain base hospital (BH) contact and transport to an appropriate receiving facility
   c. The on-scene physician must sign the completed ePCR
Refusal of Treatment and/or Transport

Discourage any refusal of treatment and/or medical transport

A patient, parent, parental designee, or guardian initiating refusal of treatment and/or transport must be:

1. A legal adult with the capacity to understand the risks and benefits of their decisions
2. Alert and oriented to person, place, time, and event
3. Fully informed of, understand, and acknowledge:
   a. The EMS provider’s level of training
   b. The EMS provider’s findings
   c. Any need for treatment, transport, and/or further evaluation by an emergency physician
   d. The possible consequences of refusal, including death when applicable
   e. Their own ability to recall 911, and that the EMS provider will return
   f. Any other options to access medical care

Contact a single REMSA authorized base hospital (BH) for:

1. Any refusal involving a non-emancipated minor
   a. Refusal must be made by the parent, parental designee, or guardian
2. Any refusal involving a patient in custody
   a. Refusal of treatment and/or medical transport must be made by the patient, parent, parental designee, or guardian, as described above
   b. In no case will EMS personnel interfere with a law enforcement officer that refuses to accommodate base hospital direction
3. Any refusal of clinically indicated advanced life support (ALS) treatment
4. Any refusal of transport following initiation of ALS treatment
5. Any situation where base hospital contact or discussion would benefit patient care or outcome

Contact a single REMSA authorized trauma base hospital or base hospital, as appropriate, for:

1. Any refusal of assessment, care and/or transportation of the Critical Trauma Patient (CTP) or possible STEMI patient
   a. CTP Criteria is included in the REMSA Policy for Trauma Triage Criteria and Destination
   b. The possible STEMI patient is described in the REMSA Performance Standard for 12-Lead Electrocardiogram

Having met the requirements above:

1. Allow the patient, parent, parental designee, or guardian to initiate refusal
2. The legal-adult patient, parent, parental designee, or guardian must sign appropriate releases
   a. A law enforcement officer may not sign for the patient in custody
3. Fully document refusal on patient care report and attachments
### BLS Patient Management

**Do Not Attempt Resuscitation**

Do not attempt or continue resuscitation when one or more of the following are present:

1. Mass casualty incident patient who remains apneic despite manual airway maneuvers
2. Apneic and pulseless with rigor mortis and/or postmortem lividity
3. Decapitation
4. Generalized decomposition or incineration
5. Separation of brain, heart, or lungs from body
6. Apneic and pulseless with total abdominal evisceration
7. Complete transection of torso
8. A valid, signed, and dated advance directive (DNR/POLST/DNR medallion/Final Attestation Form) indicating that resuscitation is not desired.

**Following Prehospital Determination of Death**

When the decision not to attempt / to discontinue resuscitation has been made at scene:

1. Leave the body as found / as last positioned during resuscitation
2. Leave the scene without further disturbance / invasive medical devices left in place
3. Comfort and care for survivors
4. Notify local law enforcement (LE) of prehospital determination of death
5. Contact the County of Riverside Coroner’s Office, give report, and answer all applicable questions
6. Arrange for the Coroner’s Office to receive a copy of the completed ePCR/PCR
7. May remove invasive medical devices at the direction of the Coroner’s Office
8. Remain at scene until released by LE

### ALS Patient Management

**Do Not Attempt Resuscitation**

In addition to the criteria listed in BLS Patient Management, do not attempt, or continue resuscitation, when one or more of the following are present:

1. Blunt traumatic arrest with persistent asystole, agonal rhythm, or PEA at a rate less than 40
2. Penetrating traumatic arrest with persistent asystole, agonal rhythm, or PEA at a rate of less than 40, and absence of signs of life.

**Discontinue Resuscitation**

Discontinue resuscitation when return of spontaneous circulation (ROSC) is not achieved in a medical cardiac arrest after a minimum of twenty (20) minutes of high performance (HP) CPR and the checklist below has been completed:

- IV or IO Access has been established;
- Airway has been successfully managed with clinically indicated airway device;
- Rhythm-appropriate medications and defibrillations have been administered according to applicable protocol with no ROSC;
- Persistent (greater than 20 min) asystole or agonal rhythm is present and reversible causes are identified and treated as clinically indicated with no positive neurologic response or ROSC;
- Patient’s rhythm is not refractory VF or VT;
- Failure to establish spontaneous circulation (palpable pulse) at any point in the arrest

**DISCONTINUING RESUSCITATION OF A PEDIATRIC PATIENT REQUIRES A BASE HOSPITAL PHYSICIAN ORDER (BHPO).**
9. Include these details on the ePCR/PCR:
   a) Location of the body
   b) All recorded times
   c) History, medications, time of death, circumstances, and description of any advance directive / DNR / POLST / DNR medallion
   d) Identification of the local law enforcement officer at scene
   e) Identification of the coroner’s investigator who received report and coroner’s case number
   f) Disposition of the body, if determined while you are still at scene

- **When the decision not to attempt / to discontinue resuscitation has been made during transport**

  1. Stop in a safe location without crossing county lines
  2. Comfort and care for any survivors present
  3. Contact the County of Riverside Coroner’s Office, give report, and answer all applicable questions
  4. Follow the Coroner’s directions for:
     a) Disposition
     b) Notification of local law enforcement
  5. Complete ePCR/PCR as described above

Contact a single base hospital (BH) and/or the Coroner’s Office as needed for guidance in unusual circumstances
PURPOSE
To establish policy for the safe and rapid transfer of patient care responsibilities between Emergency Medical Services (EMS) personnel and emergency department (ED) medical personnel.

CONSIDERATIONS
Delays in the transfer of patient care and offloading of patients delivered to designated receiving hospitals by EMS ambulance adversely affects patient care, safety, and the availability of ambulances for emergency responses throughout Riverside County. It is incumbent upon receiving hospitals and ambulance providers to minimize the time required to transfer patient care and return ambulances to service to ensure optimal patient care, safety, and EMS system integrity.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Direction of EMS Personnel
EMS personnel shall continue to provide patient care prior to the transfer of patient care to the designated receiving hospital ED medical personnel. All patient care shall be documented according to REMSA policies. Medical Control and management of the EMS system, including EMS personnel, remain the responsibility of the REMSA Medical Director and all care provided to the patient must be pursuant to REMSA treatment protocols and policies.

Patient Care Responsibility
The ultimate responsibility for patient care belongs to the designated receiving hospital once the patient arrives on hospital grounds. Designated receiving hospitals should implement processes for ED medical personnel to immediately triage and provide the appropriate emergency medical care for ill or injured patients upon arrival at the ED by ambulance.

Transfer of Patient Care
Patients under care of EMS personnel

Upon arrival of a patient at the hospital by ambulance, the ED medical personnel should make every attempt to medically triage the patient and offload the patient to a hospital bed or other suitable sitting or reclining device at the earliest possible time not to exceed thirty (30) minutes. During triage by ED medical personnel, EMS personnel will provide a verbal patient report containing any pertinent information necessary for the ongoing care of the patient. Transfer of patient care is completed once the ED medical staff has received a verbal patient report. If the transfer of care and patient offloading from the ambulance gurney exceeds the thirty (30) minute standard, it will be documented and tracked as APOD.

The transporting EMS personnel are not responsible to continue monitoring the patient or provide care within the hospital setting after transfer of patient care to ED medical personnel has occurred. EMS personnel are responsible for immediately returning to response ready status once patient care has been transferred to ED medical personnel and the patient has been offloaded from the ambulance gurney.
**APOD Mitigation Procedures**

Designated receiving hospitals have a responsibility to ensure policies and processes are in place that facilitates the rapid and appropriate transfer of patient care from EMS personnel to the ED medical personnel within 30 minutes of arrival at the ED.

ED medical personnel should consider the following to prevent APOD:

- Immediately acknowledge the arrival of each patient transported by EMS; and
- Receive a verbal patient report from EMS personnel; and
- Receive patients transported by ambulance within thirty (30) minutes of arrival in the ED; and
- Transfer the patient to the hospital gurney, bed, chair, wheelchair or waiting room as appropriate for the patient’s condition within thirty (30) minutes of arrival at the hospital ED.

If an APOD does occur, the hospital should make every attempt to:

- Provide a safe area in the ED within direct sight of ED medical personnel where the ambulance crew can temporarily wait while the hospital’s patient remains on the ambulance gurney.
- Inform the attending EMT or EMT-P of the anticipated time for the offload of the patient.
- Provide information to the supervisor of the EMS personnel regarding the steps that are being taken by the hospital to resolve the APOD.

Hospitals will provide written details to REMSA, and EMS providers, of policies and procedures that have been implemented to mitigate APODs and assure effective communication with the affected partners:

- Processes for the immediate notification of the following hospital staff through their internal escalation process of the occurrence of APOD, including but not limited to:
  - ED/Attending Physician
  - ED Nurse Manager/Director or Designee (i.e., charge nurse);
  - House supervisor;
  - Administrator on call

- Processes to alert the following affected partners via ReddiNet when a condition exists that affects the timely offload of ambulance patients:
  - Local receiving hospitals/base hospitals
  - Fire Department and ambulance dispatch centers

- Processes for ED medical personnel to immediately respond to, and provide care for, the patient if the attending EMS personnel alert the ED medical personnel of a decline in the condition of a patient being temporarily held on the ambulance gurney.

EMS personnel are directed to do the following to prevent an APOD:

- Provide the receiving hospital ED with the earliest possible notification via two-way radio that a patient is being transported to their facility.
- Utilizing the appropriate safety precautions, walk-in ambulatory patients or use a wheelchair rather than an ambulance gurney if appropriate for the patient’s condition.
- Provide a verbal patient report to the ED medical personnel within thirty (30) minutes of arrival to the ED.
- Contact the EMS supervisor for direction if the ED medical personnel do not offload the patient within the thirty (30) minute local ambulance patient offload time standard.
- Complete the REMSA required authorized patient care documentation.
- Work cooperatively with the receiving hospital staff to transition patient care within the timeframes established in this policy.
Content and Formatting of the Verbal Report
The verbal patient report may be provided by face-to-face or two-way radio communication utilizing the SBAR format. The verbal patient report will include the following elements:

**Situation**
- Patient age, sex, weight
- Patient condition (Critical, Emergent, Lower Acuity)
- Patient chief complaint

**Background**
- Mechanism of injury or history of present illness
- Assessment findings
  - Responsiveness/Glasgow Coma Scale (GCS)
  - Airway
  - Breathing
  - Circulation
  - Disability
- Vital Signs
- Past medical history, medications, and allergies

**Assessment**
- Primary impression

**Recommendations**
- Treatment/interventions provided
- Patient response to treatment/interventions
- Base Hospital orders received (If it is a medical direction call)

Clinical Practices for EMS Personnel to Reduce APOD
The EMS personnel shall utilize sound clinical judgment and follow the appropriate REMSA policies and treatment protocols including:
- Initiate care as clinically indicated with the appropriate basic life support (BLS) and advanced life support (ALS) interventions.
- Initiate vascular access only as clinically indicated. IV therapy should only be initiated pursuant to REMSA treatment protocols for patients that require the following:
  a. administration of IV medication(s), or
  b. administration of IV fluid bolus or fluid resuscitation.
- In the judgement of the attending paramedic the patient’s condition could worsen and either (a) or (b) noted above may become necessary prior to arrival at the receiving hospital ED.
- Discontinue ECG monitoring before removing the patient from the ambulance if there are no clinical indications for cardiac monitoring.

APOD Unusual Events
The proliferation of APODs that lead to the lack of sufficient ambulances to respond to emergencies are considered APOD Unusual Events. These events threaten public health and safety by preventing EMS responses to emergency medical incidents. To mitigate the effects of these APOD Unusual Events the following are hereby established:
- Criteria for an APOD Unusual Event:
  - APOD exceeding thirty (30) minutes is occurring, and
  - The ambulance provider identifies and documents low EMS system ambulance availability.

APOD Unusual Event Procedures
- EMS personnel are authorized to inform ED medical personnel that they are transitioning patient care and immediately offloading a patient on APOD to a hospital bed or other suitable hospital sitting or reclining device as appropriate for patient condition provided the patient meets the following criteria:
Vital signs are stable
Patient is alert and oriented
No ALS interventions have taken place
The patient is not on a Welfare and Institutions Code (WIC) 5150 hold

EMS personnel shall make every attempt to notify ED medical personnel that they must immediately return to service

EMS personnel may use the written EMS report for transfer of care if ED medical personnel are unavailable to take a verbal report (post ePCR to hospital dashboard)

In the event of a major emergency that requires immediate availability of ambulances, the Riverside County Medical Health Operational Area Coordinator may give direction to EMS personnel to immediately transfer patient care to ED medical personnel and return to service to support the EMS system resource needs.

HOSPITAL BEST PRACTICES FOR AVOIDING APOD
Hospitals should consider implementing polices to reduce patient offload times. The following strategies have been shown to reduce APOD and should be considered:

• ED Intake strategies
  ➢ Bedside Registration
  ➢ Orders from triage
  ➢ Direct to bed policies
  ➢ Mid-level provider or physician at triage
  ➢ Greeter/patient liaison

• ED throughput strategies
  ➢ Effective ordering of lab and imaging
  ➢ Innovating staffing utilization
  ➢ Code alert for ED overcrowding

• ED output strategies
  ➢ Accelerated inpatient intake practices
  ➢ Discharge accelerator
  ➢ Use of Clinical Decision Unit (CDU)
  ➢ Discharge instructions upon arrival

• Hospital Inpatient bed availability strategies
  ➢ Standardized discharge process
  ➢ Rapid Admission Unit (RAU)
  ➢ Bed turnover process
  ➢ Universal telemetry
  ➢ Standardized ICU step down bed management

Other strategies to reduce APOD:
• Bedside registration or assigning a bed prior to arrival of patient
• Streamlining the triage process
• Bed assignment on patient arrival
• Zero allowance for APOD time by EMS agency and hospital
• Once a bed for an admitted patient is identified, floor/unit has thirty (30) minutes to retrieve patient, if not, department head is called
• Standardize discharge program including earlier patient rounds and discharge
• Consider holding areas for patients and those who are awaiting tests or delayed procedures
• Assign patient to specific hospital medical staff prior to placement in a bed may create patient ownership
• Redesign hospital documentation to improve ease of entry and flow
• Facilitate bedside lab tests (blood, urine, etc.)
PURPOSE
To establish criteria that recognizes and accommodates a patient’s designated end of life choices and directives, in order to limit prehospital treatment by EMS field personnel in the prehospital setting, long-term care facilities, during transport between facilities and/or in the patient’s home.

CONSIDERATIONS
The underlying principle in End of Life Care is to abide by the patient’s wishes. In some circumstances, conflict may arise between the expressed wishes of the patient and the wishes of the family. EMS personnel should seek clarification from applicable REMSA policies, written documentation, the base hospital (BH) and/or the patient’s legally recognized decision maker as needed. The patient can rescind any Advance Directive or End of Life Care Act option at any time.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

End of Life Care Documentation
Forms related to patient’s end of life instructions that EMS field personnel may encounter include:
- Statewide EMSA / California Medical Association (CMA) Prehospital Do Not Resuscitate (DNR) form.
- POLST form.
- DNR medallion, bracelet, or necklace.
- A DNR order in a patient’s chart dated and signed by the physician.
- End of Life Options Act Directive and/or Final Attestation for An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner form.

Validation Criteria
1. EMS Prehospital DNR
   a. The EMS Prehospital DNR form should include the following to be considered valid:
      i. Patient’s name.
      ii. Signature of the patient or a legally recognized decision maker if the patient is unable to make or communicate informed healthcare decisions.
      iii. Signature of patients’ physician, affirming that the patient/legal representative has given informed consent to the DNR instruction.
      iv. All signatures must be dated.
      v. Correct identification of the patient is crucial. If the patient is unable to be identified after a good faith attempt to identify the patient, a reliable witness may be used to identify the patient.
      vi. In licensed healthcare facilities a DNR order written by a physician shall be honored.
         1. The staff must have the patient’s chart with the DNR order immediately available for EMS field personnel upon their arrival.
         2. The order may contain the words Do Not Resuscitate, No CPR, or No Code and contain the patient’s name and the date and signature of the physician.

2. DNR Medallion, Bracelet or Necklace
   a. The DNR medallion/bracelet/necklace is made of metal with a permanently imprinted medical insignia. For the medallion or bracelet/necklace to be valid the following applies:
      i. Patient must be physically wearing the DNR medallion/bracelet/necklace.
ii. Medallion/bracelet/necklace must be engraved with the words “Do Not Resuscitate EMS” or “California POLST EMS”, along with a toll-free emergency information telephone number and a patient identification number.

3. **Physician Order for Life Saving Treatment (POLST)**
   a. The POLST does not replace the Advanced Directive and should be reviewed along with other documents if available. The POLST:
      i. Must be signed and dated by a physician, nurse practitioner or physician assistant acting under the supervision of a physician and within the scope of practice authorized by law.
      ii. Must be signed by the patient or decision maker.
      iii. Is not valid without signatures. Verbal or telephone orders are acceptable with follow-up signature by the physician in accordance with facility/community policy. There should be a box checked indicating who the authorized healthcare provider discussed the POLST orders with. By signing the form, the healthcare provider acknowledges that these orders are consistent with the patient’s medical condition and preferences.

4. **End of Life Care Options Act**
   a. A terminally ill and competent patient may elect to obtain medications to hasten their imminent death at a time and place of their choosing. They must satisfy extensive and stringent requirements as required by California law to obtain an Aid-In-Dying Drug and complete a “Final Attestation for An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner” within 48 hours prior to self-administration.
   b. There are no standardized “Final Attestation for an Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner” forms but the law has required specific information that must be in the final attestation. If available, EMS field personnel should make a good faith effort to review and verify that the final attestation contains the following information:
      i. The document is identified as a “Final Attestation for An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner”.
      ii. Patient’s name, signature and dated.
      iii. EMS field personnel should review and verify that the “Final Attestation for An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner” is present.
      iv. Correctly identifies the patient’s name and is signed and dated by the patient.
      v. The Final Attestation for An Aid-In-Dying Drug must be completed within 48 hours prior to taking the medications.
      vi. Obtain a copy of the final attestation and attach it to the electronic patient care record (ePCR) whenever possible.
      vii. There is no mandate for the patient to maintain the final attestation in close proximity of the patient.
      viii. If a copy of the final attestation is available, EMS field personnel should confirm the patient is the person named in the final attestation. This will normally require either the presence of a form of identification or a witness who can reliably identify the patient.

**End of Life Care Guidelines**
In addition to the validation criteria, the following guidelines are provided for EMS field personnel when responding to a patient with Standardized Patient-Designated Directives.
- The POLST may be used for both adults and pediatric patients.
- EMS personnel shall contact a base hospital for direction if a DNR or POLST cannot be validated or for conflicting requests by family members. While EMS personnel are contacting the base hospital for direction, BLS treatment must be initiated and continued. If contact cannot be made, resuscitative efforts shall continue.
- The End-of-Life Care Options Act Final Attestation form is legal and binding, no surrogate decision making is permitted. In the event of suspicious circumstances surrounding the “Final Attestation for An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner” EMS Personnel should make base hospital contact.
- If a family member requests resuscitative measures despite a valid DNR or POLST, continue BLS resuscitative measures until base hospital contact is made. EMS Personnel should reaffirm the patient’s wishes with the family members to aid in clarifying the situation.
• EMS field personnel shall attach a copy of the approved DNR form or POLST form to the patient care report, along with any other appropriate written documentation. The DNR form should accompany the patient to the hospital so that it may be incorporated into the medical record at the receiving facility.
  o When DNR orders are noted in medical records in licensed facilities, that fact should be recorded by the EMS provider, along with the date of the order and the physician’s name. It should be noted on the ePCR that a written DNR order was present including the name of the physician, date signed and other appropriate information.
• If a patient dies at home and the patient is not under the care of Hospice, law enforcement must be notified. In all cases, the coroner must be notified.

Supportive Measures
• Unless a patient is actively dying, medical treatment for other conditions should not be withheld.
• Involve law enforcement and the Coroner to assist with disposition of deceased patients.
• Consider supportive organizations for the family that may be at the scene: Chaplaincy services, advocacy groups and other family support can aid in the grieving process.
## BLS Patient Management

- **Establish, maintain, and ensure:**
  - A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  - B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  - C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Oxygen**
  
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements

- Attach ECG leads to the patient when a paramedic is present

- **For symptomatic hypoglycemia with blood glucose less than 80 mg/dL in adults or 70 mg/dL in pediatrics**
  - **Adults:** Glucose (oral) 15 gm (1 tube) PO.
    - MAY REPEAT PRN.
  - **Pediatrics:**
    - ADMINISTRATION OF GLUCOSE (ORAL) TO PATIENTS WEIGHING LESS THAN 10 KG (=22 LBS) IS NOT PERMITTED.
      - o Weight is between 10 – 29 kg: Glucose (oral) as tolerated, PO. MAY REPEAT PRN.
      - o Weight = 30 kg or greater: Glucose (oral) 15 gm (1 tube) PO. MAY REPEAT PRN.

## ALS Patient Management

- Interpret and continuously monitor ECG, vital signs and SpO₂

- **For symptomatic hypoglycemia with blood glucose less than 80 mg/dL in adults or 70 mg/dL in pediatrics and neonates**
  - **Adults:** Dextrose 25 gm (D10%) IV/IO bolus or drip.
    - MAY REPEAT PRN.
  - **Pediatrics and neonates:** Dextrose 5 mL / kg (D10%) IV/IO bolus or drip. MAY REPEAT PRN. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

- **For symptomatic hypoglycemia with blood glucose less than 80 mg/dL in adults or 70 mg/dL in pediatrics and neonates WHEN UNABLE TO ADMINISTER DEXTROSE**
  - **Adults:** Glucagon 1 mg (1 mL) IM.
    - ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
  - **Pediatrics and neonates:**
    - Weight = 21 kg (≈46 lbs) or less: Glucagon 0.5 mg IM.
    - Weight = 22 kg (≈48 lbs) or more: Glucagon 1 mg IM.
    - ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

- **For symptomatic hypoglycemia with blood glucose less than 80 mg/dL in adults or 70 mg/dL in pediatrics WHEN UNABLE TO ADMINISTER DEXTROSE OR GLUCAGON**
  - **Adults:** Glucose (oral) 15 gm (1 tube) PO.
    - MAY REPEAT PRN.
  - **Pediatrics:**
    - ADMINISTRATION OF GLUCOSE (ORAL) TO PATIENTS WEIGHING LESS THAN 10 KG (=22 LBS) IS NOT PERMITTED.
      - o Weight is between 10 – 29 kg: Glucose (oral) as tolerated, PO. MAY REPEAT PRN.
      - o Weight = 30 kg or greater: Glucose (oral) 15 gm (1 tube) PO. MAY REPEAT PRN.

## Patient Disposition

- CONTACT A SINGLE BASE HOSPITAL FOR ANY PATIENT THAT REFUSES TRANSPORT FOLLOWING THE INITIATION OF AN ALS TREATMENT

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4201 — Symptomatic Hypoglycemia
### BLS Patient Management

- **Establish, maintain, and ensure:**
  - A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  - B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  - C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Oxygen**
  - As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements

- Preserve the patient’s body heat by covering them with warm blankets

- Attach ECG leads to the patient when a paramedic is present. May assist with placement of the 12-lead cables.

- Position the patient supine to meet physiologic requirements: Avoid Trendelenburg or elevating legs for shock. If the patient is pregnant, transport her in left lateral position

- Preserve the patient’s body heat by covering them with warm blankets

  *Consider the causes of shock and act as indicated by REMSA policies, protocols, and standards*

### ALS Patient Management

- **Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization, and/or as clinically indicated, in adult and pediatric patients**

  Consider the need for additional sites as clinically indicated

- **Interpret and continuously monitor ECG, vital signs, SpO₂ and waveform / digital capnography**

  Perform, interpret, and transmit 12L ECG(s), as clinically indicated, when:
  1. A STEMI is suspected
  2. A STEMI is ECG-monitor identified or
  3. The patient’s cardiac rhythm is atypical or difficult to interpret

- **For shock unrelated to trauma**
  - **Adults:** Normal saline 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.**

    Pediatrics: Normal saline 20 mL / kg IV/IO bolus. Use a volume control administration set for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  Adults and pediatrics: Push Dose Epinephrine 0.01 mg (1 mL, 0.01 mg / mL concentration) IV/IO. **MAY REPEAT PRN EVERY 1-5 MINUTES TO MAINTAIN A SYSTOLIC BP GREATER THAN:**

  - 90 mmHg – adults
  - 70 mmHg – pediatrics

  **ADMINISTRATION OF TRANEXAMIC ACID (TXA) FOR SHOCK UNRELATED TO TRAUMA IS NOT PERMITTED**
### Nausea and/or Vomiting

**BLS Patient Management**

- **Establish, maintain, and ensure:**
  
  A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  
  B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  
  C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Oxygen**
  
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements

- Attach ECG leads to the patient when a paramedic is present

**ALS Patient Management**

- **Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization, and/or as clinically indicated, in adult and pediatric patients**

- Consider the need for additional sites as clinically indicated

- Interpret and continuously monitor ECG, vital signs and SpO₂

- **For nausea and/or vomiting**

  **Adults:**
  
  Ondansetron 4 mg PO (1 ODT). **MAY REPEAT TWICE TO MAX 12 MG. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  **OR**
  
  Ondansetron 4 mg (2 mL) IV solution slow IV/IO push or IM. **MAY REPEAT TWICE TO MAX 12 MG. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  **Pediatrics:**
  
  ADMINISTRATION OF ONDANSETRON ODT TO PATIENTS WEIGHING LESS THAN 10 KG (~22 LBS) IS NOT PERMITTED.

  Weight = 10 kg or greater: Ondansetron 4 mg PO (1 ODT). **MAY REPEAT TWICE TO MAX 12 MG. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  **OR**
  
  Ondansetron 0.1 mg / kg IV solution slow IV/IO push or IM. **MAX SINGLE DOSE IS 4 MG. MAY REPEAT TWICE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).

**Adults:** Diphenhydramine 25-50 mg (0.5 – 1 mL) IM or slow IV/IO push.

**Pediatrics:** Diphenhydramine 1 mg / kg slow IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

**OR**

Diphenhydramine 2 mg / kg IM. **MAX SINGLE DOSE IS 50 MG.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
**BLS Patient Management**

- **Establish, maintain, and ensure:**
  - A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  - B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  - C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Oxygen**
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- Position the patient as clinically indicated for safety, comfort (when airway management processes allow), and to meet physiologic requirements.

  Attempt to calm and reduce anxiety. Utilize ice PRN. Immobilize and splint affected area(s) as clinically indicated.

- Assess the patient’s pain scale using the age-appropriate pain scale

- Attach ECG leads to the patient when a paramedic is present

- **VITALS SIGNS MUST BE MONITORED THROUGHOUT BLS AND ALS INTERVENTIONS FOR PAIN MANAGEMENT**

**ALS Patient Management**

- **Special consideration must be given to the type of pain, the patient’s overall condition, allergies, medical history, and drug contraindications when deciding if pain management is appropriate and which pain medication should be administered. NOT ALL PATIENTS REQUIRE MEDICATION-BASED INTERVENTIONS FOR PAIN MANAGEMENT**

- Interpret and continuously monitor ECG, vital signs, SpO₂ and waveform / digital capnography

- **Acute abdominal / flank pain, sickle cell crisis or cancer pain**
  - Adults: Fentanyl 50 mcg (1 mL) slow IV/IO push or IM/IN. Patient’s systolic BP must be greater than or equal to 90 mmHg at the time of administration. **MAY REPEAT ONCE, IN 5-10 MINUTES, DEPENDENT ON PAIN SEVERITY, TO A MAX OF 100 MCG. ADDITIONAL ADMINISTRATIONS AFTER 100 MCG REQUIRE A BASE HOSPITAL ORDER (BHO).**
  
  - Pediatrics: Fentanyl 1 mcg / kg slow IV/IO push or IM/IN. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  - Adults: Ketamine 0.3 mg / kg IVPB. Infuse in 50-100 mL Normal Saline, administer over 5 minutes. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  **OR**

  - Ketamine 0.5 mg / kg IN. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  **THE MAX SINGLE DOSE FOR EITHER ROUTE IS 30 MG.**

  **ADMINISTRATION OF KETAMINE TO PEDIATRIC PATIENTS IS NOT PERMITTED.**
### BLS Patient Management

- **Establish, maintain, and ensure cervical spine stabilization, as clinically indicated, when NSAID criteria is met**
  - Neuro deficits
  - Spinal Tenderness
  - Altered Mental Status
  - Intoxication
  - Distracting Injury

  ***The long backboard (LBB) is an extrication tool and should only be used to facilitate patient transfer to the stretcher. It is not intended, or appropriate, to use a LBB to achieve or maintain spinal stabilization. Judicious application of the LBB for purposes other than extrication require that the benefits outweigh the risks of application. If the LBB is used, patients should be removed as soon as as is safe and practical***

- **Establish, maintain, and ensure**
  - A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  - Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  - Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Oxygen**
  - As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

### ALS Patient Management

- Interpret and continuously monitor ECG, vital signs and SpO₂

- Establish, maintain, and ensure bilateral, large bore IV and/or IO access for shock due to trauma

  Establish IV/IO access during transport of the non-entrapped, transport ready critical trauma patient

  Consider the need for additional sites as clinically indicated

- **For shock due to trauma**
  - **Adults:** Normal saline 250 mL IV/IO bolus. MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.

  Pediatrics: Normal saline 20 mL / kg IV/IO bolus. Use a volume control administration set for accurate dosing. MAY REPEAT AS CLINICALLY INDICATED. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

- **For traumatic injuries within three (3) hours with signs and symptoms of hemorrhagic shock with systolic BP less than 90 mmHg**

  **OR**

  Significant hemorrhage with heart rate greater than or equal to 120

  **OR**

  Uncontrolled bleeding despite tourniquet application

  **Adults:** Tranexamic Acid (TXA) 1 gm (10 mL) IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes.

  **ADMINISTRATION OF TRANEXAMIC ACID (TXA) TO PEDIATRIC PATIENTS IS NOT PERMITTED.**
• Position the patient supine to meet physiologic requirements: Avoid Trendelenburg or elevating legs for shock. If the patient is pregnant, transport her in left lateral position

• Preserve the patient’s body heat by covering them with warm blankets

• Attach ECG leads to the patient when a paramedic is present

• **For traumatic arrest**
  Follow REMSA Treatment Protocol #4405 (Cardiac Arrest)

  • **If the patient presents with**
    Signs and symptoms of tension pneumothorax:
    o Air hunger
    o Chest pain
    o Compromised cardiac output (hypotension, hypoxemia, tachycardia, etc.)
    o Elevated hemithorax without respiratory movement
    o Neck vein distension
    o Respiratory distress
    o Unilateral absence of breath sounds
    o Cyanosis (late sign)
    o Tracheal deviation away from the side of the injury (late sign)

    AND

    rapidly progressing respiratory distress unrelieved by less invasive means

    THEN

    Perform unilateral chest decompression

• If the patient is in cardiac arrest with known/suspected torso trauma or with a presentation suggesting spontaneous pneumothorax

    THEN

    Perform bilateral chest decompression

**Patient Disposition**

• Ground ambulance is the primary means of transport for destinations 30 minutes or less by code 3.
  a. Adult patients identified as critical trauma patients will be transported to the closest Trauma Center.
  b. Pediatric patients identified as critical trauma patients should be transported to a pediatric trauma center.
  c. If the pediatric trauma center is greater than 30 minutes away by ground, go to the closest trauma center.
  d. If the closest trauma center is greater than 30 minutes by ground code 3, consider HEMS transport.
  e. If patient destination is questionable, contact the trauma base hospital for destination.
  f. Refer to REMSA policy #6103 (Ambulance Diversion) when trauma centers are on diversion

• Do not delay contacting a trauma base hospital for critical trauma patients

• Do not delay transport with nonessential treatment of non-entrapped, transport ready, critical trauma patients
Critical Trauma Patients / Traumatic Arrest Patients

- **Adult blunt traumatic arrest:**
  - If the patient meets Do Not Attempt Resuscitation / Discontinue Resuscitation criteria: DO NOT TRANSPORT.
  - If the patient is pulseless and apneic with asystole / agonal rhythm / PEA at a rate less than 40: DO NOT TRANSPORT.
    - Otherwise, transport to the closest trauma center.

- **Adult penetrating traumatic arrest:**
  - If the patient meets Do Not Attempt Resuscitation / Discontinue Resuscitation criteria: DO NOT TRANSPORT.
  - If the patient is pulseless and apneic with asystole / agonal rhythm / PEA at a rate less than 40: DO NOT RESUSCITATE OR TRANSPORT.
    - If the patient has signs of life and transport time is reasonable, then consider transport to the closest trauma center.

- **Pediatric traumatic arrest:**
  - A base hospital physician order (BHPO) is required to discontinue resuscitation.
  - Otherwise, transport to the closest pediatric trauma center

- **Burn patients:**
  - Critical trauma patients with burns will be transported to the closest trauma center.
  - Patients not meeting critical trauma patient criteria (minor and/or moderate burns) can be cared for at any prehospital receiving center.
BLS Patient Management

- Establish, maintain, and ensure cervical spine stabilization, as clinically indicated, when NSAID criteria is met
  - Neuro deficits
  - Spinal Tenderness
  - Altered Mental Status
  - Intoxication
  - Distracting Injury

***The long backboard (LBB) is an extrication tool and should only be used to facilitate patient transfer to the stretcher. It is not intended, or appropriate, to use a LBB to achieve or maintain spinal stabilization. Judicious application of the LBB for purposes other than extrication require that the benefits outweigh the risks of application. If the LBB is used, patients should be removed as soon as soon as is safe and practical***

- Establish, maintain, and ensure
  A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- Oxygen
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- Position the patient supine to meet physiologic requirements: Avoid Trendelenburg or elevating legs for shock. If the patient is pregnant, transport her in left lateral position

ALS Patient Management

- Interpret and continuously monitor ECG, vital signs and SpO₂

- Establish, maintain, and ensure bilateral, large bore IV and/or IO access for emergency stabilization and/or as clinically indicated

Establish IV/IO access during transport of the non-entrapped, transport ready critical trauma patient

Consider the need for additional sites as clinically indicated

- If the patient presents with
  Signs and symptoms of tension pneumothorax:
  - Air hunger
  - Chest pain
  - Compromised cardiac output (hypotension, hypoxemia, tachycardia, etc.)
  - Elevated hemithorax without respiratory movement
  - Neck vein distension
  - Respiratory distress
  - Unilateral absence of breath sounds
  - Cyanosis (late sign)
  - Tracheal deviation away from the side of the injury (late sign)

  AND

  rapidly progressing respiratory distress unrelieved by less invasive means

  THEN

  Perform unilateral chest decompression
• Preserve the patient’s body heat by covering them with warm blankets

• Attach ECG leads to the patient when a paramedic is present

• **For suspected traumatic brain injury**
  Increase ventilatory rate for unequal / fixed and dilated pupils and extensor posturing / no motor response:
  - Adult: 20 breaths per minute
  - Child: 25 breaths per minute
  - Infant: 30 breaths per minute

• **For impaled object(s)**
  Support and stabilize object(s) in place. Remove only if the object interferes with airway patency or with chest compressions

• **For flail chest**
  Assist ventilations as clinically indicated. Do not stabilize the flail segment by sandbagging, splinting, and/or swathing

• **For eye injury / injuries**
  Irrigate with saline as clinically indicated. Apply protective rigid shields bilaterally. Position the patient as clinically indicated to meet physiologic requirements

• **For avulsed tooth / teeth**
  Handle the tooth / teeth by the crown. Do not touch any part of the tooth that normally exists below the gum line. In the alert and cooperative patient, attempt to replace the tooth in its socket. If unable, wrap in a milk or normal saline soaked gauze sponge and transport with the patient

• **For wound care**
  Control bleeding using direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated
  
  Dress and bandage abrasions, lacerations, avulsions, punctures and/or penetrations as clinically indicated
  
  Dress an open pneumothorax with an occlusive dressing. Briefly remove (“burp”) to release pressure when signs of a tension pneumothorax appear

• **If the patient is in cardiac arrest with known/suspected torso trauma or with a presentation suggesting spontaneous pneumothorax**

  **THEN**

  Perform bilateral chest decompression

• **For pain associated with acute traumatic injury or injuries**
  - Adults: Fentanyl 50 mcg (1 mL) slow IV/IO push or IM/IN. Patient’s systolic BP must be greater than or equal to 90 mmHg at the time of administration. **MAY REPEAT ONCE, IN 5-10 MINUTES, DEPENDENT ON PAIN SEVERITY, TO A MAX OF 100 MCG.**
  
  **Pediatrics:** Fentanyl 1 mcg / kg slow IV/IO push or IM/IN. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  **Adults:** Ketamine 0.3 mg / kg IVPB. Infuse in 50-100 mL Normal Saline, administer over 5 minutes. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  **THE MAX SINGLE DOSE FOR EITHER ROUTE IS 30 MG.**

  **ADMINISTRATION OF KETAMINE TO PEDIATRIC PATIENTS IS NOT PERMITTED.**

• **For suspected hyperkalemia associated with crush injuries**
  - Adults: Normal Saline 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.**
  
  **Pediatrics:** Normal Saline 20 mL / kg IV/IO bolus. Use a volume control administration set for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
Dress evisceration(s) with saline soaked dressing(s). Do not intentionally replace evisceration

Dress injured genitalia with saline soaked dressing(s), applying direct pressure to control bleeding

- For fracture(s) or dislocation(s)
  Assess distal neurovascular functions using PMS (pulse, motor, sensation) before and after manipulation, manual stabilization and/or splinting.

  Manually stabilize and/or splint fractures and dislocations as found and as clinically indicated. Rinse exposed bone with saline and dress with saline soaked gauze sponge(s) or non-adherent dressing(s). Do not intentionally allow exposed bone to retract and do not intentionally reduce dislocation

  Using gentle traction, return grossly angulated extremity fractures to the anatomic position as clinically indicated

  Stabilize and/or splint mid-shaft femur fractures using a traction splint as clinically indicated

  CONTACT A SINGLE BASE HOSPITAL FOR ANY FRACTURE OR DISLOCATION WITH NEUROLOGICAL AND/OR VASCULAR COMPROMISE

- For amputation(s)
  Rinse amputated body part(s) with normal saline then wrap with saline soaked dressing(s). Place in a bag. Keep part(s) cool but don’t place directly on ice

- For pain management
  Apply disposable cold pack(s) as clinically indicated for pain associated with a traumatic injury or injuries

- For traumatic arrest
  Follow REMSA Treatment Protocol #4405 (Cardiac Arrest)

- ADULTS AND PEDIATRICS: INITIAL AND REPEAT ADMINISTRATIONS OF ALBUTEROL, CALCIUM CHLORIDE, AND SODIUM BICARBONATE FOR SUSPECTED HYPERKALEMIA ASSOCIATED WITH CRUSH INJURIES REQUIRES A BASE HOSPITAL ORDER (BHO)
  Adults and pediatrics: Albuterol 2.5 mg / 3 mL (one pouch), nebulized.

  Adults: Calcium Chloride 1 gm (10 mL) IVPB.

  Pediatrics: Calcium Chloride 20 mg / kg IVPB. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  Adults and pediatrics: Infuse in 50-100 mL normal saline, administer over 10 minutes.

  Adults: Sodium bicarbonate 50 mEq (50 mL) IV/IO push.

  Pediatrics: Sodium bicarbonate 1 mEq / kg IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

- For traumatic injuries within three (3) hours with signs and symptoms of hemorrhagic shock with systolic BP less than 90 mmHg

  **OR**

  Significant hemorrhage with heart rate greater than or equal to 120

  **OR**

  Uncontrolled bleeding despite tourniquet application
  Adults: Tranexamic Acid (TXA) 1 gm (10 mL) IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes.

  ADMINISTRATION OF TRANEXAMIC ACID (TXA) TO PEDIATRIC PATIENTS IS NOT PERMITTED.

Patient Disposition

- Attempt to limit scene time to ten (10) minutes or less when Trauma Triage Criteria has been met. Do not delay transport with nonessential treatment of non-entrapped, transport ready, critical trauma patients

- CONTACT A SINGLE TRAUMA BASE HOSPITAL FOR: ANY CRITICAL TRAUMA PATIENT OR MASS CASUALTY / MASS PATIENT INCIDENT (MCI / MPI),

- CONTACT A SINGLE BASE HOSPITAL FOR: ANY PATIENT THAT HAS BEEN SEXUALLY ASSAULTED OR INCIDENTS WHEN LAW ENFORCEMENT REQUESTS AN “OK TO BOOK” EXAM
### BLS Patient Management

- **Establish, maintain, and ensure:**
  - **A.** A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  - **B.** Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  - **C.** Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Oxygen**
  - As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- **Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements**

- **When the patient’s systolic BP is greater than 90 mmHg, assist them with administration of their physician prescribed Nitroglycerin, to a max of 1.2 mg. Monitor the patient for signs of hypotension. Record the patient’s self-administration in the ePCR as, “Self-administered”**

- **Assist the patient with administration of Aspirin to a max dose of 324 mg (four 81 mg chewable tablets). Monitor the patient. Record the patient’s self-administration in the ePCR as, “Self-Administered”**

- **Attach ECG leads to the patient when a paramedic is present. May assist with placement of the 12-lead cables**

### ALS Patient Management

- **STEMI Triage and Destination**
  - **Suspect a STEMI if any one (1) of the following is true:**
    - The 12-lead ECG shows 1 mm or greater ST-segment elevation in two (2) or more contiguous leads, with reciprocal depression
    - Paramedic interpretation of the 12-lead ECG is STEMI
    - The ECG monitor reads: ***Acute MI*** or ***Acute MI Suspected*** or the equivalent
  - Immediately transmit the 12-lead ECG and make early notification to the closest STEMI Receiving Center prior to transport, or as soon as a STEMI is identified. Perform serial 12-lead ECGs when an acute MI is suspected or confirmed

- **Establish, maintain, and ensure peripheral IV and/or IO access. Consider bilateral large bore IV access when a STEMI is suspected or confirmed**

- **For suspected ACS**
  - **Adults:** Aspirin 324 mg (four 81 mg chewable tablets) PO. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
    - ADMINISTRATION OF ASPIRIN TO PEDIATRIC PATIENTS IS NOT PERMITTED.
  - **Adults:** Nitroglycerin 0.4 mg (1 tablet or 1 metered spray) SL when the patient’s systolic BP is greater than 90 mmHg. MAY REPEAT TWICE AT 3-5 MINUTE INTERVALS. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
    - **AND**
      - Nitroglycerin 1 gm (1 inch) transdermal paste when the patient’s systolic BP is greater than 90 mmHg. If systolic BP falls below 90 mmHg, wipe away paste. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
Administration following the patient’s use of a PDE5 inhibitor (ex: Cialis / tadalafil, Levitra / vardenafil, Stendra / avanafil or Viagra / sildenafil) requires a base hospital physician order (BHPO).

ADMINISTRATION OF NITROGLYCERIN TO PEDIATRIC PATIENTS IS NOT PERMITTED.

- For suspected ACS with persistent chest discomfort unresponsive to Nitroglycerin
  Adults: Fentanyl 50 mcg (1 mL) slow IV/IO push or IM/IN. Patient’s systolic BP must be greater than or equal to 90 mmHg at the time of administration. **MAY REPEAT ONCE, IN 5-10 MINUTES, DEPENDENT ON PAIN SEVERITY, TO A MAX OF 100 MCG. ADDITIONAL ADMINISTRATIONS AFTER 100 MCG REQUIRE A BASE HOSPITAL ORDER (BHO).**
PURPOSE:
To describe the medical orders that EMS personnel must follow during care of the mechanical circulatory support device patient. These medical orders are performed under medical direction by the Riverside County EMS Agency (REMSA) Medical Director through this written / standing order. These medical orders may also be provided, modified, and/or supervised by the mobile intensive care nurse (MICN) and/or base hospital physician (BHP) through on-line (remote verbal order) or on-scene procedure authorization. The REMSA Medical Director is responsible and accountable for medical control of the EMS system. Each MICN and BHO is responsible and accountable for medical direction given to EMS personnel.

Mechanical Circulatory Support Devices: Comparison

<table>
<thead>
<tr>
<th>Ventricular Assist Device (VAD)</th>
<th>Total Artificial Heart (TAH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usually pulseless</td>
<td>Pulsatile</td>
</tr>
<tr>
<td>ECG shows native heart rhythm</td>
<td>ECG is meaningless because there is no heart</td>
</tr>
<tr>
<td>Do NOT administer NTG</td>
<td>NTG may be administered for systolic blood pressure greater than 140 mmHg</td>
</tr>
<tr>
<td>May perform chest compressions for a cardiac rhythm of VF, VT, or asystole</td>
<td>Do NOT perform chest compressions</td>
</tr>
<tr>
<td>May cardiovert, externally pace, or defibrillate</td>
<td>Do NOT cardiovert, externally pace, or defibrillate</td>
</tr>
<tr>
<td>Must auscultate the left upper quadrant of the patient’s abdomen for the “hum” of the VAD</td>
<td>The TAH’s Freedom Driver is audible without a stethoscope, making a “galloping” type of sound</td>
</tr>
<tr>
<td>Will usually have an ICD</td>
<td>Will not have an ICD</td>
</tr>
<tr>
<td>May be able to obtain a Mean Arterial Pressure (MAP) using a Doppler device only. Normal sphygmomanometer will not work. MAP should be from 70 – 85 mmHg</td>
<td>Blood pressure is obtainable utilizing a normal sphygmomanometer</td>
</tr>
</tbody>
</table>

BLS Patient Management

- Establish, maintain, and ensure:
  A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPA) as clinically indicated
  B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

ALS Patient Management

- Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization, and/or as clinically indicated
  Consider the need for additional sites as clinically indicated
- Do not administer Aspirin or Nitroglycerin to VAD patients
- **Oxygen**
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD.

- Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements.

- **CONTACT A SINGLE BASE HOSPITAL AS SOON AS POSSIBLE TO GIVE THEM TIME TO CONTACT THE VAD / MCS COORDINATOR**
  The VAD/MCS Coordinator will assist the base hospital with troubleshooting the equipment.

  Give report and describe any advanced directives (DNR/POLST/DNR medallion)

  Advise the base hospital of the implanting hospital. For patients from outside of the area, the default Coordinator will be Loma Linda University Medical Center (Main Campus).

- The VAD Coordinator(s) cannot provide online medical direction.

- Assist the patient’s family and/or caregiver with troubleshooting the VAD for disconnection, power or mechanical failure.

  Provide patient care as directed by applicable REMSA treatment protocols with the exception of chest compressions, defibrillation, external pacing or cardioversion in TAH patients.

  Do not assist VAD patients with Aspirin and/or Nitroglycerin administration.

- **CONSIDER:** Normal saline 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.** Volume replacement is the first-line therapy in the pre-load dependent VAD patient.

- **CONSIDER:**
  For amnesic effect in the conscious VAD patient prior to synchronized cardioversion.

  Midazolam 2.5 mg (0.5 mL) slow IV/IO push.

  **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  ****OR**

  Midazolam 5 mg (1 mL) IM/IN. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

- **CONSIDER:** Early and aggressive synchronized cardioversion for the symptomatic VAD patient who is experiencing a preload-disruptive malignant dysrhythmia (i.e., VT with pulses).
  - Initial shock – 100j
  - Second shock – 150j
  - Subsequent shocks – 200j

- Perform chest compressions on VAD patients only, only in the following circumstances:
  - If the patient is unconscious, apneic, and showing VT, VF, or asystole on the ECG monitor.
  - If the patient is apneic with cyanosis and the cardiac monitor shows a perfusing rhythm but capillary refill is greater than 3 seconds.

- Defibrillate at the manufacturer’s recommended joule setting for pulseless VT and VF.

**Patient Disposition**

- The base hospital will determine treatment, and destination, while considering the VAD coordinator’s recommendations.
### Symptomatic Tachycardia with Pulses

#### Treatment Protocol

<table>
<thead>
<tr>
<th>BLS Patient Management</th>
<th>ALS Patient Management</th>
</tr>
</thead>
</table>

**Establish, maintain, and ensure:**

A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated

B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present

C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

**Oxygen**

As clinically indicated. Titrate to maintain, or increase, \( \text{SpO}_2 \) to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

**Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements**

**Attach ECG leads to the patient when a paramedic is present. May assist with placement of the 12-lead cables**

- Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization, and/or as clinically indicated, in adult and pediatric patients

  Consider the need for additional sites as clinically indicated

- Interpret and continuously monitor ECG and vital signs

  Perform, interpret, and transmit 12-lead ECG(s), as clinically indicated, when:
  - A STEMI is suspected
  - A STEMI is ECG-monitor identified or
  - The patient’s cardiac rhythm is atypical or difficult to interpret

**For symptomatic supraventricular tachycardia (SVT) Valsalva Maneuver. MAY REPEAT PRN.**

  Adults: Adenosine 12 mg (4 mL) rapid IV/IO push. Follow immediately with 20 mL normal saline rapid IV/IO push. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

  Pediatrics: Adenosine 0.2 mg / kg rapid IV/IO push. Follow immediately with 20 mL normal saline rapid IV/IO push. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

**For symptomatic tachycardia with pulses INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)**

  Adults: Amiodarone 150 mg (3 mL) IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes.
**Pediatrics:** Amiodarone 5 mg / kg IVPB. **MAX SINGLE DOSE TO INFUSE IS 150 MG.** Infuse in 50-100 mL normal saline, administer over 10 minutes. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app. **

**INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).**

**Adults:** Lidocaine 1 mg / kg slow IV/IO push followed by the second dose (0.5 mg / kg) 8-10 minutes later, to a max of 3 mg / kg. **

**Pediatrics:** Lidocaine 1 mg / kg slow IV/IO push followed by the second dose (1 mg / kg) 8-10 minutes later. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app. **

• For shock due to symptomatic tachycardia
  **Adults:** Normal saline 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.**
  **Pediatrics:** Normal saline 20 mL / kg IV/IO bolus. Use a volume control administration set for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app. **

• For amnesic effect prior to synchronized cardioversion
  **Adults:** Midazolam 2.5 mg (0.5 mL) slow IV/IO push. **MAY REPEAT ONCE.** ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). **

**OR**

Midazolam 5 mg (1 mL) IM/IN. **MAY REPEAT ONCE.** ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). **

**INITIAL AND REPEAT PEDIATRIC ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

**Pediatrics:** Midazolam 0.1 mg / kg slow IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app. **

**OR**

Midazolam 0.2 mg / kg IM/IN. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
- Synchronized cardioversion for symptomatic SVT or VT with pulses
  - Initial shock – 100j
  - Second shock – 150j
  - Subsequent shocks – 200j
    - Adults: MAY REPEAT PRN AT 200j
    - SYNCHRONIZED CARDIOVERSION OF PEDIATRIC PATIENTS REQUIRES A BASE HOSPITAL ORDER (BHO). For assistance with accurate joule settings, refer to the REMSA PMDR or REMSA app.
### BLS Patient Management

- **Establish, maintain, and ensure:**
  - **A.** A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  - **B.** Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  - **C.** Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated
- **Oxygen**
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD
- Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements
- Attach ECG leads to the patient when a paramedic is present. May assist with placement of the 12-lead cables

### ALS Patient Management

- **Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization, and/or as clinically indicated, in adult and pediatric patients**
  - Consider the need for additional sites as clinically indicated
- **Interpret and continuously monitor ECG and vital signs**
  - Perform, interpret, and transmit 12-lead ECG(s), as clinically indicated, when:
    - A STEMI is suspected
    - A STEMI is ECG-monitor identified or
    - The patient’s cardiac rhythm is atypical or difficult to interpret
- **For symptomatic bradycardia with pulses**
  - **Adults:** Atropine 1 mg (10 mL) IV/IO. **MAY REPEAT EVERY 3-5 MINUTES TO A MAX OF 3 MG (30 mL).**
    - **INITIAL AND REPEAT PEDIATRIC ADMINISTRATION REQUIRES A BASE HOSPITAL ORDER (BHO).**
    - **Pediatrics:** Atropine 0.02 mg / kg IV/IO. **MAX SINGLE DOSE IS 0.5 MG**. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
- **For amnesic effect prior to Transcutaneous Cardiac Pacing (TCP)**
  - **Adults:** Midazolam 2.5 mg (0.5 mL) slow IV/IO push. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
    - ****OR**
      - Midazolam 5 mg (1 mL) IM/IN. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
      - ****INITIAL AND REPEAT PEDIATRIC ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
      - **Pediatrics:** Midazolam 0.1 mg / kg slow IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
**OR**

Midazolam 0.2 mg / kg IM/IN. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

- **Transcutaneous Pacing (TCP)**
  Begin at 20 mA and 70 bpm. Titrate in 5 mA increments to find the minimum current required to maintain electrical and mechanical capture. Increase in 10 bpm increments, up to 100 bpm maximum, to gain adequate cardiac output and tissue perfusion.

  **TRANSCUTANEOUS CARDIAC PACING OF PEDIATRIC PATIENTS REQUIRES A BASE HOSPITAL ORDER (BHO).**

- **For discomfort associated with TCP**
  Adults: Fentanyl 50 mcg (1 mL) slow IV/IO push or IM/IN. Patient’s systolic BP must be greater than or equal to 90 mmHg at the time of administration. **MAY REPEAT ONCE, IN 5-10 MINUTES, DEPENDENT ON PAIN SEVERITY, TO A MAX OF 100 MCG. ADDITIONAL ADMINISTRATIONS AFTER 100 MCG REQUIRE A BASE HOSPITAL ORDER (BHO).**

  **INITIAL AND REPEAT PEDIATRIC ADMINISTRATION REQUIRES A BASE HOSPITAL ORDER (BHO).**

  Pediatrics: Fentanyl 1 mcg / kg slow IV/IO push or IM/IN. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

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**Patient Disposition**

- **CONTACT A SINGLE BASE HOSPITAL FOR ALL PEDIATRIC PATIENTS EXPERIENCING SYMPTOMATIC BRADYCARDIA**
BLS Patient Management

- **Establish, maintain, and ensure:**
  - A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  - B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  - C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Oxygen**
  Utilize high flow. Optimize ventilation and oxygenation to maintain SpO2 of 94% or greater but do not hyperventilate

- Attach ECG electrodes / defibrillation pads to the patient. If / when return of spontaneous circulation (ROSC) is achieved, may assist with placement of the 12-lead cables

- **Perform CPR according to current REMSA training and standards**
  - Ensure High Performance (HP) CPR by utilizing assigned roles and tasks during resuscitation (i.e., Pit Crew CPR)
  - Emphasize correct hand placement, compression depth (hard) and rate (fast) with complete chest recoil
  - Minimize interruption of chest compressions
  - Avoid hyperventilation

  In cases of submersion incidents: do not delay hand ventilation to suction foamy secretions. Ventilate through the foam and suction once available

ALS Patient Management

- **Ensure HP CPR is being performed according to current REMSA training and standards**
  Attach, interpret, and continuously monitor EtCO2. If EtCO2 is less than 10 mmHg, attempt to improve CPR quality

- **Analyze ECG rhythm as soon as possible**
  Defibrillate when indicated. In cases of monitored shockable rhythms, stack defibrillations as clinically indicated
  - Adults: use manufacturer’s recommended joule setting
  - Pediatrics: defibrillate initially at 2 j / kg, all subsequent defibrillations at 4 j / kg. For assistance with accurate joule settings, refer to the REMSA PMDR or REMSA app

  Resume CPR immediately after each defibrillation

  Reanalyze ECG every two (2) minutes and defibrillate when indicated

- **When BLS airway management is inadequate and/or ineffective: Orotracheal Intubation (OTI)**
  PATIENTS MUST WEIGH MORE THAN 36 KG (~79 lbs) AND THEIR LENGTH (MEASURED FROM CROWN TO HEEL) MUST EXCEED THAT OF ANY COMMERCIALLY AVAILABLE, STANDARDIZED LENGTH-BASED PEDIATRIC RESUSCITATION TAPE.

  Establish, maintain, and ensure a patent airway using orotracheal intubation, as clinically indicated.

  Attach, interpret, and continuously monitor EtCO2. Utilize a colormetric device immediately after orotracheal intubation to confirm correct placement of the ETT THEN utilize waveform / digital capnography to:
  - Identify ETT dislodgement
  - Assist in monitoring the effectiveness of ventilations and perfusion in any patient
  - Monitor the quality of chest compressions in cardiac arrest patients
  - Confirm ROSC
• **Analyze AED as soon as possible**  
  Defibrillate when indicated  
  
  Resume CPR immediately after each defibrillation  
  
  Reanalyze AED every 2 minutes and defibrillate when indicated  
  
  Use pediatric attenuator (pad-cable system or key) in pediatrics less than 8 years of age  

• **Recognize ROSC when one of the following signs is observed**  
  1. ECG rhythm and skin signs improve  
  2. EtCO₂ abruptly increases to at least a normal value (between 35-40 mm Hg) or  
  3. Blood pressure becomes measurable

Use direct laryngoscopy, Magill forceps and suction as clinically indicated. When suctioning, introduce 3 mL normal saline PRN to loosen thick secretions

• **When airway management is required for a patient that is apneic in whom less invasive techniques (BLS airway management) have failed AND OTI has failed:**  
  i-gel  
  
  PATIENTS MUST WEIGH MORE THAN 36 KG (~79 lbs) AND THEIR LENGTH (MEASURED FROM CROWN TO HEEL) MUST EXCEED THAT OF ANY COMMERCIALY AVAILABLE, STANDARDIZED LENGTH-BASED PEDIATRIC RESUSCITATION TAPE.  

  INSERTION OF THE I-GEL IN PATIENTS APPEARING, OR KNOWN TO BE, 14 YEARS OF AGE OR YOUNGER IS NOT PERMITTED.  

Establish, maintain, and ensure a patent airway using an i-gel, as clinically indicated.

Attach, interpret, and continuously monitor EtCO₂.

• **For passive gastric decompression after OTI or i-gel insertion:**  
  Orogastric (OG) tube  
  
  o After successful OTI, insertion of an appropriately sized OG tube is **highly recommended**.  
  o After successful placement of the i-gel, insertion of an appropriately sized OG tube is **MANDATORY**.

• **For cardiac arrest**  
  Adults: Epinephrine 1 mg (10 mL, 0.1 mg / mL concentration) IV/IO. **MAY REPEAT EVERY 5 MINUTES TO A MAX OF 5 MG (50 mL). ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**  

  Pediatrics: Epinephrine 0.01 mg / kg (0.1 mg / mL concentration) IV/IO. **MAY REPEAT EVERY 5 MINUTES TO A MAX OF FIVE (5) ADMINISTRATIONS.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  Adults: **INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**  

  Atropine 1 mg (10 mL) IV/IO.  

  **ADMINISTRATION OF ATROPINE TO PEDIATRIC PATIENTS IN CARDIAC ARREST IS NOT PERMITTED.**
• For cardiac arrest with ventricular fibrillation (VF) or ventricular tachycardia (VT)
  Adults: Amiodarone 300 mg (6 mL) IV/IO. **MAY REPEAT ONCE AT 150 MG (3 ML) 5 MINUTES AFTER FIRST (1ST) DOSE, TO A MAX OF 450 MG. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  **INITIAL AND REPEAT PEDIATRIC ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
  Pediatrics: Amiodarone 5 mg / kg IV/IO. **MAX SINGLE DOSE IS 150 MG.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

• For cardiac arrest with ventricular fibrillation (VF) or ventricular tachycardia (VT) WHEN AMIODARONE IS UNAVAILABLE
  **INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).**
  Adults: Lidocaine 1 mg / kg slow IV/IO push followed by the second dose (0.5 mg / kg) 8-10 minutes later, to a max of 3 mg / kg.

  Pediatrics: Lidocaine 1 mg / kg slow IV/IO push followed by the second dose (1 mg / kg) 8-10 minutes later. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

• For cardiac arrest with ventricular fibrillation (VF) or ventricular tachycardia (VT) WHEN ASSOCIATED WITH TORSADES DE POINTES / POLYMORPHIC VT
  **INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
  Adults: Magnesium Sulfate 2 gm (4 mL) slow IV/IO push.

  Pediatrics: Magnesium Sulfate 50 mg / kg slow IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

• For cardiac arrest with suspected metabolic acidosis, hyperkalemia, or tricyclic antidepressant overdose
  Adults: Sodium Bicarbonate 50 mEq (50 mL) IV/IO push. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
INITIAL AND REPEAT PEDIATRIC ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
Pediatrics: Sodium Bicarbonate 1 mEq / kg IV/IO push.
For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

- For cardiac arrest with suspected hypocalcemia, hyperkalemia, hypermagnesemia, or calcium channel blocker overdose
  INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).

Adults: Calcium Chloride 1 gm (10 mL) IV/IO.

Pediatrics: Calcium Chloride 20 mg / kg IV/IO. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

- For cardiac arrest in a known / suspected dialysis patient
  Adults: Calcium Chloride 1 gm (10 mL) IV/IO.
  ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

INITIAL AND REPEAT PEDIATRIC ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
Pediatrics: Calcium Chloride 20 mg / kg IV/IO. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

- Upon ROSC:
  Perform, interpret, and transmit 12-lead ECG(s), as clinically indicated, when:
  o A STEMI is suspected
  o A STEMI is ECG-monitor identified or
  o The patient’s cardiac rhythm is atypical or difficult to interpret

- For shock following ROSC
  Adults: Normal saline 250 mL IV/IO bolus. MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.

Pediatrics: Normal saline 20 mL / kg IV/IO bolus. Use a volume control administration set for accurate dosing. MAY REPEAT AS CLINICALLY INDICATED. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
**Cardiac Arrest**

**Adults and pediatrics:** Push Dose Epinephrine 0.01 mg (1 mL, 0.01 mg / mL concentration) IV/IO. **MAY REPEAT PRN EVERY 1-5 MINUTES TO MAINTAIN A SYSTOLIC BP GREATER THAN:**

- 90 mmHg – adults
- 70 mmHg – pediatrics

WHEN PATIENT’S SYSTOLIC BP IS LESS THAN 90 MMHG:

**EPINEPHRINE DRIP**

Adults: Epinephrine 0.4 mg (0.4 mL, 1:1,000) IVPB, infused in 100 mL normal saline

**OR**

Epinephrine 0.2 mg (0.2 mL, 1:1,000) IVPB, infused in 50 mL normal saline.

**RATE WILL BE CONTROLLED VIA DIAL-A-FLOW. INCREASE DOSING EVERY 2-3 MINUTES, TO MAX 10 MCG/MIN, TO ACHIEVE OR MAINTAIN SYSTOLIC BP OF 90 MMHG OR GREATER.**

- Begin infusion at 1 mcg/min (15 ml/hr) then increase to
- 2 mcg/min (30 ml/hr) then increase to
- 4 mcg/min (60 ml/hr) then increase to
- 10 mcg/min (150 ml/hr)

IF MAX DOSING HAS BEEN REACHED AND A SYSTOLIC BP OF 90 MMHG HAS NOT BEEN ACHIEVED, BEGIN ADMINISTERING PUSH DOSE EPINEPHRINE (0.01 MG / 1 mL) PRN EVERY 1-5 MINUTES IN ADDITION TO THE DRIP UNTIL A SYSTOLIC BP OF 90 MMHG OR GREATER IS ATTAINED

**ADMINISTRATION OF EPINEPHRINE BY IVPB DRIP TO PEDIATRIC PATIENTS IS NOT PERMITTED**

- For anxiety following ROSC
  **INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

Adults: Midazolam 1 mg (0.2 mL) slow IV/IO push or IM/IN.

**ADMINISTRATION OF MIDAZOLAM TO PEDIATRIC PATIENTS FOR POST-ROSC ANXIETY IS NOT PERMITTED.**
• For pain following ROSC
  INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Fentanyl slow IV/IO push or IM/IN with dosing dependent on pain. Patient’s systolic BP must be greater than or equal to 90 mmHg at the time of administration.

  ADMINISTRATION OF FENTANYL TO PEDIATRIC PATIENTS FOR POST-ROSC PAIN IS NOT PERMITTED.

• For MEDICAL cardiac arrest patients, consider discontinuing resuscitation if all of the following steps have been taken
  1. A minimum of 20 minutes of HP CPR have been performed but ROSC has not been achieved
  2. IV or IO access has been established
  3. The patient’s airway has been successfully managed with a clinically indicated airway device
  4. Rhythm-appropriate medications, and defibrillations, have been administered according to applicable protocol(s) with no ROSC
  5. Persistent asystole or agonal rhythm is present (greater than 20 minutes). Reversible causes have been identified and treated, as clinically indicated, with no positive neurologic response or ROSC
  6. The patient’s cardiac rhythm is not refractory VF or VT
  7. Spontaneous circulation (palpable pulse) was not achieved at any point during resuscitation

  DISCONTINUING RESUSCITATION OF A PEDIATRIC PATIENT REQUIRES A BASE HOSPITAL PHYSICIAN ORDER (BHPO).

Patient Disposition

• OHCA WITH ROSC PATIENTS OF UNKNOWN OR SUSPECTED CARDIAC ETIOLOGY SHALL BE TRANSPORTED TO THE CLOSEST STEMI CENTER (SRC)

• Consider transporting patients with an obvious, non-cardiac etiology to the closest receiving facility

• In cases where the closest SRC is greater than 30 minutes away and EMS aircraft transport is not available, consider transporting to the closest receiving facility
## BLS Patient Management

- **Establish, maintain, and ensure:**
  - A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  - B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  - C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Oxygen**
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements

- If epiglottitis is suspected, do not visualize the throat. Position the patient upright / full fowlers position, leaning forward, to allow drainage of secretions. Minimize stimulation, movement and manipulation of the mouth, throat, and neck

- **For known or suspected submersion incidents in the presence of altered mental status or unresponsiveness**
  If laryngospasms are suspected, give five (5) initial breaths, and provide hand ventilations after the insertion of an airway adjunct. Ventilate through foamy secretions and suction as needed. If symptoms should resolve, encourage transport for continued evaluation

## ALS Patient Management

- **Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization, and/or as clinically indicated, in adult and pediatric patients**

- Consider the need for additional sites as clinically indicated

- Interpret and continuously monitor ECG, vital signs, SpO₂ and waveform / digital capnography

- Perform, interpret, and transmit 12-lead ECG(s), as clinically indicated, when:
  - A STEMI is suspected
  - A STEMI is ECG-monitor identified or
  - The patient’s cardiac rhythm is atypical or difficult to interpret

- **For bronchospasm**
  - **Adults and pediatrics:** Albuterol 2.5 mg / 3 mL (one pouch), nebulized. **MAY REPEAT PRN.**

  **Adults and pediatrics:** Ipratropium Bromide 0.5 mg / 2.5 mL (one pouch), mixed with one (1) pouch of Albuterol, then nebulized. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

- **For respiratory distress**
  - **INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).**
  - **Adults:** Epinephrine 0.3 mg (0.3 mL, 1 mg / mL concentration) IM.

  **Pediatrics:** Epinephrine 0.01 mg / kg (1 mg / mL concentration) IM. **MAX SINGLE DOSE IS 0.3 MG.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
• **For respiratory distress of suspected cardiac origin / CHF exacerbation**
  When the patient’s systolic BP is greater than 90 mmHg, assist them with administration of their physician prescribed Nitroglycerin, to a max of 1.2 mg. Monitor the patient for signs of hypotension. Record the patient’s self-administration in the ePCR as, “Self-administered”

• **For respiratory distress of suspected pulmonary origin**
  Assist the patient with administration of their physician prescribed MDI or other appropriate medication. Record the patient’s self-administration in the ePCR as, “Self-administered”

• Attach ECG leads to the patient when a paramedic is present. May assist with placement of the 12-lead cables

• Prepare for, assist with, and/or apply CPAP as directed when a paramedic is present

• **For asthma exacerbation unresponsive to Albuterol and Ipratropium breathing treatments**
  INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Magnesium Sulfate 2 gm / 4 mL slow IV/IO push.
  Pediatrics: Magnesium Sulfate 50 mg / kg slow IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

• **For suspected esophageal food impaction**
  INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Glucagon 1 mg (1 mL) IV/IO/IM.
  Pediatrics: Weight = 21 kg (=46 lbs) or less: Glucagon 0.5 mg (0.5 mL) IV/IO/IM. Weight = 22 kg (=48 lbs) or more: Glucagon 1 mg (1 mL) IV/IO/IM.

• **For dyspnea with suspected CHF**
  Nitroglycerin 0.4 mg (1 tablet or 1 metered spray) SL when the patient’s systolic BP is greater than 90 mmHg. MAY REPEAT TWICE AT 3-5 MINUTE INTERVALS. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

  **AND**

  Nitroglycerin 1 gm (1 inch) transdermal paste when the patient’s systolic BP is greater than 90 mmHg. If systolic BP falls below 90 mmHg, wipe away paste. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

  Administration following the patient’s use of a PDE5 inhibitor (ex: Cialis / tadalafil, Levitra / vardenafil, Stendra / avanafil or Viagra / sildenafil) requires a base hospital physician order (BHPO).

  ADMINISTRATION OF NITROGLYCerin TO PEDIATRIC PATIENTS IS NOT PERMITTED.
For severe respiratory distress suggestive of:
  o CHF exacerbation
  o COPD exacerbation
  o Asthma exacerbation
  o Non-fatal drowning

CONTINUOUS POSITIVE AIRWAY PRESSURE (CPAP)
Begin at 5 cmH₂O and increase pressure in 2.5 – 5 cmH₂O increments, to max 15 cmH₂O. **TITRATE TO RELIEF OF DYSPNEA. INCREASING PRESSURE TO 20 cmH₂O REQUIRES A BASE HOSPITAL ORDER (BHO).**

**CPAP APPLICATION AND USE IN PEDIATRICS IS NOT PERMITTED.**

Evaluate the patient for
  o Normalizing of inspiratory-to-expiratory time ratio (i.e. - 1:2)
  o Increasing SpO₂
  o Tolerance of CPAP

Attach, interpret, and continuously monitor EtCO₂

Request additional resources as required to ensure that CPAP is continued throughout the prehospital interval

**THE PATIENT’S SYSTOLIC BP MUST BE GREATER THAN 90 MMHG AT ONSET, AND DURING, CPAP TREATMENT. IF THE PATIENT’S SYSTOLIC BP FALLS BELOW 90 MMHG, CONTACT A SINGLE BASE HOSPITAL FOR DIRECTION.**

For anxiety related to the use of CPAP

Adults: Midazolam 1 mg (0.2 mL) slow IV/IO push or IM/IN. Patient’s systolic BP must be greater than or equal to 90 mmHg at the time of administration.
**ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

**ADMINISTRATION OF MIDAZOLAM TO PEDIATRIC PATIENTS FOR ANXIETY RELATED TO THE USE OF CPAP IS NOT PERMITTED.**
### BLS Patient Management

- **Establish, maintain, and ensure:**
  - A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  - B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  - C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Oxygen**
  - As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements

- Attach ECG leads to the patient when a paramedic is present

- Obtain and evaluate blood glucose

- Protect the patient from injury. Loosen restrictive clothing. Do not forcibly restrain. Preserve privacy

### ALS Patient Management

- Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization, and/or as clinically indicated, in adult and pediatric patients

- Consider the need for additional sites as clinically indicated

- Interpret and continuously monitor ECG and vital signs

- **For continuous or recurrent tonic-clonic seizures unrelated to eclampsia**
  - **Adults:**
    - Midazolam 2.5 mg (0.5 mL) slow IV/IO push. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
    - **OR**
      - Midazolam 5 mg (1 mL) IM/IN. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

  - **Pediatrics:** Midazolam 0.1 mg / kg slow IV/IO push. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
    - **OR**
      - Midazolam 0.2 mg / kg IM/IN. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

### Patient Disposition

- **CONTACT A SINGLE BASE HOSPITAL FOR ANY REFUSAL INVOLVING A NON-EMANCIPATED MINOR. THE REFUSAL MUST BE MADE BY THE PARENT, PARENTAL DESIGNEE, OR GUARDIAN.**
### BLS Patient Management

- **Establish, maintain, and ensure:**
  - A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  - B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  - C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

  Give nothing by mouth

- **Oxygen**
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements

- Protect the patient from injury. Loosen restrictive clothing. Avoid unnecessary movement. Preserve privacy

- Attach ECG leads to the patient when a paramedic is present

- Obtain and evaluate blood glucose

- **Determine**
  - Last known well time (LKWT)
  - The time the patient was discovered
  - The time the symptoms began and
  - If the patient uses of blood thinners

### ALS Patient Management

- **Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization, and/or as clinically indicated**

  Consider the need for additional sites as clinically indicated

- Interpret and continuously monitor ECG and vital signs
• Perform modified Los Angeles Prehospital Stroke Screen (mLAPSS) Exam:
  o Evaluate the patient's age, duration of symptoms, medical history implications AND
  ➢ Facial Symmetry: Ask the patient to smile or show their teeth. Abnormal findings include one side of the face not moving or not moving as well as the other
  ➢ Arm Drift: Ask the patient to close their eyes and hold their arms straight out to their front for a few seconds. Abnormal findings include one arm not moving or moving but drifting
  ➢ Grip Strength: Ask the patient to reach out and squeeze both of your hands. Abnormal findings include unilateral weakness, bilateral weakness, or the inability to perform

<table>
<thead>
<tr>
<th>mLAPSS Criteria</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Age over 17 years?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. No prior history of seizure disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. LKWT within 24 hours?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Patient was ambulatory at baseline prior to event?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Blood glucose between 60 and 400?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Exam (look for obvious asymmetry):</td>
<td>Normal- Bilaterally</td>
<td>Right</td>
</tr>
<tr>
<td>• Facial Smile/ Grimace</td>
<td></td>
<td>Droop</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Normal</td>
</tr>
<tr>
<td>• Grip</td>
<td></td>
<td>Weak Grip</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Normal</td>
</tr>
<tr>
<td>• Arm Weakness</td>
<td></td>
<td>Drifts down</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Normal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Falls down rapidly</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Normal</td>
</tr>
</tbody>
</table>

mLAPSS is positive if criteria #1-5 are YES and unilateral weakness is present in any finding of #6. If mLAPSS is positive, initiate rapid transport and early stroke receiving center notification. Transport patient to closest most appropriate stroke center.

Patient Disposition
• Attempt to limit scene time to ten (10) minutes or less, do not delay transport with nonessential treatment
• Prior to transport, contact the closest most appropriate stroke center for early notification and Stroke Team activation
### BLS Patient Management

- **Establish, maintain, and ensure:**
  - A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  - B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  - C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Oxygen**
  - As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- Obtain and evaluate blood glucose

- Attach ECG leads to the patient when a paramedic is present

- Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements

- If able, and applicable, contact Poison Control at 1-800-222-1222

**REMSA Authorized Public Safety Personnel AND first response agency BLS providers in the absence of ALS providers – LOSOP Approval Required**

- **For respiratory depression / respiratory arrest with suspected narcotic overdose**
  - Adults: Naloxone 0.5 mg (0.5 mL) IV/IO/IM/IN. MAY REPEAT PRN. TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS.

  - Pediatrics: Naloxone 0.1 mg / kg IV/IO/IM/IN. MAX SINGLE DOSE IS 0.5 MG. MAY REPEAT PRN. TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

- **For suspected dystonic reaction**
  - Adults: Diphenhydramine 50 mg (1 mL) IM or slow IV/IO push. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

  - Pediatrics: Diphenhydramine 1 mg / kg slow IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  **OR**

  - Diphenhydramine 2 mg / kg IM. MAX SINGLE DOSE IS 50 MG. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
**LOSOP required for BLS providers**

- For respiratory depression / respiratory arrest with suspected narcotic overdose
  
  **Adults:** Naloxone 0.5 mg (0.5 mL) IN ONLY. MAY REPEAT PRN. TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS.
  
  **Pediatrics:** 0.1 mg / kg IN ONLY. MAX SINGLE DOSE IS 0.5 MG. MAY REPEAT PRN. TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

- For suspected beta blocker or calcium channel blocker overdose
  
  **INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).**
  
  **Adults:** Calcium Chloride 1 gm (10 mL) IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes.
  
  **Pediatrics:** Calcium Chloride 20 mg / kg IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  **INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).**
  
  **Adults:** Glucagon 1 mg (1 mL) IV/IO/IM.
  
  **Pediatrics:** Glucagon 50 mcg / kg, IV/IO/IM. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

- For altered mental status and/or dysrhythmia with suspected cyclic antidepressant overdose
  
  **INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).**
  
  **Adults:** Sodium Bicarbonate 50 mEq (50 mL) IV/IO push.
  
  **Pediatrics:** Sodium Bicarbonate 1 mEq / kg IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
### BLS Patient Management

- **Establish, maintain, and ensure:**
  - A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  - B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  - C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Oxygen**
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- Attach ECG leads to the patient when a paramedic is present

- Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements

- Apply four-point restraints and spit sock as clinically indicated. Never restrain a patient supine or prone. Transport in low to high Fowler’s position

- Prevent positional asphyxiation by avoiding prone positioning, hog-tie applications or limiting diaphragmatic excursion

- Perform cooling measures as clinically indicated

### ALS Patient Management

- Interpret and continuously monitor ECG, SpO₂ and waveform / digital capnography

- For patients requiring chemical restraint when physical restraints are ineffective and who pose an immediate danger to themselves or others, due to:
  - Severe agitation / aggression OR
  - Severe distress, who are at potential risk for sudden death

  *IM Versed is preferred in this circumstance.*
  - Adults: Midazolam 5 mg (1 mL) IM/IN. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

  **OR**
  - Midazolam 2.5 mg (0.5 mL) slow IV/IO push. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

  Pediatrics: Midazolam 0.2 mg / kg IM/IN. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  **OR**
  - Midazolam 0.1 mg / kg slow IV/IO push. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
• For hyperthermia or heat illness symptoms related to severe agitation / aggression / distress
  Adults: 250 mL IV/IO bolus. MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.
  Pediatrics: 20 mL / kg IV/IO bolus. Use a volume control administration set for accurate dosing. MAY REPEAT AS CLINICALLY INDICATED. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

• For suspected hyperkalemia associated with heat illness / hyperthermia
  INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Sodium Bicarbonate 50 mEq (50 mL) IV/IO push.
  Pediatrics: Sodium Bicarbonate 1 mEq / kg IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
# Toxic Exposure, Inhalation, or Ingestion

## Treatment Protocol

<table>
<thead>
<tr>
<th>BLS Patient Management</th>
<th>ALS Patient Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>• If you are exposed to hazardous materials follow your agency’s procedure or, if none, begin self-decontamination and self-treatment. Don an escape hood when appropriate and if equipped. Escape to a safe location: 300 feet or more upwind, uphill, and upstream. Identify yourself as a patient. When you encounter possible hazardous materials, follow your agency’s procedure or, if none, then stage in a safe location: 300 feet or more upwind, uphill, and upstream. Maintain exit routes and deny entry. Ensure Hazardous Materials Response Team (HMRT) response. Mount a wind streamer to your vehicle’s antenna and monitor wind direction. Do not enter until the Incident Commander has deemed it reasonably ‘safe to enter.’</td>
<td>• Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization, and/or as clinically indicated, in adult and pediatric patients</td>
</tr>
<tr>
<td>• When decontaminating the patient(s), follow your agency’s procedure or, if none and you are trained/equipped, remove and bag the patient’s clothing, jewelry, etc. Brush off dry chemicals and dilute excess liquid chemicals. Wash patient with mild soap and rinse off with large amounts of clean water. Flush contaminated eyes with saline for 15 minutes or until pain and irritation subside. Cover with warm dry clothing and/or blankets. Consult container label or any onsite MSDS for decontamination instructions. Remove label or copy page from MSDS, preserve in sealed plastic bag, and transport with the patient. Antidote: Consult container label or onsite MSDS for antidote instructions. Read and relate decontamination and antidote instructions to the base hospital. Do not spread contamination! Never transport a contaminated patient, container, or materials!</td>
<td>• Interpret and continuously monitor ECG, SpO2 and waveform / digital capnography</td>
</tr>
<tr>
<td>• For bronchospasm associated with suspected toxic inhalation Adults and pediatrics: Albuterol 2.5 mg / 3 mL (one pouch), nebulized. MAY REPEAT PRN. For suspected toxic exposure, inhalation, or ingestion INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO). Assist with the administration of physician prescribed, site supplied antidote</td>
<td></td>
</tr>
<tr>
<td>• For suspected toxic ingestion INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO). Milk or Potable Water PO</td>
<td>• For cardiac dysrhythmias associated with toxic exposure, inhalation, or ingestion INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO). Adults: Calcium Chloride 1 gm (10 mL) IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes. Pediatrics: Calcium Chloride 20 mg / kg IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
</tbody>
</table>

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*Last Reviewed: October 4, 2022*  
*Last Revised: July 1, 2023*
### Establish, maintain, and ensure:

- **A.** A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
- **B.** Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
- **C.** Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Do not induce vomiting**

- **Oxygen**
  - As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- **Attach ECG leads to the patient when a paramedic is present**

- **Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements**

- **If able, and applicable, contact Poison Control at 1-800-222-1222**

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**INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).**

**Adults:** Magnesium Sulfate 2 gm (4 mL) slow IV / IO push.

**Pediatrics:** Magnesium Sulfate 50 mg / kg slow IV / IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
### BLS Patient Management

1. **If you are exposed to hazardous materials** follow your agency’s procedure or, if none, begin self-decontamination and self-treatment. Don an escape hood when appropriate and if equipped. Escape to a safe location: 300 feet or more upwind, uphill, and upstream. Identify yourself as a patient.

2. **When you encounter possible hazardous materials**, follow your agency’s procedure or, if none, then stage in a safe location: 300 feet or more upwind, uphill, and upstream. Maintain exit routes and deny entry. Ensure Hazardous Materials Response Team (HMRT) response. Mount a wind streamer to your vehicle’s antenna and monitor wind direction. Do not enter until the Incident Commander has deemed it reasonably ‘safe to enter.’

3. **When decontaminating the patient(s)**, follow your agency’s procedure or, if none and you are trained/equipped, remove, and bag the patient’s clothing, jewelry, etc. Brush off dry chemicals and dilute excess liquid chemicals. Wash patient with mild soap and rinse off with large amounts of clean water. Flush contaminated eyes with saline for 15 minutes or until pain and irritation subside. Cover with warm dry clothing and/or blankets. Consult container label or any onsite MSDS for decontamination instructions. Remove label or copy page from MSDS, preserve in sealed plastic bag, and transport with the patient.

4. **Antidote**: Consult container label or onsite MSDS for antidote instructions. Read and relate decontamination and antidote instructions to the base hospital.

   Do not spread contamination! Never transport a contaminated patient, container, or materials!

---

### ALS Patient Management

1. **Establish, maintain, and ensure peripheral IV and/or IO access** for emergency stabilization, and/or as clinically indicated, in adult and pediatric patients.

   Consider the need for additional sites as clinically indicated.

2. **Interpret and continuously monitor ECG, SpO2 and waveform / digital capnography**

3. **For symptomatic nerve agent, organophosphate, or carbamate exposure**
   **Adults**: Atropine 1 mg (10 mL of prefilled syringe) IV/IO push. **MAY REPEAT PRN.**

   **OR**
   Atropine 0.02 mg / kg IV/IO push. **MAY REPEAT PRN.**

   **Pediatrics**: Atropine 0.05 mg / kg IM x2. **MAY REPEAT PRN.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

---

**Antidote**: Consult container label or onsite MSDS for antidote instructions. Read and relate decontamination and antidote instructions to the base hospital.

Do not spread contamination! Never transport a contaminated patient, container, or materials!
• **Establish, maintain, and ensure:**
  
  A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  
  B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  
  C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated
  
• Do not induce vomiting

• **Oxygen**
  
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

• Attach ECG leads to the patient when a paramedic is present

• Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements

• **For self-administration in symptomatic nerve agent, organophosphate, or carbamate exposure, if equipped**
  
  NAAK (Nerve Agent Antidote Kit, DuoDote or Mark I) IM auto-injection(s). **MAY REPEAT TWICE.**
## Treatment Protocol

### BLS Patient Management

- If you are exposed to hazardous materials follow your agency’s procedure or, if none, begin self-decontamination and self-treatment. Don an escape hood when appropriate and if equipped. Escape to a safe location: 300 feet or more upwind, uphill, and upstream. Identify yourself as a patient.

- When you encounter possible hazardous materials, follow your agency’s procedure or, if none, then stage in a safe location: 300 feet or more upwind, uphill, and upstream. Maintain exit routes and deny entry. Ensure Hazardous Materials Response Team (HMRT) response. Mount a wind streamer to your vehicle’s antenna and monitor wind direction. Do not enter until the Incident Commander has deemed it reasonably ‘safe to enter.’

- When decontaminating the patient(s), follow your agency’s procedure or, if none and you are trained/equipped, remove, and bag the patient’s clothing, jewelry, etc. Brush off dry chemicals and dilute excess liquid chemicals. Wash patient with mild soap and rinse off with large amounts of clean water. Flush contaminated eyes with saline for 15 minutes or until pain and irritation subside. Cover with warm dry clothing and/or blankets. Consult container label or any onsite MSDS for decontamination instructions. Remove label or copy page from MSDS, preserve in sealed plastic bag, and transport with the patient.

- **Antidote:**
  - Consult container label or onsite MSDS for antidote instructions. Read and relate decontamination and antidote instructions to the BASE HOSPITAL.

  Do not spread contamination! Never transport a contaminated patient, container, or materials!

### ALS Patient Management

- Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization, and/or as clinically indicated, in adult and pediatric patients.

  Consider the need for additional sites as clinically indicated.

- Interpret and continuously monitor ECG, SpO2 and waveform / digital capnography.

- **For symptomatic nerve agent, organophosphate, or carbamate exposure**

  *INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS VIA IV OR IO REQUIRE A BASE HOSPITAL ORDER (BHO).*

  Adults: Atropine 1 mg (2.5 mL of MDV) IM x2. **MAY REPEAT PRN.**

  Pediatrics: Atropine 0.05 mg / kg IM x2. **MAX SINGLE DOSE IS 1 MG. MAY REPEAT PRN.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

- **For seizures associated with nerve agent, organophosphate, or carbamate exposure**

  *INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS VIA IV OR IO IN REQUIRE A BASE HOSPITAL ORDER (BHO).*

  Adults: Midazolam 5 mg (1 mL) IM. **MAY REPEAT TWICE AT 15 MINUTE INTERVALS. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  Pediatrics: Midazolam 0.2 mg / kg IM. **MAY REPEAT TWICE AT 15 MINUTE INTERVALS. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
• Establish, maintain, and ensure:
  A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

• Do not induce vomiting

• Oxygen
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

• Attach ECG leads to the patient when a paramedic is present

• Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements

• For self-administration in symptomatic nerve agent, organophosphate, or carbamate exposure, if equipped
  Nerve Agent Antidote Kit (NAAK) DuoDote or Mark I IM auto-injection(s). MAY REPEAT TWICE.

• For symptomatic nerve agent, organophosphate, or carbamate exposure WHEN A CDC CHEMPACK HAS BEEN DEPLOYED
  Adults: Nerve Agent Antidote Kit (NAAK) DuoDote or Mark I IM auto-injection(s). MAY REPEAT TWICE.

  ADMINISTRATION OF A NAAK (DUODOTE AND MARK I) TO PEDIATRIC PATIENTS VIA AUTOINJECTOR IS NOT PERMITTED.

  Adults: AtroPen. MAY REPEAT PRN.

  Pediatrics:
  AtroPen 0.5 mg / 0.7 mL
  Weight = 14 kg (=31 lbs) or less: 0.5 mg IM.
  Weight = 15 kg (=33 lbs) or more: 0.5 mg IM x2. MAY REPEAT PRN.

  **OR**

  INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS VIA IVPB REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Pralidoxime 600 mg (3 mL) IM. MAY REPEAT TWICE.
  Pediatrics: Pralidoxime 20 mg / kg IM. MAY REPEAT TWICE.

  ADMINISTRATION OF DIAZEPAM VIA AUTOINJECTOR TO PEDIATRIC PATIENTS IS NOT PERMITTED.

  **OR**

  Adults: Diazepam 5 mg (1 mL) IM. MAY REPEAT TWICE AT 15 MINUTE INTERVALS. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

  Pediatrics: Diazepam 0.1 mg / kg IM. MAY REPEAT TWICE AT 15 MINUTE INTERVALS. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
<table>
<thead>
<tr>
<th>AtroPen 1 mg (1 mg / 0.7 mL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight = 14 kg (≈31 lbs) or less: <strong>PEDIATRIC ADMINISTRATION IS NOT PERMITTED.</strong></td>
</tr>
<tr>
<td>Weight = 15 kg (≈33 lbs) or more: 1 mg IM. <strong>MAY REPEAT PRN.</strong></td>
</tr>
</tbody>
</table>

**ADMINISTRATION OF 2 MG / 0.7 mL ATROPEN TO PEDIATRIC PATIENTS IS NOT PERMITTED.**
## BLS Patient Management

- **Establish, maintain, and ensure**
  
  A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  
  B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  
  C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Oxygen**
  
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements

- Preserve the patient’s body heat by covering them with warm blankets

- Attach ECG leads to the patient when a paramedic is present

- **RULE OF PALMS**
  
  Surface of patient’s palm equals approximately 1% of body surface area (BSA)

- **ADULT RULE OF NINES**
  
  9% (head)
  
  9% (right arm)
  
  9% (left arm)
  
  36% (torso)
  
  1% (genitalia / perineum)
  
  18% (right leg)
  
  18% (left leg)

## ALS Patient Management

- **Establish, maintain, and ensure**
  
  Peripheral IV and/or IO access for emergency stabilization, and/or as clinically indicated, in adult and pediatric patients

  Consider the need for additional sites as clinically indicated

- **For significant burns**
  
  Adults: Normal Saline 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.**

  Pediatrics: Normal Saline 20 mL / kg IV/IO bolus. Use a volume control administration set for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

- **For pain associated with burns**
  
  Adults: Fentanyl 50 mcg (1 mL) slow IV/IO push or IM/IN. Patient’s systolic BP must be greater than or equal to 90 mmHg at the time of administration. **MAY REPEAT ONCE, IN 5-10 MINUTES, DEPENDENT ON PAIN SEVERITY, TO A MAX OF 100 MCG. ADDITIONAL ADMINISTRATIONS AFTER 100 MCG REQUIRE A BASE HOSPITAL ORDER (BHO).**

  Pediatrics: Fentanyl 1 mcg / kg slow IV/IO push or IM/IN. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  Adults: Ketamine IVPB: 0.3 mg / kg. Infuse in 50-100 mL normal saline, administer over 5 minutes. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  **OR**

  Ketamine IN: 0.5 mg / kg. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
• **INFANT RULE OF NINES**
  18% (head)
  9% (right arm)
  9% (left arm)
  36% (torso)
  14% (right leg)
  14% (left leg)

• Remove and bag patient’s clothing, jewelry, etc., paying special attention to preventing binding and constriction

• **For thermal burns: less than 20% BSA**
  Cool with wet dressing(s). Follow with dry, clean, non-adherent dressing(s)

• **For thermal burns: greater than 20% BSA**
  Apply dry, clean, non-adherent dressing(s)

• **For chemical burns**
  Brush off dry chemicals and dilute excess liquid chemicals. Wash patient with mild soap and water. Rinse and flush with large amounts of water

  Consult container label or onsite SDS for decontamination instructions.

  Remove label or copy page from SDS, preserve in sealed plastic bag, and transport with patient

• **For electrical burns**
  Consider possibility of spinal trauma / need for spinal stabilization. Treat related injuries as clinically indicated

• **For eye burns**
  Flush contaminated eye(s) with saline for 15 minutes or more. Check for contact lenses. Patch eye(s) as clinically indicated

• **For tar burns**
  Cool burns with water. Do not remove tar. Apply petrolatum gauze dressing(s)

---

**THE MAX SINGLE DOSE FOR EITHER ROUTE IS 30 MG.**

**ADMINISTRATION OF KETAMINE TO PEDIATRIC PATIENTS IS NOT PERMITTED.**

---

**Patient Disposition**

• **PREHOSPITAL TRANSPORT TO A BURN CENTER REQUIRES A BASE HOSPITAL ORDER (BHO).** Patients with minor and/or moderate burns can be cared for at any prehospital receiving center.
• Burn patients with airway involvement shall be transported to the closest prehospital receiving center. Airway involvement has priority over burns

• Burn patients meeting critical trauma patient criteria shall be transported to a trauma center. Trauma has priority over burns

• CONTACT A SINGLE BASE HOSPITAL FOR DESTINATION IN ALL:
  - Second degree (2°) burns greater than 30% BSA
  - Third degree (3°) burns greater than 10% BSA
  - Second degree (2°) or third degree (3°) burns involving face, hands, feet, genitals / perineum, major joints, fractures, or circumferential burns
  - High voltage electrical burns
  - Burns in combination with significant pre-existing medical conditions
## BLS Patient Management

- **Establish, maintain, and ensure:**
  A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Oxygen**
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- **Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements**

- **Attach ECG leads to the patient when a paramedic is present**

- **Remove from heat**
  Move to air conditioned / shaded environment and expose. Wet constantly with tepid water, fan, and encourage evaporative cooling but avoid causing shivering

  Obtain a baseline temperature and note the method: tympanic, temporal, axillary, or touch

  Apply cold packs to anterior neck, armpits, and groin. Re-assess temperature frequently. Discontinue cooling as clinically indicated to avoid causing shivering

## ALS Patient Management

- **For heat illness / hyperthermia**
  **Adults:** Cooled Normal Saline 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.**

  **Pediatrics:** Cooled Normal Saline 20 mL / kg IV/IO bolus. Use a volume control administration set for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

- **For suspected hyperkalemia associated with heat illness / hyperthermia**
  **INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  **Albuterol 2.5 mg / 3 mL (one pouch), nebulized**

  **INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  **Adults:** Calcium Chloride 1 gm (10 mL) IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes.

  **Pediatrics:** Calcium Chloride 20 mg / kg IVPB. Infuse in 50-100 mL normal saline, administer over 10 minutes. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  **INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  **Adults:** Sodium Bicarbonate 50 mEq (50 mL) IV/IO push.

  **Pediatrics:** Sodium Bicarbonate 1 mEq / kg IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
| • For shivering associated with heat illness / hyperthermia |
| INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO). |
| Adults: Midazolam 1 mg (0.2 mL) slow IV/IO push or IM/IN. |
| ADMINISTRATION OF MIDAZOLAM TO PEDIATRIC PATIENTS FOR HEAT ILLNESS-RELATED SHIVERING IS NOT PERMITTED. |
# Frostbite / Hypothermia Treatment Protocol

<table>
<thead>
<tr>
<th>BLS Patient Management</th>
<th>ALS Patient Management</th>
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<tbody>
<tr>
<td><strong>Establish, maintain, and ensure</strong></td>
<td><strong>For hypothermia</strong></td>
</tr>
<tr>
<td>A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated</td>
<td>Adults: Warmed normal saline 250 mL IV/IO bolus. MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.</td>
</tr>
<tr>
<td>B. Adequate respiations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present</td>
<td>Pediatrics: Warmed Normal Saline 20 mL / kg IV/IO bolus. Use a volume control administration set for accurate dosing. MAY REPEAT AS CLINICALLY INDICATED. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.</td>
</tr>
<tr>
<td>C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated</td>
<td><strong>For pain associated with frostbite</strong></td>
</tr>
<tr>
<td><strong>Oxygen</strong></td>
<td>Adults:</td>
</tr>
<tr>
<td>As clinically indicated. Titrate to maintain, or increase, SpO2 to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD</td>
<td>Pediatrics:</td>
</tr>
<tr>
<td><strong>Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements</strong></td>
<td>[<strong>OR</strong>] Adults: Ketamine 0.3 mg / kg IVPB. Infuse in 50-100 mL Normal Saline, administer over 5 minutes. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</td>
</tr>
<tr>
<td><strong>Preserve the patient’s body heat by covering them with warm blankets</strong></td>
<td><strong>Ketamine 0.5 mg / kg IN. MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).</strong></td>
</tr>
<tr>
<td><strong>Attach ECG leads to the patient when a paramedic is present</strong></td>
<td><strong>ADMINISTRATION OF KETAMINE TO PEDIATRIC PATIENTS IS NOT PERMITTED.</strong></td>
</tr>
<tr>
<td><strong>Remove from cold</strong></td>
<td><strong>OR</strong></td>
</tr>
</tbody>
</table>
### BLS Patient Management

- **Establish, maintain, and ensure:**
  - A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  - B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  - C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

Remove patient from contact with the allergen

- **Oxygen**
  - As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- **Assist the patient with administration of their physician prescribed Epi-pen or other appropriate medication(s).** Record the patient’s self-administration in the ePCR as, “Self-administered”

- **Attach ECG leads to the patient when a paramedic is present**

- **Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements**

- **For suspected anaphylaxis**
  - **Adults:** Epinephrine 0.3 mg (0.3 mL, 1 mg / mL concentration) IM, “EpiPen” / auto-injector. **AGENCIES MUST HAVE REMSA APPROVAL PRIOR TO CARRYING AND UTILIZING EPIPENS / EPINEPHRINE AUTO-INJECTORS.**

### ALS Patient Management

- **Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization, and/or as clinically indicated, in adult and pediatric patients**

Consider the need for additional sites as clinically indicated

- **Interpret and continuously monitor ECG, SpO₂ and waveform / digital capnography**

- **For suspected allergy and/or anaphylaxis**
  - **Adults:** Diphenhydramine 50 mg (1 mL) IM or slow IV/IO push. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  **Pediatrics:** Diphenhydramine 1 mg / kg slow IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  ****OR**

  - Diphenhydramine 2 mg / kg IM. MAX SINGLE DOSE IS 50 MG. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

- **For bronchospasm associated with allergy and/or anaphylaxis**
  - **Adults and pediatrics:** Albuterol 2.5 mg / 3 mL (one pouch), nebulized. MAY REPEAT PRN.

- **For suspected anaphylaxis**
  - **Adults:** Epinephrine 0.3 mg (0.3 mL, 1 mg / mL concentration) IM. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  **Pediatrics:** Epinephrine 0.01 mg / kg (1 mg / mL concentration) IM. MAX SINGLE DOSE IS 0.3 MG. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
• For shock associated with allergy and/or anaphylaxis
  Adults: 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.**

  Pediatrics: 20 mL / kg IV/IO bolus. Use a volume control administration set for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  **Adults and pediatrics:** Push Dose Epinephrine 0.01 mg (1 mL, 0.01 mg / mL concentration) IV/IO. **MAY REPEAT PRN EVERY 1-5 MINUTES TO MAINTAIN A SYSTOLIC BP GREATER THAN:**

  - **90 mmHg** – adults
  - **70 mmHg** – pediatric
**BLS Patient Management**

- **Establish, maintain, and ensure:**
  - A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  - B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  - C. Controlled bleeding. Use direct pressure and/or pressure dressing(s) and/or tourniquet(s) and/or hemostatic dressing(s), as clinically indicated

- **Oxygen**
  - As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- **Attach ECG leads to the patient when a paramedic is present**

- **Comfort, calm, and reassure the patient. Restrict activity. Relocate any jewelry to the unaffected extremity**

- **Mark the edge of discoloration surrounding the bite, recording the time. Re-mark the edge every 15 minutes**

- **Do not handle the snake, whether dead or alive**

- **Do not apply a constricting band, elastic bandage, cold pack, or immobilization device to the affected extremity**

- **Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements**

**ALS Patient Management**

- **Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization, and/or as clinically indicated, in adult and pediatric patients**

- **Consider the need for additional sites as clinically indicated**

  *Do not initiate IV/IO access in the affected extremity*

- **Interpret and continuously monitor ECG and vital signs**

- **For shock associated with snakebite**
  - **Adults:** 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.**

  Pediatrics: 20 mL / kg IV/IO bolus. Use a volume control administration set for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  Adults and pediatrics: Push Dose Epinephrine 0.01 mg (1 mL, 0.01 mg / mL concentration) IV/IO. **MAY REPEAT PRN EVERY 1-5 MINUTES TO MAINTAIN A SYSTOLIC BP GREATER THAN:**

  - **90 mmHg** – adults
  - **70 mmHg** – pediatrics

- **For pain associated with a snakebite**
  - **Adults:** Fentanyl 50 mcg (1 mL) slow IV/IO push or IM/IN. Patient’s systolic BP must be greater than or equal to 90 mmHg at the time of administration. **MAY REPEAT ONCE, IN 5-10 MINUTES, DEPENDENT ON PAIN SEVERITY, TO A MAX OF 100 MCG. ADDITIONAL ADMINISTRATIONS AFTER 100 MCG REQUIRE A BASE HOSPITAL ORDER (BHO).**

  Pediatrics: Fentanyl 1 mcg / kg slow IV/IO push or IM/IN. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.
**Adults:** Ketamine 0.3 mg / kg IVPB. Infuse in 50-100 mL Normal Saline, administer over 5 minutes. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

**OR**

Ketamine 0.5 mg / kg IN. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

**THE MAX SINGLE DOSE FOR EITHER ROUTE IS 30 MG.**

**ADMINISTRATION OF KETAMINE TO PEDIATRIC PATIENTS IS NOT PERMITTED.**

**Patient Disposition**

- Do no delay transport with nonessential treatment of the transport ready snakebite patient
- Transport the patient to the closest receiving center
BLS Patient Management

<table>
<thead>
<tr>
<th>APGAR</th>
<th>0</th>
<th>1</th>
<th>2</th>
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</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>Blue</td>
<td>Pink Core / Blue Extremities</td>
<td>Pink</td>
</tr>
<tr>
<td>Pulse</td>
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<td>Slow</td>
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<td>Grimace</td>
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<td>Weak</td>
<td>Strong</td>
</tr>
<tr>
<td>Activity</td>
<td>Absent</td>
<td>Weak</td>
<td>Strong</td>
</tr>
<tr>
<td>Respiration</td>
<td>Absent</td>
<td>Weak</td>
<td>Strong</td>
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</tbody>
</table>

- Dry, stimulate and swaddle in a dry receiving blanket and head cover then place with the mother as clinically indicated.

- Assess using the APGAR scoring system. Based on APGAR scores, presentation, and clinical assessment:
  - Suction secretions from mouth and nose
  - Monitor SpO2 while attached to the right upper extremity (a preductal location)
  - Provide blow-by oxygen
  - Assist ventilations with PPV and supplemental oxygen
  - Organize the resuscitation team and perform High Performance (HP) CPR according to current REMSA training and standards with a 3:1 compression ratio
    - Ensure High Performance (HP) CPR by utilizing assigned roles and tasks during resuscitation (i.e., Pit Crew CPR)
    - Emphasize correct hand placement, compression depth (hard) and rate (fast) with complete chest recoil
    - Minimize interruption of chest compressions
    - Avoid hyperventilation

ALS Patient Management

- Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization.

Consider the need for additional sites as clinically indicated.

- When required, ensure HP CPR is being performed according to current REMSA training and standards. Attach, interpret, and continuously monitor EtCO2. If EtCO2 is less than 10 mmHg, attempt to improve CPR quality.

- For neonatal resuscitation:
  
  **INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
  
  Dextrose 5 mL / kg (10% solution) IV/IO bolus or drip. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  **INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
  
  Epinephrine 0.01 mg / kg (0.1 mg / mL concentration) IV/IO. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  **INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
  
  Naloxone 0.1 mg / kg IV/IO/IM/IN. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  **INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
  
  Sodium Bicarbonate 1 mEq / kg IV/IO push. For assistance with accurate dosing, refer to the REMSA PMDR or REMSA app.

  **DISCONTINUING RESUSCITATION OF A PEDIATRIC PATIENT REQUIRES A BASE HOSPITAL PHYSICIAN ORDER (BHPO).**
### BLS Patient Management

- **Establish, maintain, and ensure:**
  A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  C. Controlled bleeding using appropriate measures, as clinically indicated

- **Oxygen**
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD

- Attach ECG leads to the patient when a paramedic is present

- Obtain and evaluate blood glucose

- Position the patient as clinically indicated for safety, comfort, and to meet physiologic requirements. If tolerated, place the patient in left lateral recumbent position

- Decrease stimuli and maintain a quiet, dark environment

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### ALS Patient Management

- **Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization, and/or as clinically indicated**

- Consider the need for additional sites as clinically indicated

- Interpret and continuously monitor ECG and vital signs

- **For suspected pre-eclampsia or eclampsia**
  **Standing order: may be given prophylactically**
  Magnesium Sulfate 5 gm (10 mL) IVPB. Infuse in 50-100 mL Normal Saline, administer over 10 minutes. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

  ****OR**
  Magnesium Sulfate 2.5 gm (5 mL) IM x2. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

- **For eclampsia unresponsive to Magnesium Sulfate**
  INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Midazolam 2.5 mg (0.5 mL) slow IV/IO push

  ****OR**
  Midazolam 5 mg (1 mL) IM/IN.

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### Patient Disposition

- **CONTACT A SINGLE BASE HOSPITAL FOR ALL PATIENTS EXPERIENCING PRE-ECLAMPSIA OR ECLAMPSIA**
## APGAR

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- **Establish, maintain, and ensure:**
  
  A. A patent and easily managed airway. Use manual maneuvers (head-tilt / chin-lift or jaw thrust), oropharyngeal suction and/or airway adjuncts (OPA / NPAs) as clinically indicated
  
  B. Adequate respirations and tidal volume. Use a mouth-to-mask device or bag valve mask (BVM), when clinically indicated. Rescue ventilations via a BVM require the use of a manometer. Waveform / digital capnography is required when paramedics are present
  
  C. Controlled bleeding using appropriate measures, as clinically indicated

- **Oxygen**
  
  As clinically indicated. Titrate to maintain, or increase, SpO₂ to a minimum of 94%. If the mother is experiencing complications, increase oxygen flow rate so that SpO₂ greater than or equal to 98%.

- **Attach ECG leads to the patient when a paramedic is present**

- **If delivery appears imminent, prepare for and/or perform an obstetrical delivery. Public safety personnel may assist only, the team lead must be either an EMT, AEMT or EMT-P**

### ALS Patient Management

- Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization

  Consider the need for additional sites as clinically indicated

- Interpret and continuously monitor ECG, SpO₂ and waveform / digital capnography

- **For shock associated with postpartum hemorrhage**
  
  Adults: 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L.**

  Push Dose Epinephrine 0.01 mg (1 mL, 0.01 mg / mL concentration) IV/IO. **MAY REPEAT PRN EVERY 1-5 MINUTES TO MAINTAIN A SYSTOLIC BP GREATER THAN 90 MMHG.**

  **ADMINISTRATION OF TRANEXAMIC ACID (TXA) FOR POSTPARTUM HEMORRHAGING IS NOT PERMITTED.**
<table>
<thead>
<tr>
<th>Patient Disposition</th>
</tr>
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<tbody>
<tr>
<td><strong>CONTACT A SINGLE BASE HOSPITAL IN ALL OBSTETRICAL DELIVERIES WITH ANY COMPLICATION OF CHILDBIRTH</strong></td>
</tr>
</tbody>
</table>

- **Manage complications as below**
  - Prolapsed cord: Position the mother as clinically indicated (i.e. – left lateral recumbent with legs / hips elevated or knees-to-chest). Remove pressure from the umbilical cord and protect it from damage by inserting a gloved hand into the vagina and gently pushing the presenting part off of the cord. Cover the exposed portion of the cord with a saline soaked dressing.
  - Breech presentation: Expedite transport to the closest facility with OB services as surgical delivery is clinically indicated. Position the mother as clinically indicated (i.e. – left lateral recumbent with legs / hips elevated or knees-to-chest).
PURPOSE
To authorize and regulate emergency medical technician (EMT) Automated External Defibrillator (AED) service providers.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Initiating EMT AED Service
Services and agencies initiating EMT AED service will submit the following documents to the County of Riverside EMS Agency (REMSA):
1. The EMT AED Service Provider’s training program for EMT AED personnel
2. The EMT AED Service Provider’s maintenance and readiness plan for AED devices
3. The EMT AED Service Provider’s annual reporting program

A service or agency may begin to provide EMT AED service once it has been approved by REMSA.

Continuing EMT AED Service
The EMT AED service provider must:
1. Provide initial training and continuing education of EMT AED personnel
   a. Maintain and update the EMT AED Service Provider’s training program for EMT AED personnel
   b. Maintain a record of all authorized EMT AED personnel
   c. Maintain a record of initial training and continuing education of all EMT AED personnel
2. Maintain AED devices and ensure that AED readiness checks are performed
   a. Maintain a record of AED devices
   b. Maintain a record of AED readiness checks
      i. Readiness checks will be performed according to manufacturer’s guidelines; at least once every 30 days; and after each use of the AED
   c. Maintain a record of AED device inspection and service
      i. Inspection and service will be performed according to manufacturer’s guidelines
3. Report EMT AED use to REMSA annually
   a. Apply to participate in the Cardiac Arrest Registry to Enhance Survival (CARES)
   b. Maintain a record of CARES data; whether accepted to participate in the registry or not
   c. Submit an annual report of its CARES data to REMSA

Each EMT AED service provider will comply with the REMSA Policy for Patient Care Records.

All non-patient care EMT AED service provider records must be retained for at least seven (7) years. These records will be provided to REMSA and/or the California EMS Authority (EMSA) within three (3) business days of a request.

Authorization of an EMT AED service provider will be revoked for failure to meet the requirements of this policy.
PURPOSE
To comply with the California Code or Regulations, Title 22, Division 9, Chapter 1.5, Article 3, 100021.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22, Division 9, and Chapter 1.5 First Aid Standards for Public Safety Personnel

Public Safety AED Service Provider
Any public safety agency employing lifeguards, firefighters, and/or peace officers trained in first aid and using automatic external defibrillation (AED) must be approved by the County of Riverside EMS Agency (REMSA) as a public safety AED service provider. Public Safety AED service provider approval may be revoked or suspended for failure to maintain the requirements of this policy.

Request for Approval
Public safety agencies requesting approval as a public safety AED service provider must submit:
1. A written request for approval as a public safety AED service provider, including:
   a. Contact information for the AED coordinator
2. A copy of the public safety agency’s policies for:
   a. Initial AED orientation and training, including:
      i. Training materials, written exams, and skills exams
   b. Continued AED competency, including any:
      i. Training materials, written exams, skills exams, or course completions
   c. Authorizing AED personnel
   d. Maintaining a roster of AED personnel available to REMSA and the California EMS Authority
   e. Maintaining AED equipment
   f. Collecting AED data
   g. AED data maintenance and its submission upon request from REMSA. Data elements will be comprised of at minimum the following:
      i. Total number of patients defibrillated
      ii. Number of witnessed arrest patients
      iii. Number of un-witnessed arrest patients
      iv. Number of patients receiving CPR prior to the arrival of EMS
      v. Number of patients whose initial monitored rhythm was V-tach or V-fib, if available
      vi. Number of patients defibrillated who were discharged from the hospital alive, if available

Standing Order for Medical Control
If no licensed or certified health care professional is available, authorized AED personnel employed by an approved public safety AED service provider are to use the AED as trained.
PURPOSE
To establish policies for emergency medical service (EMS) aircraft operations, equipment, and personnel responding to incidents within Riverside County.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

EMS Aircraft Operations, Equipment, and Personnel
The County of Riverside EMS Agency (REMSA) is responsible for the regulation of advanced life support services and for establishing policies and procedures for medical direction and control pursuant to Sections 1797.204, 1797.206, and 1797.220 of the California Health and Safety Code. REMSA is also responsible for designation and review of Emergency Medical Services (EMS) air medical services pursuant to Division 9, Chapter 8, Section 100276, et seq., of Title 22 of the California Code of Regulations.

Any aircraft seeking authorization to provide EMS in Riverside County will comply with all applicable Riverside County Ordinances and REMSA Policies, applicable sections of Title 22 of the California Code of Regulations, and pertinent F.A.A. regulations. Nothing in this policy supersedes or negates compliance with federal regulations. Exceptions to this authority are listed in Title 22, Division 9, Chapter 8, Article 2, Section 10300(c).

EMS Classification
EMS Aircraft
Any aircraft utilized for the purpose of prehospital emergency patient response and transportation. This includes Air Ambulances and all categories of Rescue Aircraft.

Air Ambulance
Any aircraft specifically constructed, modified, or equipped and used for the primary purposes of transporting critically ill or injured patients whose medical flight crew has a minimum of two attendants certified, authorized, or licensed to provide ALS care.

An Air Ambulance will:
- Have sufficient cabin space to accommodate two patients and two attendants with a clear view and full body access to either patient.

Air Ambulance services applying for a permit will provide and maintain proof of full accreditation by the Commission on Accreditation of Medical Transport Systems (CAMTS).

Rescue Aircraft
Any aircraft whose usual function is not prehospital emergency patient transport, but which may be utilized, in compliance with REMSA policies and procedures, for EMS transportation when use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft includes ALS rescue aircraft, BLS rescue aircraft, and Auxiliary rescue aircraft.

a. ALS Rescue Aircraft means a rescue aircraft whose medical flight crew has at least one attendant accredited and/or licensed to provide ALS care.

b. BLS Rescue Aircraft means a rescue aircraft whose medical flight crew has at least one attendant certified as an EMT.
c. Auxiliary Rescue Aircraft means a rescue aircraft which does not have a medical flight crew.

Air Rescue Service
An aircraft using aircraft for medical emergencies, including rescue aircraft and air ambulances.

Requirements
EMS Aircraft Operations
1. EMS Aircraft Permits
   Any EMS aircraft operators seeking to provide service in Riverside County, regardless of their base of flight operations, will have a permit to operate in accordance with the ordinance administered by the Riverside County Emergency Medical Services Agency.
   a. All Air Ambulance Service Providers working within Riverside County, regardless of their location of flight operations, must secure a written agreement with REMSA. This document is meant to ensure service consistent with REMSA policies and practices.

2. Unable to Respond
   If for any reason, other than scheduled maintenance or being engaged in an emergency response activity, an authorized Air Ambulance Service Provider is not, or will not, be able to provide immediate response for an emergency prehospital transport, the provider must:
   a. Immediately notify the Riverside County Fire Department ECC by telephone.
   b. Inform the ECC of the expected down time.
   c. Notify the Riverside County Emergency Medical Services Agency by telephone within 72 hours of the occurrence.
   d. Submit a written Incident Report documenting this event to REMSA that will include:
      i. Date and time of occurrence.
      ii. Brief description of the circumstances preventing contracted compliance.
      iii. Total down time for the aircraft before returning to full contractual obligations.
      iv. Measures taken to ensure that this situation does not reoccur.
   e. Notify both the Riverside County Fire Department ECC and REMSA when the aircraft is back in service.

3. Communications
   All aircraft will be capable of communicating with the ECC of the Riverside County Fire Department, EMS providers at the scene, and with designated Receiving Hospitals in Riverside County, per the REMSA Policy for Radio Communication Standard.

4. Patient Care and Responsibility
   a. Communication
      The Medical Flight Crew of the EMS aircraft will provide the Receiving and/or Base Hospital (as applicable) with information regarding the patient(s’) status. This information should be provided as soon as possible, but at least five minutes prior to the patient(s’) arrival to allow mobilization of necessary personnel, equipment, and supplies.
   b. The EMS Aircraft crew will be responsible for the treatment and transportation of the patient(s) they are assigned as soon as they are briefed on the patient(s) and/or accept the patient(s).
   c. A comprehensive record will be initiated for every patient that a member of the flight crew assumes primary medical responsibility for, whether or not the patient is transported by the EMS aircraft. The EMS aircraft crew will provide a copy of the patient care record to:
      i. The receiving facility or agency to whom they relinquish the patient at the time the patient is delivered; and
      ii. REMSA on a monthly basis.

5. Delivery/Distribution of Emergency Patients
   a. Patients will be transported to the closest, most appropriate acute care hospital with a licensed helipad or a “designated landing zone” approved by the appropriate public safety agency or as directed by the Medical Group Supervisor, Transport Group Supervisor, or their designee.
b. EMS Aircraft may be sent to hospitals which are not the “closest” but which may be more appropriate given the specific scene situation, e.g. spreading out the patient group to decrease the possibility of overwhelming the closest hospital.

6. Report of Information to Law Enforcement
Each authorized EMS aircraft provider who receives a report from a private party of an injury or medical condition resulting from an aircraft accident, traffic collision, gunshot wound, knife wound, drug overdose, attempted suicide, child or elder abuse, domestic violence, felonious act, or other information of possible criminal activity, will immediately report the receipt of such report and the circumstances to the law enforcement agency with jurisdiction.

7. Communicable Disease Control
The Air Ambulance or Air Rescue Service Provider will have a written policy regarding the recognition and reporting of communicable disease exposure of their personnel. This policy will be consistent with guidelines developed by the Riverside County Department of Health. These guidelines are available to the provider upon request.

8. Air Ambulance or Air Rescue Aircraft Utilization
a. Air ambulances and/or air rescue aircraft may be utilized when:
   b. Incident factors which result, or may result, in a prolonged response and transport time for the patient, e.g., very remote, or rural locale which will cause a delay in the transport of the patient due to the scene topography; or
   c. Air transportation is the most expedient transportation available to transport the patient to the most appropriate medical treatment facility; or
   d. The incident has overwhelmed the on-scene ground transportation assets resulting in the necessity of using all available transport resources.

EMS Aircraft Equipment and Inspections
1. Inspections
Each Air Ambulance or Air Rescue Service Provider will cooperate with REMSA in connection with annual and random aircraft inspections of medical equipment, supplies, personnel, and records.

2. Air Ambulance Drug and Equipment List
   a. A drug and equipment list will be approved by the Physician Advisor of the EMS aircraft provider and REMSA.
   b. Any changes in the drug and equipment list must be submitted to REMSA at least 30 days prior to the effective date of change. The changes must be mutually agreed upon by REMSA and the EMS aircraft provider.
   c. All equipment carried within or upon an air ambulance will be maintained in good working order.

3. Drug Inventory Control
A standardized written record for controlled drug administration and for daily checking will be maintained for the EMS aircraft and will be made available upon request for inspection by REMSA.

Minimum Staffing Requirements
1. Minimum Staffing for Air Ambulances
   Staffing for each air ambulance will be no less than:
   a. One paramedic who is licensed in California and accredited to work in Riverside County and who possesses current CPR, ACLS, BTLS, or PHTLS, and PALS certification. The paramedic must have a minimum of two years of full-time experience as a paramedic in the prehospital setting within the last five years before working as a flight paramedic in Riverside County; and
   b. One registered Nurse (RN) who is currently licensed in California and who possesses current CPR, ACLS, BTLS or PHTLS, and PALS certifications. The RN must have a minimum of four years of experience in an emergency department or critical care unit in the past five years before working as a flight nurse in Riverside.
   c. All staff will have proof of successful completion of an REMSA approved Air Ambulance Attendant course.
2. Alternative Staffing
   a. A Physician licensed in the state of California with recent Emergency Department experience may be substituted for the paramedic, the RN, or both.
   b. A Registered Nurse (RN) currently licensed in the state of California who possesses current CPR, ACLS, BTLS or PHTLS, and PALS certification and has a minimum of four years of experience in an emergency department or critical care unit in the past five years may be substituted for the paramedic.
   c. The required staffing may be met by utilizing a combination of any of the aforementioned categories of personnel.

3. Physician Advisor
   All Air Ambulance Service Providers will have a physician advisor who, by training and experience, is qualified in Emergency Medicine or the equivalent. The Physician Advisor will be responsible for the Supervision of the quality of the EMS aircraft patient care and the approval of medical policies, procedures, and protocols for the Air Ambulance Service Provider.

4. Scope of Practice
   a. The paramedic will operate under policies, procedures, and protocols as established by REMSA in accordance with State Regulations and Guidelines.
   b. Standardized procedures for Registered Nurses will be developed by the Physician Advisor of the Air Ambulance Service Provider, in accordance with the Nurse Practice Act. The procedures must be submitted to the REMSA Medical Director for review and mutual agreement prior to implementation.

EMS Aircraft Training
1. Medical Flight Crew training will be in accordance with Title 22, Chapter 8 (Prehospital EMS Aircraft Regulations), Article 3.

2. Continuing Education
   The medical flight crew will participate in continuing education (CE) as required by licensure, certification, or employment.

Dispatch of EMS Aircraft
1. In order to provide for a uniform system of dispatch of EMS aircraft, and to prevent potential problems with the dispatch of more than one EMS aircraft, the Riverside County Fire Department is designated as the Coordinating Agency for the dispatch of EMS aircraft. Requests for an air ambulance or rescue aircraft will be made through the Emergency Command Center (ECC) of the Riverside County Fire Department located in Perris via telephone using the following telephone numbers:
   a. 1-800-472-5697
   b. 1-951-657-2161
   Radio contact can be made via the Riverside County Intercom System.

2. EMS Aircraft Requests
   a. Notification from the scene EMS Aircraft transport will be initiated in the prehospital setting by the Incident Commander or an EMS provider, coordinating though the Incident Commander, or his designee, and will notify the Riverside County Fire Department ECC of the request for air transport. The individual making the request will notify the ECC regarding the following:
      i. Location of the incident, including (when available) longitude and latitude, and
      ii. General type of call (i.e., multi-car TC, stabbing, MCI/mpi)
   b. ECC Information Relay
      When a request for an EMS Aircraft is made, the ECC will relay to the air transport provider:
      i. The above information, and
      ii. Information regarding any other responding aircraft
      Additionally, the ECC will request from the air transport provider:
      i. An ETA and report that information back to the ground provider.
c. Additional Information
   The initial request for an air provider will NOT be delayed pending any information additional to that outlined above. However, once the ETA is reported back to the ground provider, it is the ground provider’s responsibility to provide, in a timely manner to the ECC, the following information:
   i. Radio call sign and frequency of the ground contact, and
   ii. Proposed landing zone (LZ)
      Upon the ECC’s relay of this information to the air transport provider, all further communications between ground and air will occur directly.
PURPOSE
To set equipment and medication requirements for Riverside County EMS Agency (REMSA) authorized air ambulance transport operations.

APPLICATION
This policy applies specifically to Riverside county air ambulance (helicopter) transport providers that employ Riverside County accredited paramedics (EMT-Ps), flight paramedic certified (FP-C) and critical care paramedic (CCPs).

Drug and Equipment List
This policy lists the required and optional equipment and medications, along with corresponding minimum quantities, to be carried by each paramedic staffed EMS air ambulance transport provider in Riverside County. Operational needs should be met by carrying more than the minimum quantities. Any omitted equipment is not authorized except as required by law. Equipment trials must be authorized by REMSA.

Equipment:
- Optional equipment is identified by an “O”.
  - Any agency desiring to carry and/or utilize mechanical CPR device with associated supplies must submit the “Optional Equipment Authorization Application” (Found here) and receive approval by REMSA prior to purchase
- Equipment acquired from a field provider (first response or ground transport) is identified by a “P.”

Medications:
- Alternative medications and/or concentrations are identified by an “A”.

All equipment and medications listed are per unit, unless otherwise noted.

Personal Documents
Personal documents are listed per staff person. These documents must be current and valid; and carried as originals, photocopies, or as digital reproductions.

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<thead>
<tr>
<th>Personal Documents</th>
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<tr>
<td>CA EMT-P License</td>
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<tr>
<td>CPR for the “Professional Rescuer” or “Healthcare Provider” Card</td>
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<td>ACLS Card</td>
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<td>PALS or PEPP Card</td>
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<tr>
<td>PHTLS or ITLS Card</td>
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<td>Respirator Fit Card</td>
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<tr>
<td>TB Test Card</td>
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Personal Protective Equipment (PPE)
PPE is listed per individual and must be appropriately sized and fitted. All PPE must comply with OSHA/Cal OSHA regulations. Additionally:

4. Respiratory protection requires a P100 Mask or PAPR; or a SCBA with Cal OSHA variance. Requirements for respiratory protection include Cal OSHA Title 8 Section 5144 Respiratory Protection, Cal OSHA Title 8 Section 5199 Aerosol Transmissible Diseases, and 42 CFR 84; also refer to NIOSH Respirator Selection Logic 2004 and Selection and Use of Particulate Respirators Certified Under 42 CFR 84.


6. Medical exam gloves must meet 21 CFR 880.6250, or BS EN 455-2.

PPE must meet the CAMTS criteria.

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<td>Multiple-Use Eye Protection</td>
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<tr>
<td>Respiratory Protection</td>
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<td>Uniform Shirt / Pant or Jumpsuit</td>
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<td>Uniform Cold Weather Outerwear</td>
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<td>Multiple-Use Footwear</td>
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<td>Hand Sanitizer</td>
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<td>Pocket Mask</td>
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<td>Nerve Agent Antidote Kit (NAAK)</td>
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**Personal Equipment**  
Personal equipment is listed per individual.

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<td>Penlight</td>
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<td>Seatbelt Cutter</td>
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<tr>
<td>Stethoscope</td>
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<tr>
<td>Trauma Shears</td>
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<tr>
<td>Two-way Portable Radio</td>
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<tr>
<td>Window Punch</td>
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**Incident Command System**  
Each item must be the most current revision.

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<tr>
<th>Incident Command System</th>
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<td>Emergency Response Guidebook</td>
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<td>Triage Tags</td>
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<tr>
<td>Field Operations Guide (ICS 420-1)</td>
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<tr>
<td>Packet of ICS Forms including: 214, 305, 306, 308, 310, 312</td>
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**Cervical Spine Stabilization & Splinting**

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<tbody>
<tr>
<td>Adjustable Pediatric C-Collar</td>
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<tr>
<td>Adjustable Adult C-Collar</td>
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<td>Disposable Head Stabilizer</td>
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<td>Long Spine Board</td>
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<tr>
<td>15’ D-Ring Spine Board Strap</td>
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<tr>
<td>8 Point Plus Hook &amp; Loop Spine Board Strap (Spider Strap)</td>
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<tr>
<td>Speed Clip Spine Board Straps (4 Speed Clip Straps per Board)</td>
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<td>Assessment</td>
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<td>Infant BP Cuff</td>
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<td>Adult BP Cuff</td>
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<tr>
<td>Large Adult BP Cuff</td>
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<td>Thigh BP Cuff</td>
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<td>Length Based Pediatric Resuscitation Tape*</td>
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*Must be commercially available and standardized. For consistency and accuracy, colors / kgs should correspond to REMSA’s Pediatric Medication Dosing Resource.
### Suction

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<td>Manually Powered Portable Suction Unit with Collection Container and Supplies</td>
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<td>Suction Tubing</td>
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<tr>
<td>Rigid or Semi-Rigid Suction Tip</td>
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<tr>
<td>Bulb Syringe</td>
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<td>Suction Catheter 6 Fr.</td>
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### BLS Airway

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<td>Size 5 (100 mm) Oropharyngeal Airway (OPA)</td>
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<tr>
<td>14 Fr. Nasopharyngeal Airway (NPA)</td>
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### Laryngoscopy

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<tbody>
<tr>
<td>Laryngoscope Handle with Batteries</td>
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<td>Extra Batteries</td>
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<tr>
<td>0 Straight Blade</td>
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<tr>
<td>1 Straight Blade</td>
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<td>Quantity</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Extra Bulbs (if applicable to device)</td>
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<tr>
<td>Video Laryngoscope and Supplies</td>
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<tr>
<td>Pediatric Magill Forceps</td>
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<tr>
<td>Adult Magill Forceps</td>
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**ALS Airway**

<table>
<thead>
<tr>
<th>ALS Airway</th>
<th>ALS Air Transport</th>
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<tbody>
<tr>
<td>5.5 mm Cuffed Endotracheal Tube</td>
<td>1</td>
</tr>
<tr>
<td>6 mm Cuffed Endotracheal Tube</td>
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</tr>
<tr>
<td>6.5 mm Cuffed Endotracheal Tube</td>
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<tr>
<td>7 mm Cuffed Endotracheal Tube</td>
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</tr>
<tr>
<td>7.5 mm Cuffed Endotracheal Tube</td>
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</tr>
<tr>
<td>8 mm Cuffed Endotracheal Tube</td>
<td>1</td>
</tr>
<tr>
<td>8.5 mm Cuffed Endotracheal Tube</td>
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</tr>
<tr>
<td>9 mm Cuffed Endotracheal Tube</td>
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</tr>
<tr>
<td>Size 1 - i-gel Supraglottic Airway Device</td>
<td>1</td>
</tr>
<tr>
<td>Size 2 - i-gel Supraglottic Airway Device</td>
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</tr>
<tr>
<td>Size 3 - i-gel Supraglottic Airway Device</td>
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</tr>
<tr>
<td>Size 4 - i-gel Supraglottic Airway Device</td>
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</tr>
<tr>
<td>Size 5 - i-gel Supraglottic Airway Device</td>
<td>1</td>
</tr>
<tr>
<td>Size 10 - Nasogastric / Orogastric Tube</td>
<td>1</td>
</tr>
<tr>
<td><strong>or</strong> Size 12 - Nasogastric / Orogastric Tube</td>
<td>1</td>
</tr>
<tr>
<td>Size 14 - Nasogastric / Orogastric Tube</td>
<td>1</td>
</tr>
<tr>
<td>Size 16 - Nasogastric / Orogastric Tube</td>
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</tr>
<tr>
<td><strong>or</strong> Size 18 - Nasogastric / Orogastric Tube</td>
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<tr>
<td>Adult Endotracheal Intubation Stylet</td>
<td>1</td>
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<tr>
<td>Endotracheal Tube Introducer Stylet (Bougie)</td>
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### Ventilation

<table>
<thead>
<tr>
<th>Item</th>
<th>ALS Air Transport</th>
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<tbody>
<tr>
<td>Neonate Resuscitator Mask</td>
<td>1</td>
</tr>
<tr>
<td>Infant Resuscitator Mask</td>
<td>1</td>
</tr>
<tr>
<td>Pediatric Bag Valve Mask (BVM)</td>
<td>1</td>
</tr>
<tr>
<td>Resuscitator Mask</td>
<td></td>
</tr>
<tr>
<td>O2 Reservoir</td>
<td></td>
</tr>
<tr>
<td>Adult Bag Valve Mask (BVM)</td>
<td>1</td>
</tr>
<tr>
<td>Resuscitator Mask</td>
<td></td>
</tr>
<tr>
<td>O2 Reservoir</td>
<td></td>
</tr>
<tr>
<td>Manometer for BVM</td>
<td>2</td>
</tr>
<tr>
<td>Pedi. Colorimetric CO₂ Detector</td>
<td>1</td>
</tr>
<tr>
<td>Adult Colorimetric CO₂ Detector</td>
<td>1</td>
</tr>
<tr>
<td>Ventilator with Associated Supplies</td>
<td>1</td>
</tr>
<tr>
<td>O2-RESQ™ CPAP Device</td>
<td></td>
</tr>
<tr>
<td>- Flow Generator and Circuit</td>
<td>0</td>
</tr>
<tr>
<td>- Medium Bi-Trac ED Mask</td>
<td></td>
</tr>
<tr>
<td>- Head Strap</td>
<td></td>
</tr>
<tr>
<td>- 5/7.5/10 cmH₂O Variable Valve</td>
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</tr>
<tr>
<td>O2-RESQ™ Large Bi-Trac ED Mask</td>
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<tr>
<td>O2-RESQ™ 12.5 cmH₂O Valve</td>
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<tr>
<td>O2-RESQ™ 15 cmH₂O Valve</td>
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<tr>
<td>O2-RESQ™ 20 cmH₂O Valve</td>
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<tr>
<td>1.75-2-inch 18 ga IV Catheter for Needle Chest Decompression</td>
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</tr>
<tr>
<td>3.25-inch 16 ga IV Catheter for Needle Chest Decompression</td>
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<tr>
<td>3.25-inch 14 ga IV Catheter for Needle Chest Decompression</td>
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<tr>
<td>One-way Flutter Valve for Needle Chest Decompression</td>
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### AED
### AED

<table>
<thead>
<tr>
<th>AED</th>
<th>THIS COLUMN INTENTIONALLY LEFT BLANK</th>
<th>ALS Air Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>AED with Cables, Battery/Batteries, and Supplies</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Adult AED Pads</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Pediatric AED Pads (or Pediatric Capability with Adult Pads)</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Disposable Prep Razor</td>
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<td>0</td>
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### Resuscitation

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<thead>
<tr>
<th>Resuscitation</th>
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<tbody>
<tr>
<td>Mechanical CPR Device with Supplies</td>
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### ECG

<table>
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<tr>
<td>ECG Monitor with:</td>
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</tr>
<tr>
<td>• Biphasic Defibrillation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cardioversion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 12-Lead acquisition &amp; transmission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Waveform Capnography</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Transcutaneous Pacing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cables, Battery/Batteries, and Supplies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Automated Blood Pressure with Cables, Battery/Batteries, and Supplies</td>
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<td>0</td>
</tr>
<tr>
<td>Adult Defibrillation Pad Set</td>
<td></td>
<td>2</td>
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<tr>
<td>Pediatric Defibrillation Pad Set</td>
<td></td>
<td>1</td>
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<tr>
<td>Adult ECG Electrodes</td>
<td></td>
<td>20</td>
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<tr>
<td>Pediatric ECG Electrodes</td>
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<td>8</td>
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<tr>
<td>Disposable Prep Razor</td>
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<tr>
<td>Surgical Hair Clipper with Charger, and Supplies</td>
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<td>0</td>
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<tr>
<td>Tincture of Benzoin Swabsticks</td>
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### Oxygen

<table>
<thead>
<tr>
<th>Oxygen</th>
<th>Mounting Option</th>
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<tbody>
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<td>Portable Oxygen</td>
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<tr>
<td>Mounted Oxygen</td>
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</tbody>
</table>

---

5202 — Drug and Equipment List - HEMS
O₂ for at least 20 minutes @ 10 LPM, approximately:
- D Tank @ 1450 PSI
- Jumbo-D Tank @ 1000 PSI
- E Tank @ 925 PSI

O₂ for at least 60 minutes @ 10 LPM, approximately:
- M Tank @ 600 PSI
- G Tank @ 450 PSI
- H Tank @ 400 PSI

<table>
<thead>
<tr>
<th>Oxygen</th>
<th>THIS COLUMN INTENTIONALLY LEFT BLANK</th>
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<tr>
<td>Portable O₂ System with:</td>
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<tr>
<td>• Oxygen Key</td>
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<td></td>
</tr>
<tr>
<td>• Liter Flow Regulator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Diameter Index Safety System Male Connector (DISS-M)</td>
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<td></td>
</tr>
<tr>
<td>Spare Portable O₂ Tank</td>
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<td>0</td>
</tr>
<tr>
<td>Wall Mount O₂ Regulator</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Mounted Main O₂ Tank</td>
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<tr>
<td>O₂ Supply Hoses, Adaptors and Connectors</td>
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<tr>
<td>Infant Non-Rebreather (NRB) O₂ Mask</td>
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<td>Pediatric Non-Rebreather (NRB) O₂ Mask</td>
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<td>2</td>
</tr>
<tr>
<td>Adult Non-Rebreather (NRB) O₂ Mask</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Infant Nasal Cannula</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Pediatric Nasal Cannula</td>
<td></td>
<td>1</td>
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<tr>
<td>Adult Nasal Cannula</td>
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</table>

**Wound Care**

REMSA approved tourniquets include those recommended by the Co-TCCC and the SWAT-T.

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<thead>
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<th>Wound Care</th>
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<th>ALS Air Transport</th>
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<tbody>
<tr>
<td>3X3 Sterile Gauze Sponge</td>
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<tr>
<td>4X4 Sterile Gauze Sponge</td>
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<td>P</td>
</tr>
<tr>
<td>Gauze Sponge</td>
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<td>0</td>
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<tr>
<td>Rigid Eye Shield (<a href="#">Example</a>)</td>
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<td>0</td>
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<tr>
<td>Eye Pad</td>
<td></td>
<td>0</td>
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<tr>
<td>Abdominal Pad</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Trauma Dressing</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Item</td>
<td>Quantity</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Chest Seal</td>
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<tr>
<td>Occlusive Dressing</td>
<td>0</td>
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<tr>
<td>Roller Gauze Bandage</td>
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<tr>
<td>Triangular Bandage</td>
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<tr>
<td>Hemostatic Dressing (EMSA approved only)</td>
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<tr>
<td>Combat-Application-Tourniquet (C-A-T) *</td>
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<tr>
<td>Tourniquet</td>
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</tr>
<tr>
<td>Non-Adherent Dressing</td>
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<td></td>
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<tr>
<td>Self-Adherent Wrap</td>
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<td></td>
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<tr>
<td>Elastic Wrap</td>
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<td></td>
</tr>
<tr>
<td>Transpore™ Tape</td>
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<tr>
<td>Cloth Tape</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Silk Tape</td>
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<td></td>
</tr>
<tr>
<td>Disposable Cold Pack</td>
<td>P</td>
<td></td>
</tr>
<tr>
<td>Sterile Burn Sheet</td>
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<td></td>
</tr>
<tr>
<td>1 Liter Normal Saline for Irrigation</td>
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</tr>
<tr>
<td>Eye Wash, Bottle</td>
<td>0</td>
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</tr>
<tr>
<td>Disposable OB Kit with Receiving Blanket and Head Cover</td>
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**Vascular Access**

<table>
<thead>
<tr>
<th>Vascular Access</th>
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<tbody>
<tr>
<td>Constricting Band</td>
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<tr>
<td>IV Start Kit</td>
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<td>0</td>
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<tr>
<td>Adhesive Band-Aid</td>
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<td>3</td>
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<tr>
<td>IV Stabilization Dressing</td>
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<td>0</td>
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<tr>
<td>IV Stabilization Splint</td>
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<td>0</td>
</tr>
<tr>
<td>Alcohol Swab</td>
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<tr>
<td>Item</td>
<td>Quantity</td>
<td></td>
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<tr>
<td>--------------------------------------------------</td>
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</tr>
<tr>
<td>Povidone Iodine</td>
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</tr>
<tr>
<td>Chloraprep Swabs / Sponges</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>24 ga IV Catheter</td>
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<td></td>
</tr>
<tr>
<td>22 ga IV Catheter</td>
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<td></td>
</tr>
<tr>
<td>20 ga IV Catheter</td>
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<td></td>
</tr>
<tr>
<td>18 ga IV Catheter</td>
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<td></td>
</tr>
<tr>
<td>16 ga IV Catheter</td>
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<td></td>
</tr>
<tr>
<td>14 ga IV Catheter</td>
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<td></td>
</tr>
<tr>
<td>Powered IO Device with Pediatric Capability</td>
<td>1</td>
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</tr>
<tr>
<td>Powered IO Device with Adult Capability</td>
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</tr>
<tr>
<td>EZ-IO Power Driver</td>
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<tr>
<td>EZ-IO 15 ga / 15 mm Pink Needle Set</td>
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<tr>
<td>EZ-IO 15 ga / 25 mm Blue Needle Set</td>
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<tr>
<td>EZ-IO 15 ga / 45 mm Yellow Needle Set</td>
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<tr>
<td>B.I.G. 18 ga Red Pediatric IO Device</td>
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<tr>
<td>B.I.G. 15 ga Blue Adult IO Device</td>
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<tr>
<td>Blood Collection Needle</td>
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<td></td>
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<tr>
<td>Blood Collection Needle Holder</td>
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<tr>
<td>Blood Tubes</td>
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<tr>
<td>Bio-Hazard Lab Bag</td>
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**Medication Administration**

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<tr>
<th>Item</th>
<th>ALS Air Transport</th>
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<tbody>
<tr>
<td>Handheld Nebulizer with Mouthpiece, Reservoir, and Supply Tubing</td>
<td>1</td>
</tr>
<tr>
<td>Pediatric Nebulizer Mask</td>
<td>0</td>
</tr>
<tr>
<td>Adult Nebulizer Mask</td>
<td>1</td>
</tr>
<tr>
<td>Nebulizer Tee with Adaptors</td>
<td>1</td>
</tr>
<tr>
<td>Item</td>
<td>Quantity</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Holding Chamber for MDI</td>
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</tr>
<tr>
<td>MAD® Nasal-Mucosal Atomization Device</td>
<td>2</td>
</tr>
<tr>
<td>18 - 19 ga Hypodermic Needle</td>
<td>0</td>
</tr>
<tr>
<td>18 - 19 ga Filter Needle</td>
<td>0</td>
</tr>
<tr>
<td>Blunt IV Injection Cannula for Needleless System</td>
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</tr>
<tr>
<td>21 ga X 1 - 1.5” Hypodermic Needle</td>
<td>1</td>
</tr>
<tr>
<td>23 ga X 1 - 1.5” Hypodermic Needle</td>
<td>0</td>
</tr>
<tr>
<td>25 ga X 1” Hypodermic Needle</td>
<td>1</td>
</tr>
<tr>
<td>1 mL TB Syringe</td>
<td>1</td>
</tr>
<tr>
<td>3 mL Syringe</td>
<td>2</td>
</tr>
<tr>
<td>5 mL Syringe</td>
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<tr>
<td>10 mL Syringe</td>
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<tr>
<td>20 mL Syringe</td>
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<tr>
<td>30 mL Syringe</td>
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<tr>
<td>60 mL Syringe</td>
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<tr>
<td>Carpuject® Holder</td>
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<tr>
<td>Saline Lock Extension Set</td>
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<tr>
<td>Three Way Stopcock</td>
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<tr>
<td>Luer Lock Adaptor</td>
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<tr>
<td>Volume Control Chamber IV Set</td>
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<tr>
<td>IV Pump</td>
<td>1</td>
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<tr>
<td>60 drop / mL IV Set</td>
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<tr>
<td>10 drop / mL IV Set</td>
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<tr>
<td>Pressure Infusion Bag</td>
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<tr>
<td>IV Warmer with Supplies</td>
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<tr>
<td>Narcotic Storage</td>
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**Transportation**
### Transportation

<table>
<thead>
<tr>
<th>Item</th>
<th>ALS Air Transport</th>
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</thead>
<tbody>
<tr>
<td>Ambulance Cot with 8+ Point Seat Belts</td>
<td>1</td>
</tr>
<tr>
<td>Cot Securing System</td>
<td>1</td>
</tr>
<tr>
<td>Commercial Child Restraint System</td>
<td>1</td>
</tr>
<tr>
<td>Collapsible (Folding) Stretcher</td>
<td>0</td>
</tr>
<tr>
<td>Stair Chair</td>
<td>0</td>
</tr>
<tr>
<td>Rescue Basket / Litter / Stretcher / Similar Device</td>
<td>0</td>
</tr>
<tr>
<td>Wrist Restraint*</td>
<td>2</td>
</tr>
<tr>
<td>Ankle Restraint*</td>
<td>2</td>
</tr>
</tbody>
</table>

*Restraints must be constructed of neoprene over nylon webbing with double hook and loop closure.

<table>
<thead>
<tr>
<th>Item</th>
<th>ALS Air Transport</th>
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</thead>
<tbody>
<tr>
<td>Spit Sock (Patient Hood)</td>
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### Waste Disposal

<table>
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<tr>
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<tbody>
<tr>
<td>Mounted Sharps Container</td>
<td>1</td>
</tr>
<tr>
<td>Portable Sharps Container</td>
<td>1</td>
</tr>
<tr>
<td>Covered Waste Container</td>
<td>0</td>
</tr>
<tr>
<td>Waste Bag</td>
<td>0</td>
</tr>
<tr>
<td>Biohazard Bag</td>
<td>1</td>
</tr>
<tr>
<td>Emesis Basin</td>
<td>0</td>
</tr>
<tr>
<td>Bed Pan</td>
<td>0</td>
</tr>
<tr>
<td>Urinal</td>
<td>0</td>
</tr>
</tbody>
</table>

### Linen
### Documentation

<table>
<thead>
<tr>
<th>Documentation</th>
<th>THIS COLUMN INTENTIONALLY LEFT BLANK</th>
<th>ALS Air Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobile ePCR System with:</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>• Portable Touchscreen Computer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Magnetic Strip / Barcode Reader</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ECG Monitor Connectivity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Mobile Internet Access</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clipboard</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Pen</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Paper Release Forms</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Pencil</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Writing Pad</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Light Response Program Inventory Sheet</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

### Medications

Of the authorized options, the preferred medication is in **bold** print.

<table>
<thead>
<tr>
<th>Medications</th>
<th>THIS COLUMN INTENTIONALLY LEFT BLANK</th>
<th>ALS Air Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Act. Charcoal — 50 g / 240 mL Container</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>or Act. Charcoal — 25 g / 120 mL Container</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Adenosine — 12 mg / 4 mL Prefilled Syringe or Vial</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>or Adenosine — 6 mg / 2 mL Prefilled Syringe or Vial</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Albuterol 0.083% — 2.5 mg / 3 mL Vial</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Drug</td>
<td>Quantity</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td>Albuterol — 90 mcg / 1 Dose Metered</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Dose Inhaler. May substitute vials &amp;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>equipment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amiodarone — 150 mg / 3 mL Vial</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>or Amiodarone — 900 mg / 18 mL Vial</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Aspirin — 81 mg / 1 Tab Chewable Tablet</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>in Packet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or Aspirin — 81 mg / 1 Tab, Multi-dose</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Chewable Tab Bottle</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atropine — 1 mg / 10 mL Prefilled Syringe</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>or Atropine — 0.5 mg / 5 mL Prefilled</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Syringe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or Atropine — 1 mg / 1 mL Ampule or</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Vial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Atropine — 8 mg / 20 mL Vial</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>or Atropine — 1 mg / 1 mL Ampule or</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Vial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calcium Chloride 10% — 1 g / 10 mL</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Prefilled Syringe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dextrose 10% — 25 g / 250 mL IV Bag</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>or Dextrose 50% — 25 g / 50 mL Prefilled</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Syringe or Vial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or Dextrose 25% — 2.5 g / 10 mL Prefilled</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Syringe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or Dextrose 10% — 1 g / 10 mL Prefilled</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Syringe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphenhydramine — 50 mg / 1 mL Vial, or</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Carpuject®</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epi. 1:1,000 — 1 mg / 1 mL Ampule</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>or Epi. 1:1,000 — 30 mg / 30 mL Vial</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>or “EpiPen” / Auto-Injector. — 0.3 mg /</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>0.3 mL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epi. 1:10,000 — 1 mg / 10 mL Prefilled</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Syringe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or Epi. 1:1,000 — 1 mg / 1 mL Ampule</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>or Epi. 1:1,000 — 30 mg / 30 mL Vial</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Glucagon — 1 mg / 1 mL Vial of Powder +</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Vial of Diluent</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucose Gel — 1 Container</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Ipratropium Br. — 0.5 mg / 2.5 mL Vial</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Lidocaine 2% — 100 mg / 5 mL Prefilled</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Syringe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>or Lidocaine 2% — 400 mg / 20 mL Vial</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Medicine</td>
<td>Description</td>
<td>Quantity</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>Magnesium Sulfate</td>
<td>5 g / 10 mL Prefilled Syringe or Vial</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>or Magnesium Sulfate — 1 g / 2 mL Vial</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>or Magnesium Sulfate — 4 g / 100 mL IV Bag</td>
<td>1</td>
</tr>
<tr>
<td>Naloxone — 2 mg / 2 mL</td>
<td>Prefilled Syringe or Vial</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>or Naloxone — 4 mg / 10 mL Vial</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>or Naloxone — 0.4 mg / 1 mL Prefilled Syringe, Vial or Carpuject®</td>
<td>5</td>
</tr>
<tr>
<td>Nitroglycerin — 0.4 mg / 1 Dose</td>
<td>Multi-dose Spray or Bottle of Tab.</td>
<td>1</td>
</tr>
<tr>
<td>Naloxone — 2% — 1 g / 1 Inch</td>
<td>Packet with Paper Applicators</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>or Naloxone — 2% — 30 g / 1 Tube with Paper Applicators</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>or Naloxone — 2% — 60 g / 1 Tube with Paper Applicators</td>
<td>0</td>
</tr>
<tr>
<td>Normal Saline 0.9% — 1000 mL IV Bag</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>or Normal Saline 0.9% — 500 mL IV Bag</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>or Normal Saline 0.9% — 250 mL IV Bag</td>
<td>8</td>
</tr>
<tr>
<td>Normal Saline 0.9% — 50 mL IV Bag</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Normal Saline 0.9% — 10 mL Prefilled Syringe or Vial</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Ondansetron — 4 mg / 2 mL</td>
<td>Prefilled Syringe or Vial</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>or Ondansetron — 40 mg / 20 mL Vial</td>
<td>1</td>
</tr>
<tr>
<td>Ondansetron — 4 mg / 1 Tab Oral</td>
<td>Disintegrating Tablet</td>
<td>0</td>
</tr>
<tr>
<td>So. Bicarb. 8.4% - 50 mEq / 50 mL</td>
<td>Prefilled Syringe or Vial</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>or So. Bicarb. 8.4% - 10 mEq / 10 mL Prefilled Syringe or Vial</td>
<td>5</td>
</tr>
<tr>
<td>Tranexamic Acid 1 gram/10 mL Vial</td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

### Controlled Substances

Of the authorized options, the preferred medication is in **bold** print. Minimum par levels required at all times.

<table>
<thead>
<tr>
<th>Controlled Substances</th>
<th>THIS COLUMN INTENTIONALLY LEFT BLANK</th>
<th>ALS Air Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fentanyl — 100 mcg / 2 mL Ampule, Vial, or Carpuject®</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>or Fentanyl — 100 mcg / 5 mL Ampule, Vial, or Carpuject®</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>or Fentanyl — 100 mcg / 10 mL Ampule, Vial, or Carpuject®</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>
Drug and Equipment List

**Ketamine** — 500 mg / 10 mL
Ampule, Vial or Carpuject®

- or Ketamine — 50 mg/1 mL
  Ampule, Vial or Carpuject®

- or Ketamine 200 mg / 20 mL
  Ampule, Vial, or Carpuject®

- or Ketamine 500 mg / 5 mL
  Ampule, Vial, or Carpuject®

**Midazolam** — 5 mg / 1 mL
Ampule, Vial or Carpuject®

- or Midazolam — 10 mg / 2 mL
  Ampule, Vial, or Carpuject®

- or Midazolam — 5 mg / 5 mL
  Ampule or Vial

- or Lorazepam — 4 mg / 1 mL
  Ampule, Vial, or Carpuject®

- or Lorazepam — 2 mg / 1 mL
  Ampule, Vial, or Carpuject®

- or Diazepam — 10 mg / 2 mL
  Ampule, Vial, or Carpuject®

**Morphine Sulfate** — 10 mg / 1 mL
Ampule, Vial or Carpuject®

- or Morphine Sulfate - 10 mg / 10 mL
  Ampule or Vial

**CDC Medications**

Of the authorized options, the preferred medication is in **bold** print. Note that these medications are for administration to patients; and that these same medications when listed under Personal Protective Equipment are for personal use.

<table>
<thead>
<tr>
<th>CDC Medications</th>
<th>THIS COLUMN INTENTIONALLY LEFT BLANK</th>
<th>ALS Air Transport</th>
</tr>
</thead>
<tbody>
<tr>
<td>DuoDote Nerve Agent Antidote Kit</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>or Mark I Nerve Agent Antidote Kit</td>
<td></td>
<td>0</td>
</tr>
</tbody>
</table>

**Cardiac Monitor Specification**

Attributes/capabilities for Cardiac Monitor, Pacemaker, Defibrillator

<table>
<thead>
<tr>
<th>Physical Attributes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Six (6) foot lead set with removable precordial lead connection</td>
</tr>
<tr>
<td>Multifunction cable with hands-free MFP capability</td>
</tr>
<tr>
<td>CPR diagnostic qualitative and quantitative feedback and reporting capability (*not optional – additional specification below)</td>
</tr>
<tr>
<td>A/C power adapter/battery charger</td>
</tr>
<tr>
<td>- Full functionality should be present while device is functioning with A/C power</td>
</tr>
<tr>
<td>Lithium-ion batteries, two/device, must be smart batteries lasting minimum of 3 hours each</td>
</tr>
<tr>
<td>Battery charging device, minimum of 2 bay/bank charger.</td>
</tr>
</tbody>
</table>
Charging support systems must recalibrate and test batteries in addition to charging.

<table>
<thead>
<tr>
<th>Minimum one (1) year EMS warranty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biphasic waveform with hands-free defibrillation functionality with adult and pediatric capability. Energy setting options must be compatible with applicable REMSA protocols.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Functionality to operate in Automated External Defibrillator or Semi-Automated External defibrillator mode</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functionality to provide synchronized cardioversion at multiple age-appropriate energy levels. Energy setting options must be compatible with applicable REMSA protocols.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adjustable and controllable amperage and rate for transthoracic pacing with adult and pediatric capability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ability to operate in fixed, demand, and overdrive modes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capability to detect and indicate presence of internal pacemaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capability to print field user machine test/internal diagnostic test results</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Display, select and/or cascade multiple waveforms simultaneously (e.g.: paddles/MFP, Lead I, Lead II, Lead III, capnography, SpO2 Photoplethysmograph (pleth) – all are required as options for display)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Programmable audio and visual alert systems for fatal arrhythmias, VF/VT at a minimum</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Separate programmable alerts for biometric parameters of NIBP, heart rate, respiratory rate, etCO2, SpO2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record, display, and import into the REMSA ePCR system: the etCO2 value – waveform and quantitative measure. In-line and Side-Stream capabilities are required, capability for use on the intubated and non-intubated patient.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Record, display, and import into the REMSA ePCR system: SpO2 value – waveform and quantitative measure. All patient age ranges must be accommodated in disposable/hard wired probes, and diagnostic feedback</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record, display, and import into the REMSA ePCR system: Non-invasive blood pressure measure accounting for vibration resistance both at vehicle rest and vehicle motion. All patient age ranges must be accommodated in disposable/hard wired cuffs. Cuff sizes must meet REMSA Policy for Drug and Equipment List. (*NIBP is an optional component and, if purchased, specification must be met)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calculate and display Mean Arterial Pressure reading</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record, display, and import temperature* readings into the REMSA ePCR system. Device must have a minimum of one (1) temperature channel and must be able to monitor skin and/or ambient temperature, esophageal temperature, and rectal temperature.</td>
</tr>
</tbody>
</table>

- Temperature must measure from 25°C to 45°C at minimum
  - Temperature monitoring is an optional component and, if purchased, specification above must be met

<table>
<thead>
<tr>
<th>Record, display, and import into the REMSA ePCR system: Non-invasive carbon monoxide* waveform and quantitative measure (spCO).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Display, print, and mark in events and/or code summary carbon monoxide waveforms and quantitative values. Probe for measurement shall cover adult and pediatric patients. Precision and accuracy must be at least within three (3) digits (+/-) when spCO is 0-10%.</td>
</tr>
</tbody>
</table>

- Carbon monoxide (spCO) monitoring is an optional component and, if purchased, specification above must be met

<table>
<thead>
<tr>
<th>Record, display, and import into the REMSA ePCR system: non-invasive methemoglobin* quantitative levels (spMet).</th>
</tr>
</thead>
<tbody>
<tr>
<td>Display, print, and mark in events and/or code summary methemoglobin quantitative value. Probe for measurement shall cover adult and pediatric patients. Precision and accuracy must be at least within one (1) digit (+/-) when spMet is 0-10%.</td>
</tr>
</tbody>
</table>

- Methemoglobin (spMet) level monitoring is an optional component and, if purchased, specification above must be met

<table>
<thead>
<tr>
<th>Physical Attributes continued</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record, print and have capability to import customizable Code Summary records from individual patient contacts into REMSA ePCR system.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Display that is color capable, subject to wide angle viewing, and adaptable to changes in brightness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Customizable audio/visual alerts (configurable w/o vendor involvement) of biometric parameters (at minimum NiBP, HR, RR)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capability for users to adjust automatically performed vital sign intervals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capability to mark events in Code Summary recording</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient biometric trending is automatically engaged with device use, and can be viewed on screen and/or printed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe user-driven discharge of electricity, outside of therapeutic energy delivery</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Audio/visual alerts for detached leads</th>
</tr>
</thead>
<tbody>
<tr>
<td>Device vendor must facilitate data integrations with REMSA ePCR vendor</td>
</tr>
</tbody>
</table>

| Device, including any add-on features must be upgradeable as technological advances and research permit. Including but not limited to, CPR qualitative and quantitative feedback, 12 lead ECG algorithms, capnography diagnostics, temperature monitoring. |

<table>
<thead>
<tr>
<th>12 Lead Functionalities</th>
</tr>
</thead>
</table>
Acquire, interpret, transmit and print diagnostic quality 12 lead ECGs
4. The unit shall be capable of diagnostic 12-lead monitoring in leads I, II, III, aVR, aVL, aVF, V1, V2, V3, V4, V5 and V6
5. Vendor must provide data regarding the maintenance / update of specificity and sensitivity of algorithms utilized for STEMI interpretation. Data must be provided annually and at any maintenance or update periods.
6. Transmitted data shall be secured in a HIPAA compliant manner, and meet current applicable REMSA Information Security policies / standards

| 12 lead ECG print capability shall include configuration to print interval measurements, interpretation, axes measurements, and clinician entered patient demographic variables of name, age and gender at minimum |
| Continually monitor and trend 12 lead ECG when leads are attached, without requirement of obtaining a specific 12 lead ECG |
| Acquired 12 lead ECGs must be chronologically and numerically ordered as obtained during individual patient contact (serial 12 lead ECG capability) |
| Device must be able to transmit 12 lead ECGs, to any / all REMSA designated STEMI receiving center (at minimum). |
| ECG transmissions shall generate an electronic notification, which will provide an alert to the facility, and can include multiple facility designated personnel. |
| Reports regarding 12 lead ECG transmissions – success, failure, aggregate frequency, shall be available to the service provider, STEMI receiving center, and REMSA. |
| ECG transmission shall be field-user feasible with mobile gateways, hot spots, cellular / data services, or the like. |
| ECG transmission must not require any software / server purchase, or proprietary service to view, distribute. |

Cardiopulmonary Resuscitation (CPR) diagnostics/feedback device must:

| Measure / gauge depth, rate and chest recoil of each compression / cycle of compressions during active CPR, in both static patient situations and dynamic movement of the patient |
| Provide for synchronous and asynchronous CPR qualitative and quantitative feedback |
| Provide audio and/or visual feedback to correct cadence, depth of compressions, and chest recoil/release, whether patient is static or dynamically moving |
| Provide an inactivity timer, indicating time duration of no chest compressions |
| Provide real time visual and auditory feedback to clinicians |
| CPR diagnostics/feedback must provide retrospective case by case, and aggregate feedback to EMS Providers, and REMSA. |
| Be able to transmit from device via cable or WIFI connection, into reportable software or database accessible by individual EMS Providers and REMSA. |
| Be stored by individual patient encounters and provide a minimum of two (2) unique identifiers (such as date of service, time of service, patient demographics or combinations to enable accuracy in data collection and reporting). |
| As able with ePCR technology, CPR diagnostics/feedback/summary must import into the REMSA ePCR system. |

Data Integration and Management:

| Device automatically stores patient information on internal memory per device application. Data stored must include at least two unique identifiers (incident number, date of service, time of service, patient information or combination), clinician entered events, therapies delivered. |
| Archived patient records must be able to be transmitted, printed and deleted by staff without vendor involvement. |
| Device must provide for the option of a USB cell modem for the wireless transmission of biometric parameters, CPR diagnostic feedback and 12 lead ECG. |

Data Integration and Management continued:

| Device must be capable of transferring data (including 12 Lead ECG, historical patient trends, event/code summary, CPR feedback and biometric parameters) into the REMSA ePCR system utilizing a directly connected cable or WIFI connection. |
| All applicable REMSA Information Security policies and procedures must be followed during data transmissions, imports or other sharing methodologies. |

DEFINITIONS

REFERENCES

California Health and Safety Code - Division 2.5: Emergency Medical Services
California Code of Regulations, Title 13. Motor Vehicles, Section 1103.2
California Vehicle Code Section 2418.5 Resuscitator Requirements for Ambulances
California Code of Regulations, Title 8. Industrial Relations

Occupational Safety and Health Administration (OSHA), Occupational Safety and Health Standards, Standard 1910
California Fire Service and Rescue Emergency Mutual Aid System, Mutual Aid Plan (2-12)
American National Standards Institute (ANSI)
British Standards Institution (BSI)
Canadian Standards Association (CSA)
Commission on Accreditation of Medical Transport Services (CAMTS)
National Fire Protection Association (NFPA)
National Institute for Occupational Safety and Health (NIOSH)
EMSA #216: Minimum Personal Protective Equipment (PPE)

Extending the Shelf Life of Critical Chemical Biological, Nuclear and Radiological (CBRN) Medical Materiel Using the FDA/DOD Shelf Life Extension Program

EMSC Guidelines for Equipment on Ambulances
California Incident Command Certification System (CICCS) Qualification Guide

http://www.rivcocab.org/ords/700/756.htm
PURPOSE
To establish clear and concise trauma triage indicators that are consistent with the guidelines and recommendations of the American College of Surgeons and the Centers for Disease Control, while taking into account the distinct geographic hospital locations of all Riverside county trauma centers.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22, Division 9, Chapter 7 Trauma Care Systems

Trauma Triage Indicators and Destination

Destination and Transport:
1. Ground ambulance is the primary means of transport for destinations thirty (30) minutes or less by code 3.
   a. Adult patients identified as critical trauma patients (CTPs) will be transported to the closest Level I or Level II trauma center.
   b. Pediatric patients identified as CTPs should be transported to a pediatric trauma center.
   c. If the pediatric trauma center is greater than thirty (30) minutes away by ground, go to the closest Level I or Level II trauma center.
   d. If the closest trauma center is greater than thirty (30) minutes by ground code 3, consider HEMS transport.
   e. If patient destination is questionable, contact the closest Level I or Level II Trauma Base Hospital for destination.
   f. In the event of trauma center diversion - refer to REMSA Policy #6103 (Ambulance Diversion).

2. The patient is identified as a CTP and presents with the following:
   a. An unmanageable airway: If the CTP’s airway and/or breathing is compromised and transporting personnel are unable to effectively manage them using BLS or ALS measures, the patient will be transported to the closest prehospital receiving center (PRC).
   b. Traumatic full arrest:
      i. Adult blunt traumatic arrest:
         1. If the patient meets the criteria outlined in REMSA policy #4108 (Do Not Attempt Resuscitation / Discontinue Resuscitation): DO NOT TRANSPORT.
            a. If the patient is pulseless and apneic with asystole / agonal rhythm / PEA at a rate less than 40: DO NOT TRANSPORT.
            b. Otherwise, transport to the closest Level I or Level II trauma center.
      ii. Adult penetrating traumatic arrest:
          1. If the patient meets the criteria outlined in REMSA policy #4108 (Do Not Attempt Resuscitation / Discontinue Resuscitation): DO NOT TRANSPORT.
             a. If the patient is pulseless and apneic with asystole / agonal rhythm / PEA at a rate less than 40: DO NOT RESUSCITATE OR TRANSPORT.
             b. If the patient has signs of life and transport time is reasonable, consider transport to the closest Level I or Level II trauma center.
      iii. Pediatric traumatic arrest:
          1. A Base Hospital Physician Order (BHPO) is required to discontinue resuscitation.
   c. Burn patients
      1. CTPs with burns will be transported to the closest Level I or Level II trauma center.
         a. Patients not meeting CTP criteria will be transported according to the REMSA policy #4701 (Burns).
Considerations
Under normal circumstances, scene time should be limited to ten (10) minutes.

With multiple CTPs, consult the closest Level I or Level II Trauma Base Hospital for destination determination. Refer to REMSA policy #3305 (*Multiple Patient / Casualty Incident (MPI/MCI) Management*).

The Level I or Level II trauma center must be advised of incoming CTPs as soon as possible in order to allow for timely trauma team activation.

Trauma triage criteria are on the following page:
CRITICAL TRAUMA PATIENT (CTP) CRITERIA – POLICY 5301 GUIDELINES

Any patient who is experiencing, or presenting with, any of the criteria listed below will be considered a CTP and will be transported to the closest Level I or Level II trauma center.

MECHANISM OF INJURY CRITERIA
- Fall – adults, 15 feet or greater
- Fall – pediatric, greater than 10 feet or 3x the patient’s height
- Auto vs. pedestrian OR bicycle rider greater than 20mph
- Motorcycle crash greater than 20mph
- Ejection from vehicle
- Death in the same vehicle
- Passenger space intrusion, including roof, greater than 12” at any occupied site
- Passenger space intrusion, including roof, greater than 18” at any unoccupied site
- Child (Ages 0-9) unrestrained or in unsecured child safety seat

ANATOMIC CRITERIA
- Open or depressed skull fracture
- Penetration of the head / neck / torso extremities proximal to the elbow / knee
- Chest wall instability or deformity (e.g. – flail chest)
- Suspected pelvic fracture
- New onset paralysis
- Two (2) or more proximal long bone fractures
- Crushed / mangled / degloved pulseless extremity
- Trauma with burns
- Amputation proximal to the wrist or ankle

PHYSIOLOGIC CRITERIA
- GCS less than or equal to 13
- Respiratory rate less than 10 OR greater than 29 OR need for ventilatory support
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

CO-MORBID FACTORS AND OTHER MECHANISMS
- Geriatric patients (65 years or older)
- Pediatric patients (14 years and younger)
- Patients on anti-coagulants / anti-platelet therapy
- Pregnant patients greater than 20 weeks gestation
- MVC greater than 40mph
- Reported or confirmed loss of consciousness
- EMS provider judgment
- Suspicion of child abuse

For patients who meet any of the criteria listed below, a Level I or Level II Trauma Base Hospital must be consulted to determine the appropriate destination.
PURPOSE
To allow for the expedited transport and care of the critical trauma patient (CTP) that arrives to a non-trauma hospital Emergency Department or upon recognition of any critical patient that requires urgent transfer from one trauma receiving center to a higher level of care trauma receiving center. The CTP falls within the jurisdiction of the Riverside County EMS trauma Plan and trauma System per Title 22, as does the need for coordination of all health care organizations to facilitate the transfer of the CTP. The CTP shall be accepted by the closest trauma center, regardless of the trauma center’s in-patient census / capacity. The only rationale for the closest trauma center to refuse the CTP transfer is due to the same criteria as outlined in the REMSA Policy for Ambulance Diversion.

This policy allows for two levels of triage, the CTP who needs immediate higher level of care and the trauma patient who would benefit from higher level of care to a trauma center. Please refer to the REMSA Policy for trauma Triage Indicators and Destination.

*Facilities should have a mechanism in place to bypass their transfer center triage process and route trauma transfers through the emergency department physicians. *

<table>
<thead>
<tr>
<th>Trauma Triage Continuation of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Critical Trauma Patient</strong></td>
</tr>
<tr>
<td>Needs Immediate Higher Level of are ED to ED</td>
</tr>
<tr>
<td><strong>Trauma Patient, needs Higher Level of Care to In-House Trauma Services</strong></td>
</tr>
<tr>
<td><strong>Vital Signs</strong></td>
</tr>
<tr>
<td>Respiratory Compromise</td>
</tr>
<tr>
<td>Systolic BP less than 90</td>
</tr>
<tr>
<td>• If greater than 70 y/o, systolic BP less than 100</td>
</tr>
<tr>
<td>GCS less than or equal to 13</td>
</tr>
<tr>
<td>Within Normal Limits</td>
</tr>
<tr>
<td><strong>CNS</strong></td>
</tr>
<tr>
<td>Penetrating/depressed skull injury</td>
</tr>
<tr>
<td>Open injury with or without CSF leak</td>
</tr>
<tr>
<td>Deteriorating GCS or changes in neurological status</td>
</tr>
<tr>
<td>Stable Spinal Cord Injury</td>
</tr>
<tr>
<td>Any head injury w/ combined face, chest, abdomen, or pelvis</td>
</tr>
<tr>
<td><strong>CHEST</strong></td>
</tr>
<tr>
<td>Widened mediastinum on initial XRAY</td>
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<tr>
<td>Penetrating injury</td>
</tr>
<tr>
<td>Major chest wall injury or pulmonary contusion</td>
</tr>
<tr>
<td>Prolonged ventilator requirements</td>
</tr>
<tr>
<td><strong>ABDOMEN/PELVIS</strong></td>
</tr>
<tr>
<td>Any injury w/ associated Shock (systolic BP less than 90)</td>
</tr>
<tr>
<td>Unstable pelvic ring</td>
</tr>
<tr>
<td><strong>EXTREMITIES</strong></td>
</tr>
<tr>
<td>Any injuries w/ associated shock (systolic BP less than 90)</td>
</tr>
<tr>
<td>Open long bone fracture</td>
</tr>
<tr>
<td>Crush injuries or prolonged ischemia Loss of distal pulses</td>
</tr>
</tbody>
</table>
Any injury w/ associated shock

Possible Co-morbidities with associated traumatic injury:
Less than 5, greater than 70 years of age, (RUHS for pediatrics)
known anticoagulation/anti-platelet therapy
pregnancy
immunosuppression

**Procedure for continuation of trauma care transport:**

**For critical trauma patients:**

The patient should be resuscitated, and attempts made to stabilize for transport.

**A. Referring Physician:**

1. The physician initiating continuation of care transport should call the local ALS ambulance provider. When continuation of care has been initiated, the ambulance provider will respond immediately to the requesting facility code

   OR request the patient’s current EMS crew to stand-by on premises for immediate transport of the patient to a trauma center. The stand-by of the EMS crew should not last longer than 20 minutes.

2. Notify directly the ED physician at the receiving trauma center. (see #4 for script.)

3. Coordinate diagnostics and interventions w/receiving ED physician.

4. Suggested script: “This is Dr. ABC at hospital XYZ. I want to speak to the ED physician regarding a critical trauma patient for higher level of care.”
   *(Do not use the word “transfer”)*

**B. Information to Transporting Personnel:**
Information concerning the patient’s condition and needs during transport should be communicated to transporting personnel.

**C. Documentation:** DO NOT Delay Transport
All documents are sent including, problem, treatments, status at time of transfer, lab values, X-rays, personal belongings and EMTALA higher level of care paperwork.

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**For trauma patients:**

**A. Referring Physician:**
Contact closest Trauma Center, speak to accepting Trauma Surgeon.
(Per hospital policy or ED to ED)

**B. Information to Transporting Personnel:**
Information concerning the patient’s condition and needs during transport should be communicated to transporting personnel.

**C. Documentation:**
All documents are sent including, problem, treatments, status at time of transfer, lab values, X-rays, personal belongings and EMTALA higher level of care paperwork.

**D. Prior to Transfer:**
The patient should be resuscitated, and attempts made to stabilize in respect to ABCDE’s.

**E. Management during Transport:**
Determine if patient needs CCT, ALS or BLS transport. During transport, continued management of vital functions and continuous re-evaluation are essential.

Reference: American College of Surgeons; Rural Trauma Team Development Course
PURPOSE
This policy defines the process for completing the Trauma Patient Registry Form when a critical trauma patient (CTP) presents to a non-trauma prehospital receiving center (PRC) or base hospital (BH).

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Non-Trauma Center Trauma Patient Registry
1. The data listed in this policy is to be sent to the EMS Agency via standard mail, fax, or e-mail.
   a. Data is to be sent to the EMS Agency within 30 days of patient discharge, transfer or death.
   b. Data will be used to generate a quarterly EMS trauma Report for the Trauma Audit Committee and for periodic Riverside trauma patient studies and research.
   c. Specific patient data remains confidential.

2. For trauma patients meeting any of the trauma Triage criteria (see the REMSA Policy for trauma Triage Indicators and Destination), and/or with final disposition to a trauma center, a Trauma Patient Registry Form for Non-Trauma Centers is to be completed by designated personnel from the PRC or BH. This is to include all traumatic full arrests, trauma-related deaths in the ED or after hospital admission, submersions, and hangings. Isolated hip fractures due to mechanical and/or ground level falls should NOT be included.

3. Instructions are included on the next page. The form can be found here: http://remsa.us/documents/forms/Non-TraumaCenterTraumaPRFormv12720.pdf
Instructions

Instructions for completing the Trauma Patient Registry Form for Non-Trauma Centers:

1. Section I – IDENTIFICATION
   a. Incident Location: Enter the original location of the incident.
   b. Hospital: Enter name of the PRC or BH completing the form.
   c. Patient: Enter the name of the patient.
   d. Age: Enter the patient’s age.
   e. Sexes: Check male or female.

2. Section II – EMERGENCY DEPARTMENT ADMISSION DATA
   a. Date of Arrival: Enter month, day, year admitted to the ED.
   b. Time of Arrival: Enter time of arrival to the ED.
   c. Method of Arrival: Check applicable; if “Other”, describe.
   d. Mechanism of Injury: Check one; if “Other”, describe.
   e. Vital Signs upon Arrival: Enter initial vital signs taken in the ED.
   f. Glasgow Coma Score (GCS): Enter initial GCS taken in the ED.
   g. Enter heart rate (HR).
   h. Enter respiratory rate (RR).
   i. Enter blood pressure (BP).
   j. Procedures: Check applicable and enter time; if “Other”, describe.
   k. Blood products: Enter time of first unit if any products were given.
   l. Revised Trauma Score Upon Arrival: Enter variables and calculate the Revised Trauma Score.

3. Section III – EMERGENCY DEPARTMENT DISPOSITION
   a. Admitted: Check if applicable, enter time, and specify hospital unit under comments.
   b. OR: Check if applicable, enter time, and specify procedure(s) if known under comments.
   c. Admitted Post-op: Check if applicable, enter time, and specify hospital unit under comments.
   d. Discharged: Check if applicable and enter time.
   e. Continuation of Trauma Care: Check if applicable, enter time, and specify destination under comments.
   f. Interfacility Transfer: Check if applicable, enter time, and specify destination under comments.
   g. Ground Transport: Check if applicable and enter time.
   h. Air Transport: Check if applicable and enter time.
   i. Other: Check if applicable, enter time, and include explanation under comments.
   j. Comments:
      i. Include anything pertinent, explanatory, or interesting.
PURPOSE
To reduce the morbidity and mortality related to trauma by organizing a system of trauma centers to serve our residents and visitors through preventative education, emergency care, hospitalization, rehabilitation, and research. Through data collection and the trauma registry, the EMS Agency can monitor and evaluate the trauma care system. This critical care system links prehospital and hospital care to deliver optimal treatment to the population of trauma patients.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services, Chapter 3; Chapter 6 Article 2.5
California Code of Regulations, Title 22. Social Security, Division 9. Prehospital Emergency Medical Services, Chapter 7
Trauma Care System

TRAUMA RECEIVING CENTER DEFINITIONS
Trauma Base Hospital
A licensed general acute care hospital that has been designated as a trauma Receiving Center by Riverside County EMS Agency (REMSA) and functions as a base hospital.

Trauma Receiving Center
A hospital with trauma team resources and designated by the Riverside County EMS Agency to provide rapid intervention for trauma patients.

DESIGNATION BY REMSA AS A TRAUMA CENTER
Initial REMSA Designation as a trauma center in the EMS System requires an application, satisfactory site survey, and verification of the following:
1. Currently serving in the EMS system as a Prehospital Receiving Center (PRC) or a Base Hospital (BH).
2. Compliance with all requirements listed in Title 22, Division 9, Chapter 7 Trauma Care System, for the requested level of designation.
3. Verification from the American College of Surgeons (Level I and Level II trauma centers only)
   a. Continued designation shall depend on re-verification, and a copy of the verification certificate shall be provided to REMSA not less than 30 days upon receipt of letter.
   b. Level IV trauma centers must remain in compliance with the current American College of Surgeons standards.
4. Participation in the trauma data management system and commitment to provide additional data as required by REMSA and/or the Trauma Audit Committee.
5. Current written agreement with REMSA for designation as a trauma center to provide services in Riverside County.

Designation Renewal
1. The trauma center shall be re-designated after satisfactory review of written documentation and a site survey by REMSA personnel/designees.
2. The trauma center must remain compliant with all requirements listed in Title 22, Division 9, Chapter 7 Trauma Care System, for the requested level of designation.
3. Re-designation shall occur every three (3) years. REMSA staff will attend and perform trauma center audits during the entire American College of Surgeons site visit.
4. Failure to comply with the criteria outlined in this policy will result in disciplinary action up to and including suspension or rescission of EMS trauma center designation.
TRAUMA CENTER STANDARDS FOR ALL HOSPITALS DESIGNATED BY REMSA AS A TRAUMA RECEIVING CENTER

Staffing Requirements
1. Trauma Centers shall staff the following positions:
   a. **Trauma Program Medical Director:**
      i. A qualified board-certified physician by the American Board of Medical Specialties (ABMS) as defined by the local EMS agency and designated by the hospital that is responsible for the trauma program, performance improvement, and patient safety programs related to a trauma critical care system.
   b. **Trauma Program Director/Program Manager:**
      i. A registered nurse who is designated by the hospital and is responsible for monitoring, coordinating, and evaluating the trauma program.
      1. In the event that an interim Program Director/Manager is needed in the absence of a full-time Program Director/Manager, a nurse from the hospital may be selected to fulfill the obligations and duties of the role for no more than one hundred-eighty (180) days. Should a full-time Program Director/Manager not be assigned by the conclusion of the interim period, REMSA will perform an evaluation of the position and program to ensure compliance with state regulation(s), REMSA policy, and contract language.
   c. **Registrar:** (Level I and Level II trauma centers only)
      i. A registrar dedicated to the registry must be available to process the data in compliance with the American College of Surgeons registrar standards listed in the “Resources for Optimal care of the injured patient” current manual.
   d. A trauma team, which will be multidisciplinary, responsible for the initial resuscitation and management of the trauma patient.

Data Collection and Submission
1. The trauma centers must:
   a. Enter data directly into REMSIS approved Trauma Registry.
   b. Participate in the REMSIS Trauma Registry, including the collection of both pre-hospital and hospital patient care data, providing loop closure and outcomes to EMS providers, and referring hospitals via the REMSIS ePCR system and REMSIS Trauma Registry.
   c. Submit quarterly state data file to REMSA, synchronized with data submission date per the state EMS Authority.

Trauma data collected shall include but not be limited to:
1. Data elements listed in Title 22, Division 9, Chapter 7, section 100257
2. National Trauma Data Bank data elements
3. Any additional data elements as required by REMSA

Performance Standards
1. Written EMS policies and procedures shall be revised within thirty (30) days as Continuous Quality Improvement (CQI) determines that changes need to be made to individual policies and shall be reviewed as a whole at a minimum of every two (2) years.
2. Trauma Performance Improvement Plan will be available upon request. The documentation of monitoring of the plan must reflect the structure, process, and outcome standards.
3. Trauma Center will work with REMSA to develop, monitor, evaluate and report on the necessity, quality and level of trauma care services.

Education
1. Hospital to maintain documentation of public education and injury prevention outreach activities, consistent with trauma system goals, and to submit an annual summary of completed activities to REMSA for review.
2. Education of staff listed in the American College of Surgeons resource manual must be current and up to date.
Trauma System Participation
1. Trauma Program Medical Directors, Program Directors, and other specified individuals as identified shall actively participate as members of the Trauma Audit Committee and other related committees.
2. Compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality, and a disclosure-protected review of selected trauma cases.

Hospital Services / Obligations
1. The hospital shall meet the following requirements:
   a. Must maintain American College of Surgeons verification (Level I and Level II trauma centers) or must comply with the current ACS standards for Level IV trauma centers.
   b. Hospital shall not advertise themselves as a Level of trauma center other than the Level of designation by the Local EMS Agency.
   c. The hospital shall have established protocols for triage and diagnosis following field notification of an inbound suspected trauma patients.
   d. The hospital shall have a single call activation system to activate the trauma Team directly.
   e. The hospital shall have a process in place for the treatment and triage of simultaneously arriving trauma patients.
   f. A dedicated audio recorded phone line or radio system, capable of being answered twenty-four (24) hours per day, seven (7) days per week, used by paramedics to notify trauma center of incoming trauma patients.
   g. Hospital agrees to follow the current trauma diversion criteria as specified in REMSA Ambulance diversion policy 6103.
   h. The hospital will provide the necessary medical staffing with reputable medical skills in providing trauma center services. Documentation will be maintained by the hospital.
2. Additional requirements for Level IV trauma centers:
   a. A written transfer agreement with the closest Level I or Level II trauma center, Level I or Level II pediatric trauma center, or other specialty care centers, for immediate transfer of those patients for whom the most appropriate medical care requires additional resources.

Patients may be transferred between, and from, trauma centers, provided that:
1. Any transfer shall be, as determined by the trauma center surgeon of record, medically prudent; and
2. It is in accordance with local EMS agency interfacility transfer policies

Reporting Requirements
1. Trauma Center shall notify REMSA in writing of any failure to meet these EMS trauma Receiving Center Standards within 10 (ten) business days.
2. Changes to key trauma Receiving Center personnel shall be reported to REMSA within 10 (ten) business days to include:
   a. Trauma Program Medical Director
   b. Trauma Program Director/ Program Manager
PURPOSE
To reduce the morbidity and mortality related to pediatric trauma by organizing a system of pediatric trauma centers to serve this population through preventative education, emergency care, hospitalization, rehabilitation, and research. Through data collection and the trauma registry, the EMS Agency can monitor and evaluate the pediatric trauma care system. This critical care system links prehospital and hospital care to deliver optimal treatment to the population of Pediatric trauma patients.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services, Chapter 3; Chapter 6 Article 2.5
California Code of Regulations, Title 22. Social Security, Division 9. Prehospital Emergency Medical Services, Chapter 7 Trauma Care System

TRAUMA RECEIVING CENTER DEFINITIONS
Trauma Base Hospital
A licensed general acute care hospital that has been designated as a trauma Receiving Center by Riverside County EMS Agency (REMSA) and functions as a base hospital.

Pediatric Trauma Receiving Center
A hospital with pediatric trauma team resources and designated by the Riverside County EMS Agency to provide rapid intervention for pediatric trauma patients.

DESIGNATION BY REMSA AS A TRAUMA CENTER
Initial REMSA Designation as a pediatric trauma center in the EMS System requires an application, satisfactory site survey and verification of the following:
1. Currently serving in the EMS system as a Prehospital Receiving Center (PRC) or a Base Hospital (BH).
2. Compliance with all requirements listed in Title 22, Division 9, Chapter 7 Trauma Care System, for the requested level of pediatric designation.
3. Pediatric Trauma Center Verification from American College of Surgeons
   a. Continued designation shall depend on re-verification, and a copy of the verification certificate shall be provided to REMSA not less than 30 days upon receipt of letter.
4. Participation in the trauma data management system and commitment to provide additional data as required by REMSA and/or the Trauma Audit Committee.
5. Current written agreement with REMSA for designation as a pediatric trauma center to provide services in Riverside County.

Designation Renewal
1. The pediatric trauma center shall be designated after satisfactory review of written documentation, an initial site survey by REMSA personnel/designees.
2. The pediatric trauma center must remain compliant with all requirements listed in Title 22, Division 9, Chapter 7 Trauma Care System, for the requested level of designation.
3. Re-designation shall occur every three (3) years. REMSA staff will attend and perform trauma center audits during the entire American College of Surgeons site visit.
4. Failure to comply with the criteria outlined in this policy will result in disciplinary action up to and including suspension or rescission of EMS pediatric trauma center designation.
PEDIATRIC TRAUMA CENTER STANDARDS FOR ALL HOSPITALS DESIGNATED BY REMSA AS A
PEDIATRIC TRAUMA RECEIVING CENTER

Staffing Requirements
1. Trauma Centers shall staff the following positions:
   a. Pediatric Trauma Program Medical Director:
      i. A qualified board-certified physician, with experience in pediatric trauma care, by the American Board of Medical Specialties (ABMS) as defined by the local EMS agency and designated by the hospital that is responsible for the Pediatric trauma program, performance improvement, and patient safety programs related to a Pediatric trauma critical care system.
   b. Pediatric Trauma Program Director / Program Manager:
      i. A registered nurse or qualified individual as defined by the local EMS agency, and designated by the hospital responsible for monitoring, coordinating, and evaluating the Pediatric trauma program.
   c. Pediatric Trauma Registrar:
      i. A pediatric trauma registrar dedicated to the registry, must be available to process the data in compliance with the American College of Surgeons registrar standards listed in the “Resources for Optimal care of the injured patient” current manual.

Data Collection and Submission
1. The pediatric trauma centers shall:
   a. Participate in the EMS data management system, which includes he collection of both pre-hospital and hospital patient care data utilizing specified format rules. Pediatric trauma data shall be integrated into REMSA and State EMS Authority data management systems.
   b. Submit quarterly data to REMSA, synchronized with data submission to the state EMS Authority, via the REMSA approved data collection method and on the schedule agreed upon by the Trauma Audit Committee.

   Pediatric trauma data collected shall include but not be limited to:
      i. Data elements listed in Title 22, Division 9, Chapter 7, section 100257
      ii. National Trauma Data Bank data elements
      iii. Any additional data elements as required by REMSA.

Performance Standards
1. Written EMS policies and procedures shall be revised within thirty (30) days as Continuous Quality Improvement (CQI) determines that changes need to be made to individual policies and shall be reviewed as a whole at a minimum of every two (2) years.
2. Pediatric Trauma Performance Improvement plan will be available upon request. The documentation of monitoring of the plan must reflect the structure, process, and outcome standards.
3. Trauma Center will work with REMSA to develop, monitor, evaluate and report on the necessity, quality, and level of trauma care services.

Education
1. Hospital to maintain documentation of public education and injury prevention outreach activities specific to the Pediatric population, consistent with trauma system goals, and to submit an annual summary of completed activities to REMSA for review.
2. Education of staff listed in the American College of Surgeons resource manual must be current and up to date.

Trauma System Participation
1. Pediatric Trauma Program Medical Directors, Program Directors and other specified individuals as identified shall actively participate as members of the Trauma Audit Committee and other related committees.
2. Compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality, and a disclosure-protected review of selected trauma cases.
Hospital Services / Obligations
1. The hospital shall meet the following requirements:
   a. Hospital shall not advertise themselves as a level of trauma center other than the level of designation by the
      local EMS agency.
   b. The hospital shall have established protocols for triage and diagnosis following field notification of inbound
      suspected pediatric trauma patients.
   c. The hospital shall have a single call activation system to activate the Pediatric trauma Team directly.
   d. The hospital shall have a process in place for the treatment and triage of simultaneously arriving trauma
      patients.
   e. A dedicated audio recorded phone line or radio system, capable of being answered twenty-four (24) hours per
      day, seven (7) days per week, used by paramedics to notify the trauma center of incoming trauma patients.
   f. Hospital agrees to follow the current trauma diversion criteria as specified in REMSA Ambulance diversion policy
      6103.
   g. The hospital will provide the necessary medical staffing with reputable medical skills in providing trauma center
      services. Documentation will be maintained by the hospital.

Reporting Requirements
1. Trauma Center shall notify REMSA in writing of any failure to meet these EMS Pediatric trauma Receiving Center
   Standards within 10 (ten) business days.
2. Changes to key Pediatric trauma Receiving Center personnel shall be reported to REMSA within 10 (ten) business
   days to include:
   a. Pediatric Trauma Program Medical Director
   b. Pediatric Trauma Program Director / Program Manager
PURPOSE
To reduce the morbidity and mortality related to STEMI by organizing a system of STEMI centers to serve our residents and visitors through preventative education, emergency care, hospitalization, rehabilitation, and research. This critical care system links prehospital and hospital care to deliver optimal treatment to the population of STEMI patients.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.107, 1798.150]
California Code of Regulations, Title 22. Social Security, Division 9. Prehospital Emergency Medical Services, Chapter 7.1 ST- Elevation Myocardial Infarction Critical Care System

STEMI CENTER DEFINITIONS

STEMI Referring Hospital (SRH)
A licensed general acute care facility that meets the minimum hospital STEMI care requirements to stabilize and transfer patients to a PCI-capable facility.

STEMI Receiving Center (SRC)
A hospital with cardiac capabilities (Cardiac catheterization laboratory licensed to perform emergency Percutaneous Coronary Intervention [PCI] and/ or cardiovascular surgery) and designated by the Riverside County EMS Agency to provide rapid intervention for STEMI patients.

DESIGNATION BY REMSA AS A STEMI CENTER
Initial REMSA Designation as a STEMI Center in the EMS System requires an application, satisfactory site survey and verification of the following:
1. Currently serving in the EMS system as a Prehospital Receiving Center (PRC) or a Base Hospital (BH).
2. Compliance with all standards and requirements listed in this policy.
3. Compliance with all requirements listed in Title 22, Division 9, Chapter 7.1- ST- Elevated Myocardial Infarction Critical Care System, for the requested level of designation.
4. Accreditation as a Chest Pain Center with Primary PCI from the American College of Cardiology (ACC) or Primary Heart Attack Center (PHAC) Certification level or higher from The Joint Commission (TJC).
   a. If certification is in process, the applying hospital shall provide REMSA with a copy of the certification within 30 days of receipt.
   b. Continued designation shall depend on re-certification as specified by the certifying organization, and a copy of the renewal certificate shall be provided to REMSA not less than 30 days prior to expiration of current certification.
5. Enrollment and participation in the STEMI data management system and commitment to provide additional data as required by REMSA and/or the STEMI System Committee.
6. Current written agreement with REMSA for designation as a STEMI Center to provide services in Riverside County.
7. STEMI Center designation may be granted following satisfactory review of a completed application, supporting written documentation, an initial site survey by REMSA personnel/designees.

Designation Renewal
1. The STEMI Center may be re-designated after satisfactory review of written documentation and a site survey by REMSA personnel/designees.
2. Re-designation shall occur every five (5) years. REMSA staff will attend and perform STEMI center audits during the entire American College of Cardiology site visit
3. Failure to comply with the criteria outlined in this policy at any time will result in disciplinary action up to and including suspension or rescission of EMS STEMI Center designation.

**STEMI CENTER STANDARDS FOR ALL HOSPITALS DESIGNATED BY REMSA AS A STEMI RECEIVING CENTER**

**Staffing Requirements**

1. STEMI Centers shall staff the following positions:
   a. **STEMI Program Medical Director:**
      i. A qualified board-certified physician by the American Board of Medical Specialties (ABMS) as defined by the local EMS agency and designated by the hospital that is responsible for the STEMI program, performance improvement, and patient safety programs related to a STEMI critical care system.
   b. **STEMI Program Manager:**
      i. A registered nurse who is designated by the hospital and is responsible for monitoring, coordinating, and evaluating the STEMI program.
      1. In the event that an interim Program Manager is needed in the absence of a full-time Program Manager, a nurse from the hospital may be selected to fulfill the obligations and duties of the role for no more than one hundred-eighty (180) days. Should a full-time Program Manager not be assigned by the conclusion of the interim period, REMSA will perform an evaluation of the position and program to ensure compliance with state regulation(s), REMSA policy, and contract language.
   c. **Clinical STEMI Team:**
      i. Specially trained health care professionals that perform percutaneous coronary intervention. It may include, but is not limited to, an interventional cardiologist, mid-level practitioners, registered nurses, technicians, and other health care professionals.
   d. **Registrar:**
      i. One full-time equivalent registrar dedicated to the registry must be available to process the data capturing the ACC/NCDR, CARES, and REMSA data sets for each 500–750 patients in the registry. This staffing need increases if additional data elements are collected.

**Data Collection and Submission**

1. The STEMI Centers shall:
   a. Participate in the STEMI data management system
   b. Submit data to REMSA via the REMSA approved data collection method and on the schedule agreed upon by the STEMI System Committee.

   **This data shall include but not be limited to:**
   i. All data elements included in section 100270.126 of CCR Title 22 STEMI requirements.
   ii. ACC and National Cardiovascular Data Registry (NCDR) data elements.
   iii. CARES registry elements.
   iv. Any additional data elements as requested by REMSA and/or the REMSA STEMI system committee.

**Performance Standards**

1. Written EMS policies and procedures shall be reviewed at a minimum of every two (2) years but may be updated sooner based upon identified CQI needs.

2. STEMI Centers must operate a cardiac catheterization laboratory licensed by the Department of Health Services and approved for emergency PCI’s. The hospital shall be available for treatment of STEMI patients twenty-four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year.
   a. To ensure uninterrupted services, the following equipment is required:
      i. Maintain a minimum of two (2) catheterization (cath) lab suites capable of PCI.
   b. In the event that the required capabilities cannot be maintained and an interruption in service occurs, the REMSA Duty Officer must be called immediately.
      i. REMSA does not allow STEMI diversions. When a STEMI center is placed on “Diversion” in the ReddiNet, their STEMI program will be suspended until an evaluation occurs regarding the circumstances that caused the interruption in service. The STEMI center will be permitted to continue receiving suspected STEMI patients only after a completed evaluation and re-approval by REMSA.

3. Additional performance measures as determined by REMSA and/or the STEMI Critical Care System Committee.
STEMI Center Standards

4. The STEMI center shall establish adequate procedures for self-monitoring and quality control and assurance in compliance with standards, in this policy, on a continuous basis. Documentation of such efforts shall be made available to REMSA upon request.

Education
1. Provide STEMI related continuing education to EMS personnel and annually report these activities to REMSA. A minimum of 2 educational events annually is required.
2. Provide STEMI education to the public and annually report these activities to REMSA.

STEMI System Participation
1. STEMI Center representatives shall actively participate as members of the STEMI Critical Care System Committee.
2. STEMI Centers shall maintain accreditation as a Chest Pain Center with Primary PCI from the American College of Cardiology
3. Compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality, and a disclosure-protected review of selected STEMI cases.
4. Active participation as a member of the STEMI system committee to include attendance and case review assignments.

Hospital Services / Obligations
The hospital shall meet the following requirements:
1. The hospital shall have established protocols for triage, diagnosis, and cath lab activation following field notification of an inbound suspected STEMI patient.
2. The hospital shall have a single call activation system to activate the Cardiac Catheterization Team directly.
3. The hospital shall have a process in place for the treatment and triage of simultaneously arriving STEMI patients.
4. Internal policies shall be developed for the following:
   a. Protocol to be used in unforeseen circumstances when PCI of a STEMI patient is not possible, or delay of the cath lab team to the patient exceeds 30 (thirty) minutes.
   b. Diversion of STEMI patients only during times of internal disaster designation (see REMSA Policy #6103 [Ambulance Diversion]). Immediate notification of the REMSA Duty Officer at (951) 712-3342 is required!
5. Hospital shall have the ability to receive ECGs wirelessly transmitted by prehospital personnel.
6. A Cardiovascular surgery service permit*
   *This requirement may be waived by the REMSA Medical Director when appropriate for patient or system needs. The REMSA Medical Director will evaluate conformance with existing ACC/AHA or other existing professional guidelines for standards.
7. A dedicated audio recorded phone line or radio system, capable of being answered twenty-four (24) hours per day, seven (7) days per week, used by paramedics to notify STEMI Receiving Center of incoming STEMI patients.
   a. Maintain such recordings for a minimum of one year, and use such recordings exclusively for auditing, continuing education and review approved by REMSA.
   b. Maintain a backup recording system in the event that the primary recording system fails.
8. Hospitals that must temporarily close their cardiac cath lab due to equipment failure must do the following:
   a. Immediately contact the EMS Duty Officer, the first responders, the transporting ambulance company(ies), the closest SRC, and the STEMI Base Hospital to notify them of the temporary closure and the expected downtime.
   b. Once the cath lab is open and functional, make the same contacts to notify the system that the cath lab is now open and functional.
   c. All STEMI patients that were diverted during the down time must be reported to REMSA. The accepting STEMI Receiving Center must do 100% CQI on these patients.

Reporting Requirements
1. SRC shall notify REMSA in writing of any failure to meet the EMS STEMI Receiving Center Standards within 10 (ten) business days.
2. Changes to key STEMI Receiving Center personnel (i.e., Program Medical Director and/or Program Manager) shall be reported to REMSA within 10 (ten) business days.
THIS POLICY APPLIES ONLY TO THE TRANSFER OF ACUTE STEMI PATIENTS FROM A REFERRAL HOSPITAL TO A REMSA DESIGNATED STEMI RECEIVING CENTER.

PURPOSE
To establish standardized care that ensures the rapid transport of an active STEMI patient from a referral hospital to a STEMI receiving center to achieve a door-to-door-to-Reperfusion (D2D2R) time of 120 minutes or less.

This policy shall be used for:
- Prehospital providers that are transporting unstable STEMI patients to a STEMI center that need to divert to the closest receiving hospital for stabilization before continuing to a designated STEMI Receiving Center.
- Rapid transport of an identified STEMI patient from a Referral Hospital to the closest STEMI Receiving Center.

AUTHORITY
California Health & Safety Code, Division 2.5, Sections 1797.220, 1798, 1798.170 and 1798.172

Referral Hospital Responsibilities
1. STEMI receiving centers are required to accept STEMI patients from referral hospitals if a STEMI has been confirmed by ECG.
   a. All ECG’s must be transmitted from the referral hospital to the STEMI receiving center.
2. The decisions on the need for emergency transport of a confirmed STEMI patient and mode of transport will be made by the referral hospital sending physician.
3. To facilitate and expedite the transport of STEMI patients, all non-STEMI referral hospitals are encouraged to make agreements with REMSA-permitted transport providers capable of transporting STEMI patients to STEMI receiving centers.
4. The Referral Hospital sending physician will notify the STEMI receiving center of the confirmed STEMI patient and the need to re-triage/ utilize STEMI continuation of care. The patient’s ECG findings and/or reason for re-triage/continuation of care will be communicated.
   a. The referral hospital will stabilize the patient as clinically indicated and initiate resuscitative measures within their capability when warranted by the patient’s condition.
   b. The referral hospital will not delay transport by initiating unnecessary diagnostic procedures that will not immediately benefit the patient’s condition.
   c. If the referral hospital anticipates the need to utilize this policy, they should advise the transport provider as soon as possible; they are only permitted to hold the transport provider’s unit for twenty (20) minutes.
   d. The referral hospital will provide RN to RN report to the STEMI receiving center.
5. Paramedics may transport patients on REMSA-approved IV drips only. Unless medically necessary, the referral hospital should avoid using medication drips that are outside the paramedic scope of practice to avoid delay.
6. Copies of the medical records, radiologic evaluations, laboratory results, and any supporting documents shall be sent with the patient. DO NOT DELAY TRANSPORT- documents may be faxed or electronically transmitted.

STEMI Receiving Center Responsibilities
1. STEMI receiving center will accept all referred STEMI patients, if a STEMI has been confirmed by ECG, unless they are on internal disaster.
2. STEMI continuation of care transports for higher level of care are considered ED-to-ED transfers.
3. STEMI receiving centers will have a physician immediately available to respond to STEMI patients from referral hospitals. The ED physicians have the authority to accept continuation of care STEMI transfer patients without consulting with the cardiologist.

4. STEMI receiving center shall notify REMSA of all emergency STEMI patient continuation of care within sixty (60) days.

**Transport Provider Responsibilities**

1. If an unstable STEMI/STEMI-suspected patient arrives to a referral hospital by ambulance, the referral hospital ED physician may request that the transport provider’s unit remain in the ED and immediately transport the patient once minimal stabilization is completed.
   a. If the transport provider’s Communication Center is not notified directly by the referral hospital, the transport provider’s personnel will advise that they will be performing a continuation of care STEMI transfer.
   b. The referral hospital is only permitted to hold the transport provider’s unit for twenty (20) minutes.

2. Transport personnel shall contact the accepting STEMI Receiving Center en route to provide an update on patient status during transport.

3. The transport personnel will complete an electronic patient care report (ePCR) for all continuation of care patients.

**Procedures for Continuation of STEMI Care Transport**

Facilities should have a mechanism in place to bypass their transfer center triage process and route STEMI transfers through the emergency department physicians.

1. Once the decision to send the patient to a STEMI Receiving Center has been made, the ED physician at the referral hospital must contact the ED physician at the STEMI receiving center.
   a. The ED physician at each STEMI receiving center has the authority to accept a STEMI patient from another ED without consulting with the cardiologist.

2. The referral hospital must contact a REMSA permitted transport service to arrange for the immediate transport of the patient.
   a. Contact a REMSA permitted transport service to arrange for the immediate transport of the patient. Utilize the following verbiage to the transport dispatch:
      “This is a STEMI continuation of care from (Referral Hospital) to (STEMI Receiving Center).”
   b. When continuation of STEMI care has been initiated the ground transport ambulance will respond immediately to requesting facility code 3.

3. A STEMI patient may be transported from a referral hospital to a STEMI receiving center by one of the following, as determined by the sending physician to be the most appropriate:
   a. A REMSA permitted ALS ambulance.
   b. Current transporting ground ambulance may stand by on premises, not to exceed twenty (20) minutes, for immediate transport of the patient to a STEMI receiving center.
   c. A REMSA permitted air ambulance.
PURPOSE
To establish policies and procedures for all EMS personnel who participate in, and respond to, tactical EMS (TEMS) events in Riverside County.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797 - 1863]
California Penal Code, Section 13518

REFERENCES
California Tactical Casualty Care Training Guidelines (2017)
Tactical Medicine: Operational Programs and Standardized Training Recommendations

PROGRAM REQUIREMENTS
All TEMS programs (Emergency Medical Support, Bike Medic, Boat Medic, etc.) in Riverside County must have approval from REMSA prior to deploying participating EMS personnel. The application for approval and renewal can be found here: https://forms.office.com/g/94Ugf8BAQX.

Once approved, program effective and expiration dates will be documented on a REMSA-provided approval letter. Program approval will be granted for periods of twenty-four (24) months. Renewal applications may be submitted up to six (6) months prior to the expiration date.

TRAINING AND REPORTING REQUIREMENTS
Initial training for paramedics: to participate as a member of a TEMS program, Riverside County paramedics must successfully complete one (1) of the following EMSA-approved tactical EMS courses:

- **Minimum** – Tactical Life Saver / TEMS Technician Course (forty (40) hours)
- **Recommended** - Tactical Medicine for Special Operations Course (eighty (80) hours)

Initial training for EMTs: To participate as a member of a TEMS program, Riverside County EMTs must successfully complete one (1) of the following EMSA-approved tactical EMS courses:

- **Minimum** - Tactical EMS First Responder Operational (FRO) course (four (4) hours).
- **Recommended** - Tactical Lifesaver / TEMS Technician course (forty (40) hours).

Training programs that offer all three courses (above) can be found here: https://emsa.ca.gov/tcc_approvedtrainingprograms/.

Additionally, all prospective TEMS personnel must successfully participate in, and complete, all modules and training events as required by their agency’s Tactical Program Medical Director, Tactical Medicine Program Director and/or Tactical Medicine Program Coordinator prior to their first deployment.
Refresher training: to maintain an ACTIVE status as a member of a TEMS program, Riverside County EMS personnel must participate in all scheduled TEMS team operational trainings throughout the calendar year, as required by their Tactical Program Medical Director, Tactical Medicine Program Director and/or Tactical Medicine Program Coordinator.

Firearm training: the decision to carry and potentially utilize a firearm during the course of a TEMS Team activation lies with the individual Riverside County EMS personnel, their Tactical Program Medical Director, Tactical Medicine Program Director and/or Tactical Medicine Program Coordinator, and the Law Enforcement agency sponsoring the TEMS Team. Should approval be granted, permission to carry does not extend to regular duty assignments.

Reporting: Proof of initial and refresher training completion will be provided by the individual to their Tactical Medicine Medical Director, Tactical Medicine Program Director or Tactical Medicine Program Coordinator prior to participating in TEMS team trainings or a TEMS Team activation.

PROGRAM PERSONNEL REQUIREMENTS

- Any agency that operates a TEMS Program should designate a Tactical Medicine Medical Director. This individual will be a physician currently licensed in California, who will provide medical direction, continuous quality improvement, medical oversight, and act as a resource for medical contingency planning. The Tactical Medicine Medical Director must have sufficient knowledge of tactical medicine, as demonstrated by education, experience or both.

- Any agency that operates a TEMS Program should designate a Tactical Medicine Program Director as defined within POST and EMSA guidelines.

- Any agency that operates a TEMS Program should designate a Tactical Medicine Program Coordinator to serve as a point of contact and liaison between the TEMS operational program and Riverside County TEMS Team personnel, allied agencies, and REMSA.
  - If applicable, changes in Tactical Medicine Program Director, Tactical Program Medical Director and/or Tactical Medicine Program Coordinator should be reported to REMSA as soon as possible.

- TEMS Team personnel must have, and maintain, the following:
  - EMTs: an active and unrestricted California EMT license
    RECOMMENDED: active Prehospital Trauma Life Support certification (PHTLS) OR active International Trauma Life Support (ITLS) certification.
  - Paramedics: an active and unrestricted California paramedic license AND active and unrestricted Riverside County paramedic accreditation.
    RECOMMENDED: active Prehospital Trauma Life Support certification (PHTLS) OR active International Trauma Life Support (ITLS) certification.
      - Experience: paramedics must have a minimum of two (2) years of full-time field experience as a licensed paramedic. EMTs who have reclassified to paramedic who have already obtained, and maintain, the required TEMS operational training(s) may qualify to participate without having two (2) years of experience if they receive approval from their agency’s Tactical Medicine Program Director, Tactical Program Medical Director and/or Tactical Medicine Program Coordinator.
  - RNs: an active and unrestricted California Registered Nurse license AND active and unrestricted Riverside County MICN authorization OR an active and unrestricted Certified Flight RN (CF-RN) credential.

Approval to participate in TEMS Team operations lies with the individual agency’s Tactical Medicine Program Director, Tactical Program Medical Director and/or Tactical Medicine Program Coordinator.

All changes in TEMS Team personnel must be reported to REMSA within fifteen (15) business days of the change. The Tactical EMS Program Roster can be found here: http://remsa.us/documents/programs/tems/TacticalEMSProgramRosterv71122.pdf
SCOPE OF PRACTICE
The scope of practice for all EMTs and paramedics who participate on a TEMS Team will align with California Code of Regulations, Title 22, Division 9 and REMSA policy #4104 (Skills List).

DRUG AND EQUIPMENT LIST
*Items included below do not need to be carried onto the scene, they only need to be immediately available.

<table>
<thead>
<tr>
<th>MEDICATIONS</th>
<th>BLS Par</th>
<th>ALS Par</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albuterol 2.5 mg with Atrovent 0.5 mg MDI</td>
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<tr>
<td>Aspirin chewable 81 mg tablets</td>
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<td>Atropine Sulfate</td>
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<td>Dextrose 50% 25 gm pre-filled syringe</td>
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<td>Diphenhydramine 50 mg</td>
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<tr>
<td>Epinephrine 1:10,000 1 mg (or equivalent)</td>
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<td>Glucagon 1 mg</td>
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<tr>
<td>Naloxone 2 mg pre-filled syringe</td>
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<td>Nerve Agent Antidote (DuoDote) (optional)</td>
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<td>Nitroglycerine 0.4 mg SL spray or tablets (tablets to be discarded 90 days after opening)</td>
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<td>Normal Saline 500 mL</td>
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<td>Normal Saline 10 mL prefilled syringe (“flush”)</td>
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<td>Ondansetron 4 mg IV / IM / ODT</td>
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<td>Tranexamic Acid (TXA) 1 gm</td>
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<td>Midazolam</td>
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<td>Ketamine</td>
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<tr>
<td>End tidal CO₂ (device may be integrated into BVM)</td>
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<td>Endotracheal Tubes - 6.0 and/or 6.5, 7.0 and/or 7.5, and 8.0 and/or 8.5, with stylet</td>
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<td>ET tube holder</td>
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<td>Laryngoscope kit</td>
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<td>Nasopharyngeal airways (NPA)</td>
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<td>Needle thoracostomy kit</td>
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<td>Suction (handheld)</td>
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<td>Blood pressure cuff</td>
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<td>ECG monitor</td>
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<td>IO device and needles</td>
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<td>IV catheters 14 / 16 / 18 / 20 gauge</td>
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<td>IV start kit</td>
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<td>IV tubing</td>
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<td>Pulse oximeter (optional)</td>
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<td>Saline Lock</td>
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<td>Stethoscope</td>
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<td>Syringes 3 cc / 5 cc / 10 cc</td>
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<td>Chest seal and flutter valve</td>
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<td>CoTCCC - recommended tourniquet system</td>
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<td>Elastic compression dressing</td>
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<td>Latex free gloves</td>
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<td>Occlusive dressing</td>
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<td>Roller bandage</td>
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<td>Splint - semi-ridged moldable</td>
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<td>Trauma dressing</td>
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<td>Triangle bandage</td>
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<td>Hemostatic impregnated gauze non-exothermic, i.e., Combat Gauze <em>(optional)</em></td>
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<tr>
<th><strong>MISCELLANEOUS EQUIPMENT</strong></th>
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<tr>
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<tr>
<td>Personal protection equipment (PPE)</td>
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<tr>
<td>Triage tags</td>
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<td>Tactical light</td>
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<tr>
<td>Eyewear</td>
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<tr>
<td>Rescue blanket</td>
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<tr>
<td>Self-heating blanket <em>(optional)</em></td>
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PURPOSE
To describe the County of Riverside EMS Agency (REMSA) required training in the use of the nerve agent antidote kit (NAAK) autoinjectors, and the AtroPen® autoinjector.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Nerve Agent Antidote Kit Training
The NAAK (either DuoDote® or Mark I) is optional personal protective equipment (PPE) with self-administration and use authorized by REMSA treatment protocol #4604 (Exposure to Nerve Agents, Organophosphates, or Carbamates). The Public Safety Personnel (PSP), Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), or paramedic (EMT-P) may self-administer the NAAK when so equipped. First response agencies and transport services equipping the PSP, EMT, or AEMT with the NAAK for self-administration must provide NAAK training as described below.

Additionally, when made available by deployment of a CDC CHEMPACK, the NAAK and the AtroPen® may be administered to patients as indicated by protocol. The requirements for training vary by level of authorization, certification, or license:
1. The PSP
   a. The PSP may not administer the NAAK or AtroPen® to patients unless approved through REMSA 1104.
2. The EMT or AEMT
   a. The EMT or AEMT may administer the NAAK or AtroPen® to patients. First response agencies and transport services employing the EMT or AEMT must ensure NAAK training as described below.
3. The EMT-P
   a. Atropine and Pralidoxime (2-PAM) Chloride are within the paramedic’s basic scope of practice and may be administered as indicated by protocol. NAAK training is not required.

Training Requirements
Training will consist of no less than two (2) hours of didactic and skills laboratory training including:
1. Indications
2. Contraindications
3. Side/ adverse effects
4. Routes of administration
5. Dosages
6. Mechanisms of drug action
7. Disposal of contaminated items and sharps
8. Medication administration

At the completion of this training, the student will complete a competency based written and skills examination for the administration of Atropine and Pralidoxime (2-PAM) Chloride which will include:
1. Assessment of when to administer these medications
2. Managing a patient before, during, and after administering these medications
3. Using universal precautions and body substance isolation procedures during medication administration
4. Demonstrating aseptic technique during medication administration
5. Demonstrate the preparation of medications
6. Demonstrate site selection and administration of medications by the intramuscular route
7. Proper disposal of contaminated items and sharps
8. Completion of the Notification of Usage Form

Every two (2) years the student will repeat the competency-based skills examination.

First response agencies and transport services providing NAAK training must retain these training records for a minimum of four (4) years and make them available for review at the request of REMSA or the California EMS Authority (EMSA).
PURPOSE
To define the ownership, specific capability and purpose of the Basic Life Support Trailer (BLST), specify the responsibilities of provider/hosts, identify those authorized to deploy the BLST, list criteria for deployment, and specify record keeping requirements during deployment.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Ownership
The Riverside County Emergency Management Department Preparedness Division will retain ownership of the BLSTs and contents. The BLSTs will be assigned to specific providers for the duration of each provider’s contract / memorandum of understanding (MOU) / permit with the county for provision of life support services. The PHEPR Branch has the right to remove, relocate or deploy the BLSTs in response to a current event or mutual aid request.

Responsibilities of the providers/hosts housing the BLSTs
1. The provider/host will be responsible for ensuring the security of the trailer and its contents while in storage at all times.
2. The provider/host must maintain the trailers in a state of readiness and in accordance with the requirements below:
   a. The provider/host will be responsible for ensuring that the trailer remains in working order, including having appropriate levels of air in the tires, at all times. The trailer should be stored in such a way as to ensure that the tires do not degrade.
   b. The provider/host will be responsible for ensuring that the trailers are readily accessible and not blocked in by large objects or vehicles that would impede its ability to be moved in a timely manner.
   c. The provider/host will inventory the stock in the trailer on a bi-annual basis and report the results of the inventory to the Riverside County EMS Agency (REMSA). If no deployment occurred in the previous months, missing items are the responsibility of the host/provider agency to replace.
   d. The provider/host will assure that oxygen cylinders are rotated or emptied and refilled every six months. Oxygen cylinder hydrotesting will be done per manufacturer’s recommendations.
   e. The provider host will replace all batteries and penlights at least once per year.
   f. The providers/hosts with a generator and gas can (stored empty), will be responsible for filling the generator and/or gas can upon any deployment of the BLST.
   g. Any changes to trailer locations must be approved in advance by REMSA.

Activation/Utilization of the BLST
The decision to deploy the BLST will be made in accordance with the Incident Command System (ICS) through the Cal Fire/Riverside County Fire Department Emergency Command Center (ECC).
1. Personnel who can authorize deployment of BLST
   a. REMSA Duty Officer or Branch Chief
   b. PHEPR Duty Officer or Branch Chief
   c. Health Officer or designee
   d. Riverside County Public Health Department Departmental Operations Center (DOC) staff
   e. Medical Health Operational Area Coordinator (MHOAC)
   f. Regional Disaster Medical/Health Coordinator (RDMHC)
   g. The Incident Commander of a qualifying mass/catastrophic event
   h. EMS COMM staff
2. Criteria to consider in deploying the BLST include but are not limited to:
   a. Any event that spans a large geographical area.
   b. Any catastrophic event (as defined above).
   c. Any event that destroys a large building or structure (e.g. convention center, college, hotel etc.).
   d. Any Weapons of Mass Destruction (WMD) event.
   e. Any natural or man-made disaster which can be classified as a mass casualty incident.
   f. Preplanned staging at or near large events/mass gatherings where the possibility of a major medical event exists.
   g. As a mutual aid request from neighboring counties, regions, the state, or the federal government.

3. The BLST will not be deployed to routine multiple casualty incidents or to other events that can be handled with standard daily resources. BLSTs hold supplies to treat up to 100 victims and are to be used for mass casualty incidents only.

4. Transportation of the BLST:
   a. The provider/host will be responsible for transporting the BLST when deployed.
   b. If necessary, the provider/host’s supervisor/duty officer will coordinate transportation of the BLST by another responsible entity.
   c. The provider/host will have the BLST on the road within 20 minutes of receiving the request for deployment, including filling the generator and/or gas can upon any deployment of the BLST

5. All instances in which a BLST is utilized must be reported to the REMSA Duty Officer immediately. The EMS Duty Officer can be reached 24/7 at (951) 712-3342.
   a. “Immediately” is defined as within one (1) hour or less of BLST deployment.

**Recordkeeping during utilization of the BLST**

1. Each BLST has an inventory of all equipment and supplies.
2. Accurate records must be kept by the requesting agency on all supplies used to be eligible for reimbursement following the Standardized Emergency Management System (SEMS) / National Incident Management System (NIMS) model. Records must include:
   a. Incident name and number
   b. Incident commander and agency
   c. Time of BLST deployment
   d. Individual who authorized BLST deployment
   e. Number and types of BLST contents used
   f. Number of patients involved in the incident
   g. Time and name of the REMSA Duty Officer that was notified
PURPOSE
To identify the ownership, specific capability and purpose of the CHEMPACK, specify the responsibilities of the hosts, identify those authorized to deploy the CHEMPACK, list criteria for deployment, and specify record keeping requirements during deployment.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Ownership
The Centers for Disease Control (CDC) and Prevention maintains ownership of all CHEMPACK assets. The state provides overall management of the CHEMPACK assets (coordinates exchanges of expired/recalled drugs, trainings, information sharing). Each CHEMPACK cache will be assigned to specific providers for the duration of each provider’s contract / memorandum of understanding (MOU) / permit with the county for response/treatment of a significant nerve agent and/or organophosphate (OPP) exposure that exceeds current field capabilities. The Public Health Emergency Preparedness and Response (PHEPR) Branch has the right to remove, relocate or deploy any of the CHEMPACK caches in response to a current event or mutual aid request.

Responsibilities of the CHEMPACK Host
1. The host is responsible for ensuring the security of the CHEMPACK while at their facility.
2. The host must maintain the CHEMPACK in a state of readiness and in accordance with the requirements outlined in the signed MOU as well as the list below:
   a. The provider/host will be responsible for ensuring that the CHEMPACK is maintained in a controlled environment and is not opened without a proper formal request;
   b. The host will be responsible for ensuring that the CHEMPACK is readily accessible and not blocked in by anything that would impede access to or movement of the CHEMPACK in a timely manner;
   c. The host will complete the Strategic National Stockpile (SNS) program CHEMPACK Monthly Quality Assurance Assessment;
   d. The host site shall maintain a 24/7/365 point of contact and back up point of contact for access to the CHEMPACK after normal business hours. (Request may be actual or for an exercise).
   e. Any changes to the Host point of contact(s) must be immediately communicated with the PHEPR branch.
   f. The host shall ensure the CHEMPACK assets be available within twenty (20) minutes from initial request.

Authorization/Utilization of the CHEMPACK
The requests for deployment of a CHEMPACK can be made by an Incident Commander (IC) or Medical Group Supervisor at the scene of a suspected nerve agent or organophosphate release with symptomatic patients that exceed field capabilities. The base hospital physician (BHP) or mobile intensive care nurse (MICN) at the base hospital (BH) may also authorize release of a CHEMPACK after consultation with the on-scene IC.
1. Personnel who can authorize deployment of a CHEMPACK
   a. The Incident Commander of a qualifying mass casualty incident (MCI)
   b. EMS Duty Officer or Branch Chief
   c. PHEPR Duty Officer or Branch Chief
   d. Health Officer or designee
   e. Riverside County Department of Public Health (DOPH) Departmental Operations Center (DOC) Operations (OPS) Chief or DOC Director
f. Riverside County Medical Health Operational Area Coordinator (MHOAC)
g. Regional Disaster Medical Health Coordinator VI (RDMHC)

2. Criteria to consider in deploying a CHEMPACK include but are not limited to:
   a. Any catastrophic event involving nerve agents and/or organophosphate exposure.
   b. Any Weapons of Mass Destruction (WMD) event involving nerve agents and/or organophosphate exposure.
   c. A credible threat of an imminent event likely to require the use of CHEMPACK assets.
   d. A physical threat to a CHEMPACK asset at a fixed location (Fire, Theft, and Flood).
   e. Any natural or man-made disaster which can be classified as an MCI, where patient’s exhibit symptomology consistent with nerve agent / organophosphate exposure.
   f. Preplanned staging at or near large events / mass gatherings where the possibility of a major event exists.
   g. As a mutual aid request from neighboring counties, regions, the state, or the federal government.

3. The CHEMPACK will not be deployed to routine MCIs or to other events that can be managed with current field/hospital supplies. There are two different types of CHEMPACKs; EMS and Hospital CHEMPACKs. An EMS CHEMPACK holds enough supplies to treat approximately 454 patients and has a higher percentage of Pre-load medications (auto-injector) and a lower percentage of multi-dose vials. The Hospital CHEMPACK holds enough supplies to treat approximately 1000 patients and has a higher percentage of multi-dose vials and a lower percentage of pre-load medications.

**CHEMPACKs are to be used for mass casualty incidents only.**

   a. See table A1 and A2 for CHEMPACK Container Contents (by type of container, EMS/Hospital)
   b. See tables B, C & D for partial deployment of EMS containers-breakdown for 450 patients, 250 patients and 125 patients.
   c. See tables E, F & G for partial deployment of Hospital Containers- breakdown for 500 patients, 250 patients and 125 patients.
   d. No ancillary supplies are included, if a Hospital CHEMPACK is deployed in the pre-hospital environment, additional supplies will be necessary. See table H for recommendations of numbers and types of supplies.

4. All CHEMPACK requests must include:
   a. The nature and severity of the release/exposure,
   b. The number of patients,
   c. The potential number of patients that may self-presentation at a receiving facility.
      **Consider safety for delivery personal, including potential hazards.

5. Transportation of the CHEMPACK:
   a. The host will be responsible for transporting the CHEMPACK when requested.
   b. If necessary, the host’s supervisor/duty officer will coordinate transportation of the CHEMPACK by another responsible entity.
   c. The provider/host will/should have the requested CHEMPACK supplies deployed to the scene within twenty (20) minutes of receiving a request.

6. The CHEMPACK Controlled Substance Transfer Form and CHEMPACK Tracking Release and Receipt of Materiel Form must be completed- (Mandatory) See attachment “G & H” - in the Operational Plan located in each CHEMPACK container.

7. In all instances in which a CHEMPACK is requested and/or utilized, the PHEPR Duty Officer must be notified within sixty (60) minutes of the initial request. The PHEPR Duty Officer can be reached 24/7 at (951) 830-8041.
Recordkeeping during Utilization of the CHEMPACK

1. Each CHEMPACK has an inventory of all equipment and supplies.
2. Accurate records must be kept by the requesting agency on all supplies used to be eligible for reimbursement following the Standardized Emergency Management System (SEMS)/National Incident Management System (NIMS) model. Records must include:
   a. Incident name and number
   b. Incident commander and agency
   c. Time of CHEMPACK deployment
   d. Individual who authorized CHEMPACK deployment
   e. Name and title of person receiving deployment
   f. Number and types of CHEMPACK contents used
   g. Number of patients involved in the incident
   h. Time and name of the PHEPR/EMS Duty Officer that was notified

Table A1 & A2: EMS AND HOSPITAL CHEMPACK CONTAINER INVENTORY LIST

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>Unit Pack</th>
<th>Cases</th>
<th>QTY</th>
<th>COLOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark 1 auto-injector</td>
<td>240</td>
<td>5</td>
<td>1200</td>
<td>YELLOW</td>
</tr>
<tr>
<td>Atropine Sulfate 0.4mg/mL 20mL</td>
<td>100</td>
<td>1</td>
<td>100</td>
<td>BLUE</td>
</tr>
<tr>
<td>Pralidoxime 1gm inj 20mL</td>
<td>276</td>
<td>1</td>
<td>276</td>
<td>RED</td>
</tr>
<tr>
<td>AtroPen® 0.5 mg</td>
<td>144</td>
<td>1</td>
<td>144</td>
<td>PURPLE</td>
</tr>
<tr>
<td>AtroPen® 1.0 mg</td>
<td>144</td>
<td>1</td>
<td>144</td>
<td>GRAY</td>
</tr>
<tr>
<td>Diazepam 5mg/mL auto-injector</td>
<td>150</td>
<td>2</td>
<td>300</td>
<td>GREEN</td>
</tr>
<tr>
<td>Diazepam 5mg/mL vial, 10mL</td>
<td>25</td>
<td>2</td>
<td>50</td>
<td>ORANGE</td>
</tr>
<tr>
<td>Sterile water for injection (SWFI) 20mL</td>
<td>100</td>
<td>2</td>
<td>200</td>
<td>WHITE</td>
</tr>
<tr>
<td>Sensaphone® 2050</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Satco C DEA Container</td>
<td>1</td>
<td>1</td>
<td>1</td>
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### TABLE A2 - Hospital CHEMPACK Container Inventory – 1000 Patient Capacity

<table>
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<tr>
<th>ITEMS</th>
<th>Unit Pack</th>
<th>Cases</th>
<th>QTY</th>
<th>COLOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark 1 auto-injector</td>
<td>240</td>
<td>2</td>
<td>480</td>
<td>YELLOW</td>
</tr>
<tr>
<td>Atropine Sulfate 0.4mg/mL 20mL</td>
<td>100</td>
<td>9</td>
<td>900</td>
<td>BLUE</td>
</tr>
<tr>
<td>Pralidoxime 1 gm inj 20 mL</td>
<td>276</td>
<td>10</td>
<td>2760</td>
<td>RED</td>
</tr>
<tr>
<td>AtroPen® 0.5 mg</td>
<td>144</td>
<td>1</td>
<td>144</td>
<td>PURPLE</td>
</tr>
<tr>
<td>AtroPen® 1.0 mg</td>
<td>144</td>
<td>1</td>
<td>144</td>
<td>GRAY</td>
</tr>
<tr>
<td>Diazepam 5 mg/mL auto-injector</td>
<td>150</td>
<td>1</td>
<td>150</td>
<td>GREEN</td>
</tr>
<tr>
<td>Diazepam 5 mg/mL vial, 10 mL</td>
<td>25</td>
<td>26</td>
<td>650</td>
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<td>Sterile water for injection (SWFI) 20 mL</td>
<td>100</td>
<td>28</td>
<td>2800</td>
<td>WHITE</td>
</tr>
<tr>
<td>Sensaphone® 2050</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Satco C DEA Container</td>
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<td>1</td>
<td>1</td>
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### Tables B, C, & D: EMS CHEMPACK CONTAINER BREAKDOWN SCHEDULES

#### TABLE B - EMS CHEMPACK Container Breakdown Schedule - 450 Patients

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>UNIT QTY</th>
<th>CASES TO ISSUE</th>
<th>COLOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark 1 auto-injector</td>
<td>1200</td>
<td>5</td>
<td>YELLOW</td>
</tr>
<tr>
<td>Atropine Sulfate 0.4mg/mL 20mL</td>
<td>100</td>
<td>1</td>
<td>BLUE</td>
</tr>
<tr>
<td>Pralidoxime 1 gm inj 20 mL</td>
<td>276</td>
<td>1</td>
<td>RED</td>
</tr>
<tr>
<td>AtroPen® 0.5 mg</td>
<td>144</td>
<td>1</td>
<td>PURPLE</td>
</tr>
<tr>
<td>AtroPen® 1.0 mg</td>
<td>144</td>
<td>1</td>
<td>GRAY</td>
</tr>
<tr>
<td>Diazepam 5 mg/mL auto-injector</td>
<td>300</td>
<td>2</td>
<td>GREEN</td>
</tr>
<tr>
<td>Diazepam 5 mg/mL vial, 10 mL</td>
<td>50</td>
<td>2</td>
<td>ORANGE</td>
</tr>
<tr>
<td>Sterile water for injection (SWFI) 20 mL</td>
<td>200</td>
<td>2</td>
<td>WHITE</td>
</tr>
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### TABLE C - EMS CHEMPACK Container Breakdown Schedule - 250 Patients

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>UNIT QTY</th>
<th>CASES TO ISSUE</th>
<th>COLOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark 1 auto-injector</td>
<td>720</td>
<td>3</td>
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<tr>
<td>Atropine Sulfate 0.4mg/mL 20mL</td>
<td>100</td>
<td>1</td>
<td>BLUE</td>
</tr>
<tr>
<td>Pralidoxime 1 gm inj 20 mL</td>
<td>276</td>
<td>1</td>
<td>RED</td>
</tr>
<tr>
<td>AtroPen® 0.5 mg</td>
<td>144</td>
<td>1</td>
<td>PURPLE</td>
</tr>
<tr>
<td>AtroPen® 1.0 mg</td>
<td>144</td>
<td>1</td>
<td>GRAY</td>
</tr>
<tr>
<td>Diazepam 5 mg/mL auto-injector</td>
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<td>1</td>
<td>GREEN</td>
</tr>
<tr>
<td>Diazepam 5 mg/mL vial, 10 mL</td>
<td>25</td>
<td>1</td>
<td>ORANGE</td>
</tr>
<tr>
<td>Sterile water for injection (SWFI) 20 mL</td>
<td>100</td>
<td>1</td>
<td>WHITE</td>
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### TABLE D - EMS CHEMPACK Container Breakdown Schedule - 125 Patients

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>UNIT QTY</th>
<th>CASES TO ISSUE</th>
<th>COLOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark 1 auto-injector</td>
<td>480</td>
<td>2</td>
<td>YELLOW</td>
</tr>
<tr>
<td>Atropine Sulfate 0.4mg/mL 20mL</td>
<td>100</td>
<td>1</td>
<td>BLUE</td>
</tr>
<tr>
<td>Pralidoxime 1 gm inj 20 mL</td>
<td>276</td>
<td>1</td>
<td>RED</td>
</tr>
<tr>
<td>AtroPen® 0.5 mg</td>
<td>144</td>
<td>1</td>
<td>PURPLE</td>
</tr>
<tr>
<td>AtroPen® 1.0 mg</td>
<td>144</td>
<td>1</td>
<td>GRAY</td>
</tr>
<tr>
<td>Diazepam 5 mg/mL auto-injector</td>
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<td>1</td>
<td>GREEN</td>
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<tr>
<td>Diazepam 5 mg/mL vial, 10 mL</td>
<td>25</td>
<td>1</td>
<td>ORANGE</td>
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<tr>
<td>Sterile water for injection (SWFI) 20 mL</td>
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### Tables E, F, & G: HOSPITAL CHEMPACK CONTAINER BREAKDOWN SCHEDULES

### TABLE E - Hospital CHEMPACK Container Breakdown Schedule – 500 Patients

<table>
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<tr>
<th>ITEMS</th>
<th>QTY</th>
<th>CASES TO ISSUE</th>
<th>COLOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark 1 auto-injector</td>
<td>240</td>
<td>1</td>
<td>YELLOW</td>
</tr>
<tr>
<td>Atropine Sulfate 0.4mg/mL 20mL</td>
<td>500</td>
<td>5</td>
<td>BLUE</td>
</tr>
<tr>
<td>Pralidoxime 1 gm inj 20 mL</td>
<td>1380</td>
<td>5</td>
<td>RED</td>
</tr>
<tr>
<td>AtroPen® 0.5 mg</td>
<td>144</td>
<td>1</td>
<td>PURPLE</td>
</tr>
<tr>
<td>AtroPen® 1.0 mg</td>
<td>144</td>
<td>1</td>
<td>GRAY</td>
</tr>
<tr>
<td>Diazepam 5 mg/mL auto-injector</td>
<td>150</td>
<td>1</td>
<td>GREEN</td>
</tr>
<tr>
<td>Diazepam 5 mg/mL vial, 10 mL</td>
<td>375</td>
<td>15</td>
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### TABLE F - Hospital CHEMPACK Container Breakdown Schedule – 250 Patients

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<th>ITEMS</th>
<th>QTY</th>
<th>CASES TO ISSUE</th>
<th>COLOR</th>
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</thead>
<tbody>
<tr>
<td>Mark 1 auto-injector</td>
<td>480</td>
<td>2</td>
<td>YELLOW</td>
</tr>
<tr>
<td>Atropine Sulfate 0.4mg/mL 20mL</td>
<td>300</td>
<td>3</td>
<td>BLUE</td>
</tr>
<tr>
<td>Pralidoxime 1 gm inj 20 mL</td>
<td>828</td>
<td>3</td>
<td>RED</td>
</tr>
<tr>
<td>AtroPen® 0.5 mg</td>
<td>144</td>
<td>1</td>
<td>PURPLE</td>
</tr>
<tr>
<td>AtroPen® 1.0 mg</td>
<td>144</td>
<td>1</td>
<td>GRAY</td>
</tr>
<tr>
<td>Diazepam 5 mg/mL auto-injector</td>
<td>150</td>
<td>1</td>
<td>GREEN</td>
</tr>
<tr>
<td>Diazepam 5 mg/mL vial, 10 mL</td>
<td>175</td>
<td>7</td>
<td>ORANGE</td>
</tr>
<tr>
<td>Sterile water for injection (SWFI) 20 mL</td>
<td>700</td>
<td>7</td>
<td>WHITE</td>
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### TABLE G - Hospital CHEMPACK Container Breakdown Schedule – 125 Patients

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<tr>
<th>ITEMS</th>
<th>QTY</th>
<th>CASES TO ISSUE</th>
<th>COLOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark 1 auto-injector</td>
<td>480</td>
<td>2</td>
<td>YELLOW</td>
</tr>
<tr>
<td>Atropine Sulfate 0.4mg/mL 20mL</td>
<td>300</td>
<td>3</td>
<td>BLUE</td>
</tr>
<tr>
<td>Pralidoxime 1 gm inj 20 mL</td>
<td>828</td>
<td>3</td>
<td>RED</td>
</tr>
<tr>
<td>AtroPen® 0.5 mg</td>
<td>144</td>
<td>1</td>
<td>PURPLE</td>
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<tr>
<td>AtroPen® 1.0 mg</td>
<td>144</td>
<td>1</td>
<td>GRAY</td>
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<tr>
<td>Diazepam 5 mg/mL auto-injector</td>
<td>150</td>
<td>1</td>
<td>GREEN</td>
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<tr>
<td>Diazepam 5 mg/mL vial, 10 mL</td>
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<td>ORANGE</td>
</tr>
<tr>
<td>Sterile water for injection (SWFI) 20 mL</td>
<td>700</td>
<td>7</td>
<td>WHITE</td>
</tr>
</tbody>
</table>
**Table H: RECOMMENDED CHEMPACK ANCILLARY SUPPLIES (Hospital Units Only)**

We recommend that these supplies be kept available with the Hospital CHEMPACKs for deployment/use; these supplies are not included in the CHEMPACKs.

<table>
<thead>
<tr>
<th>ITEM</th>
<th>UNIT OF ISSUE</th>
<th>HOSPITAL QTY</th>
<th>DOPH/PHEPR*</th>
<th>HOST SITE**</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAR Saline Lock Kit</td>
<td>200/case</td>
<td>5 cases</td>
<td>2 cases</td>
<td>3 cases</td>
</tr>
<tr>
<td>Kit Includes:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- adult IV catheter 18 ga x 1.25”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 10 cc luer-lock syringe</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- 18 ga x 1.5” needle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- locking saline plug</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- constricting band</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- securing device</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- cleaning/dressing supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Saline mini-bag 250 mL (0.9% IV piggyback mix) | 36/case | 28 cases | 7 cases | 21 cases |

| Pediatric IV Catheter (24g x 3/4” length) | 50/case | 5 cases | 2 cases | 3 cases |

| IV Administration Set (Micro-drip 60 gtts non-vented) | 50/case | 20 cases | 5 cases | 15 cases |

*The Department of Public Health / Prehospital Emergency Preparedness and Response Branch (DOPH/PHEPR) will provide these ancillary supplies as a onetime purchase, for use when Hospital CHEMPACK supplies are required by an outside facility. It will be hospital host site’s responsibility to rotate items through current stock to maintain current product.

**Remaining supplies will be the end user’s responsibility to provide.

**CHEMPACK ANCILLARY SUPPLIES Break Out by Number of Casualties**

<table>
<thead>
<tr>
<th>ITEM</th>
<th>1000 PATIENTS (up to 25% peds)</th>
<th>500 PATIENTS (up to 25% peds)</th>
<th>250 PATIENTS (up to 25% peds)</th>
<th>125 PATIENTS (up to 25% peds)</th>
<th>60 PATIENTS (up to 25% peds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAR Kits</td>
<td>5 cases</td>
<td>3 cases</td>
<td>2 cases</td>
<td>1 case</td>
<td>½ case</td>
</tr>
<tr>
<td>Saline mini bag</td>
<td>28 cases</td>
<td>14 cases</td>
<td>7 cases</td>
<td>4 cases</td>
<td>2 cases</td>
</tr>
<tr>
<td>Peds IV Catheter</td>
<td>5 cases</td>
<td>3 cases</td>
<td>2 cases</td>
<td>1 case</td>
<td>1 case</td>
</tr>
<tr>
<td>IV Administration Set</td>
<td>20 cases</td>
<td>10 cases</td>
<td>5 cases</td>
<td>3 cases</td>
<td>2 cases</td>
</tr>
</tbody>
</table>
CHEMPACK DEPLOYMENT TO NON-HOST HOSPITALS

Large number of patients at local hospital with signs/symptoms of nerve agent/organophosphate exposure

Appropriate hospital staff estimates number of affected patients and review supply

Adequate supply in hospital. CHEMPACK supplies not accessed

Inadequate or exhausted supply in hospital for presenting patients

NOTIFY all CHEMPACK Storage Facilities of exposure through PHEPR Duty Officer, 951-830-8041

PHEPR authorizes CHEMPACK deployment and provides transportation and security escort per protocol.

PHEPR polls area hospitals for antidotes and other resources. PHEPR requests additional CHEMPACK assets according to protocol.

Nearest CHEMPACK storage facility TRANSFERS requested assets to incident site.

Non-impacted storage facilities PREPARE CHEMPACK for access and transport of selected items to requesting hospital/s (standby)

Requesting hospitals and issuing storage facilities ensure tracking and documentation of all movement, use of supplies and submit mandated report/s following incident. Both maintain chain of custody for controlled substances. Issuing storage facilities recover all unused CHEMPACK materiel. PHEPR will arrange replacement of used CHEMPACK assets, if available.

PHEPR will notify the following immediately:
1. RCDOPH Health Officer
2. RDMHS/C
3. CDPH/EPO Duty Officer (after business hours)
4. Riverside County OES who will notify: State Warning Center & State Emergency Operations Center
FIELD CHEMPACK DEPLOYMENT ALGORITHM

INCIDENT

First responders arrive on scene: suspect that a nerve agent is present

ICP estimates number of affected persons and supply need

On scene supplies are sufficient

On scene supplies insufficient for scope of incident

Incident Commander provides estimate of number of victims and requests additional supplies through their local dispatch

If local dispatch unable to provide supplies, local dispatch requests additional supplies through Riverside County Fire Rescue Operational Area Dispatch Center (ECC-Perris) - 951-657-2161

Riverside County Fire Rescue Operational Area Dispatch Center contacts host facility and dispatches resources.

Requested CHEMPACK assets are TRANSFERRED to incident site.

Documentation of supply used is maintained.

Clearly label all unused materiel deployed with date, time and where deployed. Once removed from the CHEMPACK container these materials may not be returned to materials in the Shelf Live Extension Program (SLEP)

RETURN unused deployed CHEMPACK material to Deployment site
# CDHS CHEMPACK Controlled Substance Transfer Form

**CALIFORNIA DEPARTMENT OF HEALTH SERVICE**  
**CHEMPACK CONTROLLED SUBSTANCE TRANSFER FORM**

**Instructions:**  
The delivery agent should verify the type of diazepam - EMT- (single use) or Hospital (multi-use) and the amount, to be transferred, sign for custody, part A below, and transfer the diazepam to the designated location(s). **Hospital (multi-use) packages must be physically received by a staff physician and/or a pharmacist,** part B, C, or D below. EMS materials should be delivered, and physically received by the Person in Charge (PIC) on the emergency scene, part B, C or D.

## PART A - RECEIPT of DIAZEPAM

<table>
<thead>
<tr>
<th>Substance Description</th>
<th>Quantity/Details</th>
<th>Number of Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital- Diazepam 5mg/ml 10 ml vials (25 per box)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS- Diazepam 5mg/ml auto-injector (150 per box)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name & Shield Number of courier __________________ Signature __________________

Date __________________ Time __________________

## PART B - Delivery of Diazepam to Location #1

<table>
<thead>
<tr>
<th>Substance Description</th>
<th>Quantity/Details</th>
<th>Number of Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital- Diazepam 5mg/ml 10 ml vials (25 per box)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS- Diazepam 5mg/ml auto-injector (150 per box)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name & Shield Number of courier __________________ Signature __________________

Date __________________ Time __________________

## PART C - Delivery of Diazepam to Location #2

<table>
<thead>
<tr>
<th>Substance Description</th>
<th>Quantity/Details</th>
<th>Number of Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital- Diazepam 5mg/ml 10 ml vials (25 per box)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS- Diazepam 5mg/ml auto-injector (150 per box)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name & Shield Number of courier __________________ Signature __________________

Date __________________ Time __________________

## PART D - Delivery of Diazepam to Location #3

<table>
<thead>
<tr>
<th>Substance Description</th>
<th>Quantity/Details</th>
<th>Number of Boxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital- Diazepam 5mg/ml 10 ml vials (25 per box)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EMS- Diazepam 5mg/ml auto-injector (150 per box)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Name & Shield Number of courier __________________ Signature __________________

Date __________________ Time __________________
## CHEMPACK TRACKING

### RELEASE AND RECEIPT OF MATERIEL

<table>
<thead>
<tr>
<th>CHEMPACK LOCATION:</th>
<th>Unit Total</th>
<th>Cases Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHEMPACK ID NUMBER:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Release Date:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- ENTIRE CHEMPACK CONTAINER w/all materiel
- Mark 1 auto-injector
- Atropine Sulfate 0.4mg/mL 20mL
- Pralidoxime 1 gm inj
- AtroPen® 0.5 mg
- AtroPen® 1.0 mg
- Diazepam 5 mg/mL auto-injector (See Attached Controlled Substance Transfer Form)
- Diazepam 5 mg/mL vial, 10 mL (See Attached Controlled Substance Transfer Form)
- Sterile water for injection (SWFI) 20 mL Vials

**Received by:** X  
**Print:**

**Agency Name:**

**Phone Number:**

**Released by:** X  
**Print:**

**Name of Agency:**

**Phone Number:**

**Released by:** X  
**Print:**

**Name of Agency:**

**Phone Number:**
PURPOSE
To reduce the morbidity and mortality related to stroke by organizing a system of stroke centers to serve our residents and visitors through preventative education, emergency care, hospitalization, rehabilitation, and research. This critical care system links prehospital and hospital care to deliver optimal treatment to the population of stroke patients.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.107, 1798.150]
California Code of Regulations, Title 22. Social Security, Division 9. Prehospital Emergency Medical Services, Chapter 7.2 Stroke Critical Care System

STROKE RECEIVING CENTER DESIGNATION LEVELS
Acute Stroke Ready Hospital (ASR)
A hospital able to provide the minimum level of critical care services for stroke patients in the emergency department and are paired with one or more hospitals with a higher level of stroke services.

Primary Stroke Center (PSC)
A hospital that treats acute stroke patients and identifies patients who may benefit from transfer to a higher level of care when clinically warranted.

Thrombectomy-capable Stroke Center (TSC)
A stroke center with the ability to perform mechanical thrombectomy for the ischemic stroke patient when clinically warranted.

Comprehensive Stroke Center (CSC)
A hospital with specific abilities to receive, diagnose and treat all stroke cases and provide the highest level of care for stroke patients.

DESIGNATION BY REMSA AS A STROKE CENTER
Initial REMSA Designation as a Stroke Center in the EMS System requires an application, satisfactory site survey and verification of the following:
1. Currently serving in the EMS system as a Prehospital Receiving Center (PRC) or a Base Hospital (BH).
2. Compliance with all standards and requirements listed in this policy.
3. Compliance with all requirements listed in Title 22, Division 9, Chapter 7.2- Stroke Critical Care System, for the requested level of designation.
4. Current certification as an Acute Stroke Ready Hospital, Primary Stroke Center, Thrombectomy-capable Stroke Center, or Comprehensive Stroke Center from one of three CMS-approved accreditation organizations (The Joint Commission (TJC), Det Norske Veritas (DNV) or the Accreditation Commission for Healthcare (ACHC)).
   a. Certification must match the level of stroke center designation.
   b. If certification is in process, the applying hospital shall provide REMSA with a copy of the certification within thirty (30) days of receipt.
   c. Continued designation shall depend on re-certification as specified by the certifying organization and a copy of the renewal certificate shall be provided to REMSA not less than 30 days prior to expiration of current certification.
5. Enrollment and participation in the stroke data management system and commitment to provide additional data as required by REMSA and/or the Stroke System Advisory Committee.
6. Current written agreement with REMSA for designation as a Stroke Center to provide services in Riverside County.

Designation Renewal
1. The Stroke Center may be re-designated after satisfactory review of written documentation and a site survey by REMSA personnel/designees.
2. Re-designation shall occur every three (3) years. REMSA staff will attend and perform Stroke Center audits during one (1) entire Joint Commission, Det Norske Veritas (DNV) or Accreditation Commission for Healthcare (ACHC) site visit within a three-year designation contract cycle.
3. Failure to comply with the criteria outlined in this policy at any time will result in disciplinary action up to and including suspension or rescission of EMS Stroke Center designation.

STROKE CENTER STANDARDS FOR ALL HOSPITALS DESIGNATED BY REMSA AS A STROKE RECEIVING CENTER

Staffing Requirements
1. Stroke Centers shall staff the following positions:
   a. Stroke Program Medical Director:
      i. A board-certified physician in neurology or neurosurgery or another board with sufficient experience and expertise dealing with cerebrovascular disease as determined by the hospital credentialing committee that is responsible for the stroke service, performance improvement, and patient safety programs related to a stroke critical care system.
   b. Stroke Program Manager:
      i. A registered nurse who is designated by the hospital and is responsible for monitoring, coordinating, and evaluating the stroke program.
      1. In the event that an interim Program Manager is needed in the absence of a full-time Program Manager, a nurse from the hospital may be selected to fulfill the obligations and duties of the role for no more than one hundred-eighty (180) days. Should a full-time Program Manager not be assigned by the conclusion of the interim period, REMSA will perform an evaluation of the position and program to ensure compliance with state regulation(s), REMSA policy, and contract language.
   c. Clinical Stroke Team:
      i. A team of healthcare professionals who provide care for the stroke patient and may include, but is not limited to, neurologists, neuro-interventionists, neurosurgeons, anesthesiologists, emergency medicine physicians, registered nurses, advanced practice nurses, physician assistants, pharmacists, and technologists.
   d. Registrar:
      i. One full-time equivalent registrar dedicated to the registry must be available to process the data capturing the California Stroke Registry/Coverdell, GWTG, and REMSA data sets for each 500–750 patients in the registry. This staffing need increases if additional data elements are collected.

Data Collection and Submission
1. Stroke Centers shall:
   a. Participate in the stroke data management system.
   b. Submit data to REMSA via the REMSA approved data collection method and on the schedule agreed upon by the Stroke System Advisory Committee.
   c. Collect additional data as required by REMSA and/or the Stroke System Advisory Committee.

Performance Standards
1. Written EMS policies and procedures shall be revised within thirty (30) days as Continuous Quality Improvement (CQI) determines that changes need to be made to individual policies and shall be reviewed, as a whole, at a minimum of every two (2) years.
2. Stroke Centers must maintain the uninterrupted ability to perform advanced imaging, laboratory services, and treatment capabilities commensurate with the requirements for their level of designation. Imaging, laboratory, and treatment modalities shall be on site and available at all times, except for periods of approved internal disaster.
   a. To ensure uninterrupted services, the following equipment is required:
      i. Primary, Thrombectomy-capable, and Comprehensive stroke centers must have a minimum of two (2) CT scanners and one (1) MRI scanner.
Thrombectomy-capable and Comprehensive centers must have a minimum of two (2) interventional suites capable of performing mechanical thrombectomy and/or neuro-endovascular procedures.

b. In the event that the required capabilities cannot be maintained and an interruption in service occurs, the REMSA Duty Officer must be called immediately.

   i. REMSA does not allow stroke diversions. When a stroke center is placed on “Diversion” in the ReddiNet, their stroke program will be suspended until an evaluation occurs regarding the circumstances that caused the interruption in service. The stroke center will be permitted to continue receiving suspected stroke patients only after a completed evaluation and re-approval by REMSA.

3. Additional performance measures as determined by REMSA and/or the Stroke System Advisory Committee.

4. The stroke center shall establish adequate procedures for self-monitoring and quality control and assurance in compliance with standards in this policy on a continuous basis. Documentation of such efforts shall be made available to REMSA upon request.

Education

1. Provide stroke related continuing education to EMS personnel, the clinical stroke team, and related hospital staff; annually report these activities to REMSA. A minimum of 2 educational events annually is required.

2. Provide stroke education to the public; and annually report these activities to REMSA.

Stroke System Participation

1. Stroke Center representatives shall actively participate as members of the Stroke System Advisory Committee.

2. Stroke Centers shall maintain CMS-approved accreditation equivalent with their level of designation.

3. Compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality, and a disclosure-protected review of selected stroke cases.

Hospital Services / Obligations

   The hospital shall meet the following requirements:

1. The hospital shall have established protocols for stroke services including triage, diagnosis, and stroke team activation following field notification of an inbound suspected stroke patient.

2. The hospital shall have a single call activation system to activate the stroke team directly.

3. The hospital shall have a process in place for the treatment and triage of simultaneously arriving stroke patients.

4. A dedicated audio recorded phone line or radio system, capable of being answered twenty-four (24) hours per day, seven (7) days per week, used by paramedics to notify facility of incoming stroke patients.

   a. Maintain such recordings for a minimum of one (1) year, and use such recordings exclusively for auditing, continuing education and review approved by REMSA.

   b. Maintain a backup recording system in the event that the primary recording system fails.

Reporting Requirements

1. Stroke Center shall notify REMSA in writing of any failure to meet these EMS Stroke Center Standards within 10 (ten) business days.

2. Changes to key Stroke Center personnel shall be reported to REMSA within 10 (ten) business days to include:
   a. Stroke Program Medical Director
   b. Stroke Program Manager
THIS POLICY APPLIES ONLY TO THE TRANSFER OF ACUTE STROKE PATIENTS FROM A REFERRAL HOSPITAL TO A REMSA DESIGNATED STROKE RECEIVING CENTER FOR A HIGHER LEVEL OF CARE. IT IS NOT TO BE USED FOR INTERFACILITY TRANSFER OF PATIENTS.

PURPOSE
To establish standardized care that ensures the rapid transport of a stroke patient from a referral hospital to a stroke receiving center to achieve door-to-needle and/or door-to-intervention in a timely manner.

This policy shall be used for:
• Prehospital providers that are transporting unstable stroke patients to a stroke center but need to divert to the closest receiving center for stabilization before continuing to a designated Stroke Receiving Center.
• Rapid transport of a stroke patient from a referral hospital to the appropriate Stroke Receiving Center.
• Rapid transport of an identified large vessel occlusion stroke patient for higher level of stroke care.

AUTHORITY
California Health & Safety Code, Division 2.5, Sections 1797.220, 1798, 1798.170 and 1798.172

Referral Hospital Responsibilities
1. Stroke receiving centers are required to accept Stroke patients from referral hospitals if a stroke is suspected, confirmed as an acute stroke, or identified as a Large Vessel Occlusion (LVO) with a Last Known Well (LKW) < 24 hours.
2. The decisions on the need for emergency transport of a suspected / confirmed Stroke patient, and mode of transport, will be made by the referral hospital sending physician.
3. To facilitate and expedite the transport of Stroke patients, all Stroke referral hospitals are encouraged to make agreements with REMSA-permitted transport providers capable of transporting Stroke patients to Stroke receiving centers.
4. The Referral Hospital sending physician will notify the Stroke receiving center of the suspected / confirmed stroke patient and the need to re-triage / utilize Stroke continuation of care. The patient’s findings and/or reason for re-triage / continuation of care will be communicated.
   a. The referral hospital will stabilize the patient as clinically indicated and initiate resuscitative measures within their capability when warranted by the patient’s condition.
   b. The referral hospital will not delay transport by initiating unnecessary diagnostic procedures that will not immediately benefit the patient’s condition.
   c. If the referral hospital anticipates the need to utilize this policy, they should advise the transport provider as soon as possible; they are only permitted to hold the transport provider’s unit for twenty (20) minutes.
   d. The referral hospital will provide RN to RN report to the Stroke receiving center.
5. Paramedics may transport patients on REMSA-approved IV drips only. Unless medically necessary, the referral hospital should avoid using medication drips that are outside the paramedic scope of practice to avoid delay.
6. Copies of the medical records, radiologic evaluations, laboratory results, and any supporting documents shall be sent with the patient. DO NOT DELAY TRANSPORT - documents may be faxed or electronically transmitted.
Receiving Stroke Center Responsibilities
1. Stroke receiving centers will accept all referred suspected / confirmed Stroke patients < 24hrs LKW, unless they are on internal disaster.
2. Stroke receiving centers will have a physician immediately available to respond to Stroke patients from referral hospitals. These ED physicians have the authority to accept continuation of care Stroke transfer patients without consulting with the neurologist.
3. Higher level stroke centers are encouraged to meet a thirty (30) minute door-to-needle and/or door-to-puncture time goal.
4. Stroke receiving centers shall notify REMSA of all emergency Stroke patient continuations of care within sixty (60) days.

Transport Responsibilities
1. If an unstable stroke / suspected stroke patient arrives to a referral hospital by ambulance, the referral hospital ED physician may request that the transport provider’s unit remain in the ED and immediately transport the patient once minimal stabilization is completed.
   a. If the transport provider’s Communication Center is not notified directly by the referral hospital, the transport provider’s personnel will advise that they will be performing a continuation of care Stroke transfer.
   b. The referral hospital is only permitted to hold the transport provider’s unit for twenty (20) minutes.
2. Transport personnel shall contact the accepting Stroke Receiving Center en route to provide an update on patient status during transport.
3. Transport personnel shall complete an electronic patient care report (ePCR) for all continuation of care patients.

Procedure for Continuation of Stroke Care Transport
Facilities should have a mechanism in place to bypass their transfer center triage process and route stroke transfers through the emergency department physicians.

GUIDELINES FOR USE OF CONTINUATION OF CARE POLICY
- Less than twenty (20) minutes to complete ALS continuation of care transport
- Less than thirty (30) minutes (door-in / door-out) at non stroke designated referral hospital
- Less than sixty (60) minutes (door-in / door-out) for rapid identification of an LVO at a primary center

1. Once the decision to send the patient to a Stroke Receiving Center has been made, the ED physician at the referral hospital must contact the ED physician at the Stroke Receiving Center.
   a. The ED physician at each Stroke Receiving Center has the authority to accept a stroke patient from another ED without consulting with the neurologist.
2. The referral hospital must contact a REMSA permitted transport service to arrange for the immediate transport of the patient.
   a. Contact a REMSA permitted transport service to arrange for the immediate transport of the patient.
      Utilize the following verbiage to the transport dispatch:
      “This is a stroke continuation of care from (Referral Hospital) to (Stroke Receiving Center).”
   b. When continuation of Stroke care has been initiated, the ground transport ambulance will respond immediately to the requesting facility code 3.
3. A Stroke patient may be transported from a referral hospital to a Stroke receiving center by one of the following as determined by the sending physician to be the most appropriate:
   a. A REMSA permitted ALS ambulance, air ambulance, or Critical Care Transport (CCT).
   b. Current transporting ground ambulance may stand by on premises, not to exceed twenty (20) minutes, for immediate transport of the patient to a Stroke receiving center.
PURPOSE
This policy defines the requirements for a California Department of Public Health (CDPH) licensed general acute care hospital with a CDPH permit to operate a basic or comprehensive emergency medical service to be designated as a Prehospital Receiving Center (PRC) in Riverside County.

AUTHORITY
California Health & Safety Code, Division 2, Chapter 2, Article I, Section 1255.1
California Health & Safety Code, Division 2.5, Chapter 2, Section 1797.67
California Health & Safety Code, Division 2.5, Chapter 2, Section 1797.88
California Health & Safety Code, Division 2.5, Chapter 6, Article 3, Section 1798.170
California Code of Regulations, Title 22, Division 9, Chapter 7, Section 100243

Prehospital Receiving Centers
Initial Designation of a new Prehospital Receiving Center
1. Hospitals applying for initial designation as a PRC must submit an application to the Riverside County EMS Agency (REMSA) along with evidence of compliance to all criteria in this policy.
2. REMSA will review the submitted material, perform a site visit, and meet with appropriate hospital personnel. Following a thorough review, REMSA will provide its findings to the Emergency Medical Care Committee (EMCC) for recommendations for endorsement or denial of endorsement of PRC designation.

Continuing Designation as a Prehospital Receiving Center
1. REMSA shall monitor designated PRC’s compliance with the provisions of this policy. A compliance review will occur one (1) year after the effective date of this policy and then at three (3) year intervals, or more often as deemed necessary by the REMSA Medical Director. PRCs may be required to submit specified written materials to demonstrate compliance with this policy. Site visits may be performed at the discretion of REMSA with or without prior notification for the purposes of verifying compliance with this policy. The PRC will make records and personnel available to REMSA that are pertinent for compliance verification.
2. REMSA will provide its findings to the EMCC for recommendations for endorsement or denial of PRC designation.
3. Final authority for PRC designation rests with the REMSA Medical Director.

Emergency/Temporary Designation as a Prehospital Receiving Center
During EMS surge events such as pandemic flu outbreaks or mass casualty incidents (MCIs) that overwhelm or threaten to overwhelm the patient care capacity of designated PRCs and the EMS system, REMSA may designate temporary PRCs to meet EMS system needs. These may include but not be limited to the following as authorized by the REMSA Medical Director and/or Public Health Officer:
   a. Any hospital within Riverside County
   b. Any activated Field Treatment Site (FTS)
   c. Any activated Alternate Care Site (ACS)
   d. Any medical clinic

Change in Ownership/Change in Executive or Management Staff
Prehospital Receiving Centers will notify REMSA in writing at least 30 days prior to the effective date of any changes in hospital ownership as defined in 42 C.F.R. 489.18 adopted by the Centers for Medicare & Medicaid Services. Any change in hospital service levels as a result of a change in ownership may require re-designation by REMSA. Key personnel...
Changes in chief executive staff, emergency department (ED) management (e.g., ED physician group, nurse manager) will be communicated in writing to REMSA within 10 days of the effective date of the change.

Reduction or Elimination of Services by the Prehospital Receiving Center
Prehospital Receiving Centers considering a reduction or elimination of emergency services must notify the State Department of Health Services and REMSA a minimum of 90 days prior to the planned reduction or elimination of services.

Hospital Licensing and Accreditation
Hospital will notify REMSA in writing if the hospital is found to not be in compliance with regulations applicable to services provided within the scope of being a PRC. If REMSA determines that the non-compliance materially interferes with the ability of the hospital to meet its obligations under this policy or threatens the health and safety of emergency patients, REMSA, subject to the written notice and appeal rights of this policy, will determine whether the hospital may continue to receive 9-1-1 patients during the periods that corrective actions are underway.

Confidentiality
1. Except as required by law, all information obtained by REMSA in the investigation process are treated as confidential matters between REMSA and the PRC.
2. All data and other information submitted by a PRC to REMSA under this Policy for the purpose of monitoring, evaluating, or reporting on the necessity, quality, and level of emergency services, including data or other information under the heading below entitled "Data Collection/Continuous Quality Improvement," shall be subject to California Evidence Code §1157.7, to the maximum extent of the law. REMSA shall establish a committee for the purpose of monitoring, evaluating, or reporting on the necessity, quality and level of specialty health services; in the absence of establishing a committee, REMSA shall be deemed a "committee" within the meaning of California Evidence Code §1157.7. A PRC may enforce California Evidence Code §1157.7, and the protections of California Evidence Code §1157 (as referenced by California Evidence Code §1157.7), with respect to any or all data and other information submitted by a PRC to REMSA under this Policy.

Medical Personnel/Staffing
Medical personnel and staffing shall be maintained to ensure continuous licensure as a general acute care hospital and permitting for basic or comprehensive emergency services.

Disaster Coordinator
1. Each PRC will have a qualified individual designated to serve as a point of contact for medical and health emergency planning and operations, in addition to a designated back-up point of contact.
2. The PRC will participate in medical and health disaster planning and exercises in cooperation with the Department of Public Health.

Participation in EMS System Administration
A designated emergency department staff person and alternate will be responsible for:
1. Coordination of PRC activities with the base hospitals, the Prehospital Medical Advisory Committee (PMAC) and REMSA to include:
   a. Representation at a minimum of one (1) PMAC meetings per year;
      i. This representative can be the PRC ED Medical Director, nurse manager, or designee.
   b. Notification and education of the ED staff on matters discussed at PMAC and EMCC;
   c. Notification of the assigned base hospital prehospital liaison nurse / base hospital medical director and/or REMSA of concerns or identified problems in the EMS system and delivery of care by EMS personnel;
   d. Participation in EMS system-wide training initiatives and operations.
Daily Operations / Interface with the EMS System

Prehospital Receiving Centers will conduct operations necessary to ensure the effective transfer and continuation of care for patients received from the EMS system. This includes but is not limited to the following:

PRCs shall accept any and all patients transported to their facility by authorized prehospital EMS personnel.

1. Ensure all necessary staff, equipment and hospital resources are available 24 hours a day to receive patients from the EMS system and continue emergency medical care.

2. Implement a process utilizing evidence-based practices with a commitment to continuous performance improvement to ensure the timely transfer of patient care from EMS personnel to ED staff and the return to service of 9-1-1 ambulances.
   a. A PRC shall make every effort to accept ambulance patients and free the ambulance to be available to respond to other calls within 30 minutes of arrival at the hospital.
   b. A PRC shall implement processes to work cooperatively with ambulance providers and REMSA staff to return ambulances to service as soon as possible when multiple ambulances are being held in the ED for extended periods of time.

3. A PRC shall agree to follow applicable REMSA protocols, policies and procedures promulgated pursuant to Federal, State and Local laws.

4. Implement procedures for notifying the EMS duty officer of issues and incidents that affect or may affect the EMS system, including but not limited to:
   a. Activation of internal disaster procedures
   b. Safety issues for patients or EMS provider agencies
   c. Disruption of emergency medical care capability or ability to receive patients
   d. Need for hospital evacuation
   e. Disruption in communications capability(ies) with the field, base hospitals or EMSCOM
   f. Excessive delay in transfer of care time leading to the holding of 9-1-1 ambulances

5. Participate in all HA/Bed or other polls as requested by REMSA.

Data Collection/Continuous Quality Improvement

Each PRC will:

1. Complete the REMSA trauma Patient Registry form when indicated and submit to REMSA within 30 days of patient’s arrival at the PRC (applies to non-trauma hospitals only).

2. Designate an ED staff member as the CQI liaison. The CQI liaison’s name and contact information will be provided to REMSA. If the CQI liaison changes, the PRC is responsible for notifying REMSA.

3. Participate in continuous quality improvement activities (e.g., system-wide focused audits, participation on REMSA CQI committees, CA EMSA Core Measures).

4. Collaborate with local EMS response agencies for improvement of patient care and EMS system efficiency.

5. Notify REMSA and/or the assigned base hospital if EMS personnel deviate from REMSA policies, protocols, or standards.

6. Comply with CARES Data collection for the EMS Agency and National CARES database.

7. Provide patient outcome data to REMSA, upon request, for individual patients transported to the PRC for evaluation and treatment. Patient outcome data is to be used internally by REMSA to meet requirements for continuous quality improvement review and EMS system oversight pursuant to Federal, State and Local laws. All data and other information submitted by a PRC to REMSA under this policy for the purpose of monitoring, evaluating or reporting on the necessity, quality and level of emergency services, including data or other information under the heading above entitled "Data Collection / Continuous Quality Improvement," shall be subject to California Evidence Code §1157.7, to the maximum extent of the law.

Prehospital Receiving Center Policies

Prehospital Receiving Centers will have formal policies for the provision of care to all patients received from the EMS system pursuant to all applicable Federal, State and Local laws, regulations and policies governing the credentialing of acute care hospitals and permitting of basic or comprehensive emergency services. Policies will be made available to REMSA upon request.
Notification of Non-Compliance and Corrective Actions
Notification and corrective actions for non-compliance with the provisions of this policy by the PRC may include one or more of the following:
1. The PRC will receive written notice from REMSA outlining specific areas of non-compliance.
2. Other affected entities will receive written notice from REMSA outlining specific areas of non-compliance, any historical issues of non-compliance and potential impacts if the areas of non-compliance go uncorrected.
3. The PRC will formulate a corrective action plan and send the written action plan to REMSA within 30 days of said written notice.
4. Assigned REMSA staff will meet with the PRC’s administration and affected local entities to review the written action plan.

Denial/Suspension/Revocation of Designation as a Prehospital Receiving Center
1. REMSA may deny, suspend, or revoke the designation of a PRC for substantial or uncorrected failure to meet the provisions of this policy as determined by the REMSA Medical Director to ensure patient safety.
2. Prior to taking any action, REMSA shall provide to the PRC written notice of proposed suspension, denial or revocation including the reasons for the proposed action.
3. Denial, suspension, or revocation of PRC designation will include a public report to the EMCC.

Appeal Rights to Hearing
1. A PRC that has been denied approval/designation or has received notice for non-compliance is entitled to appeal and request a hearing before the EMCC.
2. The PRC will be provided an opportunity to present evidence and testimony during the appeal process.
3. The EMCC will hear all evidence and testimony before formulating a recommendation to the REMSA Medical Director.
4. The EMCC recommendation will be by majority vote with the EMCC chair casting the deciding vote in the event of a tie.
5. The final authority to deny, suspend or revoke PRC status rests with the REMSA Medical Director.
PURPOSE
To provide a mechanism for REMSA to evaluate and report on the potential impact on the EMS system due to the reduction or closure of emergency services in hospitals.

AUTHORITY
California Health and Safety Code - Division 2, Chapter 2, Article 5, Section 1300

Hospital Emergency Services Reduction Impact Assessment
Acute care hospitals intending to implement either a reduction or closure of emergency services must advise REMSA as soon as possible, but at least 90 days prior to the proposed change. The notification of change proposal must include:
1. Reason for the proposed change(s).
2. Itemization of the services currently provided and the exact nature of the proposed change(s).
3. Description of the local geography, surrounding services, the average volume of calls.
4. Description of potential impact on the EMS community regarding patient volume and type of prehospital and emergency department services available. A pre/post comparison of services should be included.
5. Description of potential impact on the public regarding accessibility of comparable alternative facilities or services. Include a pre/post comparison.

Evaluation Process
1. Upon receiving notification from a hospital or the California Department of Public Health (CDPH) of a planned reduction or elimination of emergency medical services, all local hospitals, fire departments, and ambulance providers, and all local planning authorities will be notified.
2. Within 30 days of notification, REMSA, in consultation with emergency service providers and planning/zoning authorities, will complete and distribute a draft EMS Impact Evaluation and set a public hearing date. At a minimum, the Impact Evaluation shall include:
   a. Assessment of community access to emergency medical care.
   b. Effect on emergency services provided by other entities.
   c. Impact on the local EMS system.
   d. System strategies for accommodating the reduction or loss of emergency services.
   e. Potential options, if known.
   f. Public and emergency services provider comments.
   g. Suggested/recommended actions.
3. Within 45 days of notification, REMSA will release the draft impact evaluation report to EMS stakeholders for a ten (10) business day comment period. Following the ten (10) day comment period, REMSA will conduct at least one (1) public hearing and incorporate the results of the hearing/s into a final Impact Evaluation. Public hearing(s) may be incorporated with other public meetings held by the Public Health Department, Board of Supervisors and/or other government agencies, commissions, or committees.
4. Within 60 days of receiving notice, REMSA will prepare the final Impact Evaluation, and submit these findings to the CDPH, California EMS Authority, Board of Supervisors, Emergency Medical Care Committee, and all impacted city councils, fire departments, ambulance services, hospitals, planning authorities, local EMS participants and other interested parties.
5. REMSA will serve notice of the public hearing to the community through standard and reasonable efforts (e.g., local newspapers and notices at hospitals) within the affected areas of the County.
6. Within five (5) days of notification of reduction or closure of service(s), the hospital proposing a reduction or closure of service(s) will be charged a $1,500.00 fee by REMSA for the Impact Evaluation.
PURPOSE
To describe the criteria and processes for the diversion of ground and air ambulances in Riverside County.

AUTHORITY
California Health & Safety Code - Division 2.5, Chapter 4, Article 1, Section 1797.220.
California Code of Regulations - Title 13, Division 2, Chapter 5, Article 1, Section 1105 c.

ReddiNet
Hospitals will use the ReddiNet as the primary communication tool to notify the EMS system of ambulance diversions. Please refer to the most current training ([https://www.reddinet.net/support/Home/Videos](https://www.reddinet.net/support/Home/Videos)) and/or the applicable user guide ([https://www.reddinet.net/support/Home/UserGuides](https://www.reddinet.net/support/Home/UserGuides)) for instructions. NOTE: you will need the specific username and password for your facility to access these materials.

Diversion Status Column
Alert Status
- Alert 1 – “Getting Busy” (three (3) or more ambulances on APOD for greater than thirty (30) minutes)
- Alert 2 – “On the verge of ED saturation” (five (5) or more ambulances on APOD for greater than 30 minutes)

Status changes are initiated autonomously, and automatically, through the use of the FirstWatch system. Ambulance diversion due to (Emergency Department) ED saturation is not permitted in Riverside County.

ED Closure
ED closures are initiated when unusual and/or unforeseen events occur, at or within any prehospital receiving center (PRC), that cause a significant disruption in physical plant operations, preventing the ability to treat patients in the ED.

Examples of significant disruptions that will result in an ED closure include but are not limited to incidents involving:
- The safety and/or security of the facility (active shooter(s) and/or the threat of gunfire, bomb threats and/or explosions, etc.)
- A fire
- A hazardous materials exposure
- A disruption or contamination of the facility’s water supply
- A power outage AND a nonfunctional backup generator
- Flooding
- Critical damage to physical infrastructure(s) and/or systems that would impact patient care

The REMSA Duty Officer must be contacted immediately ((951) 712-3342) when any of the events listed above have occurred.

Examples of events that do NOT qualify as significant disruptions in physical plant operations include staffing shortages (immediate, short- or long-term), lack of available inpatient beds, an outage of telephone, internet and/or intranet connectivity (including the inability to use an EHR system, i.e., “downtime”), etc.
**ED Closure and Internal Disaster Declarations**

Any incident or event that occurs within a PRC that:
1. Meets or surpasses that facility's internal policy description of “Internal Disaster” **AND**
2. Would result in a disruption of services so severe that they would be unable to continue to accept walk-in patients for any period of time (i.e., “closing their front doors”)

Will be recognized by REMSA as having also met ED Closure criteria.

With the exception of significant disruptions involving critical damage to physical infrastructure(s) and/or systems that would impact patient care, patients experiencing the following conditions in the field will be transported to the closest ED:
- Unresolved anaphylaxis
- The inability to effectively ventilate with a bag-valve-mask (BVM) (i.e., unmanageable airway)
- Uncontrolled non-traumatic hemorrhage

**Ambulance Diversion Due to Significant Disruption in Physical Plant Operations**

When a PRC’s status in ReddiNet is designated “ED Closure,” patients will be transported to next closest, most appropriate PRC as determined by their preference, clinical needs, and operational requirements.

**Trauma Patient Diversion**

Criteria
1. All trauma surgeons / trauma teams (1st **AND** 2nd on-call) are engaged with patients that meet critical trauma patient (CTP) criteria.
2. All operating rooms are occupied with patients that meet CTP criteria.
3. The CT scanner is inoperable.

**Ambulance Diversion of the Trauma Patient**

When the ReddiNet status of the closest trauma center to an incident is “TRAUMA,” the CTP will be transported to the next closest Level I or Level II trauma center.

When the ReddiNet status of the closest trauma center to an incident is “TRAUMA” with “CT” selected as well, patients with isolated head injuries that meet CTP criteria will be transported to an alternate destination using the following decision-making algorithm:
1. The closest open trauma center within 45 minutes from the initial scene
   a. Consider transport by air ambulance when required
2. The closest, most medically appropriate, facility as directed by the Base Hospital when:
   a. There are no open trauma centers within 45 minutes from the initial scene by ground or air
   b. The ambulance has been diverted from an alternate destination
3. Trauma diversions will be reviewed internally at each trauma center and reported to the Trauma Audit Committee (TAC).

**Specialty Care Patient Diversion**

REMSA does not allow the diversion of specialty care (stroke and/or STEMI) patients.
PURPOSE
To describe the conditional redirection of ambulances from hospitals that have extended Ambulance Patient Offload Delays (APOD) to the closest most appropriate hospital that does not have an extended APOD. Extended APOD is a patient remaining on an ambulance gurney for 90 minutes or greater after arrival at a hospital. This policy is intended to be used in conjunction with REMSA Policy 4109 - Ambulance Patient Offload Delay.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

CRITERIA
Ambulance redirection shall only occur when efforts to offload the patient(s) to a hospital gurney, bed, or chair have failed and the patient(s) remains on extended APOD.

1. Ambulance redirection will activate when extended APOD exists.
2. Ambulance redirection will only apply to ambulances still at the scene, prior to transporting.
3. Ambulance redirection will apply to 9-1-1 paramedic ambulances from any provider.
4. Ambulance redirection will cancel when the extended APOD no longer exists.

PATIENT SAFETY
Ambulance redirection is authorized only for patients that, in the judgment of the paramedic responsible for patient care and consistent with applicable treatment protocols, are stable and can safely be transported to an alternative, closest, most appropriate hospital not presently experiencing extended APOD.

1. APOD ambulances redirection is not permitted after arrival at a hospital.
2. Specialty care patients (trauma, stroke, or STEMI) as defined by policy 5301, 4502, or 4401 will not be redirected by this policy.
3. The decision to redirect ambulances away from a hospital will be made with coordination of the ambulance provider communication center, EMS supervisors, and EMS personnel providing patient care.

PROCEDURES
Prior to activating ambulance redirection, the ambulance provider will verify with the hospital that extended APOD exists. Once extended APOD is confirmed the following procedures will be activated:

1. The affected ambulance provider is authorized to activate ambulance redirection.
2. Patients shall be transported to the closest most appropriate hospital emergency department not presently experiencing extended APOD that is best able to accept and offload patients. Hospitals experiencing extended APOD shall be identified by the ambulance provider communication center in consultation with the affected hospital(s) and other applicable communications centers.
3. Any questions or concerns regarding any hospital’s ability to accept redirected patients should be directed to the REMSA Duty Officer.
4. When ambulance redirection is activated, EMS personnel responsible for patient care must fully inform the patient(s) of the reasons for redirection.
5. When ambulance redirection is activated, EMS personnel shall note “APOD REDIRECTION” within the narrative section of the electronic patient care record (ePCR).
6. Hospitals are encouraged to call the ambulance provider once care of the patient has been transferred to the hospital in order to cancel ambulance redirection.
7. The REMSA Duty Officer shall be notified for unusual occurrences not addressed by this policy.
8. REMSA Ambulance Patient Offload Time reports will include APOD Ambulance Redirection.

**ACTIVATION PROCESS**
To ensure the effective activation of ambulance redirection, it is essential for each extended APOD to be accurately and rapidly confirmed. Extended APODs and EMS personnel impacted by APODs must coordinate as outlined below.

**Confirmation Phase:**
1. Ambulance personnel shall notify their communications center at the beginning of extended APOD.
2. Once notified, the communications supervisor will contact the ED charge nurse to confirm if a true APOD exists; and if so, when would be the projected transfer of patient care.
3. If available, an EMS supervisor should respond to the hospital ED.

**Activation Phase:**
1. Ambulance redirection will activate when one (1) ambulance is on extended APOD.
2. The ambulance provider communications supervisor is required to:
   a. Utilize the ReddiNet Diversion Status board to place the hospital ED on “Redirect”

**Cancellation Phase:**
1. Ambulance redirection will cancel when the extended APOD no longer exists.
2. Ambulance personnel shall notify their communications center at the end of extended APOD.
3. The ambulance provider communications supervisor is required to:
   a. Utilize the ReddiNet Diversion Status board to place the hospital ED on “Open.”
PURPOSE
1. To define the criteria that shall be met by Prehospital Receiving Centers in Riverside County for Base Hospital designation.
2. To define the role of the Base Hospital within the EMS system in Riverside County.
3. To establish operational, medical, and personnel standards for the Base Hospital in Riverside County.

AUTHORITY
California Health & Safety Code - Division 2.5, Chapter 2, Section 1797.58
California Health & Safety Code - Division 2.5, Chapter 5, Section 1798 and 1798.2
California Health & Safety Code - Division 2.5, Chapter 6, Article 1, Sections 1798.100 through 1798.105
California Code of Regulations - Title 22, Division 9, Chapter 4, Article 7, Section 100169
California Code of Regulations - Title 22, Division 9, Chapter 11, Article 1, Section 100390
California Code of Regulations - Title 22, Division 9, Chapter 12, Article 1, Section 100400 through Article 5, Section 100405

Designation
Initial designation
1. Hospitals meeting Title 22 requirements and designated as a Prehospital Receiving Center in Riverside County that are interested in designation as a Base Hospital shall submit a request to the Riverside County EMS Agency (REMSA).
2. REMSA shall evaluate the request and determine the system need for an additional Base Hospital. Hospital shall provide evidence of compliance with all criteria in this policy.
3. REMSA will review the submitted material, perform a site visit, and meet with appropriate hospital personnel.
4. Following a review, REMSA shall provide its findings to the Emergency Medical Care Committee (EMCC) for recommendations on Base Hospital designation.
5. If selected as a Base Hospital, hospital shall have a written agreement as described on page five of this policy (Hospital Policies / Agreements) and shall agree to seek approval as a Riverside County EMS Continuing Education Provider.

Continuing Designation
1. REMSA shall review each designated Base Hospital’s compliance to criteria at least every three years or more often if deemed necessary by the REMSA Medical Director. Hospital shall provide evidence of compliance with all criteria in this policy. A site visit may be performed at the discretion of REMSA.
2. REMSA shall provide its findings to the EMCC for recommendations on Base Hospital designation.

Change in Ownership / Change in Base Hospital Program Management Staff
1. In the event of a change in ownership of the hospital, continued Base Hospital designation will be at the discretion of REMSA.
2. REMSA shall be notified, in writing, within ten (10) days of any changes in the Base Hospital Medical Director and/or the Prehospital Liaison Nurse (PLN).

Suspension / Revocation of designation by REMSA
1. REMSA may suspend or revoke the designation of a Base Hospital for failure to comply with any applicable REMSA policy and procedure, state and/or federal laws.
Base Hospital Obligations

The Base Hospital shall:
1. Maintain approval as a REMSA Continuing Education Provider; offer at least two (2) EMS CE events annually.
2. Notify REMSA immediately any time the Base Hospital is unable to perform the basic functions of a Base Hospital (i.e., Internal Disaster necessitating the closure of the hospital or any part of it, malfunction of communications equipment such that communication with prehospital personnel is no longer possible, no qualified personnel available at the hospital to communicate with prehospital personnel).
3. Participate in research studies as requested and approved by REMSA.
4. Implement procedures for notifying the EMS Duty Officer of issues and incidents that affect or may affect the EMS system, including but not limited to:
   a. Activation of internal disaster procedures.
   b. Safety issues for patients or prehospital providers.
   c. Disruption of emergency medical care capability or ability to receive patients.
   d. Need for hospital evacuation.
   e. Disruption in communications capability with the field, Base Hospital, or the REMSA Communications Center.
   f. Excessive delay in transfer of care time leading to the holding of 9-1-1 ambulances.
5. Participate in all HAvBED or other polls as requested by REMSA.
6. Provide appropriately authorized or certified personnel 24 hours per day in sufficient numbers to provide uninterrupted on-line medical direction.
7. Hospital shall make every effort to accept ambulance patients and free the ambulance to be available to respond to other calls within thirty (30) minutes of arrival at the Hospital.
8. Hospital shall implement processes to work cooperatively with ambulance providers and REMSA staff to return ambulances to service as soon as possible when multiple ambulances are being held in the Emergency Department (ED) for extended periods.

Medical Personnel / Staffing

Base Hospital Medical Director
1. The hospital shall designate a Base Hospital Medical Director who shall be:
   a. A physician in good standing on the hospital staff and licensed in the State of California.
   b. Certified or eligible for certification by the American Board of Emergency Medicine or the Advisory Board for Osteopathic Emergency Medicine.
   c. Regularly assigned to the emergency department, with experience in and knowledge of Base Hospital radio operations and REMSA policies and procedures.
   d. Responsible for functions of the Base Hospital, including the CQI plan as designated by REMSA.
2. The Base Hospital Medical Director or his/her designee shall:
   a. Be responsible for the medical direction and supervision of the prehospital program within the Base Hospital’s catchment area, including review of patient care records and evaluation of personnel.
   b. Establish a continuous quality improvement (CQI) program that complies with the requirements of California Title 22, Division 9, Chapter 12, with REMSA policies, and approved by REMSA.
   c. Review patient care initiated in the field for adherence to REMSA policies, protocols, and procedures.
   d. Maintain ongoing evaluation of EMTs, AEMTs, paramedics and MICNs within the Base Hospital catchment area and making recommendations for performance reviews.
   e. Report deficiencies in patient care to REMSA, including review of patient care records and critique with personnel involved. REMSA shall be notified of unusual occurrences according to the REMSA Policy for the CQI System.
   f. Report any action of licensed/certified prehospital personnel which may potentially constitute a violation under Section 1798.200 of the California Health & Safety Code.
   g. Ensure that at least one (1) Base Hospital Physician (defined below) is on duty 24 hours per day, seven (7) days per week.
   h. Assure that Emergency Department Physicians new to the Base Hospital are provided with a REMSA-approved orientation to the Riverside County EMS system.
i. Attend at least two (2) of Riverside County’s Prehospital Medical Advisory Committee (PMAC) meetings per year.

j. Annually provide a one (1) hour education offering at a base sponsored class.

Base Hospital Physicians
1. Base Hospital Physicians responsible for providing Base Hospital Orders to prehospital personnel and medical direction to Base Hospital MICNs shall:
   a. Have an initial EMS orientation with the PLN or Base Hospital Medical Director prior to being assigned responsibility for providing Base Hospital Orders and medical direction.
   b. Annually attend at least two (2) of Riverside County PMAC meetings, Emergency Medical Care Committee (EMCC) meetings, or attend at least 50% of other internal Base Hospital Emergency Department where minutes and attendance are taken and REMSA topics are presented and discussed.
   c. On an as-needed basis, but at least annually, Base Hospital Physicians working less than 80 hours per month (averaged) must receive an update by the PLN or the Base Hospital Medical Director to review changes in REMSA policies, protocols, and procedures.
   d. The Base Hospital Medical Director may impose additional requirements to fulfill the responsibilities of the Base Hospital.

Prehospital Liaison Nurse (PLN)
Base Hospitals that are also designated as specialty care centers (i.e., STEMI, Stroke and/or trauma) will employ a nurse, on a full-time basis, to fill the role of PLN. “Full-time” is defined as forty (40), or more, hours per week.

1. The Base Hospital shall designate a PLN who shall have experience in, and knowledge of, Base Hospital radio operations and local EMS policies and procedures. The PLN shall assist the Base Hospital Medical Director in his/her duties.

2. The PLN must be a Registered Nurse and must meet all of the following employment and experience qualifications:
   a. Employed full-time, in the Emergency Department, within the Base Hospital.
      i. The role of PLN is time-consuming yet critical; task saturation can happen quickly and frequently if/when duties outside of this role are assigned. REMSA requires that all PLNs remain dedicated to the tasks listed below (#3) and that the assignment of other duties outside of the PLN role occur rarely, if ever.
   b. Current REMSA authorization as a Mobile Intensive Care Nurse (MICN).
      i. A minimum combined experience of three (3) years in any of the following disciplines: emergency department nursing, prehospital EMS, critical care transport, or specialty care program management. One (1) of the three (3) years of experience must be as an MICN in Riverside County.
   c. In the event that an interim PLN is needed in the absence of a full-time PLN, a current MICN from within the base hospital that meets the PLN minimum employment and experience qualifications will be selected to fulfill the obligations and duties of the role for no more than one hundred-eighty (180) days.
      i. REMSA will be notified of changes in PLN staffing within ten (10) calendar days.
      ii. Should a full-time PLN not be assigned by the conclusion of the interim period, REMSA will perform an evaluation of the position and program to ensure compliance with state regulation(s), REMSA policy, and contract language.

3. The PLN shall, in conjunction with the Base Hospital Medical Director:
   a. Act as a liaison with other EMS system participants on behalf of REMSA and the Base Hospital.
   b. Participate in continuous quality improvement activities (e.g., internal base activity audits, system wide audits, participation on REMSA CQI committees and other ad-hoc groups as requested by REMSA, and development of the Base Hospital CQI plan).
   c. Provide CQI rounds, continuing education, and training to EMTs, AEMTs, paramedics, MICNs and Emergency Department staff, based upon identified needs or continuous quality improvement audits, including mandatory education required by REMSA policies, procedures, and protocols.
   d. Select appropriate nursing staff for MICN authorization and ensure that these nurses are prepared for MICN authorization.
   e. Complete competency-based MICN evaluations for all MICN staff once per reauthorization cycle.
   f. Ensure that staff providing base hospital guidance to EMS personnel have current MICN authorization.
g. Notify REMSA of any change in staffing of the hospital, such as PLN, ED Manager, Base Hospital Medical Director, Chief Executive Officer, Chief Nursing Officer, Chief Operating Officer, or Disaster Coordinator within ten (10) days of change.

h. Review selected calls directed by the Base Hospital for compliance with REMSA policies and protocols, medical appropriateness, and documentation. Review shall include, but not be limited to, review of the patient care reports and any audio recordings of such calls.

i. Monitor protocol compliance by field personnel and report deviations from REMSA protocols to the appropriate prehospital provider agency(s) and REMSA.

j. Concurrent evaluation of field personnel. This may include ride-along, mega codes, and scenario-based simulations.

k. Investigate and perform appropriate follow-up with involved personnel for deviations in practice from REMSA protocols and performance standards, with REMSA notification when indicated per the REMSA Policy for the CQI System, in collaboration with other involved organizations.

l. Be responsible for developing an internal policy or process that delineates remedial pathways for MICNs that are disallowed from functioning as an MICN in the hospital.

m. Maintain a file for each MICN (refer to the section: Data Collection / Records).

n. Coordinate with prehospital care providers for presenting reviews/field care audits/Base Hospital meetings a minimum of two times per year per Base Hospital.

Mobile Intensive Care Nurses (MICNs)

1. Base Hospital Emergency Department Registered Nurses assigned to provide Base Hospital Orders shall maintain REMSA authorization as a MICN.

2. At least one (1) MICN shall be on duty and immediately available within the Emergency Department 24 hours/day, seven (7) days/week, to provide Base Hospital orders to prehospital personnel. One (1) MICN per shift shall be the dedicated MICN, a position which will have primary responsibility for providing Base Hospital Orders to prehospital personnel. Additional MICN staffing is necessary to provide back up to the dedicated MICN.

3. MICN shall meet the criteria in MICN Authorization (REMSA Policy 1209) and/or MICN Reauthorization (REMSA Policy 1210).

4. The Base Hospital shall maintain a file for each MICN sponsored by the Base Hospital including:
   a. Evidence of compliance with requirements for MICN authorization per the REMSA Policy for MICN Authorization for the current Base Hospital designation period, as defined by Base Hospital contract.
   b. Unusual occurrences, issues identified through the CQI process
   c. Performance evaluations once per MICN reauthorization cycle.
   d. Other appropriate documentation.

Equipment

The Base Hospital shall:

1. Have and agree to maintain telecommunications equipment, as specified by REMSA, capable of direct voice communication with prehospital personnel.

2. Have and agree to utilize and maintain, computer equipment and data software, as specified by REMSA, for the purpose of data entry and data collection for monitoring EMS activities within the Base Hospital’s scope of responsibility.

3. Record all radio and telephone medical communication directions, maintain such recording for a minimum of one (1) year, and use such recordings exclusively for auditing, continuing education and review approved by REMSA.

4. Have and agree to utilize and maintain, an inter-hospital communications system such as ReddiNet, or other such system approved by REMSA.

5. Equip the Emergency Department with any additional equipment as may be specified by REMSA as it relates to emergency preparedness.

Data Collection / Records

The Base Hospital shall:

1. Adhere to all Federal, State, and County regulations, policies, and protocols concerning the confidentiality of patient/medical records.
2. Complete a Base Hospital log, utilizing a REMSA approved form. Retain the original record as required by applicable state and federal laws.

3. Agree to maintain and provide upon request to REMSA, within sixty (60) days after the end of the preceding month, all relevant data for program monitoring and evaluation of the EMS system. Such data may include, but not be limited to:
   a. ST Segment Elevation Myocardial Infarction (STEMI) data
   b. CARES
   c. Stroke Data
   d. Airship utilization
   e. Volume indicators, such as the total number of Base Hospital contacts, multi-casualty incident (MCI)/ multiple-patient incident (MPI) calls managed by the Base Hospital, or specialty center designation calls (e.g., trauma, STEMI) managed by the Base Hospital.
   f. Core Measures, as required by the state or REMSA
   g. Other data as requested, including copies of Base Hospital reports pertaining to specified incidents.

4. By April 30 of each year, submit to REMSA a list of physicians authorized to provide Base Hospital Orders to prehospital personnel who have been oriented to EMS policies, and the date(s) of such orientation.

5. Actively participate in REMSA’s data system

**Hospital Policies / Agreements**

1. The Base Hospital shall have a written agreement with REMSA indicating the concurrence of hospital administration, medical staff, and emergency department staff to meet the requirements for program participation as specified in Title 22 and by REMSA’s policies.

2. The Base Hospital shall have a continuous quality improvement (CQI) plan, which assists REMSA with monitoring of EMS operations. Such plans shall be approved by REMSA and shall be submitted for re-approval one (1) year after the initial plan has been submitted, then every five (5) years thereafter. An annual update shall be submitted to REMSA, to include but not be limited to:
   a. Indicators monitored
      i. Key findings/priority issues identified
      ii. Improvement action plans/plans for further action
      iii. Follow-up needed, or noted if goals were met
      iv. Recommendations for changes needed in the CQI plan for the coming year
PURPOSE
To establish criteria for approved EMS Fellows to assist paramedic personnel in advanced life support procedures according to REMSA policies & protocols and/or to serve as direct medical control when at the scene of an incident.

DEFINITION
An EMS Fellow is a licensed physician who is participating in an accredited postgraduate EMS Fellowship training program following successful completion of a residency program in emergency medicine.

APPLICATION
This policy applies specifically to REMSA approved physicians currently training as EMS Fellows and does not apply to:
- Physician bystanders on scene who wish to assume medical control OR
- Physicians at the scene who are part of an established EMS response element (i.e., tactical physicians, aeromedical flight teams, Search and Rescue teams, etc.)

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Procedure
- The EMS Fellow will be added to the ePCR as a 3rd crew member.

- The EMS Fellow may perform medical care and procedures at the scene of an emergency.

- The EMS Fellow has the authority to provide on-scene medical direction for procedures and/or medications that are designated as Base Hospital Orders (BHOs) in all REMSA treatment protocols.

- EMS Field personnel may receive and carry out BHOs orders from the EMS Fellow so long as they fall within their scope of practice AND what is currently permitted per the appropriate REMSA treatment protocol.
  - In these instances, the EMS Fellow is acting as an alternate Base Hospital and the catchment Base Hospital does not need to be contacted; however, thorough, and appropriate documentation in the ePCR is required.

- In the event of an MCI / MPI, REMSA policy #3305 (Multiple Patient / Casualty Incident (MPI / MCI) Management) will be followed; the EMS Fellow will act as a support.

Patient Destination
Patient destination is indicated by the patient’s preference, their clinical needs, and the current operational requirements of the EMS system. In all cases, EMS personnel may utilize the EMS Fellow at the scene to collaboratively determine the medically appropriate destination.

Presence of an EMS Fellow at the scene does not excuse prehospital providers from the requirement to notify receiving facilities of their inbound patient. Additionally, early activation / notification is still required when transporting patients to a specialty care center.
PURPOSE
To establish standards for the designation, re-designation, and de-designation, of specialty care centers (Trauma, STEMI, and Stroke) in Riverside county.

AUTHORITY
California Health and Safety Code - Division 2.5, Chapter 6: Facilities [1798.100 - 1798.183.]
California Code of Regulations, Title 22, Division 9, Chapter 7: Trauma Care Systems
California Code of Regulations, Title 22, Division 9, Chapter 7.1: ST-Elevation Myocardial Infarction Critical Care System
California Code of Regulations, Title 22, Division 9, Chapter 7.2: Stroke Critical Care Systems

SPECIALTY CARE SYSTEM ASSESSMENT
The need for additional specialty care centers in Riverside county, regardless of type, shall be assessed by the Riverside County EMS Agency (REMSA). This assessment will include, but not be limited to:
- Geographic location(s) of the proposed specialty care center(s) which will include, at a minimum, appropriateness based on projected population growth
- Prehospital transport time(s)
- Projected patient volume
- Projected impact on existing designated center(s)
- Hospital services available for specialty care

INITIAL DESIGNATION / HIGHER LEVEL CENTER DESIGNATION PROCEDURES
Prior to receiving an application for specialty care designation, the requesting hospital must submit a letter of intent to REMSA. Once reviewed, a specialty care system assessment will be performed within ninety (90) days of the date of the received request.

- Applicants requesting consideration to be designated as a Trauma receiving center in Riverside county must refer to policy #5304 (Trauma Center Standards) for more information regarding designation requirements.
- Applicants requesting consideration to be designated as a STEMI receiving center in Riverside county must refer to policy #5401 (STEMI Center Standards) for more information regarding designation requirements.
- Applicants requesting consideration to be designated as a Stroke receiving center in Riverside county must refer to policy #5701 (Stroke Center Standards) for more information regarding designation requirements.

REMSA approved accreditation/ certification/ verifying programs:

<table>
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<tr>
<th>STEMI</th>
<th>Stroke</th>
<th>Trauma</th>
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<tbody>
<tr>
<td>American College of Cardiology (ACC)</td>
<td>Joint Commission (TJC) OR Det Norske Veritas (DNV) OR Accreditation Commission for Healthcare (ACHC)</td>
<td>American College of Surgeons (ACS)</td>
</tr>
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*Level IV trauma centers must remain in compliance with current ACS standards

If it is determined that the addition of a new or higher level of specialty care service would fill a recognized service gap in that geographical area, the requesting hospital must present a proposal of their program to the appropriate committee (Trauma, STEMI, or Stroke), which will include all relevant data that validates how their program will fill that gap.
1. Following the committee meeting, a recommendation will be made to the REMSA Medical Director.
2. If the requesting hospital’s proposal establishes that they are able to satisfy the needs of the system, they will receive an application for their specialty care program.

Once submitted to REMSA, the application review process will be completed within ninety (90) days. Specialty care center designation may be granted only after the following criteria have been met:
- A system assessment of program gaps
- Recommendation to the REMSA Medical Director from the appropriate specialty care committee(s)
- A satisfactory review of a completed application
- REMSA participation in initial accreditation / certification / verification survey(s)
- Supporting written documentation and
- An initial, and satisfactory, site survey by REMSA personnel

RE-DESIGNATION PROCEDURES
To achieve re-designation as a specialty care center in Riverside County, each specialty care center must:
1. Meet all applicable regulations listed in Title 22, Division 9, for the specific requested program, and the standards and requirements listed in all applicable REMSA policies
2. Successfully pass an audit performed by REMSA
3. Achieve re-accreditation / recertification / reverification by one (1) of the below organizations:

<table>
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</tr>
</tbody>
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*Level IV trauma centers must remain in compliance with current ACS standards

REMSA staff will attend and perform audits during the entirety of all accreditation, certification, or verification surveys. A copy of the renewal certificate will be provided to REMSA no less than thirty (30) days prior to current expiration.

DESIGNATION TERMINATION / SUSPENSION PROCEDURES
Termination for Cause
REMSA may terminate its specialty care center designation agreement with any designated specialty care center if it is determined that they have:
1. Failed to comply with current regulations as outlined in Title 22, Division 9
2. Failed to comply with current REMSA policy as outlined in policies 5304, 5401 and/or 5701
3. Had their license to operate as a PRC revoked or suspended

Suspension of Designation
REMSA may immediately suspend its specialty care center designation agreement with any designated specialty care center upon written notice if it is determined that they:
1. Have failed to cooperate with quality assurance procedures, audit findings and/or recommendations provided by REMSA.
2. Are in gross default of material obligation as specified in their agreement with REMSA.

Failure to remedy the issues identified in #1 and/or #2 above (“Suspension of Designation”) within the time specified by REMSA will result in termination of the agreement for specialty care designation.

Voluntary De-Designation
Any specialty care center may voluntarily terminate their agreement for specialty care services upon thirty (30) days written notice to REMSA.
PURPOSE
To serve as the utilization standard for all patient transfers between acute care facilities within Riverside County.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Interfacility Transfer
Patient transfers between acute care facilities will be completed based upon the medical needs of the patient and through the cooperation of both the sending and receiving facilities in accordance with approved procedures.

- These procedures are suggested for patient transfers from sub-acute and chronic care facilities to acute care facilities.
- These procedures are not necessary for transfers to sub-acute and chronic care facilities.

Procedures
1. Application of Policy and Procedure
   This policy will be utilized for all patient transfers between acute care facilities. This procedure is not a substitute for required transfer agreements. Each facility shall have its own internal written transfer policy that clearly establishes administrative and professional responsibilities. Transfer agreements must be negotiated and signed with facilities that have specialized services not available at the transferring facility. [H&S Code 1317.3(a) and 1317.2(b)]

2. Responsibilities
   Facilities licensed to provide emergency services must fulfill their obligation under California Health and Safety Code to provide emergency treatment to all patients regardless of patient’s ability to pay. Transfers made for reasons other than immediate medical necessity must be evaluated to assure that the patient can be safely transferred without hazard to the patient’s health and without decreasing the patient’s chance for or delaying a full recovery. In these cases, the involved physicians and facilities should generally take a conservative view, deciding in favor of patient safety. [H&S Code 1317.3(a) and 1317.2(b)]

   If a facility does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency exists and shall direct the persons seeking emergency medical care to a nearby facility which can render the needed services, and shall assist in obtaining the services, including transportation services, in every way reasonable under the circumstances. [H&S Code 1317(e)]

   Notwithstanding the fact that the receiving facility or physicians at the receiving facility have consented to the patient transfer, the transferring physician and facility have responsibility for the patient that he or she transfers until that patient arrives at the receiving facility. The transferring physician determines what professional medical assistance should be provided for the patient during the transfer (if necessary, with the consultation of the appropriate EMS Base Hospital Physician). [H&S Code 1317.2(d)]

   The transferring physician has a responsibility to candidly and completely inform the receiving physician of the patient’s condition so that the receiving physician can make suitable arrangements to receive the patient. [H&S Code 1317.2(e)].

   It is the responsibility of the receiving facility, when accepting the patient, to provide personnel and equipment reasonably required in the exercise of good medical practice for the care for the transferred patient, in order to assure continuity of care. [H&S Code 1317.2a(e)]
Standards for Transfers

a. Physicians considering patient transfer should exercise conservative judgment, always deciding in favor of patient safety.

b. If the patient presents to an emergency department, the patient must be examined and evaluated to determine if the patient has an emergency medical condition or is in active labor. If an emergency exists, the emergency department must provide emergency care and emergency services when appropriate facilities and qualified personnel are available.

i. “Emergency services and care” means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of the physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. [H&S Code 1317.1(a)]

Where necessary, the examination shall include consultation with specialty physicians qualified to give an opinion or to render treatment necessary to stabilize the patient. [H&S Code 1317.1(i) and 1317.2(a)]

ii. The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient’s health in serious jeopardy.
2. Serious impairment to bodily function, or
3. Serious dysfunction of any bodily organ or part. [H&S Code 1317.1(b)]

iii. The term “active labor” means labor at a time at which:

1. Delivery is imminent.
2. There is inadequate time to effect safe transfer to another hospital prior to delivery, or
3. A transfer may pose a threat to the health and safety of the patient or the unborn child. [H&S Code 1317.1(c)]

c. Immediate transfer of critical trauma patients – Patients who meet the REMSA trauma triage criteria as outlined in REMSA Policy, Continuation of Trauma Care, may be immediately transferred to a trauma center (Refer to REMSA Policy, EMS System Resource List, for approved trauma centers)

1. Immediate transfer is at the discretion of the examining physician. It is recommended to select the most appropriate, expeditious transport modality available. It may be based on patient condition, availability of surgeon and operating room, but NOT financial factors.
2. Those patients immediately transferred will be audited for both medical care and compliance with this procedure.

d. Immediate transfer of acute STEMI patients – Patients who meet the REMSA STEMI criteria as outlined in REMSA Policy, STEMI Receiving Centers, may be immediately transferred to a STEMI Center (Refer to REMSA Policy, EMS System Resource List, for Approved STEMI Centers)

1. Immediate transfer is at the discretion of the examining physician. It is recommended that the most appropriate and expeditious transport modality available be selected. The mode of transportation may be based on patient condition, availability of cardiologist and cardiac cath. facility, but NOT financial considerations.
2. Those patients immediately transferred will be audited for both medical care and compliance with this procedure.

e. The transferring physician must determine whether the patient is medically fit to transfer and, when indicated, will take steps to stabilize the patient’s condition.

f. No transfer shall be made without the consent of the receiving physician and receiving facility. The receiving facility may designate a physician who may provide consent for both the physician and the facility. It is the responsibility of the receiving physician to inform the transferring physician of the need for additional administrative consent.

g. The patient or the patient’s legal representative must be advised, if possible, of the need for the transfer. Adequate information shall be provided regarding the proposed transportation plans. This process should be documented according to State and Federal requirements. [H&S Code 1317.2(i) and 1317.3(d)]

h. Facilities making transfers of Medi-Cal patients should refer to the California Medi-Cal Stable for Transport Guidelines, which contain the guidelines for transfer outlined by the State of California. Any inconsistent
requirements imposed by the Medi-Cal program shall preempt SB 12 with respect to Medi-Cal beneficiaries. [H&S Code 1317.7]

i. Interfacility Transports for reasons of higher level of care which are life threatening and requiring time critical intervention (non-trauma/non-STEMI), requiring ALS or CCT services, should have a reasonable response time of one (1) hour, in the absence of previously agreed upon contractual obligations. Any response times which may exceed this performance standard shall be communicated by the responding ambulance provider to the transferring facility.

Facility will refrain from activating multiple agencies for a single response. Once the decision to transfer the patient has been reached, every effort should be made to affect the transfer as rapidly and safely as possible. The transferring physician must take into account the needs of the patient during transport and the ability of the transport personnel to care for the patient. Transport personnel are not authorized to, and will not provide, services beyond their scope of practice.

“Appendix A” details the level of service for REMSA EMT’s, paramedics, CCTRN & Air CCTRN. If the patient’s needs are within the scope of practice of an EMT, no interaction with the base hospital is necessary. Paramedic personnel may only deviate from existing REMSA protocols under the direction of a Base Hospital Physician. Initial contact with the transferring physician is approved and recommended in the interest of preserving the continuity of care of the patient. If the patient requires paramedic level of care, the transferring physician may potentially be contacted by the base hospital so that the patient’s care can be coordinated during transport. If the patient’s care needs exceed the scope of practice of the available transport personnel, the transferring physician may utilize CCT or Air transport providers. Alternatively, the transferring physician may arrange for the patient to be accompanied by appropriate facility staff, equipment or supplies necessary for patient care. In these cases, while assisting the M.D. or R.N. with patient care, ambulance personnel must function in accordance with this policy, subsections BLS, ALS, CCT & Air Transfers.

ii. Additional Requirements for Transfer for Non-Medical Reasons:
When patients are transferred for non-medical reasons, the transferring facility must follow all of the above requirements. In particular, the transferring physician must ensure that emergency care and emergency services have been provided and shall determine the transfer would not create a medical hazard to the patient and would not decrease the patient’s chances for or delay the patient’s full recovery. [H&S Code 1317.2]

4. Transfer Procedures
The following are the basic transfer procedures for all patient transfers:
a. Transferring facility:
i. The transferring facility will first provide all diagnostic tests, procedures, and treatment (including, if necessary, consultation) deemed appropriate by the transferring physician.

ii. After determining the need for transfer, the transferring physician will notify the patient or his/her representative, explaining the reason for transfer. This process should be documented according to State and Federal requirements. [H&S Code 1317.3(d)]

iii. The transferring physician will contact and consult the receiving physician. The receiving physician will be advised of all information regarding the patient’s condition, test results, procedures, and current treatment. The patient may be transferred only with the approval of the receiving facility and physician. The receiving facility may designate physicians who may provide consent for both the physician and the facility. It is the responsibility of the receiving physician to inform the transferring physician of the need for additional administrative consent.

If paramedic personnel are requested for the transfer, the transferring physician shall submit written orders designating the precise level of care deemed necessary during the transport. These orders shall be in accordance with accepted REMSA paramedic protocols and policy and within the state-recognized paramedic scope of practice. 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, necessitate contacting the transferring physician (primarily) or base station hospital (secondarily) in accordance with this policy’s subsections: Advanced Life Support Transfers and paramedic transfers with patients with IV lines. The
transferring physician may then be consulted by base hospital personnel to facilitate care by transport personnel.

iv. To request a transport:
   1. Call the appropriate ambulance service directly.
   2. Identify sending and receiving facilities.
   3. Identify sending and receiving physicians.
   4. Provide patient’s name, location, and condition.
   5. Detail the level of care needed (BLS, ALS, CCT, Air, or advise if an R.N. or physician will accompany the patient.

v. The transferring physician and nurse will complete documentation of the medical record. All test results, x-rays, and other patient data, including an appropriate patient transfer form will be copied and sent with the patient at the time of the transfer. If data are not available at the time of transfer, such data will be telephoned to the receiving facility and sent as soon thereafter as possible.

vi. In accordance with JCHO standards, the transferring facility shall provide any relevant patient care information to transport personnel using face-to-face communication. [Joint Commission Resources (2010). National Patient Safety Goal #2: Improving effectiveness of communication among caregivers.]

b. Receiving Facility
   The receiving facility shall instruct its personnel (including physicians, who are authorized to accept patient transfers) on the appropriate procedures for completing transfers.

5. Audit of Transfer Procedures
   All transfers using these guidelines are subject to review. Violations of transfer procedures can result from either clinical or procedural errors on the part of individual facilities and physicians, and/or other parties involved in the transfer process. Examples might include:
   • Inadequate stabilization of the patient by the sending facility.
   • Inadequately qualified transport personnel or equipment.
   • Patient subject to excessive delay in transfer.
   • Patient transferred without documentation or other records as requested by receiving facility.
   • Serious deterioration of the patient’s condition en route.
   • Inappropriate or denial of transfer of patient to another facility.
   • Inappropriate utilization of facility staff to accommodate transport.

6. Procedure for Complaint Review
   It is recommended that complaint reporting shall be performed in accordance with established internal policy & procedures. The receiving facility, and all physicians, other licensed emergency room health personnel, and certified pre-hospital emergency personnel at the receiving facility who know of apparent violations of EMTALA transfer procedures shall and the corresponding personnel at the transferring facility and the transferring facility may, report within one week of the actual or suspected violation to the State Department of Health Services on a form prescribed by the Department of Health Services. The report may be submitted by phone, fax or letter. [H&S Code 1317.4(c)]

State Department of Health Services Licensing and Certification.
Division Circle
464 West 4th Street, Suite 529 5th Floor
San Bernardino, CA 92401
(909) 383-4777

The Department of Health Services shall promptly send a copy of the form to the facility administrator and appropriate medical staff committee of the transferring facility and the Emergency Medical Services Division, unless the Department of Health Services concludes that the complaint does not allege facts which require further investigation, or is otherwise
unmeritorious, or the Department of Health Services concludes, based upon the circumstances of the case, that its investigation of the allegations would be impeded by disclosure of the form. [H&S Code 1317.4]

When two or more persons, each otherwise mandated to report EMTALA violations, have joint knowledge of an apparent violation, a single report may be made by on behalf of the individuals if agreed to by all members. However, any individual who is otherwise required to file a report by the Health and Safety Code who disagrees with the proposed joint report has a right and duty to file a separate report. [H&S Code 1317.4(c)]

**BASIC LIFE SUPPORT TRANSFER**

**PURPOSE**
Define when it is appropriate for the EMT to assist a patient with their medications and/or medical devices.

**Prescribed Medical Devices**

1. When requested, EMTs with appropriate training may assist patients with their own personal pre-prescribed medications and medical devices, limited to:
   a. Epi-pens and epinephrine administration devices, in cases of acute allergic reactions.
   b. Glucometers and penlets.
   c. Home nebulizers and metered dose inhalers (MDIs) of bronchodilators, in cases of bronchospasm and wheezing.
   d. Nitroglycerin tablets or metered dose spray device for patients who have been both diagnosed with heart problems or who are currently experiencing suspected cardiac related pain/discomfort.
   e. Patient-controlled analgesia administration devices.

2. Any assistance given by an EMT shall be based upon the results of a physical assessment performed on the patient as well as an evaluation of the patient’s medical history. All findings and actions will be thoroughly documented.

3. EMTs are to inform patients that any treatment rendered by emergency personnel is of a temporary nature only and should be followed by/with a comprehensive medical examination by a licensed practitioner.

4. EMTs may assist patients with:
   a. Retrieval of medications from storage locations.
   b. Site preparation with alcohol or antiseptic wipes at the direction of the patient.
   c. Loading/preparation of Epi-pens, penlets, glucometer or other devices.
   d. Assisting with the placement and aiming of medication delivery systems.
   e. Application of pressure or bandage.

5. EMTs shall not draw up, measure, mix or solely administer any medications and shall not assist with the administration of medication or medical devices that are not prescribed to the patient. Any medication administered must be clearly labeled and identified as belonging to the patient.

6. In cases of assistance with nitroglycerin tablets or spray, the EMT shall monitor administration to ensure that doses are given at the prescribed times and in the prescribed amounts. If no specific directions are noted on the prescription, the EMT shall ensure that doses are given at five (5) minute intervals and that no more than a total of three (3) doses are given.
   a. Blood pressure will be taken and recorded prior to each dose.
   b. The EMT should not assist with the administration of nitroglycerin when the patient’s blood pressure is < 90 mmHg systolic OR the patient has an altered level of consciousness.

**PURPOSE**
Define the procedure for the transfer and monitoring of patients with invasive tubes and other medical adjuncts.
**EMT Medical Adjunct Monitoring**

1. Nasogastric Tubes (NGTs)
   a. NGTs shall be clamped. No form of suction shall be allowed during transport.
   b. The tube shall be secured to the nose appropriately and shall also be secured to the patient’s clothing to prevent accidental dislodgement or patient discomfort.
   c. Any tubing shall be clamped and no feedings shall be infused during transport to prevent the possibility of aspiration.
   d. Unless contraindicated by medical condition, any patient fed within the last two (2) hours shall be placed on the gurney in semi-fowler’s position to help prevent the possibility of aspiration.

2. Abdominal Tubes - (Gastrostomy tubes, ureterostomy tubes, wound drains, etc)
   a. EMTs shall check that tubes are secured in place in an appropriate fashion, the integrity of the drainage system is intact and drainage bags are emptied prior to transfer, with the time noted. Drainage amount and characteristics shall be noted.
   b. Any tubing shall be clamped and no feedings shall be infused during transport to prevent the possibility of aspiration.
   c. Drainage bags shall be secured to the patient in an appropriate fashion to prevent dislodgement, disconnection or backflow.
   d. Any dressing drainage shall be noted and charted.
   e. Dislodged tubes shall not be reinserted. A clean, dry dressing shall be applied to the site. Time and circumstances of dislodgement shall be noted on the PCR.
   f. Unless contraindicated by medical condition, any patient fed within the last two (2) hours shall be placed on the gurney in semi-fowler’s position to help prevent the possibility of aspiration.

3. Foley Catheters
   a. Catheters shall be checked prior to transfer to assure that the catheter is appropriately secured to the patient, the system is intact and the drainage bag is secured to prevent dislodgement, disconnection and backflow.
   b. Amount and characteristics of urine shall be noted.
   c. If the drainage system becomes disconnected or dislodged during transport, the EMT will clamp the foley if disconnected, but in no circumstances shall the catheter be reinserted if dislodged.

4. Tracheostomy Tubes
   a. Tracheostomy tubes shall be checked to assure they are secured to the patient in an appropriate fashion.
   b. EMTs may suction at the opening only to remove secretions the patient is unable to clear. Amount and characteristic of secretions shall be noted.
   c. If the inner cannula becomes dislodged or is expelled, the EMT shall rinse it in sterile NaCl and gently reinsert it or allow the patient to reinsert it, if capable. Do not force during reinsertion.

**PURPOSE**

To define the procedure for transfers by EMTs with IV lines.

**EMT Transport of Patients with IV Lines**

1. During transfers, a certified EMT may monitor peripheral and long-term venous access lines including, but not limited to, heplocks, Broviacs, Hickmans, Port-a-Catheters and PICC lines, provided the following conditions are met:
   a. A written order signed by the transferring physician is provided to the EMTs, stating that in the opinion of the transferring physician the patient is non-critical and deemed stable for transportation by an EMT staffed ambulance. The written order must include the rate of infusion for the IV fluids and the type of solution infusing.
   b. No medications can be added to the IV fluids prior to or during transport.
   c. The following are the only IV solutions that may be monitored by the EMT during interfacility transports:
      i. D5/Water
ii. D5/0.2 NaCl  
iii. D5/0.45 NaCl  
iv. D5/0.9 NaCl  
v. D5/Lactated Ringers  
vi. 0.9 NaCl (Normal Saline)  
vii. 0.45 NaCl  
viii. 0.225 NaCl  
ix. Ionosol-T  
x. Lactated Ringers  

2. Patients with vascular access lines through shunts or fistulas are not transportable by EMTs.  

3. IV infusions in pediatric patients less than 8 years of age shall be administered with the use of Buretrol, dial-a-flow, mini-infuser or any other such metered infusion to safeguard against the over infusion of IV fluids.  

4. IV sites shall be initially assessed and documented by the EMT. Periodic assessment for signs of infiltration or irritation shall be conducted and recorded.  

5. The EMT may take no action regarding the IV infusion other than to monitor the IV flow rate and turn off the infusion if infiltration occurs.  
a. If infiltration does occur, the EMT shall document signs and symptoms, and actions taken, then notify the receiving center of such on arrival.  

6. Care of lines inadvertently disconnected shall follow standard medical practice, to include site pressure and a dry sterile dressing if the cannula pulls completely out of the skin. If the IV tubing becomes disconnected, but the cannula remains in place, the disconnected tip of the line shall be cleansed with an appropriate germicide and the line reconnected at the original flow rate. Monitor IV site closely for signs of infiltration (reference #4 above). Appropriate written documentation of the incident and a verbal report on arrival will be made.  

ADVANCED LIFE SUPPORT TRANSFERS  

PURPOSE  
To define the procedure for establishing medical control for transfers by paramedics.  

1. The ALS Provider must verify with the receiving facility prior to transferring the patient that the patient transfer has been approved and that the patient is accepted for admission.  

2. The paramedics shall receive patient specific transferring orders from the transferring physician prior to leaving the sending facility. These orders shall be documented in writing as directed by the transferring physician and must include a telephone number where the transferring physician can be reached during the patient transport.  

3. The transferring physician, or designee, shall provide the paramedics with verbal report and written documentation regarding the care provided to the patient. This documentation shall be reviewed by the paramedic prior to the transfer.  

4. The name of the receiving facility and the name of the receiving physician who has accepted the patient shall be provided in the transfer documents.  

5. The paramedic shall monitor the patient during transport and shall document the ongoing assessment on the Prehospital Care Report.
6. The paramedics shall monitor the IV infusions as ordered. Refer to this policy’s subsection paramedic Interfacility Transport of patient with IV lines.

7. The paramedic shall follow the directions of the transferring physician. If there are any questions or problems during transport, the paramedic should attempt to contact the transferring physician. If unable to contact the transferring physician, the paramedic may contact a Riverside County Base Hospital.

8. Paramedics may not transport patients who are being treated with procedures, medications and/or IV solutions which are outside of the paramedic scope of practice as defined by Title 22 and the Riverside County EMS Agency; nor may any such transfer orders, either written or verbal, be initiated. Excluded procedures include, but are not limited to, monitoring arterial lines and/or pulmonary artery catheters. Such transports may be done if a Registered Nurse (RN), qualified to provide such care, is available to accompany the patient who shall monitor and provide care to the patient during the transport. The RN should function pursuant to the Nurse Practice Act and the standardized procedures approved by the employing hospital.
   a. If the patient is receiving a medication which is outside the paramedic’s scope of practice, but that medication is being delivered either by dermal patch, implant or patient controlled pump, the paramedic can accept the patient for transfer without the removal or discontinuance of the medication.

9. Procedures that may be performed include any of the Advanced Life Support skills as defined in the Riverside County EMS Agency Protocol, Policy, and Procedure Manual and any additional skills that the EMS Agency has approved for a provider’s specialty transfer program. This includes but is not limited to: monitoring chest tubes that are connected to water sealed drainage, heplocks, and utilizing patent pre-existing vascular access devices as the transferring physician authorizes, including the administration of emergency medications through devices such as indwelling subclavian catheters (e.g., Hickman, CVP catheters). This shall be done in consultation with the transferring physician.

**Paramedic Transport of Patients with IV Lines**

1. During transfers, an accredited paramedic may monitor peripheral and long-term venous access lines including, but not limited to, heplocks, Broviacs, Hickmans, Port-a-Catheters and PICC lines, provided the following conditions are met:
   a. A written order by the transferring physician is provided to the paramedics, stating that, in the opinion of the transferring physician, the patient is non-critical and deemed stable for transportation by a paramedic staffed ambulance. The written order must include the rate of infusion for the IV fluids and the type of solution infusing.
   b. The following are the only IV solutions that may be monitored by the paramedic during interfacility transports:
      i. D5/Water
      ii. D5/0.2 NaCl
      iii. D5/0.45 NaCl
      iv. D5/0.9NaCl
      v. D5/Lactated Ringers
      vi. 0.9% NaCl (Normal Saline)
      vii. 0.45 NaCl
      viii. 0.225 NaCl
      ix. Ionosol-T
      x. Lactated Ringers
   c. The following medicated IV infusions are the only ones that may be monitored by the paramedic during interfacility transports:
      i. Intropin (Dopamine)
      ii. Isoproterenol (Isuprel)
      iii. KCl of < 40mEq/1000cc
      iv. Morphine Sulfate
      v. Xylocaine HCL (Lidocaine)
2. IV sites shall be initially assessed and documented by the paramedic. Periodic assessment for signs of infiltration or irritation shall be conducted and recorded.

3. Paramedic interventions will be performed under the medical direction of the transferring physician or Base Hospital physician, either directly or through pre-signed “Standing Orders”. Refer to this policy’s subsection Advanced Life Support Transfers.

CRITICAL CARE TRANSFER

PURPOSE
To state the requirements for Critical Care Transport (CCT) units meeting all local, county, Riverside County Emergency Medical Services Agency (REMSA) and state requirements.

1. Request for program approval must be made in writing ninety (90) days prior to the anticipated starting date of service to the REMSA Administrator and include:
   a. Proposed identification and location of the CCT unit
   b. All procedures and protocols
   c. Documentation of qualifications for the Physician Advisor
   d. Documentation of qualifications for the Clinical Coordinator
   e. Quality Assurance plan
   f. Agreement to comply with all REMSA policies and procedures

2. Within twelve (12) working days of receiving the applicant’s request for approval, REMSA will notify the applicant of any further documentation requirements.

3. The applicant shall be notified in writing within thirty (30) days of receipt of complete package of the approval or denial of program.

4. Definition: A CCT unit shall be defined as minimally meeting Riverside County Ambulance Ordinance 756 CCT Transport unit staffing requirements and may include staffing such as physicians, mid-level providers (Registered Nurse Practitioner or Physician Assistant) in-lieu or in adjunct to Registered Nurse. Critical Care Transport Paramedic may be an adjunct team member.

5. Minimum requirements for Registered Nurse personnel:
   a. RN with current unrestricted licensed to practice in the State of California.
   b. At the CCT provider’s option, an RN may be employed by the CCT ambulance provider or be a contract employee
   c. Current American Heart Association BLS, ACLS and PALS or PEPP certification. One of the following courses will be required within 6 months of hire: Trauma Nurse Core Curriculum (TNCC), Advanced Trauma Care for Nurses (ATCN) or Prehospital Trauma Life Support (PHTLS).
   d. A minimum of two (2) years full time experience as RN AND either two (2) years of full time ICU/ED experience OR two (2) years of full-time experience as a CCTRN with a CCT provider in the previous three (3) years prior to employment with the CCT ambulance provider.
   e. Successful completion of an in-house orientation program related to REMSA protocol and procedures and as approved by REMSA, additional training, continuing education, tailored to the CCT-RN specific job description and scope including but not limited to basic and advanced airway management commensurate with Advanced Life Support (ALS) level of care.
   f. Needle Cricothyrotomy will remain an option for each agency.
   g. Certification in any of the following is desirable but not required: Certified Emergency Nurse (CEN); Certified Critical Care Registered Nurse (CCRN); Certified Transport Registered Nurse (CTRN); Mobile Intensive Care Nurse (MICN); Neonatal Resuscitation Provider (NRP).
   h. Continuing education requirement documentation:
      i. Maintain current California State RN license, BLS, ACLS and PALS or PEPP certification.
On-going training and competencies for low frequency and high-risk skills will be based on the individual provider’s CCT scope of practice and standardized procedures. However, REMSA reserves the right to review.

6. Equipment
   a. In addition to the items required by California Administrative Code, Title 13, the ambulance provider shall provide, at a minimum, the following equipment:
      i. BLS equipment and supplies per REMSA Policy for Drug and Equipment List.
      ii. Cardiac monitor with external pacemaker/defibrillator, 12 lead, SPO2, and capnography capabilities.
      iii. Infusion pump(s).
      iv. Portable ventilator.
      v. Back-up power source (Inverter).
      vi. Each CCT unit shall have equipment and supplies commensurate with the scope of practice for the medical personnel. This requirement may be fulfilled through the utilization of appropriate kits (pack/cases), which must be removed if the vehicle is being utilized for BLS transport purposes.
      vii. CCT providers shall ensure that transport personnel are thoroughly trained in the safe operation of all patient care equipment utilized on board the CCT unit.
      viii. Nothing in this policy is intended to limit a CCT provider agency from utilizing or maintaining additional equipment or medications on board the CCT unit, as long as patient care personnel are fully trained on the safe and effective use of that equipment or medication.

7. Physician Advisor
   a. Physician Advisor: A full or part-time physician licensed in the State of California and qualified by training and experience with recent, within the last five (5) years, practice in emergency or acute critical care medicine. The REMSA Medical Director must approve the candidate for physician advisor. The duties of the physician advisor shall include but not be limited to:
      i. Sign and approve, in advance, all medical protocols to be followed by the CCT personnel.
      ii. The CCT provider agency physician advisor shall ensure that all nursing/medical staff on a CCT collectively possesses the skills and knowledge to provide a level of care commensurate with the specific and anticipated needs of the patient. The CCT provider agency physician advisor shall be accountable for all medical procedures performed by provider agency staff.
      iii. Ensure the quality of patient transfers being conducted by the provider agency, including familiarity with COBRA (Consolidated Omnibus Budget Reconciliation Act) and EMTALA (Emergency Medical Treatment & Active Labor Act).
      iv. The CCT provider agency physician advisor shall ensure that a comprehensive, written quality assurance (QA) and quality improvement (QI) program or Performance Improvement Program (PIP) is in place to evaluate the medical/nursing care provided to all patients. This QA/QI or PIP program shall integrate with the countywide prehospital QA/QI or PIP program. Any incidents that result in a negative patient outcome shall be reported to the REMSA Medical Director according to the timeline defined in REMSA policy for the CQI System.
   b. Clinical Coordinator: A provider shall have a Clinical Coordinator who minimally meets the requirements of Section 5 and has a minimum of one (1) year full time experience in ambulance transports.
      i. The Clinical Coordinator may function as the Respiratory Care Practitioner (RCP) Coordinator in conjunction with the Transport Physician Advisor.
      ii. Duties of the CCT Clinical Coordinator include:
          1. Sign and approve, in advance, all nursing procedures to be followed by the RN.
          2. Oversee ongoing training for all medical personnel involved.
          3. Ensure quality of patient transfers being conducted by the provider by conducting patient care audits.

8. Procedure/Protocols
   a. Each company providing Critical Care Transport units shall develop and maintain procedures for the hiring and training of personnel and vehicle staffing
   b. Each provider must develop a manual to include the following:
      i. Malpractice insurance coverage.
ii. Identity and accessibility of the Physician Director and Clinical Coordinator.

iii. Vehicle inventory lists.

iv. Copies of all related inter-facility transfer paperwork.

v. The identity of the Transport Physician Advisor, the CCT Clinical Coordinator, and RCP Coordinator (if applicable). The EMS Agency shall be notified in writing of any changes of these key personnel.

vi. A description of the procedure for contacting the Transport Physician Advisor, CCT Clinical Coordinator and RCP Coordinator if needed during a patient transport.

vii. Statement of Responsibility of the sending physician for the patient during transfer in accordance with COBRA and EMTALA laws.

viii. Narcotics:

1. Physician Order Form for Narcotics (DEA 222)
2. Waste procedure
3. Turnover procedure
4. Storage of Narcotics
5. Usage documentation
6. Discrepancy procedure
7. Copy of the Physician Advisor’s DEA License.

9. Quality Assurance
   a. Submit to REMSA a quality improvement plan.
   b. All CCT providers shall conform to REMSA policy, the CQI System.
   c. Periodic staff conference on audits of Patient Care Reports and outcomes are required in order to improve or revise protocols.
   d. Records of all these activities shall be kept by the provider and be made available for inspection and audit by REMSA.
   e. REMSA shall perform periodic on-site audits of records to ensure compliance with this policy.

**AIR MEDICAL TRANSFER**

**PURPOSE**
To state the requirements for air (rotor wing) medical staffed units meeting all local, county, Riverside County Emergency Medical Services Agency (REMSA) and state requirements.

1. Request for program approval must be made in writing ninety (90) days prior to the anticipated starting date of service to the REMSA Administrator and include:
   a. Proposed identification and location of the air medical staffed unit
   b. All procedures and protocols
   c. Documentation of qualifications for the Physician Advisor
   d. Documentation of qualifications for the Clinical Coordinator
   e. Quality Assurance plan
   f. Agreement to comply with all REMSA policies and procedures
   g. Provide and maintain proof of full accreditation by the Commission on Accreditation of Medical Transport Services (CAMTS) Certification

2. REMSA will notify the applicant in writing within twelve (12) working days following receipt of request for approval if any further documentation is needed.

3. The applicant shall be notified in writing within thirty (30) days of receipt of complete package of the approval or denial of program.

4. Minimum requirements for air medical personnel:
   a. RN currently unrestricted licensed to practice in the State of California.
b. At the air medical provider’s option, an RN may be employed by the air medical provider or be a contract employee.

c. Current American Heart Association BLS, ACLS, NRP and PALS /PEPP certification. One of the following courses will be required within 6 months of hire: Trauma Nurse Core Curriculum (TNCC), Advanced Trauma Care for Nurses (ATCN) or Prehospital Trauma Life Support (PHTLS).

d. A minimum of four (4) years of experience in emergency department or critical care unit in the past five (5) years before working as a flight nurse in Riverside.

e. Successful completion of an in-house orientation program related to REMSA protocol and procedures and as approved by REMSA, additional training, continuing education, tailored to the flight nurse specific job description and scope including but not limited to basic and advanced airway management commensurate with Advanced Life Support (ALS) level of care.

f. Needle Cricothyrotomy will remain an option for each agency.

g. Certification in any of the following is desirable but not required: Certified Emergency Nurse (CEN); Certified Critical Care Registered Nurse (CCRN); Certified Transport Registered Nurse (CTRN); Mobile Intensive Care Nurse (MICN); Certified Flight Registered Nurse (CFRN).

h. Continuing education requirement documentation:
   i. Maintain current California State RN license, BLS, ACLS, NRP and PALS or PEPP certification.
   ii. On-going training and competencies for low frequency and high-risk skills will be based on the individual provider’s air transport scope of practice and standardized procedures. However, REMSA reserves the right to review.

5. Equipment

a. In addition to the items required by California Administrative Code, Title 13, the ambulance provider shall provide, at a minimum, the following equipment:
   i. BLS equipment and supplies per REMSA Policy for the Drug & Equipment List. (This may have to be revised – Air exemption)
   ii. Cardiac monitor with external pacemaker/defibrillator, 12 lead, SpO₂, and capnography capabilities.
   iii. Infusion pump(s).
   iv. Portable ventilator.
   v. Back-up power source (Inverter).
   vi. Each air transport unit shall have equipment and supplies commensurate with the scope of practice for the medical personnel. This requirement may be fulfilled through the utilization of appropriate kits (pack/cases).
   vii. Air transport providers shall ensure that transport personnel are thoroughly trained in the safe operation of all patient care equipment utilized on board the air transport unit.
   viii. Nothing in this policy is intended to limit a air transport provider agency from utilizing or maintaining additional equipment or medications on board the air transport unit, as long as patient care personnel are fully trained on the safe and effective use of that equipment or medication.
   ix. Air provider’s list.

6. Physician Advisor

a. Physician Advisor: A full or part-time physician licensed in the state of California and qualified by training and experience with recent, within the last five (5) years, practice in emergency or acute critical care medicine. The REMSA Medical Director must approve the candidate for physician advisor. The duties of the physician advisor shall include but not be limited to:
   i. Sign and approve, in advance, all medical protocols to be followed by the RN.
   ii. The air transport provider agency physician advisor shall ensure that all nursing/medical staff on an air transport unit collectively possess the skills and knowledge to provide a level of care commensurate with the specific and anticipated needs of the patient. The air transport provider agency physician advisor shall be accountable for all medical procedures performed by provider agency staff.
   iii. The air transport provider agency physician advisor shall ensure that a comprehensive, written quality assurance (QA) and quality improvement (QI) program or Performance Improvement Program (PIP) is in place to evaluate the medical/nursing care provided to all patients. This QA/QI or PIP program shall integrate with the countywide prehospital QA/QI or PIP program. Any incidents that result in a negative patient outcome
shall be reported to the REMSA Medical Director according to the timeline defined in REMSA policy, the CQI System.

b. Clinical Coordinator: A provider shall have a Clinical Coordinator who meets the requirements of Section 4 and has a minimum of one (1) year full time experience in air medical transports.
   i. Duties of the air transport Clinical Coordinator include:
      1. Sign and approve, in advance, all nursing procedures to be followed by the RN.
      2. Oversee ongoing training for all air medical personnel involved.
      3. Ensure quality of patient transfers being conducted by the provider by conducting patient care audits.

7. Procedure/Protocols
   a. Each company providing air medical staffed Critical Care units shall develop and maintain procedures for the hiring and training of nursing personnel and helicopter staffing.
   b. Each provider must develop a manual to include the following:
      i. Malpractice insurance coverage.
      ii. Identity and accessibility of the Physician Director and Clinical Coordinator.
      iii. Helicopter inventory lists.
      iv. Copies of all related inter-facility transfer paperwork.
      v. The identity of the air transport Physician Advisor and the air transport Clinical Coordinator. The EMS Agency shall be notified in writing of any changes in these key personnel.
      vi. A description of the procedure for contacting the air transport Physician Advisor or air transport Clinical Coordinator if needed during a patient transport.
      vii. Statement of Responsibility of the sending physician for the patient during transfer in accordance with COBRA and EMTALA laws.
      viii. Narcotics:
         1. Physician Order Form for Narcotics (DEA 222)
         2. Waste procedure
         3. Turnover procedure
         4. Storage of Narcotics
         5. Usage documentation
         6. Discrepancy procedure
         7. Copy of the Physician Advisor’s DEA License.

8. Quality Assurance
   a. Submit to REMSA a quality improvement plan.
   b. All air medical providers shall conform to REMSA policy for the CQI System.
   c. Periodic staff conference on audits of Patient Care Reports and outcomes are required in order to improve or revise protocols.
   d. Records of all these activities shall be kept by the provider and be made available for inspection and audit by REMSA.
   e. REMSA shall perform periodic on-site audits of records to ensure compliance with this policy.
APPENDIX A
This appendix is provided to give facilities a general guideline of the provider’s capabilities.

<table>
<thead>
<tr>
<th>IV FLUID &amp; MEDICATION ADMINISTRATION AND MONITORING</th>
<th>BLS</th>
<th>ALS</th>
<th>CCT</th>
<th>Air</th>
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<td>ACLS Medications</td>
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<td>Blood/Blood Products</td>
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<td>Isoproterenol (Isuprel)</td>
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<td>KCl of &gt; 40 mEq/1000 cc</td>
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<td>Lactated Ringers</td>
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<td>Morphine Sulfate</td>
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<td>Nutritional IV</td>
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<td>Capnography (Continuous CO2 monitoring)</td>
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<td>Combitube (insertion)</td>
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<td>Automatic External Defibrillation*</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cardioversion</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>ECG (monitoring)</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>ECG (12-lead) (initiate and interpret)</td>
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<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Hemodynamic Monitoring</td>
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<td>No</td>
<td>Yes</td>
<td>Yes</td>
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<td>IABP or Intra-Aortic Balloon Pump</td>
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<td>No</td>
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<td>Manual Defibrillation</td>
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<td><strong>CARDIOTHORACIC MONITORING AND PROCEDURES</strong></td>
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<td>Chest Tube Insertion*</td>
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<td>Chest Tube to Suction</td>
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<td>Chest Tube to Water Seal</td>
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<td>Needle Thoracostomy (initiate)</td>
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<td>Pericardiocentesis*</td>
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<td><strong>CATHETER / TUBE ACCESS AND MONITORING</strong></td>
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<td>Abdominal Tube (G-tube, J-tube, Peg, JP, etc.)</td>
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<td>Foley Catheters</td>
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<td>Nasogastric Tube (Clamped)</td>
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<td>Yes</td>
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<tr>
<td>Nasogastric Tube (Suction Required)</td>
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<td>Orogastric Tube (Clamped)</td>
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<tr>
<td>Orogastric Tube (Suction Required)</td>
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<td><strong>NEURO / CRANIAL MONITORING</strong></td>
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<td>ICP or Intracranial Pressure Lines</td>
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<td>OTHER PROCEDURES AND MONITORING</td>
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<td>Air</td>
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<td>Blood Glucose Monitoring (Capillary)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Escharotomy* (monitoring)</td>
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<td>Fetal Monitoring (External)</td>
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<td>No</td>
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<td>Wound Vac</td>
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PURPOSE
To describe the continuous quality improvement (CQI) system, the responsibilities of the County of Riverside EMS Agency (REMSA), the responsibilities of each major EMS provider agency or service, and the incident review process.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

The Continuous Quality Improvement (CQI) System
The County of Riverside EMS Agency (REMSA) has established and will continue to facilitate a system wide CQI program to monitor, review, evaluate and improve the delivery of prehospital care services. The program involves all system participants and includes, but is not limited to, the following activities:
1. Prospective - designed to prevent potential problems.
2. Concurrent - designed to identify problems or potential problems during the course of patient care.
3. Retrospective - designed to identify potential or known problems and prevent their recurrence.
4. Reporting/Feedback - CQI activities will be reported to REMSA in a manner to be jointly determined by system participants. As a result of CQI activities, changes in system design may be made.

Agencies will conduct an annual review of their CQI plan and submit all prospective updates to REMSA for approval prior to implementation, but no later than December 31 of the same year. Section VI of the CQI Plan (Annual CQI Update) will be due by January 31.

EMS Continuous Quality Improvement Leadership Team (CQILT)
CQILT is an open group and participation is encouraged for all EMS stakeholders who participate in a CQI role. Responsibilities of the CQILT include:
1. Attendance at CQILT meetings. If a representative is unable to attend a meeting, he or she is responsible to have a replacement to represent his/her agency.
2. Prepare and follow-up as appropriate for CQILT meetings.
3. Disseminate the information discussed at CQILT meetings to the represented group.
4. Maintain responsibility for monitoring, collecting data on, reporting on, and evaluating state and locally required and optional EMS System indicators from the EMS providers and hospitals within the jurisdiction of the Riverside County EMS Agency.
5. Identify and develop Riverside County EMS specific indicators for system evaluation.
6. Re-evaluate, expand upon, and improve local and state required EMS system indicators annually or as needed.
7. Prepare plans for improving the Riverside County EMS Agency's CQI program.
8. Establish a mechanism to incorporate input from EMS provider advisory groups for the development of performance improvement plan templates.
9. Recommend the chartering of Quality Task Forces and review of their reports.
10. Seek and maintain relationships with all EMS participants.

The EMS CQILT meets quarterly according to a planned agenda. Results from indicators are reviewed and either continued or retired. New indicators are selected by the committee based on identified trends. Data from indicators decided upon by REMSA and CQILT are required from all providers and Base Hospitals. Prehospital Receiving Centers (PRCs) are strongly encouraged to participate in QI committees and in data collection. One of the primary functions of the CQILT is Root Cause Analysis (RCA). All system data and information is passed to the CQILT who performs an RCA. Once that is completed, the issue is passed to a specific group (Stroke System Committee, STEMI System Committee,
MCI Group, HEMS, TAC, etc.) to more fully investigate the issue. Once the group has reached consensus on the issue their recommendations are passed back to the CQILT. Outputs of the CQILT include, but are not limited to, data for reporting on REMSA.US.

REMSA makes a distinction between system issues (“common cause”) and individual issues (“special cause”). REMSA looks at the system first to identify a system event and data is used to identify the differences between the two. REMSA stores the data collected on each incident as “special cause” could potentially be an early herald of a “common cause” issue. REMSA always looks at a first event as an early herald of failure for the system.

**REMSA Responsibilities**

**Prospective Responsibilities**
1. Comply with all pertinent rules, regulations, laws, and codes of Federal, State, and County applicable to emergency medical services.
2. Coordinate prehospital CQI committee(s).
3. Plan, implement, and evaluate the emergency medical services system including public and private agreements and operational procedures.
4. Implement advanced life support systems
5. Approve and monitor prehospital training programs.
6. Certify/authorize/accredit prehospital personnel.
7. Establish policies and procedures to assure medical control which may include dispatch, basic life support, advanced life support, patient destination, patient care guidelines, and quality assurance guidelines.
8. Facilitate implementation by system participants of required CQI plans.
9. Design reports for monitoring identified problems and/or trends analysis.
10. Approve standardized corrective action plans for identified deficiencies in prehospital and base hospital personnel.
11. Monitor other systems for trends and plans.
12. Conduct disaster planning and coordination.
13. Monitor procedure(s) for informing all system participants of system changes.

**Concurrent Responsibilities**
1. Site visits to monitor and evaluate system components.
2. On call availability for unusual occurrences, including but not limited to:
   a. Mass Casualty Incidents (MCIs).
   b. Ambulance diversion.
   c. Disasters and major incidents.

**Retrospective Responsibilities**
1. Evaluate the process developed by system participants for retrospective analysis of prehospital care.
2. Evaluate identified trends in the quality of prehospital care delivered in the system.
3. Establish, monitor, and evaluate procedures for implementing the Incident Review Process for prehospital emergency medical personnel.
4. Collect, aggregate, and develop reports based on data submitted by providers and hospitals.

**Reporting/Feedback**
1. Evaluate submitted data from system participants and make changes in system design as necessary.
2. Provide feedback to system participants when applicable or when requested on CQI issues.
3. Design prehospital research and efficacy studies regarding the prehospital use of any drug, device or treatment procedure where applicable.
4. Regularly publish reports developed from data submitted by providers and hospitals.
EMD Provider Responsibilities
The EMD Provider will establish a CQI program.

A CQI program will address structural, resource, and/or protocol deficiencies as well as measure compliance to minimum protocol compliance standards as established by the EMD Physician Advisor through on-going random case review for each emergency medical dispatcher.

The CQI process will:
1. Monitor the quality of medical instruction given to callers including on-going random case review for each emergency medical dispatcher and observing telephone care rendered by emergency medical dispatchers for compliance with defined standards.
2. Conduct random or incident specific case reviews to identify calls/practices that demonstrate excellence in dispatch performance and/or identify practices that do not conform to defined policy or procedures so that appropriate training can be initiated.
3. Review EMD reports, and/or other records of patient care to compare performance against medical standards of practice.
4. Recommend training, policies, and procedures for CQI.
5. Perform strategic planning and the development of broader policy and position statements.
6. Identify Continuing Dispatch Education (CDE) needs.
8. Comply with reporting and other quality assessment requirements as specified by REMSA.

EMD case review is the basis for all aspects of CQI in order to maintain a high level of service and to provide a means for continuously checking the system. Consistency and accuracy are essential elements of EMD case review.

1. Critical components of the EMD case review process:
   a. Each CQI program will have a case reviewer(s) who is:
      i. A currently licensed or certified physician, registered nurse, physician assistant, paramedic, AEMT or EMT, who has at least two (2) years of practical experience within the last five (5) years in pre-hospital emergency medical services with a basic knowledge of emergency medical dispatch, and who has received specialized training in the case review process; or
      ii. An emergency medical dispatcher with at least two (2) years of practical experience within the last five (5) years, and who has received specialized training in the case review process.
   b. The case reviewer will measure individual emergency medical dispatcher performance in an objective, consistent manner, adhering to a standardized scoring procedure.
   c. The regular and timely review of a pre-determined number of EMD calls will be utilized to ensure that the emergency medical dispatcher is following protocols when providing medical instructions.
   d. Routine and timely feedback will be provided to the emergency medical dispatcher to allow for Improvement in their performance.
   e. The case reviewer will provide compliance-to-protocol reports at least annually to the EMD Physician Advisor to ensure that the EMD Provider Agency is complying with their chosen Emergency Medical Dispatch Protocol Reference System (EMDPRS) minimum protocol compliance standards, and agency policies and procedures.

BLS Provider Responsibilities
Prospective Responsibilities
1. Participation on committee(s) as specified by REMSA.
2. Education
   a. Orientation to EMS system.
   b. Continuing education activities to further the knowledge base of the field personnel.
   c. Participation in certification courses and the training ofprehospital care providers.
   d. Establish procedure for informing all field personnel of system changes.
   e. Ensure attendance at skills proficiency demonstration sessions as required by the REMSA Medical Director.
3. Evaluation - Develop criteria for evaluation of field personnel to include, but not be limited to:
a. Patient Care Report (PCR) or other documentation if available.
b. Direct observation.
c. Evaluation of new employees.
d. Routine annual performance evaluations.
e. Problem-oriented.
f. Design corrective action plans for individual first responder deficiencies.

Concurrent Activities
1. Establish a procedure for evaluation of personnel utilizing performance standards through direct observation.
2. Provide availability of field supervisors and/or CQI liaison personnel for consultation/assistance.

Retrospective Analysis
1. Develop a process for retrospective analysis of field care, utilizing the PCR or other available documentation (if applicable), to include but not be limited to:
   a. Low Frequency – average less than 20 uses annually per EMT/paramedic.
   b. High Risk Skills – Improper technique can cause harm to the patient.
   c. Problem-oriented.
   d. Those calls requested to be reviewed by REMSA or other appropriate agencies.
   e. Specific audit topics established through REMSA or CQILT.
2. Develop performance standards for evaluating the quality of care delivered by field personnel through retrospective analysis.
3. Participate in the incident review process.
4. Comply with reporting and other CQI requirements as specified by REMSA.
5. Participate in prehospital research and efficacy studies requested by REMSA or other quality assessment committees.

Reporting/Feedback
1. Develop a process for identifying trends in the quality of field care.
2. Submit reports as specified by REMSA.
3. Design and participate in educational offerings based on problem identification and trend analysis.
4. Make approved changes in internal policies and procedures to comply with REMSA policies.

ALS Provider Responsibilities
Prospective Responsibilities
1. Participation on committee(s) as requested by REMSA.
2. Education.
   a. Orientation to the EMS system.
   b. Field Care Audits.
   c. Participate in continuing education courses and the training of prehospital care providers.
   d. Offer educational opportunities based on problem identification, job scope and trend analysis.
   e. Establish procedure for informing all field personnel of system changes.
3. Evaluation - develop criteria for evaluation of individual paramedics to include but not limited to:
   a. Patient Care Report review/tape review or other documentation as available.
   b. Direct observation.
   c. Evaluation of new employees.
   d. Routine annual performance evaluation.
   e. Problem-oriented.
   f. Design corrective action plans for individual EMT and paramedic deficiencies.

Concurrent Activities
1. Establish a procedure for the evaluation of paramedics utilizing performance standards through direct observation.
2. Provide availability of field supervisors and/or CQI liaison personnel for consultation/assistance.
Retrospective Analysis
1. Develop a process for retrospective analysis of field care, utilizing PCRs, audio tapes, or other applicable documentation, to include but not limited to:
   a. Low Frequency – average less than 20 uses annually per EMT/paramedic.
   b. High Risk Skills – Improper technique can cause harm to the patient.
   c. Problem-oriented.
   d. Those calls requested to be reviewed by REMSA or other appropriate agencies.
   e. Specific audit topics established through REMSA or CQILT.
2. Develop performance standards for evaluating the quality of care delivered by field personnel through retrospective analysis.
3. Participate in the incident review process.
4. Comply with reporting and other CQI requirements as specified by REMSA.
5. Participate in prehospital research and efficacy studies requested by REMSA or other CQI committees.

Reporting/Feedback
1. Develop a process for identifying trends in the quality of field care.
   a. Submit reports as specified by REMSA.
   b. Design and participate in educational offerings based on problem identification and trend analysis.
   c. Make approved changes in internal policies and procedures to comply with REMSA policies.

Base Hospital Responsibilities

Prospective Responsibilities
1. Participation on committees as specified by REMSA.
2. Education
   a. Field care audits.
   b. Continuing education activities to further the knowledge base of the field and base hospital personnel.
   c. Offer educational programs based on problem identification, job scope, and trend analysis.
   d. Participation in certification courses and the training of prehospital care providers.
   e. Establish procedures for informing all base hospital personnel of system changes.
   f. Establish criteria for offering supervised student clinical experience to field personnel.
3. Evaluation - develop criteria for evaluation of individual base hospital personnel to include but not be limited to:
   a. Base hospital run sheets/tape review.
   b. Evaluation of new employees.
   c. Routine annual performance evaluation.
   d. Problem oriented.
   e. Design corrective action plans for individual MICN or base hospital physician deficiencies.
4. Authorization - establish procedures, based on REMSA policies, for MICNs regarding:
   a. Initial authorization.
   b. Maintaining authorization.
   c. Reauthorization.
   d. Challenge process.

Concurrent Activities
1. Provide on-line medical control for field personnel within the REMSA approved scope of practice.
2. Develop a procedure for identifying problem calls.
3. Develop internal policies regarding base hospital physician involvement in medical control according to REMSA policies and procedures.
4. Develop a procedure for obtaining patient follow-up when requested by REMSA.
5. Develop performance standards for evaluating the quality of on-line medical control delivered by the MICNs and the base hospital physicians through direct observation by the base hospital liaison personnel.
Retrospective Analysis
1. Develop a process for retrospective analysis of field care and base direction utilizing the base hospital run sheet, audio tape, PCR, and patient follow-up, to include but not be limited to:
   a. Low Frequency – average less than 20 uses annually per EMT/paramedic.
   b. High Risk Skills – Improper technique can cause harm to the patient.
   c. Problem-oriented.
   d. Those calls requested to be reviewed by REMSA or other appropriate agencies.
   e. Specific audit topics established through REMSA or other CQI committees.
   f. Review of ALS non-transport with base hospital contact.
2. Develop performance standards for evaluating the quality of medical control delivered by the MICNs and base hospital physicians through retrospective analysis.
3. Evaluate medical care delivered by prehospital care providers based on performance standards through retrospective analysis.
4. Perform audits on calls as required by Title 22, California Code of Regulations, and REMSA policy.
5. Participate in the incident review process.
6. Comply with reporting and other CQI requirements as specified by REMSA.
7. Participate in prehospital research and efficacy studies requested by REMSA or other CQI committees.

Reporting/Feedback
1. Develop a process for identifying trends in the quality of medical control delivered by base hospital MICNs and base hospital physicians.
   a. Submit reports as specified by REMSA.
   b. Design and participate in educational offerings based on problem identification, scope of practice and trend analysis.
   c. Make approved changes in internal policies and procedures to comply with REMSA policies.
2. Participate in the process of identifying trends in the quality of field care delivered by EMS personnel.
PURPOSE
The purpose of this policy is to define the counseling and remediation parameters associated with the review, processing, and adjudication of unusual occurrences. Use of the online Policy 7102 Reporting Form (found here: https://forms.office.com/g/yAMDeLNq1S) to submit incidents is mandatory.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22. Social Security, Division 9, Chapter 12 - EMS System Quality Improvement

DEFINITIONS
Reporting Party
The individual, agency, or organization that first discovers, or becomes aware of, an occurrence.

Coordinating Party
The organization responsible for coordinating the review of occurrences. If the personnel involved are from:
- An ALS provider agency AND a base hospital (BH): The BH will be the coordinating party.
- An ALS provider agency only: The ALS provider agency will be the coordinating party.
- Any non-ALS provider agency or non-base hospital: REMSA will be the coordinating party. When necessary, REMSA may assign the review to an appropriate coordinating party.

Designated Agent
The individual within a coordinating party who is responsible for participating in the review of an occurrence.
- For EMTs and paramedics: The Designated Agent will be the CQI Coordinator within the individual’s organization.
- For MICNs, BH physicians (BHP), and other BH personnel: The Designated Agent will be the Prehospital Liaison Nurse (PLN).
- All other parties: The Designated Agent will be the employers’ CQI Coordinator. In the event that the organization does not have a CQI Coordinator, or an equivalent, REMSA will act as the Designated Agent.

Occurrence
An incident or event in which any Federal, State, or local law, or any REMSA policy or protocol was violated, either intentionally or unintentionally. Occurrences are identified by level of severity, which include the following:

Level A
a. Identified occurrence(s) not meeting the criteria listed below (Level B), where education/remediation is necessary to mitigate the root cause of the occurrence.

Level B
a. Non-compliance with treatment protocols or policies with or without the potential for patient harm.
b. Care rendered or ordered outside scope of practice as defined by REMSA policies and procedures.

Based on its severity and confounding circumstances, REMSA may choose to assign an occurrence to a higher or lower level than what is described above.

Occurrence Review Process
Level A
1. The Coordinating party receiving the initial report will forward it to their Designated Agent.
2. The Designated Agent will notify the involved personnel of a Level A occurrence. A copy of the notification is to be kept by the Coordinating party. Additional copies may be sent to other involved agencies as needed.
a. The notification will include information regarding the incident as well as clear articulation of the cause(s) for concern. Involved personnel will be required to submit all requested documentation within fourteen (14) calendar days. The documentation must be kept by each agency participating in the occurrence review.

3. If no response is received within fourteen (14) days, a second request will be sent.

4. If no response to the second request is received within fourteen (14) days, REMSA may be notified for assistance.

5. Review of responses, and decisions regarding case disposition, will be performed by the Designated Agent.
   a. A BH Physician (BHP) and/or provider agency Physician Advisor may be involved in Level A occurrences and may collaborate with Designated Agent, if/when necessary.

6. In all cases, the coordinating party is responsible for concluding the review.

Level A – Counseling / Remediation
- The Designated Agent may involve a BHP and/or provider agency Physician Advisor in the counseling and remediation process of Level A occurrences.
- Expectations of specific remediation will be clearly defined.
  o Documentation of Level A occurrences will be kept with the Designated Agent for each agency involved.

Level A – Loop Closure
Loop closure and feedback will be provided by the Designated Agent via email, letter, and/or phone call to the involved parties after the review process is complete. Once all involved parties have been notified, the Designated Agent will complete the report process by submitting the occurrence to REMSA using the online Policy 7102 Reporting Form (here: https://forms.office.com/g/yAMDeLNq1S).

Level B
1. The party discovering the occurrence will be considered the Reporting Party. Notification to REMSA’s CQI Coordinator, as well as the Designated Agent within the involved personnel’s organization, is required within five (5) business days by phone, email, AND online submission form (here: https://forms.office.com/g/yAMDeLNq1S). Each coordinating party will submit all supporting documents listed below.

2. Only one (1) occurrence review report needs to be submitted; this should be done by the Designated Agent. Occurrence reviews cannot be initiated unless (when applicable) all items below have been provided.

3. Final occurrence reviews will be conducted by REMSA. The occurrence process may include but not be limited to review of pertinent medical records including the ePCR, BH log ePCR, crew and staff narratives, BH voice recordings, etc. A formal interview with involved personnel to review the facts may be arranged through the involved personnel’s Designated Agent if requested by REMSA.

4. REMSA may ask for additional documentation to support the occurrence review process.

5. The statute of limitations for each identified problem is one (1) year, or more, based on the individual agency’s policies.

Supporting documents
Pre-Hospital reporting:
1. Narrative(s) from all crew members involved
2. Dispatch recordings, if applicable
3. Dispatch log of events
4. Remediation/education delivered (Record(s) of Conversation, summations, PIP, CEP, or equivalent)
5. BH recording, if applicable to the review

Hospital reporting
1. BH voice recording(s)
2. BH log notes
3. Hospital ePCR
4. MICN or RN narrative(s)
5. MD dictation, if applicable
6. Documentation of remediation/education that was delivered (Record(s) of Conversation, summations, PIP, CEP or equivalent)

**Level B – Counseling / Remediation**

- Terms of counseling and/or remediation (as applicable) for Level B occurrences are decided on a case-by-case basis, only after the fact-finding phase has been completed.
- All Level B occurrences may be subject to peer-review by a subcommittee of the CQI Leadership Team (CQILT), including at least one (1) Prehospital Liaison Nurse.
- The Designated Agent will develop disposition recommendations following final review of a case. These recommendations will be forwarded to, or discussed with, the REMSA EMS Specialist, Medical Director, or RN in the form of a formal Record of Conversation, summation, or clinical performance plan. The final disposition decision will be made by the REMSA Medical Director.

- The disposition(s) of Level B occurrences may include but not be limited to:
  - Case review and counseling with a focused quality assessment evaluation to monitor performance. The evaluation period will last for six (6) months.
  - Refresher didactic courses for remediation, which may include topic-oriented research, case scenarios, etc.
  - Supervised field care audit(s) and/or clinical time with a written outcome summary.
  - Development of an in-service training or written paper based on a specific topic, clinically reviewed.
  - ePCR review with a written outcome summary.

- Written educational plans will include but not be limited to:
  - Identification of concerns and associated educational objectives, as well as timelines for completion of each.
  - Consequences for failing to comply with or meet the identified educational objectives.
    - Involved personnel will be required to sign an acknowledgement of the counseling, recommendations, and/or remediation plan they are expected to follow.

Failure to comply with, or successfully complete, counseling/remediation plan(s) may result in the coordinating party / Designated Agent requesting that REMSA initiate administrative or disciplinary action(s) against the provider’s certification / accreditation / authorization, in accordance with REMSA Policy #1301 (Discipline and Enforcement - http://www.remsa.us/policy/1301.pdf). Potential outcomes may include denial, probation, a temporary suspension order (TSO) and/or revocation of a provider’s certification / accreditation / authorization.

**Loop Closure**

Loop closure and feedback will be provided by the Designated Agent via email, letter, and/or phone call to the involved parties after the review process is complete.
PURPOSE
This policy sets the minimum requirements for data collection & reporting, initiation, completion, reconciliation, review, distribution, and retention of patient care records. Each first response agency and/or transport service provider may adopt additional internal requirements based on their administrative and operational needs. Any / all additional requirements shall not supersede or replace any elements required by REMSA.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22, Chapter 4, Article 8, and Section 100170

System Requirements
The Elite platform was built for a variety of devices. REMSA recommends using or procuring devices, operating systems and browser combinations that have already been tested, and are currently supported, by ImageTrend, Inc. prior to deployment and use.

It is the responsibility of each agency utilizing the Elite platform to ensure that all minimum required hardware and software needs are met. System requirements can be found here.

Data Collection & Reporting
The ImageTrend Elite system shall be the sole approved electronic patient care record (ePCR) platform for capturing incident response and patient care data by all first response and ground transport programs in Riverside county. Any / all modifications to data elements and/or the user interface shall be evaluated by the ePCR Workgroup, and approved by REMSA, prior to implementation. Doing so allows each program’s data to be pooled for county-wide analysis, quality improvement processes, and research.

All data collected will be validated and reported to the California EMS Authority database using the California EMS Information System (CEMSIS). Additionally, the information collected may be used for the improvement of public health and Department of Social Services programs, to obtain grant funding, to assist with Coroner cases, etc. throughout Riverside county.

Technical alerting and syndromic surveillance activities may be conducted by REMSA for the purposes of overall EMS system enhancement.

Initiation of ePCR
An ePCR must be initiated by each EMS provider, for every EMS response, regardless of patient disposition.
- When two (2) or more apparatus / units from the same EMS provider are dispatched, the EMS field personnel with the highest level of certification from each separate apparatus / unit are required to initiate and complete an ePCR.
- When two (2) or more apparatus / units from different EMS providers are dispatched, the EMS field personnel with the highest level of certification from each separate apparatus / unit from each agency is required to initiate and complete an ePCR.

The ePCR must accurately and completely document the patient response, and care provided, while including all required information. Additionally, the ePCR must comply with NEMSIS 3.4 or 3.5 as determined by REMSA policy.
Prehospital providers will only document assessments and procedures that were performed, and/or medications that were administered, by personnel within their own organization with one (1) exception: in the event that CPR is performed, or medications are administered by laypersons prior to first responder arrival, providers will document those procedures and/or medications in the applicable ePCR fields as those lay persons are not participants in the organized EMS system.

In the case of an MCI / MPI incident, a minimum of one (1) ePCR must be completed by the first responder agency, with the required ICS form(s) or worksheet(s) attached within the ePCR.

Students are not permitted to participate in completing the ePCR; it must be completed by the licensed or certified provider(s) directly participating in the patient encounter.

**Completion of ePCRs**
All created ePCRs must be completed and uploaded to the ImageTrend server with a validation score of 100. Any record with a validation score of 98 or less will be considered incomplete and will be subject to review and reconciliation to address deficiencies.

ePCRs from both the transport agency and the first response agency (if applicable) must be completed and posted to the ImageTrend server within two (2) hours of completion of the response.
- ePCR upload requirements may be delayed due to an emergency response; however, submission must be completed as soon as possible but no later than the end of the shift when the patient contact occurred.

**Record Reconciliation**
All prehospital system participants will develop and maintain reconciliation reports in conjunction with an associated program to account for missing and incomplete ePCRs.

Within 24 hours of notification, paramedics will be required to complete missing and/or incomplete ePCRs, unless they are off duty. In those instances, paramedics will have until the end of their next scheduled shift to complete missing and/or incomplete ePCRs.

Reconciliation of missing and/or incomplete ePCRs shall be part of an agency’s CQI activities and will be reported to REMSA in the manner and frequency as determined by REMSA.

**Record Review**
All first response and ground transport programs, hospitals, and REMSA, will review ePCRs as required by the Riverside County EMS System Quality Improvement Program and associated policies.

Utilization of the ImageTrend Elite CQI Module shall be the only REMSA approved method for record review. Manual paper-based review systems are not compliant with this policy.

**Record Distribution & Retention**
Any record contained in the Riverside EMS Information System (REMSIS) version of Elite may be made available to system participants (prehospital/hospital) for shared patients through established practices when that system participant has a clinical need related to direct patient care or if / when required by the Riverside County EMS System Quality Improvement Program and associated policies.

All Patient care records shall be securely retained for at least seven (7) years, or for two (2) years after the patient reaches the age of majority (18 years of age), whichever is longer. Privacy will be protected by compliance with the Health Insurance Portability and Accountability Act (HIPAA).
PURPOSE
To identify standards for the authorized access and security of the Riverside County Emergency Medical Services Information System (REMSIS) for the purposes of data collection, data submission, and data analysis. REMSIS refers to the centralized EMS data system and repository to which all electronic patient care data is collected, submitted, stored, and analyzed. This policy shall apply to all cases of access and utilization of any component of REMSIS.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Data Rights and Utilization
1. Each organization submitting data to REMSIS shall retain access rights to their own data.
2. EMS Provider organizations utilizing REMSIS shall have access to their own data for the purposes of CQI, billing, statistical analysis, operational use, and data submission to REMSA.
3. Base Hospitals shall have access to and may utilize REMSIS for the provision of medical direction and CQI.
4. Hospitals accessing REMSIS shall only have access to patient care data for those patients transported to their facilities.
5. REMSA shall have access to all data submitted into REMSIS for regulatory purposes, including but not limited to: CQI, statistical analyses, and data submission to the State EMS Authority.
6. REMSA shall redirect information requests, such as subpoenas, to the applicable organization upon receiving such a request.

Types of User Permission Groups
1. User permission groups for provider organizations:
   a. Provider – This type of access is for field providers who will be utilizing REMSIS to complete electronic PCRs in the field. Users at this level will only be able to create and edit electronic PCRs. Examples of users at this level are the EMTs and paramedics working on an ambulance or fire apparatus.
   b. Service reports – This type of access is for provider organization personnel who will need access to their organization’s data for analytics. This level of access is able to run existing reports on data but may not create custom reports. This level of access will not generate electronic PCRs.
   c. Service QA/QI – This type of access is for provider organization personnel who will need to perform advanced or custom analytics on their organization’s data. This level of access is able to create custom reports in addition to running existing reports. This level of access may not generate electronic PCRs.
   d. Service billing – This type of access is for provider organization billing personnel who will need access to their organization’s data for billing purposes. This level of access is able to run existing reports on data but may not create custom reports. This level of access will not generate electronic PCRs.
   e. Service admin – This type of access may view all data owned by the respective organization and perform all tasks granted to the previous three levels of access. The Service Admin may also create and edit user accounts for authorized users at the Service Staff, Service Report, and Service QA/QI levels.
2. User permission groups for hospitals:
   a. Hospital Hub user – This type of access is for hospital staff members who may only view the hospital dashboard and print electronic PCRs for their respective facility.
   b. Hospital Hub reports – This type of access is for hospital staff members who need to run existing reports on patient care data for patients transported to their facility.
c. **Hospital Hub admin** – This type of access is for the designated administrator(s) at each hospital who shall create and maintain user access of the previous two types.

3. Use permission groups for training institutions:
   a. **Student** – This type of access is for currently enrolled EMS students to create demonstration electronic PCRs to facilitate an introduction to REMSIS as well as data collection during designated training periods (e.g., field or clinical internships).
   b. **Training program admin** – This type of access is designated for the administrator(s) at each training institution who shall verify student user accounts during designated enrolled training periods.

**Authorization of Access**

1. Each organization utilizing any component of REMSIS shall designate one (1) individual as the primary administrator and at least one (1) different individual as the secondary administrator for that organization. The administrators shall have access to their organization’s data and shall serve as the point of contact for REMSIS-related communications between their organization and REMSA. The administrators shall issue and maintain non-administrator access for all other personnel within their organization as appropriate.
2. REMSA shall issue and maintain administrative user access to REMSIS and will audit authorized administrative users annually, and as needed, for system QA/QI.
3. Any user found to have been inactive within REMSIS for a period exceeding 180 days shall have their access temporarily suspended until their respective organization’s administrator officially notifies REMSA that the user is still authorized to access the system.
4. Provider organization shall officially notify REMSA to initiate or terminate administrator access.

**Data Security and Privacy**

1. Each person authorized to access any portion of REMSIS shall maintain a unique password which may not be shared with any other person.
2. Each agency or organization which collects, utilizes, or transmits patient care data in any fashion shall comply with all local, State, and Federal laws pertaining to such activities, including but not limited to the Health Information Portability and Accountability Act (HIPAA) and the California Confidentiality Medical Information Act (CMIA).
3. Each agency or organization which collects, utilizes, or transmits patient care data in any fashion shall implement electronic security measures to protect the data from unauthorized access, including but not limited to the password protection and encryption of all electronic devices used to interface with REMSIS.
4. Each agency or organization which collects, utilizes, or transmits patient care data in any fashion shall implement a data security plan, including but not limited to:
   a. HIPAA and CMIA compliance procedures and policies
   b. Electronic data capture device security procedures and policies
5. All employees accessing any device connected to REMSIS shall receive initial and annual training in data security and protection of patient health information.
6. Each agency or organization utilizing any component of REMSIS shall immediately notify REMSA of any suspected or actual breach of data security or integrity. A breach includes but is not limited to:
   a. Suspected or actual unauthorized access of data systems
   b. Theft or loss of electronic or non-electronic media containing information that could lead to unauthorized access of data systems
   c. Theft or loss of electronic or non-electronic media containing protected health information as defined by HIPAA and/or CMIA
   d. Suspicious or unusual activity discovered on, in, or around hardware able to access REMSIS
PURPOSE
To define the standards and requirements for design and use of the Continuous Quality Improvement (CQI) module embedded within the Riverside EMS Information System (REMSIS) Elite ePCR system. The CQI module will be used by all EMS providers and Riverside county Base Hospitals (BH) to allow for concurrent, and retrospective, data analysis in accordance with REMSA policy #7701 (Patient Care Records).

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Definitions
Agency Administrator: CQI Coordinator, or individual in a leadership role, that monitors CQI activities within an agency.

Base Hospital CQI group: A permission group that allows Paramedic Liaison Nurses from Riverside county BHs to conduct CQI activities on pre-defined and agreed upon categories of incidents where a patient was transported to their hospital or they were utilized as a BH for online medical direction.

CQI Category: Grouped incidents that share specific characteristics based on predefined criteria. Criteria can include disease etiology, injury patterns, etc. and will be defined as indicators in any REMSA based CQI plan.

CQI Rule: A functionality within the REMSIS CQI module that allows the end user to determine if expected documentation needs are met based on specific, predefined criteria. This is accomplished through logic statements (i.e.: “if… then… else…” ) and can be developed for Patient Level care or individual / agency performance. This will be attached to any CQI category or indicator defined in a REMSA based CQI plan.

CQI Question: A question defined by the end user that fits any format of answer (i.e.: Numeric, Alphanumeric, Textbox, Single Select, Multi-select, and decimal). These questions, once answered, can be used to create observational feedback that can be used for loop closure, targeted education, and/or aggregated data for system metrics.

Inbox / Message: An 1157-compliant messaging utility available to all ImageTrend Elite users to receive messages contained within the REMSIS system specifically for the purposes of CQI feedback. These are to be regularly reviewed and acknowledged by both CQI personnel and providers.

Individual Level Measure: A CQI rule defined to measure individual / agency performance within a two-tiered EMS response system. This measure can be based on provider, or operational, documentation regardless of patient care.

Patient Level Measure: A CQI rule defined to measure and validate patient level care within a two-tiered EMS response system. This type of measure is used to evaluate the care that a patient receives from multiple EMS participants during a single incident.

Provider – Peer Review: A permission group that allows select personnel, usually a training officer or other qualified provider, to conduct concurrent and /or retrospective CQI activities. Peer review permissions will be based on already established categories of review.
REMSA CQI Staff: A permission group comprised of REMSA personnel that are tasked with monitoring concurrent and retrospective CQI activities within the REMSIS Elite System.

Naming Convention
The CQI Module contained within REMSIS will adopt a unified naming convention. This will allow for ease of navigation and assist with overall aggregation, and subsequent reporting activities, on system wide CQI activities which may include optional agency based CQI categories.

1. CQI Category names will follow the naming convention used in the California Core Measures. This will begin with the numerical year followed by the name of indicator and finally the number location where the measure falls in the REMSA CQI Plan. The description of the category will be contained within the entire title, measure and description as defined by the CQI Plan Indicator sheet.
   a. Ex: 2021 – Tra-1
   b. Once indicators have been retired, either by CQI Plan revision or CQILT directive, the category will be inactivated – but not deleted – within the system.
   c. Once the calendar year has ended, that specific category will be retired. If the indicator is to be continued during the following calendar year, it will be copied and renamed to reflect the current calendar.
      i. Ex: On 01/01/2022, 2021 – Tra-1 would become 2022 – Tra-1

2. CQI Category questions will include: Prefix of category name that the question relates to.
   a. Ex: RhCAR – Was the RHeaRT medication Protocol used?
   b. Once questions have been retired, either by CQI Plan revision or CQILT directive, the questions will be inactivated – but not deleted – within the system.

REMSA Responsibilities
Concurrent
1. Development of REMSIS CQI rules consistent with REMSA CQI Indicators for system participation.
2. Development of REMSIS CQI categories consistent with REMSA CQI plan for system participation.
3. REMSIS CQI module monitoring and compliance reporting to providers.
4. Assist ALS / BLS providers with additional optional CQI category and rule development as needed.

Retrospective
1. Overall reporting of data metrics regarding CQI categories and measures related to Indicators contained in the REMSA CQI plan.
2. Development of education initiatives.
3. Data and metrics development for stakeholder groups (CQILT & PMAC) and specialty care committees.

ALS & BLS Provider Responsibilities
Concurrent
1. Participate in, and comply with, all REMSIS based categories according to REMSA CQI plan indicators.
2. Develop as needed optional agency level CQI categories outside of the REMSA CQI plan for additional monitoring.
3. Participate in CQI module monitoring and compliance reporting to REMSA.
   a. These activities will not replace already established practices for concurrent direct observation such as Field Training Programs and/or new hire orientation activities.

Retrospective
1. Provide feedback to the respective advisory committees regarding data and metric development.
2. Receive and execute education initiatives developed by REMSA.
3. Provide feedback and assistance with development of education initiatives.
Base Hospitals Responsibilities
Base hospitals will conduct CQI activities contained within REMSIS in accordance with REMSA CQI Plan indicators and their own base hospital CQI plan indicators as defined by 22 CCR § 100403.

Concurrent
1. In accordance with REMSA and base hospital CQI plans, conduct CQI reviews of predefined REMSIS CQI categories.
2. Collaborate in education initiatives created by REMSA that concerns any prehospital provider agency.
3. Use existing Inbox messaging utility to contact EMS coordinators for all CQI related feedback and communication.
4. Through respective committee participation, provide feedback on data metrics and/or reported data.

Retrospective
1. Within respective advisory committees, provide feedback regarding data and metric development.
2. Receive and execute education initiatives developed by REMSA.
3. Provide feedback and assist with development of REMSA initiated education programs.

Feedback and Loop closure
Each individual agency’s respective CQI plan will dictate the procedures to be followed while using the CQI module within the REMSIS Elite platform.
PURPOSE
To define the +EMS Project, its system participants, and its implementation as an interoperable health information exchange (HIE) between EMS providers and Prehospital Receiving Center through the SEARCH, ALERT, FILE, and RECONCILE (SAFR) functionality.

APPLICATION
This policy applies to the following:

<table>
<thead>
<tr>
<th>Prehospital Receiving Facilities</th>
<th>Ground Transport Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corona Regional Medical Center</td>
<td>American Medical Response – Riverside County (includes the Desert Cities, Hemet, and Riverside Operations)</td>
</tr>
<tr>
<td>Desert Regional Medical Center</td>
<td>Riverside County Fire Department</td>
</tr>
<tr>
<td>Inland Valley Medical Center</td>
<td></td>
</tr>
<tr>
<td>John F. Kennedy Memorial Hospital</td>
<td></td>
</tr>
<tr>
<td>Loma Linda Medical Center – Murrieta</td>
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<tr>
<td>Parkview Community Hospital Medical Center</td>
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</tr>
<tr>
<td>Rancho Springs Medical Center</td>
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</tr>
<tr>
<td>Riverside University Health System – Medical Center</td>
<td></td>
</tr>
<tr>
<td>Temecula Valley Hospital</td>
<td></td>
</tr>
</tbody>
</table>

COMPONENTS
- **SEARCH** – Enhanced search functionality through linked databases (REMSIS Elite and MX) returns potential matches of patients with prior medical history, home medications, medication allergies, and home demographics. Enhances clinical decision-making during emergency cases.
- **ALERT** – Participating emergency departments receive alert messages to pre-register inbound ambulance patients. Improves clinical decision support and preparation.
- **FILE** – Pre-hospital ePCRs integrate directly into the patient’s electronic health record at the receiving hospital to support a seamless transition of care.
- **RECONCILE** – On patient discharge, transfer, or expiration, the hospital EHR system will reconcile the patient’s prehospital record by integrating the outcome data into the ePCR that was created by the transporting agency, creating a complete continuum of care.
## Riverside County Agencies

<table>
<thead>
<tr>
<th>Organization</th>
<th>Address</th>
<th>Phone 1</th>
<th>Phone 2</th>
<th>Phone 3</th>
<th>URL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 EMS Agency</td>
<td>450 E. Alessandro Blvd, Riverside, CA 92508</td>
<td>(951) 358-5029</td>
<td>(951) 712-3342 - Duty Officer</td>
<td><a href="http://www.rivcoems.org">www.rivcoems.org</a></td>
<td></td>
</tr>
<tr>
<td>2 Em. Mgmt. - Operations</td>
<td>450 E. Alessandro Blvd, Riverside, CA 92508</td>
<td>(951) 358-7100</td>
<td>(951) 312-5167 - Duty Officer</td>
<td><a href="https://www.rivcoready.org">https://www.rivcoready.org</a></td>
<td></td>
</tr>
<tr>
<td>3 Em. Mgmt. - Preparedness</td>
<td>450 E. Alessandro Blvd, Riverside, CA 92508</td>
<td>(951) 358-7100</td>
<td></td>
<td><a href="http://www.rivcophepr.org">www.rivcophepr.org</a></td>
<td></td>
</tr>
<tr>
<td>4 Fire Department</td>
<td>210 W San Jacinto Ave, Perris, CA 92570</td>
<td>(951) 940-6900</td>
<td></td>
<td><a href="http://www.rvffire.org">www.rvffire.org</a></td>
<td></td>
</tr>
<tr>
<td>5 Sheriff's Department</td>
<td>4095 Lemon St, Riverside, CA 92501</td>
<td>(800) 950-2444</td>
<td></td>
<td><a href="http://www.riversidesheriff.org">www.riversidesheriff.org</a></td>
<td></td>
</tr>
<tr>
<td>6 Coroner’s Bureau</td>
<td>800 S Redlands Ave, Perris, CA 92570</td>
<td>(951) 443-2300</td>
<td></td>
<td><a href="http://www.riversidesheriff.org">www.riversidesheriff.org</a></td>
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</tr>
<tr>
<td>7 Environmental Health</td>
<td>4065 County Cir Dr, Riverside, CA 92503</td>
<td>(888) 722-4234</td>
<td>(951) 782-2968 - after hours / holidays</td>
<td><a href="http://www.rivcoeh.org">www.rivcoeh.org</a></td>
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<tr>
<td>8 Mental Health</td>
<td>4095 County Cir Dr, Riverside, CA 92503</td>
<td>(888) 768-4968</td>
<td>(951) 509-2499 - ETS</td>
<td>(951) 686-4357 - HELPLine Suicide <a href="http://www.rivcdmh.org">www.rivcdmh.org</a></td>
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</tr>
<tr>
<td>9 Public Health</td>
<td>4065 County Cir Dr, Riverside, CA 92503</td>
<td>(951) 358-5000</td>
<td>(951) 358-5122 - DOC (when activated)</td>
<td><a href="http://www.rivcoph.org">www.rivcoph.org</a></td>
<td></td>
</tr>
<tr>
<td>10 Disease Control</td>
<td>4065 County Cir Dr, Riverside, CA 92503</td>
<td>(951) 358-5107</td>
<td></td>
<td><a href="http://www.rivco-diseasecontrol.org">www.rivco-diseasecontrol.org</a></td>
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<tr>
<td>11 Injury Prevention</td>
<td>4065 County Cir Dr, Suite 207, Riverside, CA 92503</td>
<td>(951) 358-7171</td>
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<td><a href="http://www.rivcopips.org">www.rivcopips.org</a></td>
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<tr>
<td>12 Public Social Services</td>
<td>4060 County Cir Dr, Riverside, CA 92503</td>
<td>(951) 358-3000</td>
<td>(800) 491-7123 - Adult Abuse Hotline</td>
<td>(800) 442-4918 - Child Abuse Hotline <a href="http://dpss.co.riverside.ca.us/">http://dpss.co.riverside.ca.us/</a></td>
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## First Response Agencies

<table>
<thead>
<tr>
<th>Organization</th>
<th>Address</th>
<th>Phone 1</th>
<th>Phone 2</th>
<th>URL</th>
<th>BLS</th>
<th>ALS</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>1 Blythe Volunteer Fire Department</td>
<td>201 N Commercial St, Blythe, CA 92225</td>
<td>(760) 922-6117</td>
<td></td>
<td><a href="http://www.cityofblythe.ca.gov">www.cityofblythe.ca.gov</a></td>
<td>X</td>
<td></td>
<td>Volunteer Agency</td>
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<tr>
<td>2 Calimesa Fire Department</td>
<td>908 Park Avenue, Calimesa, CA 92320</td>
<td>(909) 795-9801</td>
<td></td>
<td><a href="http://www.cityofcalimesa.net">www.cityofcalimesa.net</a></td>
<td>X</td>
<td></td>
<td>Municipal Agency</td>
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<tr>
<td>3 Canyon Lake Fire Department</td>
<td>31516 Railroad Canyon Road, Canyon Lake, CA</td>
<td>(951) 244-2955</td>
<td></td>
<td><a href="http://canyonlakeca.gov/clfd">http://canyonlakeca.gov/clfd</a></td>
<td>X</td>
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<td>Municipal Agency</td>
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<tr>
<td>4 Cathedral City Fire Department</td>
<td>32100 Desert Vista Rd, Cathedral City, CA 92234</td>
<td>(760) 770-8200</td>
<td></td>
<td><a href="http://www.cathedralityfire.org">www.cathedralityfire.org</a></td>
<td>X</td>
<td></td>
<td>Authorized ALS transport service</td>
</tr>
<tr>
<td>5 Chuckawalla Fire Department</td>
<td>19025 Willey's Well Rd, Blythe, CA 92225</td>
<td>(760) 922-5300 Ext. 7700</td>
<td></td>
<td><a href="http://www.cdcr.ca.gov">www.cdcr.ca.gov</a></td>
<td>X</td>
<td></td>
<td>Federal agency</td>
</tr>
<tr>
<td>6 Corona Fire Department</td>
<td>735 Public Safety Way, Corona, CA 92882</td>
<td>(951) 736-2220</td>
<td></td>
<td><a href="http://www.coronaca.gov">www.coronaca.gov</a></td>
<td>X</td>
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<td>Municipal Agency</td>
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<tr>
<td>7 Hemet Fire Department</td>
<td>510 E Florida Ave, Hemet, CA 92543</td>
<td>(951) 765-2450</td>
<td></td>
<td><a href="http://www.hemetca.gov">www.hemetca.gov</a></td>
<td>X</td>
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<td>Municipal Agency</td>
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<tr>
<td>8 Idylwild Fire Protection District</td>
<td>54160 Maranatha Dr, Idylwild-Pine Cove, CA 92549</td>
<td>(951) 659-2153</td>
<td></td>
<td><a href="http://www.idylwildfire.com">www.idylwildfire.com</a></td>
<td>X</td>
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<td>Authorized BLS &amp; ALS transport services</td>
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<tr>
<td>9 MARB Fire Department</td>
<td>6450 8 St, March Air Reserve Base, CA 92518</td>
<td>(951) 655-2075</td>
<td></td>
<td><a href="http://www.march.afrc.af.mil">www.march.afrc.af.mil</a></td>
<td>X</td>
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<td>Federal agency</td>
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<tr>
<td>10 Morongo Fire Department</td>
<td>12700 Pummarra Road, Banning, CA 92220</td>
<td>(951) 755-5315</td>
<td></td>
<td>morongonation.org/fire</td>
<td>X</td>
<td></td>
<td>Tribal agency</td>
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<tr>
<td>11 Murrieta Fire and Rescue</td>
<td>41825 Juniper Street, Murrieta, CA 92562</td>
<td>(951) 304-3473</td>
<td></td>
<td><a href="http://www.murrietaca.ca/Fire">www.murrietaca.ca/Fire</a></td>
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<td>Municipal Agency</td>
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<tr>
<td>12 Palm Springs Fire Department</td>
<td>300 El Cielo Rd, Palm Springs, CA 92262</td>
<td>(760) 323-8181</td>
<td></td>
<td><a href="http://www.palmspringsca.gov">www.palmspringsca.gov</a></td>
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<td>Municipal Agency</td>
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<tr>
<td>13 Pechanga Fire Department</td>
<td>48240 Pechanga Rd, Temecula, CA 92592</td>
<td>(951) 506-5332</td>
<td></td>
<td><a href="http://www.pechanga-nsn.gov">www.pechanga-nsn.gov</a></td>
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<td>Tribal agency</td>
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<tr>
<td>14 Riverside City Fire Department</td>
<td>3401 University Ave, Riverside, CA 92504</td>
<td>(951) 826-5321</td>
<td></td>
<td><a href="http://www.riversideca.gov/fire/">www.riversideca.gov/fire/</a></td>
<td>X</td>
<td></td>
<td>Riverside County Contracted Fire Agency</td>
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<tr>
<td>15 Riverside County Fire Department</td>
<td>210 West San Jacinto Ave, Perris, CA 92570</td>
<td>(951) 940-6900</td>
<td></td>
<td><a href="http://www.rvffire.org">www.rvffire.org</a></td>
<td>X</td>
<td></td>
<td>Two areas with authorized ALS transport services</td>
</tr>
<tr>
<td>16 Soboba Fire Department</td>
<td>23121 Soboba Rd, San Jacinto CA 92583</td>
<td>(951) 654-1092</td>
<td></td>
<td><a href="http://www.soboba-nsn.gov">www.soboba-nsn.gov</a></td>
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<td>Tribal agency</td>
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<td>17 US BLM</td>
<td>1201 Bird Center Dr, Palm Springs, CA 92262</td>
<td>(760) 833-7100</td>
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<td>18 US CBP - Blythe</td>
<td>16870 W Hobson way, Blythe, CA 92225</td>
<td>(760) 922-6715</td>
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<td><a href="http://www.cbp.gov">www.cbp.gov</a></td>
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<td>19 USFS - Cleveland</td>
<td>10845 Rancho Bernardo Rd, San Diego, CA 92127</td>
<td>(858) 673-6180</td>
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<td><a href="http://www.fs.fed.us">www.fs.fed.us</a></td>
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<td>20 USFS - San Bernardino</td>
<td>602 S Tippecanoe Ave, San Bernardino, CA 92408</td>
<td>(909) 383-5651</td>
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### Ground Transport Services

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<td>Advantage Ambulance</td>
<td>6180 Quail Valley Ct, Riverside, CA 92507</td>
<td>(866) 962-3826</td>
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<td>AMR - Desert Cities / Blythe</td>
<td>1111 Montalvo Way, Palm Springs, CA 92262</td>
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<td>AMR - Hemet</td>
<td>208 E Devonshire Ave, Hemet, CA 92543</td>
<td>(951) 765-3900</td>
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<td>AMR - Riverside</td>
<td>879 Marlborough Ave, Riverside, CA 92507</td>
<td>(951) 782-5200</td>
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<td>Cathedral City FD</td>
<td>32100 Desert Vista Rd, Cathedral City, CA 92234</td>
<td>(760) 770-8200</td>
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<td>Cavalry</td>
<td>423 Jenkins Circle Suite 213, Corona, CA 92880</td>
<td>(951) 278-3700</td>
<td><a href="http://www.cavalryems.com">www.cavalryems.com</a></td>
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<td>Desert CCT</td>
<td>121 E. Hobson, Blythe, CA 92225</td>
<td>(760) 922-5911</td>
<td><a href="http://www.desertairambulance.com">www.desertairambulance.com</a></td>
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<td>Idyllwild FPD</td>
<td>54160 Maranatha Dr, Idyllwild-Pine Cove, CA 92549</td>
<td>(951) 659-2153</td>
<td><a href="http://www.idyllwildfire.com">www.idyllwildfire.com</a></td>
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<td>Lynch</td>
<td>2950 La Jolla Street, Anaheim, CA 92806</td>
<td>(800) 347-1526</td>
<td><a href="http://www.lynchambulance.com">www.lynchambulance.com</a></td>
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<td>*Children’s Hospital of Orange County calls only.</td>
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<td>PMT</td>
<td>1801 Orange Tree Ln #130, Redlands, CA 92374</td>
<td>(909) 880-2979</td>
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<td>PRN</td>
<td>8928 Sepulveda Blvd. North Hills, CA 91343</td>
<td>(951) 962-1234</td>
<td><a href="http://www.prnambulance.com">www.prnambulance.com</a></td>
<td>X*</td>
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<td>Riverside County FD - Coves</td>
<td>44400 Town Center Way, Palm Desert, CA 92260</td>
<td>(760) 346-6234</td>
<td><a href="http://www.rvcfire.org">www.rvcfire.org</a></td>
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<td>Riverside County FD - Indio</td>
<td>46990 Jackson St, Indio, CA 92201</td>
<td>(760) 347-0726</td>
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<td>Symbiosis / Symons</td>
<td>1801 Orange Tree Ln #130, Redlands, CA 92374</td>
<td>(866) 728-3548</td>
<td><a href="http://www.symonsambulance.com">www.symonsambulance.com</a></td>
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### Air Transport Services

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<td>Air Methods / Mercy Air</td>
<td>625 E Carnegie Dr, San Bernardino, CA 92408</td>
<td>(909) 357-9006</td>
<td><a href="http://www.aimethods.com">www.aimethods.com</a></td>
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<td>CHP - Air Rescue</td>
<td>56-855 Liberator Ln, Thermal, CA 92274</td>
<td>(760) 984-5300</td>
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<td>Desert Air Ambulance</td>
<td>121 E. Hobson, Blythe, CA 92225</td>
<td>(760) 922-5911</td>
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<td>REACH Air 9</td>
<td>1111 Airport Rd, Imperial, CA 92251</td>
<td>(760) 670-6659</td>
<td><a href="http://www.reachair.com">www.reachair.com</a></td>
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<td>REACH Air 27</td>
<td>37610 Sky Canyon Drive Hangar 51, Murrieta, CA 92563</td>
<td>(949) 291-4778</td>
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### EMS Training

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<td>(951) 782-5200</td>
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<td>Center for Healthcare Education</td>
<td>6377 Riverside Ave, Riverside, CA 92506</td>
<td>(951) 782-8200</td>
<td>(888) 834-8700</td>
<td><a href="http://www.healthcareeducation.org">www.healthcareeducation.org</a></td>
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<td>College of the Desert</td>
<td>43-500 Monterey Ave, Palm Desert, CA 92260</td>
<td>(760) 776-7313</td>
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<td><a href="http://www.collegeofthedesert.edu">www.collegeofthedesert.edu</a></td>
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<td>HealthPro Education and Certification</td>
<td>2900 Adams Street Suite C5, Riverside, CA 92504</td>
<td>(951) 370-1617</td>
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<td><a href="http://www.hpec.org">www.hpec.org</a></td>
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<td>Moreno Valley College</td>
<td>16888 Bundy Ave, Riverside, CA 92518</td>
<td>(951) 571-6300</td>
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<td>Mt. San Jacinto College</td>
<td>28237 La Piedra Road., Menifee, CA 92584</td>
<td>(951) 672-6752</td>
<td>(951) 487-6752</td>
<td><a href="http://www.msjc.edu">www.msjc.edu</a></td>
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<td>National College of Technical Instruction</td>
<td>895 Marlborough Ave #100, Riverside, CA 92507</td>
<td>(951) 384-7813</td>
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<td><a href="https://ntci.edu">https://ntci.edu</a></td>
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<td>Southern California EMS Training</td>
<td>21440 Lemon Street, Wildomar, CA 92395</td>
<td>(951) 304-0099</td>
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<td><a href="http://www.emttrainingca.com">www.emttrainingca.com</a></td>
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<td>West Coast EMT</td>
<td>1960 Chicago Ave Suite D19, Riverside, CA 92507</td>
<td>(714) 558-9604</td>
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<td><a href="http://www.westairstemd.com">www.westairstemd.com</a></td>
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<td>1 Corona Regional</td>
<td>800 S Main St, Corona, CA 92882</td>
<td>(951) 737-4342</td>
<td>(951) 736-6241</td>
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<td>2 Desert Regional</td>
<td>1150 N Indian Canyon Dr, Palm Springs, CA 92262</td>
<td>(760) 323-6511</td>
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<td>3 Eisenhower</td>
<td>39000 Bob Hope Dr, Rancho Mirage, CA 92270</td>
<td>(760) 340-3911</td>
<td>(760) 837-8016</td>
<td>(760) 568-4197</td>
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<td>1117 E Devonshire Ave, Hemet, CA 92543</td>
<td>(951) 652-2811</td>
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<td>36485 Inland Valley Dr, Wildomar, CA 92595</td>
<td>(951) 677-1111</td>
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<td>6 JFK Memorial</td>
<td>47111 Monroe St, Indio, CA 92201</td>
<td>(760) 347-6191</td>
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<td>27300 Iris Avenue, Moreno Valley, CA 92555</td>
<td>(951) 243-0811</td>
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<td>10800 Magnolia Ave, Riverside, CA 92505</td>
<td>(951) 353-2000</td>
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<td>28062 Baxter Rd, Murrieta, CA 92563</td>
<td>(951) 290-4000</td>
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<td>(951) 788-6149</td>
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<td>28400 McCall Blvd, Menifee, CA 92585</td>
<td>(951) 679-8888</td>
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<td>11 Palo Verde</td>
<td>250 N 1st St, Blythe, CA 92225</td>
<td>(760) 922-4115</td>
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<td>(951) 696-6000</td>
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<td>(951) 696-6035</td>
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<td>4445 Magnolia Ave, Riverside, CA 92501</td>
<td>(951) 788-3000</td>
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<td>26520 Cactus Ave, Moreno Valley, CA 92555</td>
<td>(951) 486-4000</td>
<td>(951) 486-5650</td>
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<td>(951) 845-1121</td>
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<td>31700 Temecula Pkwy, Temecula, CA 92592</td>
<td>(951) 331-2200</td>
<td>(951) 331-2280</td>
<td>(951) 331-2242</td>
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### Out of County Hospitals

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<td>1 Arrowhead Regional</td>
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<td>400 N. Pepper Ave., Colton, CA 92324</td>
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<td>(909) 335-5500</td>
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*Redlands Community Hospital is thrombectomy capable only

**Legend**

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PURPOSE
To define the membership, rules of operation, and functions of the local Emergency Medical Care Committee (EMCC).

AUTHORITY
California Health and Safety Code - Division 2.5, Chapter 4, Article 3, Sections 1797.270 - 1797.276
Resolution 2013-052 of the Board of Supervisors of the County of Riverside

Emergency Medical Care Committee
The Board of Supervisors of the County of Riverside originally established the local EMCC on October 15, 1985. The composition of the EMCC was last amended by Resolution 2013-052, dated March 12, 2013.

The Riverside County EMCC shall consist of seventeen (17) members. All nominated members are to be appointed by the Board of Supervisors and the composition of this committee is as follows:
1. One (1) Emergency Department physician, practicing in a hospital located within Riverside County, nominated by the Prehospital Medical Advisory Committee (PMAC);
2. One (1) representative from the Hospital Association of Southern California (HASC) to be the Vice President of the Inland Regional Office;
3. One (1) physician representative of the Riverside County Medical Association (RCMA), nominated by that organization;
4. One (1) representative from the county contracted emergency ground ambulance provider that serves a majority of the county’s Exclusive Operating Areas (EOAs);
5. One (1) representative from the Ambulance Association of Riverside County, nominated by that organization;
6. One (1) representative from the county’s permitted air ambulance providers, nominated by the air ambulance permitted providers;
7. One (1) Fire Chief representing the Riverside County Fire Chiefs Association (RCFCA), nominated by that organization;
8. One (1) city manager from the Coachella Valley Association of Governments (CVAG), nominated by that organization;
9. One (1) city manager from the Western Riverside Council of Governments (WRCOG), nominated by that organization;
10. One (1) representative of the Riverside County Law Enforcement Agency Administrators’ Association (RCLEAAA), nominated by that organization;
11. One (1) prehospital representative of PMAC, nominated by that committee;
12. One (1) representative of the Riverside County Fire Department, appointed by the Riverside County Fire Chief; and
13. One (1) member-at-large from Riverside County Supervisorial District 1;
14. One (1) member-at-large from Riverside County Supervisorial District 2;
15. One (1) member-at-large from Riverside County Supervisorial District 3;
16. One (1) member-at-large from Riverside County Supervisorial District 4;
17. One (1) member-at-large from Riverside County Supervisorial District 5.

Nominated members, and members-at-large, shall serve a three (3) year term with staggered expiration dates so that no more than one-third (1/3) of the membership may require replacement or reappointment at any one time. The Committee shall choose its chairperson and vice-chairperson annually and shall determine the time and place for regular meetings of the Committee.
A quorum shall consist of one more than half the number of filled committee positions. Action taken shall require the affirmative vote of a majority of those present. The Chairman votes only in case of a tie.

The Committee shall perform the functions of an Emergency Medical Care Committee defined by the California Health and Safety Code, Division 2.5, Chapter 4, Article 3, Sections 1797.274 and 1797.276:

The emergency medical care committee shall, at least annually, review the operations of each of the following:

a. Ambulance services operating within the county.

b. Emergency medical care offered within the county, including programs for training large numbers of people in cardiopulmonary resuscitation and lifesaving first aid techniques.

c. First aid practices in the county.

Every emergency medical care committee shall, at least annually, report to the authority, and the local EMS agency its observations and recommendations relative to its review of the ambulance services, emergency medical care, and first aid practices, and programs for training people in cardiopulmonary resuscitation and lifesaving first aid techniques, and public participation in such programs in that county. The emergency medical care committee shall submit its observations and recommendations to the county board or boards of supervisors which it serves and shall act in an advisory capacity to the county board or boards of supervisors which it serves, and to the local EMS agency, on all matters relating to emergency medical services as directed by the board or boards of supervisors.

The Committee shall serve in an advisory capacity for the Board of Supervisors concerning all aspects of emergency medical care within the county and report to the Board in conjunction with its review of the various aspects of the emergency medical care within the county. The Committee shall report to the Board of Supervisors its observations and recommendations concerning the feasibility and content of emergency medical care programs within the county in conjunction with cities within the county, other counties, the state, and the United States.

Except for supervisory appointees, each organization may designate an alternate to serve in the event of an absence by that organization's primary member.

The EMCC shall prepare an annual report to the Board of Supervisors on the current and anticipated condition of Emergency Medical Services (EMS) and EMS system operation within the county.
PURPOSE
To describe the role and composition of the Prehospital Medical Advisory Committee (PMAC); including its rules of operation.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

The Prehospital Medical Advisory Committee
The purpose of the PMAC is to provide advice and expertise to the County of Riverside EMS Agency (REMSA), and to enhance cooperation between the multiple EMS system participants on administrative, operational, and emergency medical issues.

Active membership will consist of:
1. The Emergency Department Physician Director of each paramedic receiving center in Riverside County or his/her physician designee
2. The chairman of the Trauma Audit Committee (TAC) or his/her designee
3. A representative from the Trauma Program Managers committee
4. The Prehospital Liaison Nurse (PLN) of each base hospital and the Emergency Department (ED) Nurse Manager of each non-base paramedic receiving center
5. A representative from each Riverside County permitted emergency ALS ambulance service
6. A representative elected from the EMS training program(s)
7. A representative from the Riverside County Police Chiefs’ Association
8. A representative from Riverside County Fire Department
9. A representative from a non-transporting BLS fire department selected by the Riverside County Fire Chiefs’ Association
10. A representative from a non-transporting ALS fire department selected by the Riverside County Fire Chiefs’ Association
11. A representative elected from the Riverside County permitted air transport providers
12. A representative elected from the Riverside County permitted BLS ambulance services
13. An active field EMT elected by the committee (EMT-at-Large)
14. An active field paramedic elected by the committee (Paramedic-at-Large)

Ex-officio members will include:
1. The county Director of Public Health / Health Officer
2. The REMSA Medical Director
3. The REMSA Administrator
4. The Deputy REMSA Administrator
5. A representative from the Hospital Association of Southern California (HASC)
6. The Emergency Department Physician Director(s) or their physician designees from out-of-county acute care hospitals impacted by Riverside County residents

The committee-elected membership positions of EMT-at-Large and Paramedic-at-Large will serve a two (2) year term. Elections will be at the last meeting of even-numbered years. Should either of the at-large members vacate their seat
prior to the end of their term, a person who meets the qualifications will be elected by the committee for the remainder of that term.

The committee will elect from the membership a chairperson, who will be a physician, and a vice-chairperson, who will be a prehospital care provider, both of whom will serve a two (2) year term. Elections will be at the last meeting of even-numbered years.

1. Should either of the committee officers vacate their seat prior to the end of their term, a member who meets the qualifications will be elected by the committee for the remainder of that term.
2. The position of Chairman is a non-voting position except in cases where a tie vote must be broken.

REMSA will provide support for the PMAC, including but not limited to, the scheduling and recording of meetings, developing agendas, supplying needed research information, and the dissemination of information generated from PMAC.

The PMAC will meet at least quarterly.

The meetings of the PMAC will be open to the public.

Functions of the PMAC will include, but not be limited to:

1. Providing specialized advice to the REMSA Medical Director in carrying out the agency's statutory responsibilities to develop written medical protocols
2. Providing specialized advice to the REMSA Medical Director in carrying out the agency's statutory responsibilities to maintain medical control of the EMS system
3. Providing physician representatives to the Medical Advisory Committee defined in Section 100145(b) of Division 9, Title 22, California Code of Regulations for the approval of EMS prehospital treatment procedures or drugs on a trial basis
4. Providing communication and coordination between REMSA and EMS system participants
5. Providing other specialized advice as deemed necessary and appropriate
PURPOSE
To establish an advisory committee to the local Emergency Medical Services (EMS) Agency Medical Director to monitor and evaluate the medical care of patients with traumatic injury.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Trauma Audit Committee (TAC)
1. Trauma System Monitoring Role:
   a. To assist the REMSA Medical Director in the review and evaluation of the medical aspects of each County’s trauma system.
   b. This committee shall meet to monitor and assess the effectiveness of the trauma system and make known its findings and recommendations to the EMS Agencies.

2. Scope of Review: The scope of review to be conducted by the committee shall include, but not be limited to, a review of the following in Riverside / San Bernardino counties:
   a. All trauma deaths.
   b. Prehospital trauma care.
   c. Appropriateness of triage criteria and performance.
   d. Hospital trauma care.

3. The TAC will provide input to the EMS Agencies in:
   a. Development, implementation, and evaluation of trauma audit criteria.
   b. Definition of medical goals.
   c. Identification of errors in medical care, with recommendations.
   d. Research projects.
   e. Periodic on-site inspection of trauma centers.
   f. Trauma System improvements.

4. Membership:
   a. Members will be appointed according to the following format. Any changes in appointed members will take place at the end of the calendar year.
   b. Members:
      i. Trauma Surgeon from each trauma center.
      ii. Trauma Program Manager / Nurse Coordinator from each trauma center.
      iii. An Emergency Department Physician from each trauma center.
      iv. Attending pediatrician.
      v. Representative from local medical society (general surgeon, anesthesiologist, neurosurgeon and orthopedic surgeon) – on an “as needed” basis.
      vi. Physician representative from the Prehospital Medical Advisory Committee (PMAC), preferably from a non-trauma center.
      vii. County representatives from the following:
         1. County Deputy Coroner (2) Ex-officio - non-voting
         2. EMS Agency Director (2) Ex-officio - non-voting
3. EMS Medical Director (2) Ex-officio - non-voting
4. EMS Trauma Coordinator (2) Ex-officio - non-voting
5. County Public Health Officer (2) Ex-officio - non-voting

c. The TAC shall elect a Chairperson who is a trauma surgeon who shall serve a two (2) year term.
i. Elections shall be at the last meeting of each even year.

5. Attendance:
a. The committee will meet a minimum of quarterly per year.
b. Members will notify the EMS Agency staff, (951) 358-5029, in advance of any scheduled meeting they will be unable to attend.
c. After two (2) unexcused absences in a calendar year, an appointed member may be removed from the TAC.
d. Resignation from the committee should be submitted, in writing, to the EMS Agency Trauma Coordinator, and is effective upon receipt, unless otherwise specified.
e. Invitees may participate in the medical review of specified cases where their expertise is requested. All requests for invitees must be approved by the EMS Agencies and TAC Chairperson in advance of the scheduled meeting.

6. Voting:
Due to the “advisory” nature of the committee, many issues will require input rather than a vote process. Vote process issues will be identified as such by the TAC Chairperson. When voting is required, the majority of the voting members of the committee need to be present.

7. Committee Documentation:
Meeting summaries will be kept by the EMS staff and distributed to the members at each meeting. Due to the confidentiality of the committee, confidential committee documents will be collected by EMS staff at the close of each meeting and no copies may be made or possessed by members of the committee. All official correspondence and communication generated by the TAC will be approved by the REMSA Medical Director and sent on Riverside County Department of Public Health, or EMS Agency, letterhead.

8. Confidentiality:
a. All proceedings, documents and discussions of the TAC are confidential and are covered under Sections 1040 and 1157.7 of the California State Evidence Code. The prohibition relating to discovery of testimony provided to the Committee shall be applicable to all proceedings and records of this Committee, which is one established by a local government agency to monitor, evaluate and report on the necessity, quality and level of specialty health services, including but not limited to, trauma care services.
b. Issues requiring system input may be sent to the EMS Agencies for presentation to the System Advisory Committees (PMAC or EMCC) for input. Guests may be invited to discuss specific cases and issues in order to assist the Committee in making final case or issue determinations. Guests may only be present for the portion of the meeting for which they have been requested.
c. All members shall sign a confidentiality agreement not to divulge or discuss information that would have been obtained solely through TAC membership. Prior to the guest(s) participating in the meeting, the Chairperson is responsible for explaining and obtaining a signed confidentiality agreement from invited guests.
PURPOSE
To establish an advisory committee to the Trauma Audit Committee (TAC) that advises the local Emergency Medical Services (EMS) Agency on trauma system issues.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22, Social Security, Division 9. Prehospital Emergency Medical Services

Trauma Program Managers Committee (TPMC)
1. Trauma System Monitoring Role:
   a. To discuss and evaluate trauma data/registry issues;
   b. To review policy and recommend changes if required;
   c. To perform performance improvement evaluations through an audit/report.

2. Scope of Reports: The scope of reports to be conducted by the TPMC will include, but not be limited to, a report of:
   a. Specified audits as requested by TAC;
   b. Outcome by category as specified by the TAC / TPMC;
   c. EMS Agency requests.

3. The Trauma Program Managers will provide input to the TAC on:
   a. Development, implementation and evaluation of trauma audit criteria;
   b. Definition of system goals for the Riverside County Trauma System;
   c. Outcome Studies.

4. Membership:
   a. The committee shall elect a Chairperson who shall serve a two (2) year term. Elections shall be at the last meeting of the even year.
   b. Members:
      i. Trauma Program Manager from each trauma center;
      ii. Prehospital Liaison Nurse from each trauma center: non-voting member;
      iii. Trauma Coordinator from each participating EMS agency: ex-officio, non-voting.

5. Attendance:
   a. The committee will meet at least quarterly, or as scheduled, per year;
   b. Members will notify REMSA staff in advance of any scheduled meeting they will not be able to attend.

6. Voting:
   Due to the advisory nature of the committee, many issues will require input rather than a vote process. Vote process issues will be identified as such by the Committee Chairperson in consultation with the Trauma Coordinators. When voting is required, the majority of the voting members of the committee need to be present. Each facility will have one vote.

7. Committee Documentation:
   Meeting summaries will be kept by the Trauma Coordinators and distributed to the members.
8. Confidentiality:
   a. Any proceedings, documents, and discussions of the TPMC deemed as confidential are covered under Sections 1040 and 1157.7 of the California State Evidence Code. The prohibition relating to discovery of testimony provided to the committee shall be applicable to all proceedings and records of this committee, which is one established by a local government agency to monitor, evaluate and report on the necessity, quality and level of specialty health services, including but not limited to, trauma care services.
   b. Issues requiring system input may be sent to the TAC and forwarded to REMSA for presentation to the System Advisory Committees (PMAC or EMCC) for input. Guests may be invited to discuss specific cases and issues in order to assist in the resolution of issues.
PURPOSE
To establish an advisory committee to REMSA and subcommittees on EMS system issues.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]

Prehospital Liaison Nurses (PLN) Committee
1. EMS System Monitoring Role:
   a. To discuss and evaluate data/registry issues;
   b. To review policy and recommend changes if required;
   c. To perform performance improvement evaluations through an audit/report.

2. Scope of Reports: The scope of reports to be conducted by the PLNs may include but not be limited to, a report of:
   a. Specified audits as requested by REMSA or subcommittees
   b. Identified trend or need determined by PLN group

3. The Prehospital Liaison Nurses will provide input to REMSA or subcommittees on:
   a. Development, implementation and evaluation of system audit criteria;
   b. Definition of system goals for the Riverside County EMS System;
   c. Outcome Studies.

4. Membership:
   a. The Committee shall elect a Chairperson who shall serve a one (1) year term. Election shall be at the last meeting of the year. The Chair position will rotate through each PLN, as appropriate.
   b. Members:
      i. PLN from each base hospital;
      ii. Ad-hoc member from REMSA: non-voting member;
      iii. Invited guest as determined by PLN group

5. Attendance:
   a. The committee will meet at least quarterly/as scheduled per year.
   b. Members will notify the EMS Agency staff ad-hoc member in advance of any scheduled meeting to facilitate participation

6. Voting:
   Due to the advisory nature of the committee, many issues will require input rather than a vote process. Vote process issues will be identified as such by the Committee Chairperson in consultation with the Prehospital Liaison Nurses. When voting is required, the majority of the voting members of the committee need to be present. Each facility will have one vote.

7. Committee Documentation:
   Meeting summaries will be kept by the committee Chairperson or designee and distributed to the members.
8. Confidentiality:
   a. Any proceedings, documents and discussions of the PLN Committee deemed as confidential are covered under Sections 1040 and 1157.7 of the California State Evidence Code. The prohibition relating to discovery of testimony provided to the Committee shall be applicable to all proceedings and records of this Committee, which is one established by a local government agency to monitor, evaluate and report on the necessity, quality and level of specialty health services, including but not limited to, trauma care services.
   b. Issues requiring system input may be sent to the EMS Agency for presentation to the System Advisory Committees (PMAC or EMCC) for input. Guests may be invited to discuss specific cases and issues in order to assist in the resolution of issues.
PURPOSE
To establish an advisory committee to the local Emergency Medical Services (EMS) Agency Medical Director to monitor and evaluate the medical care of patients with Stroke.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.107]
California Health and Safety Code - Division 2.5: Emergency Medical Services [1798.150]

Stroke System Advisory Committee
1. The Stroke System Advisory Committee:
   a. Shares best practices and recommends improvements;
   b. Works collaboratively in making improvements within the EMS system for improved outcomes;
   c. Awareness, education, and feedback to the field personnel for stroke patients and/or uncommon presentations.

2. The committee reports to:
   a. REMSA;
   b. The EMS Agency Administrator
   c. The EMS Agency Medical Director

3. The committee responsibilities include:
   a. Feedback to EMS personnel
   b. Submit required quarterly data within the required timeframes;
      i. Review all data prior to sending for accuracy and to ensure that the calls originated in Riverside County.
   c. Review and comment upon any policy changes;
   d. Communication with REMSA on all issues, concerns and ideas regarding the prehospital stroke system;
   e. Maintain stroke center accreditation requirements;
   f. Identify specific stroke patients for case presentation at the quarterly prehospital stroke system meetings
      i. Prior to presentation to the committee, all organizations involved with the case (fire department, EMS transport provider, sending hospital (if appropriate), and stroke center) must be involved in the preliminary case review
   g. Provide evidence that processes are in place to best utilize interventional radiology centers;
      i. Metrics to be decided upon annually by the Stroke System Advisory Committee

4. Membership:
   a. The committee shall elect a Chairperson who shall serve a two (2) year term. Elections shall be at the last meeting of the even year.
   b. The committee is open to all hospital and prehospital care personnel in Riverside County;
   c. On an ad-hoc basis, subject matter experts will be invited to attend and/or present at the meetings

5. Attendance:
   a. The committee will meet at least quarterly, or as scheduled, per year;
   b. Members will notify REMSA staff in advance of any scheduled meeting they will not be able to attend.
6. **Voting:**
   When a vote is necessary for a formal recommendation to the REMSA Medical Director or REMSA Administrator, a simple majority of meeting participants will carry the authority needed for the recommendation. One (1) vote from each organization will be counted.

7. **Committee Documentation:**
   Meeting minutes will be kept by the EMS Agency and posted on the Stroke Committee webpage on remsa.us

8. **Confidentiality:**
   a. All proceedings, documents and discussions of the Stroke System Advisory Committee are confidential and are covered under Sections 1040 and 1157.7 of the California State Evidence Code. The prohibition relating to discovery of testimony provided to the committee shall be applicable to all proceedings and records of this committee, which is one established by a local government agency to monitor, evaluate and report on the necessity, quality, and level of specialty health services, including but not limited to, stroke critical care services.
   b. Issues requiring system input may be sent to the EMS Agencies for presentation to the System Advisory Committees (PMAC or EMCC) for input.
PURPOSE
To charter an advisory committee to the local Emergency Medical Services (EMS) Agency Medical Director to monitor and evaluate the medical care of patients with ST-Elevation Myocardial Infarction.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.107]
California Health and Safety Code - Division 2.5: Emergency Medical Services [1798.150]
California Code of Regulations, Title 22. Social Security, Division 9. Prehospital Emergency Medical Services, Chapter 7.1 ST- Elevation Myocardial Infarction Critical Care System

Prehospital STEMI System Advisory Committee
1. The STEMI System Advisory Committee:
   a. Shares best practices and recommends improvements;
   b. Works collaboratively in making improvements within the EMS system for improved outcomes;
   c. Awareness, education, and feedback to the field personnel for STEMI patients and/or uncommon presentations.

2. The committee reports to:
   a. REMSA:
   b. The EMS Agency Administrator
   c. The EMS Agency Medical Director

3. The Committee responsibilities include:
   a. Feedback to EMS personnel;
   b. Submit required quarterly data within the required timeframes;
      i. Review all data prior to sending for accuracy and to ensure that the calls originated in Riverside County
   c. Review and comment upon any policy changes;
   d. Communication with REMSA on all issues, concerns, and ideas regarding the prehospital STEMI System;
   e. Maintain accreditation requirements for STEMI receiving centers;
   f. Identify specific STEMI cases for presentation at the quarterly prehospital STEMI system meetings
      i. Prior to presentation to the committee, all organizations involved with the case (fire department, EMS transport provider, sending hospital (if appropriate), and STEMI receiving center) must be involved in the preliminary case review

4. Membership:
   a. The committee shall elect a Chairperson who shall serve a two (2) year term. Elections shall be at the last meeting of the even year.
   b. The committee is open to all hospital and prehospital care personnel in Riverside County
   c. On an ad-hoc basis, subject matter experts may be invited to attend and/or present at the meetings

5. Attendance:
   a. The committee will meet at least quarterly, or as scheduled, per year;
   b. Members will notify REMSA staff in advance of any scheduled meeting they will not be able to attend.
6. Voting:
When a vote is necessary for a formal recommendation to the REMSA Medical Director or REMSA Administrator, a simple majority of meeting participants will carry the authority needed for the recommendation. One (1) vote from each organization will be counted.

7. Committee Documentation:
Meeting minutes will be kept by the EMS Agency and posted to the STEMI Committee webpage on remsa.us

8. Confidentiality:
a. All proceedings, documents and discussions of the STEMI Advisory Committee are confidential and are covered under Sections 1040 and 1157.7 of the California State Evidence Code. The prohibition relating to discovery of testimony provided to the committee shall be applicable to all proceedings and records of this committee, which is one established by a local government agency to monitor, evaluate and report on the necessity, quality and level of specialty health services, including but not limited to, STEMI critical care services.
b. Issues requiring system input may be sent to the EMS agencies for presentation to the System Advisory Committees (PMAC or EMCC) for input.
PURPOSE
To charter an advisory committee to the Riverside County Emergency Medical Services Agency (REMSA) Medical Director to monitor and evaluate data standards in Riverside County.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22, Social Security, Division 9. Prehospital Emergency Medical Services

REMSA Data Standards Committee
5. The REMSA Data Standards Advisory Committee:
   a. Shares best practices and establishes data collection standards and initiatives for prehospital care in Riverside County.
   b. Works collaboratively in making improvements within the EMS system for improved outcomes.
   c. Maintains systemic awareness, delivers education, and provides feedback to field personnel regarding data standards.

6. The Committee reports to:
   a. REMSA
   b. The EMS Agency Administrator
   c. The EMS Agency Medical Director

7. The Committee’s responsibilities include:
   a. Providing feedback to EMS personnel.
   b. Reviewing and commenting on policy changes.
   c. Communicating with REMSA on all issues, concerns, and ideas regarding data collection methods and initiatives.
   d. Establishing data collection standards related to NEMSIS 3.4 and 3.5, to be submitted to CEMSIS.

8. Membership:
   a. The Chairperson will be the Lead REMSIS Administrator.
   b. The committee is open to all hospital and prehospital care personnel in Riverside County.
      i. Committee membership will consist of provider agency appointed EMS Coordinators, CQI Managers, Operations officers and/or agency Medical Advisors.
   c. On an ad-hoc basis, subject matter experts may be invited to attend and/or present at the meetings

9. Attendance:
   a. The committee will meet at least once (1x) per month, or as scheduled.
   b. Members must notify the REMSIS Lead Administrator in advance of any scheduled meeting(s) they will not be able to attend. Should an attempt to contact the REMSIS Lead Administrator prove unsuccessful, members may call the REMSA Help Desk to facilitate notification to the REMSIS Lead Administrator.

9. Voting:
   When a vote is necessary for a formal recommendation to the REMSA Medical Director or REMSA Administrator, a simple majority of meeting participants will carry the authority needed for the recommendation. One (1) vote from each organization will be counted.
For members that are unable to attend a meeting, proxy voting by email is permitted; however, at a minimum, the meeting transcript must be reviewed after the fact to ensure full understanding of any proposals that were made. In addition to examining the meeting minutes, REMSA recommends members view the video recording of the meeting that they were unable to attend.

10. Committee Documentation:
Meeting minutes will be kept by REMSA and will be made available to committee members upon request.

11. Confidentiality:
   a. All proceedings, documents and discussions at the Data Standards Advisory Committee are confidential and are covered under Sections 1040 and 1157.7 of the California State Evidence Code. The prohibition relating to discovery of testimony provided to the Committee shall be applicable to all proceedings and records of this committee, which is one established by a local government agency to monitor, evaluate, and report on the necessity, quality, and level of specialty health services, including but not limited to Specialty care, 911 Response, and Interfacility Transport providers.
   b. Data standards issues requiring system input may be sent to the Lead REMSIS Administrator for consideration and/or presentation at the Data Standards Advisory Committee.
PURPOSE
To describe the Riverside County EMS Agency’s (REMSA) policy review process.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
2013 Strategic Continuous Quality Improvement Plan (SCQIP)

Policy Categories

Administrative
These policies inform the EMS system of REMSA-specific rules and procedures that cover a wide array of internal tasks and functions.

- Their intent is to serve as a guide for REMSA operations.
- They are rarely revised, with modifications occurring to ensure alignment with changes to federal, state, or local law.
- System input is not required, and is usually not obtained, when these policies are modified.

Operational
These policies describe the rules and expectations that REMSA has for all EMS system participants, which cover a wide array of day-to-day tasks and functions.

- Their intent is to provide direction and guidance to agencies and individual personnel to ensure compliance with federal, state, and local laws.
- They are revised infrequently, sometimes only once (1x) per calendar year, sometimes not at all.

Provisional
These policies are created as a result of an immediately identified system need when sufficient time to obtain public comment and stakeholder input does not exist.

- Their intent is to provide immediate direction and guidance to agencies and individual personnel that addresses the identified system need.
- Unlike other policies, their effective periods usually last only a few weeks to a few months before they either expire or are renewed for another specific, finite period of time.

Treatment Protocols
These policies constitute medical control by the REMSA Medical Director, as specified in Section 1798 of the California Health and Safety Code, and describe the REMSA approved scope of practice for public safety personnel, EMTs, and paramedics in Riverside County.

- Their intent is to detail the approved treatments and procedures that may be utilized based on a thorough assessment of the patient’s complaint as well as their clinical presentation.
- They are revised infrequently, sometimes only once (1x) per calendar year, sometimes not at all.

REMSA has a responsibility to the public, as well as the EMS system as a whole, to improve the delivery of prehospital care services through the monitoring, review, and evaluation of system performance and activities. Occasionally, immediately identified system needs may necessitate policy and/or protocol modification(s) that do not allow sufficient time to obtain EMS system stakeholder input. These needs may include but are not limited to the recognition of untoward events and/or poor patient outcomes due to specific policy / protocol content, realignment of treatment algorithms resulting from external updates to scientific and industry accepted patient care standards, REMSA-approved
first response, transport provider and/or hospital operational needs, etc. In these events, REMSA will provide notification of the change(s) as soon as possible through the use of a System Advisory.

**Annual Policy Review Schedule**

REMSA’s policy review process is facilitated through the Continuous Quality Improvement Leadership Team (CQILT) and the Prehospital Medical Advisory Committee (PMAC), with additional advisory group input from the Trauma Audit Committee (TAC), the STEMI system committee, the Stroke system committee and/or others, as needed and as appropriate. All input received through these committees will be utilized in an advisory capacity only; the final authority to adopt additions, modifications and/or deletions to policy and/or protocol content, in whole or in part, rests with the REMSA Medical Director.

In order to streamline the policy creation and review process so that it promotes efficient and effectual advisement to the REMSA Medical Director, while also ensuring meaningful conversation that is respectful of each participant’s time, loose but formal procedures will be used. Beginning January 1, 2023, REMSA will initiate and maintain the policy and protocol review process as follows:

- **January CQILT**: In addition to all new business and standing agenda items, individual CQILT participants, on behalf of the agency, department, or organization that they represent, may propose modifications to any policy or protocol that they believe would benefit from modification. In order to effectively articulate the positive impact the change(s) will have on the EMS system, REMSA recommends that the proposing agency, department, or organization make a brief presentation that consists of objective, empirical data that validates their proposal.

  **Motion to Discuss**: after the proposal has been made, a Motion to Discuss may be brought up.
  - Should a qualifying* Motion to Discuss be made, discussion will occur.  
    
    *(NOTE: a Motion to Discuss is not necessarily an endorsement; it is simply the mechanism used to invite group discussion about the pros and cons of, as well as consider possible changes to, the proposal in question)*
  - Should no qualifying* Motion to Discuss be made, a qualifying* Motion to Proceed must be made to initiate a consensus vote of attendees to determine if the proposal should be addressed during the public comment period.
    
    × Should no qualifying* Motion to Proceed be made, the proposal will be considered moot and no further time will be spent addressing it.

  **Motion to Proceed**: After discussion has concluded, or if no qualifying* Motion to Discuss was made, a qualifying* Motion to Proceed must be made to advance the proposal to a consensus vote of attendees.
    
    - If the consensus vote to allow the proposal to proceed to public comment is greater than 50% + 1 of the attendees, the proposal will be made available for public comment.
    - If the consensus vote to allow the proposal to proceed to public comment is less than 50% of the attendees, the proposal will be considered moot and no further time will be spent addressing it.

*NOTE*: Qualifying motions to discuss and proceed must be made by individuals outside of the agency, department, or organization that made the proposal. The purpose of this is to ensure that there is a shared interest in furthering discussion of, and giving attention to, the proposal.

**Public Comment Period**: The public comment acceptance period will remain open for fourteen (14) days, beginning the day after the CQILT. Electronic form submission will be used to collect all comments. Upon completion of the public comment period, REMSA will close the electronic form then aggregate all comments. Comments will be reviewed publicly, as they were received, at the February PMAC; comments sent to REMSA staff using anything other than the identified electronic form will not be addressed directly, or at the PMAC.

*Due to this review schedule, items that are not carried into the public comment period will not have the opportunity to be addressed again until the next January CQILT meeting.*
- **February PMAC:** In addition to all new business and standing agenda items, all public comment submissions that were received during the public comment period will be addressed openly with the committee.

  **Motion to Discuss Further:** after all public comments have been addressed, a motion to discuss further may be brought up.
  - Should a motion to discuss further be made, discussion will occur.
  - Should no motion to discuss further be made, the proposal will be brought to a consensus vote of attendees to determine if a recommendation to adopt will be made to the REMSA Medical Director.

  **Motion For a Consensus Vote:**
  - If the consensus vote to recommend adoption of the proposal is greater than 50% + 1 of the attendees, pending REMSA Medical Director approval, REMSA will begin producing the necessary educational content for the EMS system the day after the PMAC.
  - If the consensus vote to recommend adoption of the proposal is less than 50% of the attendees, it will be considered moot and no further time will be spent addressing it.

Proposals that are being addressed at this PMAC have already received qualifying motions through the previous CQILT. Anyone participating at this PMAC may make a Motion to Discuss Further after public comments have been reviewed or they may make a motion to move directly to a consensus vote of attendees should no Motion to Discuss Further be made.

*Due to this review schedule, items that do not reach majority support at this PMAC, as evidenced by a consensus vote of attendees to formally adopt, will need to be re-addressed at the next January CQILT meeting if the agency, department, or organization that brought the issue to attention believes that it still remains.*

- **March:** **Train the Trainer Meetings** – present, conduct, and publish educational content no later than April 1. Agency, department, and organization trainers are required to participate in these meetings order to receive all PUC-related training materials.

- **April CQILT:** In addition to all new business and standing agenda items, REMSA will provide additional time to answer any outstanding questions that trainers may have regarding all PUC-related training materials.

- **April through June:** Agency, department, and organization-level training occurs.

- **July 1:** All applicable policies and protocols become effective.

All other required education, as identified through the CQILT and PMAC outside of the schedule noted above, will be delivered using REMSA’s online Learning Management Platform.

**Policy and Protocol Effective and Expiration Dates**
Beginning July 1, 2023, all REMSA policies and protocols will go into effect, and remain in effect, unless and until agencies, departments and/or organizations utilize the steps outlined above (Annual Policy Review Schedule), an immediate system need is identified (REMSA initiated review and change), or the triennial review period begins (below).

**Triennial Policy Review Schedule**
Beginning January 1, 2026, and continuing on a triennial basis (every three (3) years thereafter), REMSA will review all policies and protocols contained in the REMSA Policy and Procedure manual to ensure that their content remains accurate.

REMSA requests that all agencies, departments, and organizations take time to review each policy and provide public comments after the January CQILT occurring during the triennial review period in order to provide meaningful feedback to the REMSA Medical Director at that February PMAC.
Credentialing Forms

- ALS Skills Competency Verification
- ALS Skills Competency Verification (Complete Packet)
- EMT Skills Competency Verification
- EMT Request for Live Scan
- EMT Challenge Examination
- MICN Field Observation (Ride Out) (MICNs only)
- Vaccine Administration Skill Verification Form

CQI Forms

- Exceptional Performance Report
- Naloxone Use by Public Safety Personnel Reporting Form
- Stroke Patient Registry Form (Non-Stroke Center)
- Trauma Patient Registry Form (Non-Trauma Center)
- Unusual Occurrence Review Reporting Form

Incident Command System (ICS) Forms

- ICS Forms (Complete booklet)
- MCI Forms (305 / 306 / 308 / 310 / 312)

Public Access Defibrillation (PAD) Forms

- PAD Application
- PAD Event Summary

Reporting Forms

- Code 3 Notification
- Communicable Disease Exposure Request Form
- DEA Report of Lost or Stolen Controlled Substances
- Medication Waiver Form
  - Alternative Medication Administration Form
  - Point of Care Epinephrine Dilution & Administration Form
- Escape Hood Notification
- Nerve Agent Antidote Kit (NAAK) Notification
- Optional Equipment Authorization Form
- Radio Communication Failure Notification
- Suspected Adult / Elder Abuse Report (May be submitted online)
- Suspected Child Abuse Report (Must be printed then faxed)