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	Agency Authority **Administrative Policy**	
Last Reviewed: **November 30, 2023**		Last Revised: **July 1, 2025**

PURPOSE
To identify the acts, amendments, codes, guidelines, laws, ordinances, regulations, standards, and statutes that grant and delegate authority to regulate the emergency medical services (EMS) system in Riverside County to the Riverside County Emergency Medical Services Agency (REMSA).

NATIONAL

Data Standards:
National Emergency Medical Services Information System (NEMSIS)
- Version 3.5 Resources

National Fire Protection Association (NFPA)
- Codes and Standards

STATE OF CALIFORNIA

All policies:
California Code of Regulations
- Title 22, Division 9 – *Social Security* | *Prehospital Emergency Medical Services*
  - Chapters 1 – 14

California Health and Safety Code
- Division 2.5 – *Emergency Medical Services*
  - Chapters 1 – 14, § 1797 - 1857

Ambulance Diversion
California Code of Regulations
- Title 13, Division 2, Chapter 5, Article 1 - *Motor Vehicles* | *Department of the California Highway Patrol* | *Special Vehicles* | *Ambulances*
  - § 1105(c) – Destination Restriction

Detention of Mentally Disordered Persons for Evaluation and Treatment
California Welfare and Institutions Code
- Division 5, Part 1, Chapter 2 Article 1 – *Community Mental Health Services* | *The Lanterman-Petris Short Act* | *Involuntary Treatment*
  - § 5150

Discipline and Enforcement
California Code of Regulations
- Title 22, Division 9, Chapter 4.1, Article 4 – *Social Security* | *Prehospital Emergency Medical Services* | *EMT and Advanced EMT Disciplinary Action* | *Determination and Notification of Action*
  - § 100108.06. Denial or Revocation of a Certificate

California Government Code

- Title 2, Division 3, Part 1, Chapter 5 - *Government of the State of California* | *Executive Department* | *State Departments and Agencies* | *Administrative Adjudication: Formal Hearing*
  - § 11500 - 11529

California Health and Safety Code

- Division 2.5, Chapter 7 – *Emergency Medical Services* | *Penalties*
  - § 1798.200(c)

California Penal Code

- Part 4., Title 1, Chapter 1. – *Investigation, Identification, and Information Responsibilities of the Department of Justice*
  - § 11006 - 11144

Emergency Medical Services Authority

- Recommended Guidelines for Disciplinary Orders and Conditions of Probation (*Model Disciplinary Orders*)

Hospital Emergency Services Reduction Impact Assessment

California Health and Safety Code

- Division 2, Chapter 2, Article 5 – *Licensing Provisions* | *Health Facilities* | *Suspension and Revocation*
  - § 1300

Incident Command System (ICS)

FIRESCOPE Position Manual

- Fireline EMT & EMT-P

Leave Behind Naloxone

California Civil Code

- Division 3, Part 3 – *Obligations* | *Obligations Imposed by Law*
  - § 1714.22

Mutual Aid

Governor's Office of Emergency Services (Cal OES)

- Mutual Aid Plan

Prehospital Receiving Center Planned Reduction or Elimination of Emergency Medical Services

California Health and Safety Code

- Division 2, Chapter 2, Article 1 – *Licensing Provisions* | *Health Facilities, General*
  - § 1255.1

Tactical EMS

California Penal Code

- Part 4, Title 4, Chapter 1 - *Prevention of Crimes and Apprehension of Criminals* |*Standards and Training of Local Law Enforcement Officers* | *Commission on Peace Officer Standards and Training*
  - § 13518 – Field Services, Standards, and Certification

LOCAL

Riverside County Ordinance No. 756.1

- An Ordinance Of The County Of Riverside Amending Ordinance No. 756 Establishing Regulations For ALS Ambulance, Air Ambulance, BLS Ambulance, And Critical Care Transport Providers

Riverside County Resolution No. 2013-052

- Resolution of the Board of Supervisor of the County of Riverside Providing for an Emergency Medical Care Committee for the County of Riverside
    - EMCC

101	REMSA Approved Definitions
	Administrative Policy

Last Reviewed: **March 29, 2022**	Last Revised: **July 1, 2026**

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

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

8. 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.

9. 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)

10. 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)

11. Brief Resolved Unexplained Event (BRUE)
    A transient event with no clear cause that is frightening to the observer and consists of a combination of apnea, color change, muscle tone change, and choking/gagging in a pediatric patient that is 1 year of age or less.

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. IV Infusion
    Use of primary tubing to administer IV fluids or medications to a patient at a controlled rate or bolus. Medications may be administered as an IV Infusion utilizing a second primary or secondary tubing set with the primary infusion.

22. 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.

23. 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.

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

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

26. 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.

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

28. "NSAID Criteria"
    The assessment tool that is used to determine the necessity for cervical spine stabilization:
    - **N**euro deficits
    - **S**pinal Tenderness
    - **A**ltered Mental Status
    - **I**ntoxication
    - **D**istracting Injury

29. Online Contact / Direction
    Direct verbal contact, direction or consultation provided to prehospital personnel by an MICN, or BHP, from a base hospital.

30. 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

31. Patient, Geriatric

A patient appearing or known to be 65 years of age or more.

32. Patient, Adult

A patient appearing or known to be 15 years of age or more.

33. Patient, Pediatric

A patient appearing or known to be older than 29 days but less than or equal to 14 years of age.

34. Patient, Neonate

A patient appearing or known to be newborn, and up to 28 days old.

35. Patient, Critical Trauma (CTP)

A patient who meets REMSA's trauma triage criteria.

36. 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.

37. Pediatric Normal Vital Signs

Pediatric Normal Vital Signs				
Age	**RR**	**HR**	**Systolic**	**Diastolic**
0-3 months	35-55	110-160	65-85	45-55
3-6 months	30-45	100-160	70-90	50-65
6-12 months	22-38	90-160	80-100	55-65
1-3 years	22-30	80-150	90-105	55-70
3-6 years	20-24	70-120	95-110	60-75
6-12 years	16-22	60-110	100-120	60-75
12+ years	12-20	60-100	110-135	65-85

38. Persistent

Continuing to exist despite treatment.

39. 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.

40. 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.

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

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

43. 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.

44. 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 + (age x 2)]

45. 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.

46. 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
- Have a blood glucose less than 60 mg/dl if greater than 48 hours old but less than 28 days old
- ***OR***

Have a blood glucose less than 45 mg/dl in neonates less than 48 hours old

47. Titrate
    Slowly increasing the dose of a medicine by very small amounts over time to achieve the best clinical response.

48. Transfer of Patient Care
    The orderly transition of patient care duties from EMS personnel to receiving hospital ED medical personnel.

49. 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

50. 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

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

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

53. 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.

102	REMSA Approved Abbreviations
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **October 23, 2024**

ACS	acute coronary syndrome	CPAP	continuous positive airway pressure	ICU	intensive care unit
AEMT	advanced emergency medical technician	CPR	cardiopulmonary resuscitation	IDDM	insulin-dependent diabetes mellitus / Type I diabetes
AED	automated external defibrillator	DNR	do not resuscitate order	IM	intramuscular
AICD	automatic implantable cardioverter defibrillator	ECG	electrocardiogram	IO	intraosseous
ALOC	altered level of consciousness	EMT	emergency medical technician	IOP	intraosseous push
ALS	advanced life support	EMT-P	emergency medical technician - paramedic	IV	intravenous
AMS	altered mental status	ePCR	electronic patient care record	IVP	Intravenous push
APGAR	appearance, pulse, grimace, activity, respiration	$EtCO_2$	end-tidal carbon dioxide	kg	kilogram(s)
BG	blood glucose	ETT	endotracheal tube – (refers to the tube itself)	LLQ	left lower quadrant
BLS	basic life support	FBAO	foreign body airway obstruction	LUQ	left upper quadrant
BP	blood pressure	FR	French sizing	mcg	microgram(s)
BRUE	brief resolved unexplained event	ga	gauge	MDV	multidose vial
BVM	bag-valve-mask	GCS	Glasgow coma score	mg	milligram(s)
CHF	congestive heart failure	gm	gram(s)	MICN	mobile intensive care nurse
cm	centimeter	GSW	gunshot wound	mL	milliliter
CO2	carbon dioxide	H_2O	water	mm	millimeter
COPD	chronic obstructive pulmonary disease	HTN	hypertension	MRI	magnetic resonance imaging
CP	chest pain	Hx	history	NIDDM	non-insulin-dependent diabetes mellitus/Type II diabetes
ACS	acute coronary syndrome	CPR	cardiopulmonary resuscitation	NKDA	no known drug allergies

1101	Emergency Medical Dispatch Training
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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.

NPA	nasopharyngeal airway
IDDM	insulin-dependent diabetes mellitus / Type I diabetes
NPO	"*nil per os*," nothing by mouth
NS	normal saline
NSAID	non-steroidal anti-inflammatory drug
"NSAID criteria"	criteria used to determine the need for cervical spine immobilization
NTG	nitroglycerin
O_2	oxygen
OD	overdose
OPA	oropharyngeal airway
OTI	orotracheal intubation *(refers to the skill only)*
PO	"*per os*," by mouth
POLST	physician orders for life-sustaining treatment
PRN	"*pro re nata*," when necessary
PSFA	public safety first aid
RLQ	right lower quadrant
RN	registered nurse
ROSC	return of spontaneous circulation
RSV	respiratory syncytial virus
RUQ	right upper quadrant
SL	sublingual
SNF	skilled nursing facility
SOB	shortness of breath
SpO_2	oxygen saturation of peripheral hemoglobin
STD	sexually transmitted disease
STEMI	ST elevated myocardial infarction
Sx	symptoms
TCP	transcutaneous cardiac pacing
TB	tuberculosis
VF	ventricular fibrillation
VT	ventricular tachycardia
X (Times)	(used as multiplication sign)

1102	Emergency Medical Technician Training
Administrative Policy	

Last Reviewed: **October 12, 2023**	Last Revised: **July 1, 2025**

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.

Emergency Medical Technician Training

1. An agency or institution may request approval from the Riverside County EMS Agency as an EMT training provider.

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 (Chapter 2, Article 3, Section 100067.01).

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 complete the following:
    a. Request an application for EMS Training Program Approval by emailing the request to emstraining@rivco.org.
    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.

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.

1103	Paramedic Training
	Administrative Policy

Last Reviewed: **October 12, 2023**	Last Revised: **July 1, 2025**

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.

Paramedic Training

1. An agency or institution will request approval from the Riverside County EMS Agency to become a paramedic training provider.

2. Any institution/agency requesting approval as a paramedic training provider must meet the qualifications for training providers as outlined in California Code of Regulations Title 22, Division 9, Chapter 4, Article 3, Section 100092.02.

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 may include but not be limited to:
    a. A completed application for EMS Training Program Approval An applicable can be requested through emstraining@rivco.org.

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/option 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.

1104	Public Safety First Aid / CPR and Optional Skill Training
Administrative Policy	

Last Reviewed: **October 16, 2023**	Last Revised: **July 1, 2025**

PURPOSE

To establish procedures which allow for the approval of Public Safety 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.

Public Safety First Aid and CPR Training Programs

1. An agency or institution may request approval from the Riverside County EMS Agency as a Public Safety First Aid and CPR training course provider.

2. Any institution/agency requesting approval as a Public Safety First Aid and CPR Training course provider must meet the qualifications for training courses as outlined in Title 22 Regulations (Chapter 2.3, Article 4, Section 100028.01). The requesting institution/agency must have a physical headquarters located within Riverside County. All courses shall be conducted and administered withing Riverside County. 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. Any institution/agency approved as a Public Safety First Aid and CPR Training course provider may appoint a Program Director to assist with administrative and organizational tasks as is required for the efficient operation of the program. Any candidates considered by the program for a Program Director position must meet the minimum qualifications of a Training Instructor as outlined in Section 100028.06, 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 100028.01 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.

8. Training Instructor (PI) candidates for Public Safety First Aid and CPR Training Programs must be approved by REMSA prior to instruction of courses. To be eligible, Training Instructor candidates must have completed a course consistent with Section 100028.01 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 Primary Instructor 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, 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:
    a. A completed application for EMS Training Program Approval. An application can be requested through emstraining@rivco.org.
    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.

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 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 First Aid (PSFA) and CPR Local Optional Scope of Practice (LOSOP) Approval

1. An agency that utilizes Public Safety First Aid (PSFAs) may request approval from the Riverside County EMS Agency to utilize any of the Public Safety First Aid level REMSA approved local optional scope of practice (reference Section 100027.03). *All Public Safety First Aid providers utilizing REMSA Optional Skills for Public Safety First Aid must have completed a REMSA approved Public Safety First Aid and CPR Training Course.*

2. Any agency requesting approval to utilize Public Safety First Aid and CPR LOSOP must meet the qualifications as outlined in Title 22 Regulations (Chapter 2.3, Article 3, Section 100027.01). 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 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 2.3, Section 100027.01.
    a. Training instructors must meet this criterion 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 100027.03.

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 PSFA 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 PSFA 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 PSFA 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 PSFA 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 PSFA 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 First Aid 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 PSFA 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 PSFA 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 PSFA 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 PSFA 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 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 PSFA 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 PSFA provider agency performing the skill.

1105	Paramedic Internship Approval
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 26, 2023**

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.

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.

1201	Fee Schedule
Administrative Policy	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

PURPOSE

To provide a transparent fee schedule for all REMSA-credentialed providers, ground and air ambulance transport organizations, specialty care and base hospitals, EMS training programs, and continuing education providers within REMSA's jurisdiction.

NOTE

Fees will be reviewed and adjusted annually based on the Consumer Price Index (CPI) data published by the U.S. Bureau of Labor Statistics. Do not rely on printed copies of this document for accurate fee information; always refer to RivCoReady.org/remsa for the most current schedule.

Application Type - CREDENTIALING	**Fee[1]**	**Frequency**
EMT Certification - Initial	$206.40	Once[2]
EMT Recertification, New to Riverside County	$206.40	Once[2]
EMT Recertification	$206.40	Every two (2) years[2, 3]
LATE FEE	$10	When applicable
EMT Replacement Card	$10	As needed
Paramedic Accreditation - Initial	$206.40	Once[4]
Paramedic Accreditation - Reverification	$206.40	Every two (2) years[3]
LATE FEE	$25	When applicable
MICN Authorization – Initial	$206.40	Once
MICN Authorization – Reauthorization	$206.40	Every two (2) years[3]
LATE FEE	$25	When applicable

[1] All fees paid to REMSA for the purposes of credentialing are non-refundable.

[2] Includes EMSA's Personnel Registry fee; does NOT include costs associated with LiveScan fingerprinting ("re-rolling" is not required for applicants who are recertifying).

[3] Frequency may be less than two (2) years depending on credential expiration date.

[4] May be required to pay more than once if / when certain conditions are met.

Application Type – PERMITTING	**Fee**	**Frequency**
Advanced Life Support (ALS) Critical Care Transport (CCT) and Air Ambulance / Helicopter (HEMS)	$7,224 (each permit)	Annually
Basic Life Support (BLS)	$4,128	Annually
INSPECTION: Individual Unit Fee	$516	Annually and when required

Application Type – HOSPITAL DESIGNATION	Fee	Frequency
Trauma Designation	$67, 080	Annually
Stroke / STEMI Designation	$51, 600 (each)	Annually
Pediatric Receiving Designation	$46,440	Annually
Base Hospital Designation	$36,120	Annually

Application Type – EDUCATION AND WORKFORCE DEVELOPMENT	Fee	Frequency
EMT Training Program Approval	$3,096	Every four (4) years
Paramedic Training Approval	$5,160	Every four (4) years
Continuing Education Provider Approval	$2,064[1]	Every four (4) years

[1] Continuing Education Provider application fees are not included in base hospital designation application fees.

1202	EMT Certification
	Administrative Policy

Last Reviewed: **March 14, 2023**	Last Revised: **July 1, 2026**

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

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
   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, § 100066.02 through 100066.05 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. 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
     - Unexpired U.S. **OR**
     - 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).
  - All information on the card must be typed.
  - The card must be valid for a minimum of thirty (30) days past the application date.
  - REMSA does not accept CPR certifications from "100% online" providers. All examinations for CPR certification must include a psychomotor (i.e., hands-on) component.
- **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: REMSA EMT Request for LiveScan Service). It is recommended that the applicant keep a copy of this form for their records.
  - **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) 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 § 100067.02 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. 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 $275.40 – 295.40. Approximate costs are itemized below:

Fee Type	Funds Paid To	Cost
Live Scan Fingerprinting[1]		
"Rolling" Fee	3rd Party Servicer	$20 - $40
CA DOJ Analysis Fee	3rd Party Servicer on behalf of the CA DOJ	$32
FBI Analysis Fee	3rd Party Servicer on behalf of the FBI	$17
		Total due to 3rd Party Servicer = $69 - $89
LEMSA certification fee	REMSA	$131.40
EMSA Personnel Registry	REMSA (collected on behalf of Cal EMSA)	$75
		Total due to REMSA = $206.40

[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.

1203	EMT Recertification
Administrative Policy	

Last Reviewed: **March 14, 2023**	Last Revised: **July 1, 2026**

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

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).

a. Only currently certified EMTs who hold an active California EMT certification are eligible to apply for recertification
b. 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).
c. Applicants whose EMT certification is expired are not eligible for recertification
    1. Refer to REMSA Policy #1204 (EMT Reinstatement)
d. 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
    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 § 100066.02 through 100066.05 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.

- **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:
  - **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: REMSA EMT Request for LiveScan Service).
    - **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) for more information.**

  AND (if not already on file with REMSA)

  - **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. The card must be valid for a minimum of thirty (30) days past the application date.
   c. REMSA does not accept CPR certifications from "100% online" providers. All examinations for CPR certification must include a psychomotor (i.e., hands-on) component.
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**
      ii. Unexpired foreign, with a valid U.S. visa and approved U.S. Department of Homeland Security Lawful Record of Admission.
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 3.5 (EMS Continuing Education).
5. **EMT SCV**: an original Skills Competency Verification (SCV) form, EMSA-SCV (01/17), completed by an approved verifier in accordance with REMSA Policy #1402 (Skills Competency Verification).

Approved CE Providers in California can be found here: https://emstraining.emsa.ca.gov/ShowTraining/ContinuingEducation/GroupByContinuingEducationTable.aspx.CAPCE-accredited CE providers can be found here: https://cecbems.org/Home/Providers. Only those course topics meeting Chapter 3.5 requirements will be accepted for CE credit. More information regarding CE requirements for EMS personnel can be found here: REMSA CE Guide for Personnel.

After assembling the above materials, the application can be accessed by going directly to the online license management portal, found HERE. 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 $206.40 when a complete and correct application is submitted and paid on time, and $216.40 when the application is incomplete, incorrect, or paid after expiration. Costs are itemized below:

Fee Type	Funds Paid To	Cost
LEMSA certification fee	REMSA	$169.40
EMSA Personnel Registry Fee	REMSA (collected on behalf of Cal EMSA)	$37
		Total due to REMSA = $206.40
*LEMSA certification fee – **LATE****	*REMSA*	*$179.40 ($169.40 **+ $10 LATE FEE**)*
EMSA Personnel Registry Fee	REMSA (collected on behalf of Cal EMSA)	$37
		Total due to REMSA = $216.40
Recertification, New to Riverside County	REMSA	$131.40
EMSA Personnel Registry Fee/ Change Certifying Entity	REMSA (collected on behalf of Cal EMSA)	$75
		Total due to REMSA = $206.40

*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 3.5, (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.

1204	EMT Reinstatement
Administrative Policy	

Last Reviewed: **March 14, 2023**	Last Revised: **July 1, 2026**

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

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
   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, § 100066.02 through 100066.05 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.

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. The card must be valid for a minimum of thirty (30) days past the application date.
   c. REMSA does not accept CPR certifications from "100% online" providers. All examinations for CPR certification must include a psychomotor (i.e., hands-on) component.
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
      ii. Unexpired foreign, with a valid U.S. visa and approved U.S. Department of Homeland Security Lawful Record of Admission.

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: REMSA EMT Request for LiveScan Service) 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) 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 3.5 (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), completed by an approved verifier in accordance with REMSA Policy #1402 (Skills Competency Verification), 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: REMSA CE Guide for Personnel.

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 3.5 (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 CEs.
2. **EMT SCV**: an original Skills Competency Verification (SCV) form, EMSA-SCV (01/17), completed by an approved verifier in accordance with REMSA Policy #1402 (Skills Competency Verification), 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 3.5 (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 CEs.
2. **EMT SCV**: an original Skills Competency Verification (SCV) form, EMSA-SCV (01/17), completed by an approved verifier in accordance with REMSA Policy #1402 (Skills Competency Verification).
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. 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 $216.40. Approximate costs are itemized below:

Fee Type	Funds Paid To	Cost
LEMSA Reinstatement Fee	REMSA	*$179.40 ($169.40* ***+ $10 LATE FEE****)*
EMSA Personnel Registry	REMSA (collected on behalf of Cal EMSA)	$37
		Total due to REMSA = $216.40

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:

Fee Type	Funds Paid To	Cost
Live Scan Fingerprinting[1, 2]		
1. "Rolling Fee"	3rd Party Servicer	$20 - $40
2. CA DOJ Analysis Fee	3rd Party Servicer on behalf of the CA DOJ	$32
3. FBI Analysis Fee	3rd Party Servicer on behalf of the FBI	$17
		Total due to 3rd Party Srvc = $69 - $89
LEMSA certification fee	REMSA	*$141.40 ($131.40* ***+ $10 LATE FEE****)*
EMSA Personnel Registry	REMSA (collected on behalf of Cal EMSA)	$75
		Total due to REMSA = $216.40

[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.

1205	EMT Certification by Challenge
	Administrative Policy

Last Reviewed: **March 14, 2023**	Last Revised: **July 1, 2026**

PURPOSE

1. To explain the EMT certification challenge process
2. To delineate who is eligible to challenge the EMT certification process

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 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
   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 § 100066.02 through 100066.05 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. 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. The card must be valid for a minimum of thirty (30) days past the application date.
   c. REMSA does not accept CPR certifications from "100% online" providers. All examinations for CPR certification must include a psychomotor (i.e., hands-on) component.

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
      ii. Unexpired foreign, with a valid U.S. visa and approved U.S. Department of Homeland Security Lawful Record of Admission.

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: REMSA EMT Request for LiveScan Service) 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) 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. 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 $275.40 – 295.40. Approximate costs are itemized below:

Fee Type	Funds Paid To	Cost
Live Scan Fingerprinting[1]		
"Rolling" Fee	3rd Party Servicer	$20 - $40
CA DOJ Analysis Fee	3rd Party Servicer on behalf of the CA DOJ	$32
FBI Analysis Fee	3rd Party Servicer on behalf of the FBI	$17
		Total due to 3rd Party Servicer = $69 - $89
LEMSA certification fee	REMSA	$131.40
EMSA Personnel Registry	REMSA (collected on behalf of Cal EMSA)	$75
		Total due to REMSA = $206.40

[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.

1207	Paramedic Accreditation
	Administrative Policy

Last Reviewed: **February 6, 2023**	Last Revised: **July 1, 2026**

PURPOSE

To describe the process of:

- Receiving initial paramedic accreditation
- Reinstating paramedic accreditation after invalidation
- Reverifying paramedic accreditation

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 **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.emsa.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 $200 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 § 100091.02 (Scope of Practice of Paramedic) as well as the REMSA Policy and Protocol Manual.
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 § 100094.02).
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. 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/ALS or REMSA-approved equivalent***: current and valid American Heart Association (AHA) Advanced Cardiac Life Support (ACLS) **OR** American Red Cross (ARC) Advanced Life Support (ALS) provider card.
- **PALS/ALS PEPP/NAEMT-EPC**: current and valid American Heart Association (AHA) **OR** American Red Cross (ARC) Pediatric Advanced Life Support (PALS) provider card **OR** proof of successful completion of the American Academy of Pediatrics (AAP) Advanced Life Support (ALS) Pediatric Education for Prehospital Professionals (PEPP) course **OR** proof of completion of the National Association of Emergency Medical Technicians (NAEMT) Emergency Pediatric Care (EPC) course.
- **PHTLS/ITLS/TPATC**: proof of successful completion of the National Association of EMTs (NAEMT) Prehospital Trauma Life Support (PHTLS) course **OR** the American College of Emergency Physicians' (ACEP) International Trauma Life Support (ITLS) course **OR** Air and Surface Transport Nurse Association (ASTNA) Transport Professional Advanced Trauma Course (TPATC).
  - ALS provider agency staff will ensure that all paramedic personnel who are active on their service rosters obtain, and continuously maintain, active PHTLS/ITLS/TPATC certification.
    1. Paramedics who are newly employed in Riverside County who do not possess an active PHTLS/ITLS/TPATC certification at the time that they apply for Riverside County paramedic accreditation still meet the qualifications to become accredited. These paramedics will be granted a one-time "grace period," lasting no longer than one hundred eighty (180) days, in which time they must successfully obtain PHTLS/ITLS/TPATC certification and upload a copy to their ImageTrend Licensure profile. Paramedics who are found to have failed to obtain their PHTLS/ITLS/TPATC certification one hundred eighty-one (181) days or more after their Riverside County paramedic accreditation has been approved will have their accreditation invalidated, and they may be subject to further disciplinary action(s).
- **REMSA ALS SCV form**: proof of successful completion, as evidenced by the ALS SCV form containing names, dates, signatures, etc. in all appropriate fields.
  - A previously submitted SCV form will be accepted a second time if:
    1. The paramedic is reverifying their accreditation for the first time **AND**
    2. Their current accreditation period has been active for less than 365 days

**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.*

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.

After assembling the above materials, the application can be accessed by going directly to the online license management portal, found HERE. 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.

- PARAMEDICS APPLYING FOR INITIAL ACCREDITATION ONLY: paramedics who are (1) new to Riverside County **AND** (2) do not hold either an active Pre-Hospital Trauma Life Support (PHTLS), International Trauma Life Support (ITLS), or Transport Professional Advanced Trauma Course (TPATC) certification at the time their application is submitted will be granted local accreditation so long as the only certification they are missing is PHTLS/ITLS/TPATC. All other missing documents will result in a delay in application processing. 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 $200:

- If the expiration of the CA Paramedic license is less than (<) 60 days from the initial application, there will be no fee associated with the initial reverification submission.

Fee Type	Funds Paid To	Cost
Local Accreditation - Initial	REMSA	$206.40
		Total = $206.40

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:

Fee Type	Funds Paid To	Cost
Local Accreditation - Reinstatement	REMSA	$206.40
		Total = $206.40

Accreditation Reverification Fees

When paid	Fee Type	Funds Paid To	Cost
On time	Local Accreditation - Reverification	REMSA	$206.40
			Total = $206.40

When paid	Fee Type	Funds Paid To	Cost
LATE	Local Accreditation - Reverification	REMSA	$206.40
	Late Fee	**REMSA**	**$25**
			Total = $231.40

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**.

1209	MICN Authorization
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

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. If a nurse has completed the REMSA approved MICN course, they are considered "provisional" and cannot independently communicate with EMS providers until they have completed AND been approved through the REMSA MICN authorization application process and signed off by Base Hospital Prehospital Liaison Nurse (PLN).

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. 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 the online credentialing portal, 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.
   - 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 $206.40.

- If the expiration of the CA RN license is less than (<) 60 days from the initial application, there will be no fee associated with the initial reauthorization submission.

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 REMSA Policy 1210 (*MICN Reauthorization*) so long as re-employment is in the Emergency Department at another base hospital in Riverside County and the separation from the previous base station was less than (<) 12 months.
- If the separation from the previous base station is greater than (>) 12 months but less than (<) 36 months, the MICN may follow the process outlined in REMSA Policy 1211 (*MICN Challenge*) if their current employer elects to sponsor the MICN.

It is the MICN's responsibility to keep his/her contact information updated with REMSA via the on-line credentialing system, found HERE. 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.

1210	MICN Reauthorization
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

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.

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 REMSA 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.
   b. A previously submitted SCV form will be accepted a second time it:
      1. The MICN is reauthorizing for the first time **AND**
      2. Their current authorization period has been active for less than 365 days.

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, NAEMT-EPC, 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. 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 the online credentialing portal, 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.
   - 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/Conditions of Expiration

The fee for MICN reauthorization is $206.40.

- If the expiration of the MICN authorization/CA RN license is less than (<) 60 days from the initial application, there will be no fee associated with the initial reauthorization submission.

A late fee of $25 will be applied to:

- All applications that have been initiated, but remain incomplete, after authorization has expired.
- Expiration less than (<) 6 months, late fee only
- Expiration greater than (>) 6 months and less than (<) 12 months, late fee plus an additional 15 CE hours (total 45 CE hours required for authorization)
- Expiration greater than (>) 12 months and less than (<) 36 months, not able to submit for reauthorization. MICN will need to follow REMSA Policy 1211 *MICN Challenge*
- Expiration greater than (>) 36 months, completion of the "MICN Initial Authorization" application is required.

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.

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

1. A MICN Employment Change form (submitted by the MICN)
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 MICN IS RE-EMPLOYED BETWEEN NINETY-ONE (91) DAYS BUT LESS THAN (<) 365 DAYS OF SEPARATION, the following must be submitted to REMSA to reinstate accreditation:

1. A MICN Reverification application (submitted by the MICN)
2. Verification of employment (submitted by the employer)
3. A fee of $200 for reinstatement of accreditation is required.

IF A MICN IS RE-EMPLOYED GREATER THAN (>) 365 DAYS BUT LESS THAN (<) 36 MONTHS OF SEPARATION, THEY ARE NOT ELIGIBLE FOR REINSTATEMENT OF ACCREDITATION. THE MICN MAY FOLLOW THE PROCESS OUTLINED IN REMSA POLICY 1211 *MICN CHALLENGE* IF SPONSERED BY A BASE STATION. GREATER THAN (>) 36 MONTHS OF SEPARTATION, COMPLETION OF THE "MICN INITIAL AUTHORIZATION" APPLICATION IS REQUIRED.

It is the MICN's responsibility to keep his / her contact information updated with REMSA via the on-line credentialing system, found HERE. 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.

1211	MICN Challenge
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

PURPOSE
To define the requirements for authorization by challenge as a mobile intensive care nurse (MICN) in Riverside County.

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 greater than (>) 1 year, but less than (<) three (3) years expired/separated from REMSA base station, **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. Twelve (12) 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 CA RN license, whichever comes first, provided Base Hospital ED employment is maintained. If the expiration of the CA RN license is less than (<) 60 days from the initial application, there will be no fee associated with the initial reauthorization submission.

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. 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's face. 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. An original ALS Skills Competency Verification (SCV) form, completed by an approved verifier in accordance with REMSA Policy #1402 (Skills Competency Verification), must also be submitted.

After navigating to the online credentialing portal, 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.

2. 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 "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 challenge authorization is $206.40.

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 REMSA Policy 1210 (*MICN Reauthorization*) so long as re-employment is in the Emergency Department at another base hospital in Riverside County and the separation from the previous base station was less than (<) 12 months.

It is the MICN's responsibility to keep his / her contact information updated with REMSA via the on-line credentialing system, found HERE. 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.

1212	Out-of-County Certification Acknowledgment
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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, https://rivcoready.org/remsa. 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.

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1301	Discipline and Enforcement Reference
Administrative Policy	

Last Reviewed: **May 1, 2025**	Last Revised: **March 3, 2026**

PURPOSE

To define the steps and processes used by the Riverside County EMS Agency (REMSA) when initiating, notifying, investigating, and adjudicating legal issues involving prehospital personnel as well as the statutory authority delegated to REMSA to execute these actions. To provide clarity to those affected by investigations and procedures, REMSA has created the Discipline and Enforcement Reference, which can be found HERE. It is a comprehensive document that has been made available for the benefit of the Riverside County EMS system that includes information pertaining to California Health and Safety Codes (HSC), the California Code of Regulations (CCR 22) Title 22, the Emergency Medical Services Authority of California (EMSA)'s Model Disciplinary Orders (MDOs), REMSA policies and procedures, and more.

Any reference(s) to this document in a subsequent charging document will be identified as a violation of REMSA Policy #1301.

Investigative Authority

REMSA has the delegated authority to conduct investigations according to statutes and regulations, which include but are not limited to violations of:

- HSC § 1798.200 et seq.
- CCR 22, Division 9, Chapters 3.1, 3.2, 3.3, 4.1, and 4.2

1302	Unusual Occurrence Submission, Process, and Review (Discipline)
Administrative Policy	

Last Reviewed: **June 12, 2023**	Last Revised: **June 18, 2024**

PURPOSE
To outline the process of submitting formal disciplinary complaints to REMSA. Use of REMSA's online Complaint and Investigation Form to submit incidents is mandatory unless the nature or severity of the unusual occurrence is particularly egregious or heinous. If this is the case, REMSA's Discipline and Enforcement Unit may be contacted directly, by phone, at 951-358-5029 x2. REMSA takes all reported concerns seriously, whether or not the official reporting form is used.

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.

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 (Unusual Occurrence Submission, Process, and Review (Clinical)).

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 Complaint and Investigation Form.
   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).
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.)

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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.

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1402	Skill Competency Verification
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

PURPOSE
To outline the responsibilities of an organization in Riverside County that performs ALS and/or EMT skill competency verifications (SCV).

DEFINITION
Organization
For the purposes of this policy, an organization is an EMS service provider agency, an approved continuing education (CE) provider, and/or an EMS training program.

APPLICATION
Organizations must be approved by REMSA before they are permitted to verify skill competency.

ANNUAL APPROVAL PERIOD
Skill competency verifier (SCVr) approval is valid for a 12-month period, beginning July 1, and ending on June 30, of the following year.

ANNUAL REPORTING PERIOD
Due by July 1st of every calendar year. Updated SCVr Attestation Forms will be submitted to REMSA at this time by emailing them to emstraining@rivco.org.

Failure to submit an SCVr Attestation Form by an approved organization during the Annual Reporting Period will result in the termination of approval of all of previously approved SCVrs.

PROCESS
Upon initial completion/reverification of an SCVr competency course, attendees will sign the SCVr Attestation Form verifying that they have been approved to verify the skill competency of others. SCV verifying agencies must notify REMSA within five (5) business days of any additions, modifications, or removals of their SCVr staff.

TO BECOME A SKILL VERIFYING AGENCY OR ORGANIZATION
If your agency or organization is not currently an approved skill competency verifying entity but they wish to be, contact the REMSA Clinical team (remsa_clinical@rivco.org) to schedule a meeting so that an evaluation of your site and potential trainers can take place.

Responsibilities of the Skill Verifying Organization

For EMT skill verifications:
1. Form EMSA – SCV (01/17) is currently the only REMSA-recognized document to record skill competency for EMTs.
2. REMSA encourages organizations to verify an EMT's skill against National Registry (NR) standards; NR skills sheets can be found here. If an organization prefers to utilize a skill sheet that is a variation of an NR skill sheet, it must be approved by REMSA prior to implementation and use.
   a. Any / all updates to non-NR skills sheets must be reviewed and approved by REMSA prior to implementation.

For paramedic and MICN skill verifications:
1. ALS Skill Competency Verification Form v72922 is currently the only REMSA-recognized document to record skill competency for paramedics and MICNs.

For skill competency verifier (SCVr) training:
BEGINNING JULY 1, 2024, organizations will use and submit to REMSA the REMSA Skills Competency Verifier (SVCr) Attestation Form to document initial and reverification training as well as to notify of removal of SCVrs from their roster.

SCV-designated organizations will approve/sign off SCVrs using the REMSA Skills Competency Verifier (SCVr) Attestation Form only after having directly observed, evaluated, and validated competency.

Minimum Qualifications of SCVrs

SCVrs must:

1. Hold current, unexpired certification or licensure as an EMT, paramedic, registered nurse (RN), physician's assistant (PA), or physician (MD/DO) **AND**
2. Be employed by a REMSA-approved organization **AND**
3. Have received approved training from the organization approving their SCVr status.

Responsibilities of the SCVr:

- SCVrs may only verify the competency of skills for which they are credentialed (i.e., EMT SCVrs may only verify and sign off BLS level skill competency. ALS skill verifiers may only sign off ALS skill competency; however, ALS personnel who have attended and successfully completed training for both EMT and ALS levels of skill may then be approved to sign off both EMT and ALS skills).
- SCVrs will verify skills only in a setting (time/place) that has been pre-approved by their organization.
- SCVrs will only sign an SCV form after verifying that all appropriate information has been documented on the form prior to the individual performing skills.
    - For EMT skills: individuals must include their name as shown on their California EMT Certificate, their EMT Certificate Number, and a wet signature.
    - For ALS skills: individuals must include their name as shown on their paramedic license or MICN authorization, their certificate or license number, and their wet signature.
- SCVrs will only sign an SCV form after having directly observed, evaluated, and validated the competency of the individual requesting skill competency verification.

Responsibilities of the SCV Candidate:

- Individuals participating in an SCV course must be sure to completely fill out the appropriate sections of their SCV form prior to completing any skill verification station. See above ("For EMT skills:" and "For ALS skills:") for direction.
- Individuals participating in an SCV course must ensure that the SCVr signs their SCV form immediately after their skill competency has been verified.
- EMTs, paramedics, and MICNs will submit a scanned copy of their completed, original SCV form as part of their initial and/or renewal application for licensure, accreditation, or authorization. Completed SCV forms are valid for two (2) years; it is the responsibility of the SCV candidate to retain it.
    - MICNs are only required to submit an ALS SCV form if they are initially authorizing OR elect to participate in an ALS SCV course rather than a PLN coordinated / scheduled ride-out when reauthorizing.

For paramedics and MICNs only

A previously submitted SCVform will be accepted a second time if:

1. The paramedic or MICN is reverifying/reauthorizing their accreditation for the first time **AND**
2. Their current accreditation/authorization period has been active for less than 365 days.

For EMTs only

- **Skill 5**: "*Cardiac Arrest Management w/AED,*" is not equivalent to obtaining and maintaining current and valid American Heart Association, American Red Cross, or California-approved BCLS/CPR ("professional" level) certification. This certification must be submitted in addition to the EMT SCV form.
- **Skill 9**: Successful completion of this skill is not equivalent to submitting proof of Epinephrine Administration, Naloxone Administration, and Glucometer Training, as required by Title 22 § 100067.11.
  Additionally, SCV candidates are not required to have all skills validated in a singular setting. They must, however, use the same SCV form during the same licensure, accreditation, or authorization cycle for the purposes of having their skill competency evaluated and validated.

2101	Emergency Medical Dispatch
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **April 17, 2024**

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.

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 one hundred and eighty (180) 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.

2102	Emerging Infectious Disease Screening
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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
      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.

2102A	Emerging Infectious Disease Screening: Non-EMD
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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. REMDSA 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

Riverside University HEALTH SYSTEM Medical Center

DISPATCH CENTER EMERGING INFECTIOUS DISEASE SCREENING TOOL

COUNTY OF RIVERSIDE EMD Emergency Management Department

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

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

https://www.cdc.gov/coronavirus/2019-ncov/index.html

4/6/2020 4:06 PM

Riverside University HEALTH SYSTEM Public Health

INTERIM 2019 NOVEL CORONAVIRUS (2019-nCoV) PATIENT UNDER INVESTIGATION (PUI) FORM

Today's date: Time of call:

Form completed by:

Crew identifier: Unit identifier: Incident number:

Patient age: **Gender** ☐ **M** ☐ F D **Other**

PU/ Criteria

Approximate date of symptom onset _____

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

☐ Fever ☐ Cough D Sore throat D Shortness of breath

D Chills D Headache D Muscle aches D Vomiting D Abdominal pain D Diarrhea

D Other, specify _____

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

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

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

Was the case ill at the time of contact? ☐ Yes ☐ No ☐ Unknown

Did the case originate in the United States? D Yes ☐ No ☐ Unknown

Did the case originate **OUTSIDE** of the United States? D Yes ☐ No ☐ Unknown

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

☐ China D Iran D Italy D Japan D South Korea D 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? D Yes D No D Unknown

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

D China D Iran D Italy D Japan D 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? D Yes D No D Unknown

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

https://www.cdc.gov/coronavirus/2019-nCoV (index.html

*Updated: 4/7/2020 8:23 AM

2120	Closest ALS Ambulance – Mountain Plateau
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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).

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.

2201	Radio Communication Standard
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

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.

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 an 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 EMS Surge / multi-casualty 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, EMS Surge/MCI 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/zFLpbDYHqH.

2202	ReddiNet
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

PURPOSE
To describe the capabilities of the ReddiNet, the responsibilities associated with its use, and its operation.

ReddiNet Capabilities
The ReddiNet is used by the EMS system for operational communications, including: ambulance diversion status, EMS Surge / Multiple Casualty Incident (MCI) 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) and/or the applicable user guide (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 Tab
   a. During an/a EMS Surge/Multi-Casualty Incident (MCI), the contacted base hospital will initiate the EMS Surge/MCI 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/a EMS Surge/MCI
   d. The base hospital initiating an/a EMS Surge/MCI will end the event once all patients have arrived at a receiving center
   e. When necessary, REMSA may take over responsibility for managing an/a EMS Surge/MCI
      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

BED TYPE	BED / ROOM / WARD / FLOOR DEFINITION	PATIENT CENSUS INFORMATION NEEDED	HAvBED INFORMATION NEEDED
Medical / Surgical (MED/S)	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.	The total number of currently admitted patients occupying a bed in an area that meets the MED/S bed / room / ward / floor definition	The total number of **unoccupied, staffed** beds / rooms in an area that meets the MED/S bed / room / ward / floor definition
Telemetry (TELE)	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.	The total number of currently admitted patients occupying a bed in an area that meets the TELE bed / room / ward / floor definition	The total number of **unoccupied, staffed** beds / rooms in an area that meets the TELE bed / room / ward / floor definition
Adult Intensive Care or Adult Critical Care Unit (ICU / CCU)	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.).**	The total number of currently admitted patients occupying a bed in an area that meets the ICU / CCU bed / room / ward / floor definition	The total number of **unoccupied, staffed** beds / rooms in an area that meets the ICU / CCU bed / room / ward / floor definition
Pediatric Intensive Care Unit (PICU)	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.**	The total number of currently admitted patients occupying a bed in an area that meets the PICU bed / room / ward / floor definition	The total number of **unoccupied, staffed** beds / rooms in an area that meets the PICU bed / room / ward / floor definition
(Neonatal Intensive Care Unit (NICU)	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.**	The total number of currently admitted patients occupying a bed in an area that meets the NICU bed / room / ward / floor definition	The total number of **unoccupied, staffed** beds / rooms in an area that meets the NICU bed / room / ward / floor definition
Pediatrics (PEDS)	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.	The total number of currently admitted patients occupying a bed in an area that meets the PEDS bed / room / ward / floor definition	The total number of **unoccupied, staffed** beds / rooms in an area that meets the PEDS bed / room / ward / floor definition
Obstetrics and Gynecological (OB/GYN)	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&D) units, L&D delivery rooms / suites (private or otherwise), well-baby nurseries (not otherwise included in a separate NICU) or any combination of these terms.	The total number of currently admitted patients occupying a bed in an area that meets the OB/GYN bed / room / ward / floor definition. **Mother alone counts as one (1) patient, mother and baby count as two (2)**	The total number of **unoccupied, staffed** beds / rooms in an area that meets the OB/GYN bed / room / ward / floor definition
Trauma	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**	The total number of currently admitted patients occupying a bed in an area that meets the Trauma bed / room / ward / floor definition	The total number of **unoccupied, staffed** beds / rooms in an area that meets the Trauma bed / room / ward / floor definition

Burn	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. **NOTE: This does not include patients being treated or held in an ED trauma bed / bay prior to transfer, inpatient admission or emergent surgery**	The total number of currently admitted patients occupying a bed in an area that meets the Burn bed / room / ward / floor definition	The total number of **unoccupied, staffed** beds / rooms in an area that meets the Burn bed / room / ward / floor definition
Isolation (ISO)	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.	The total number of currently admitted patients occupying a bed in a room that meets the Isolation room-type definition	The total number of **unoccupied, staffed** rooms that meet the Isolation room-type definition
Psychiatric (Psych)	Psych beds / rooms / wards / floors are typically reserved for and occupied by any **admitted** 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. **NOTE: This does not include patients being held the ED prior to transfer**	The total number of currently admitted patients occupying a bed in an area that meets the Psych bed / room / ward / floor definition	The total number of **unoccupied, staffed** beds / rooms in an area that meets the Psych bed / room / ward / floor definition
Operating Rooms (OR)	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.	The total number of patients occupying a bed in a location that meets the OR bed / suite / area definition	The total number of **unoccupied, staffed** beds in a location that meets the OR bed / suite / area definition
Emergency Department (ED) Admission Hold	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.	The total number of patients occupying a bed in the ED that meet the ED Admission Hold patient-type definition	N/A
Ventilators Available	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. **Note**: 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.	N/A	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.

Citations:

COVID Tracking Tool. (2020, April 18). Retrieved May 15, 2020, from https://www.calhospital.org/sites/main/files/file-attachments/data_dictionary_cha_covid_tracker_4-17-20.pdf

National Healthcare Safety Network (NHSN) Patient Safety Component Manual. (2020, January). Retrieved May 15, 2020, from https://www.cdc.gov/nhsn/pdfs/pscmanual/pcsmanual_current.pdf

2203	Patient Care Continuum Time Standards
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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

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

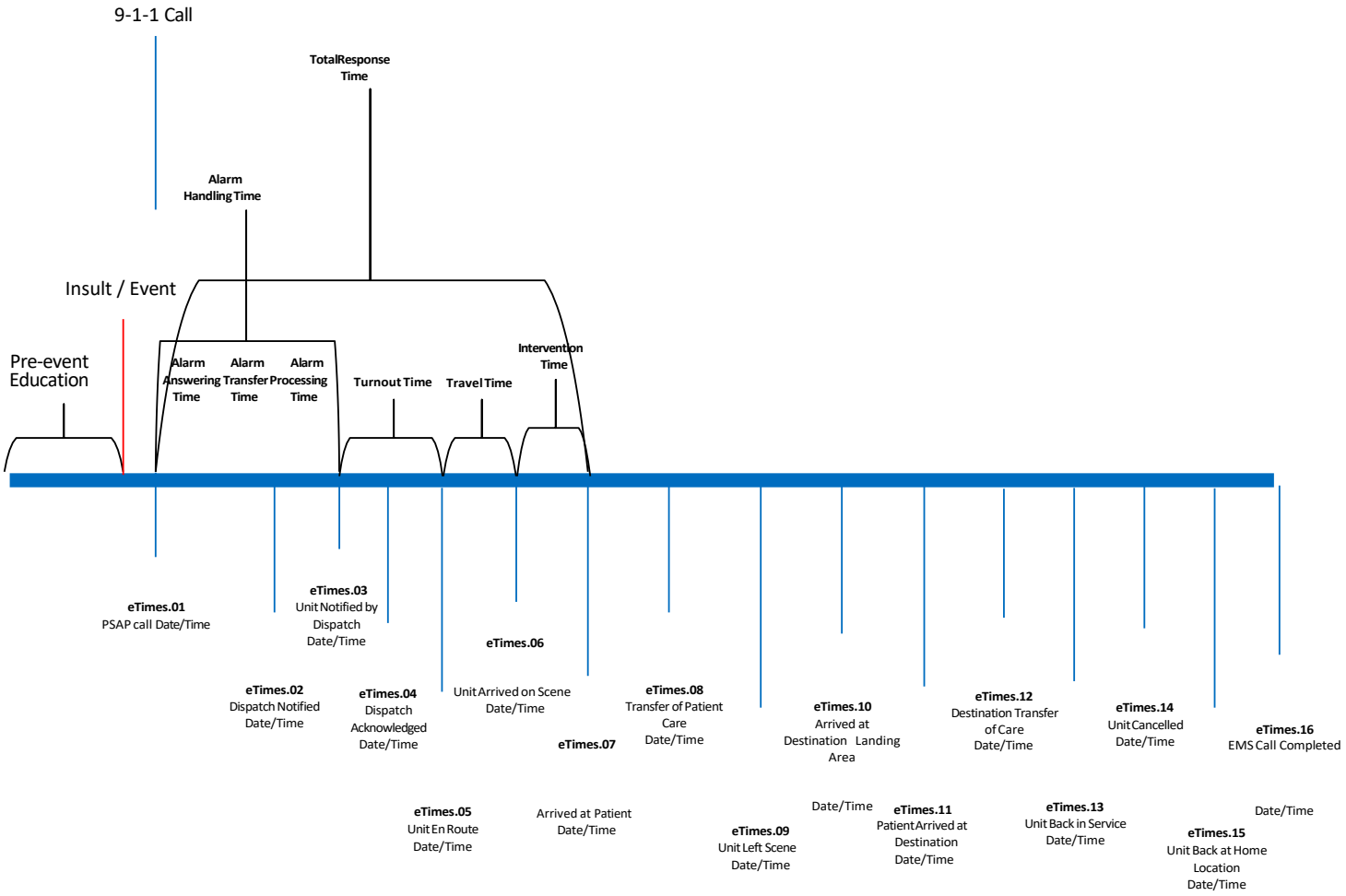
EMS Providers
All EMS providers are required to submit to REMSA verifiable NEMSIS compliant response time data through electronic Patient Care Reports (ePCR). Please refer to REMSA Patient Care Records Policy and REMSIS Authorization and Security Policies for further information on data utilization /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

(Prehospital Patient Time Continuum Chart)

Prehospital Response Intervals

NFPA 1710 Time Intervals and
NEMSIS 3.4 eTimes Elements



3101	First Response Agencies
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

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).

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 Public Safety First Aid(PSFA)
   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 (PSFA, 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), International Trauma Life Support (ITLS), or Transport Professional Advanced Trauma Course (TPATC)
      i. Current proof of course completion required for REMSA authorization as an AEMT, or paramedic

d. Advanced Cardiac Life Support (ACLS) or Advanced Life Support (ALS)
   i. Current proof of course completion required for REMSA authorization as a paramedic
e. Pediatric Advanced Life Support (PALS), Pediatric Education for Prehospital Professionals (PEPP), or National Association of Emergency Medical Technicians – Emergency Pediatric Care (NAEMT-EPC)
   i. Current proof of course completion required for REMSA authorization as a paramedic

3102	Use of Alternative Ambulance
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **May 5, 2025**

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.

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 756.1 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.

3103	Fireline EMT and Paramedic
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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.

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 756.1 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 756.1 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.

3201	Ambulance Permits
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

PURPOSE
To establish criteria for permitting ambulance operations within Riverside County.

Initial Permit Application

To receive an ambulance service permit, the applicant must:

1. Complete and submit an interest letter in the form of a the REMSA Ambulance Service Pre-Application.
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 756.1.
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 756.1; 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. Maintain current CAAS accreditation.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.
8. Comply with all requirements of the County of Riverside Ordinance 756.1 Section H.
9. The permit officer may deny the renewal of, suspend, or revoke a provider permit issued under the provisions of the County of Riverside Ordinance 756.1 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.
10. During an/a EMS Surge/Mass Casualty Incident (MCI), 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/a EMS Surge/MCI. 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/a EMS Surge/MCI, 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 EMS Surge/MCI Plan (Refer to REMSA Policy 3305 *EMS Surge/MCI Management)*.
    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.
11. 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.

3202	Transport Services
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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).

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), Pediatric Education for Prehospital Professionals (PEPP), National Association of Emergency Medical Technicians – Emergency Pediatric Care (NAEMT-EPC)
      i. Current proof of course completion required for REMSA authorization as a paramedic

3203	Safety-Net EMS
Administrative Policy	

Last Reviewed: **July 1, 2024**	Last Revised: **November 27, 2024**

PURPOSE

To define occasions when first response agencies and AMR may need to activate Safety-Net EMS within its jurisdiction.

Use of Safety-Net EMS Ambulance

1. An agreement between first response agency and AMR must be in place prior to utilization of Safety-Net EMS ambulances.
2. The Safety-Net EMS ambulance use, staffing, inventory, and its dispatch services must be consistent with the procedures defined in the agreement between the first response agency and AMR.
3. All ambulances defined and utilized for Safety-Net EMS must be compliant to the Riverside County Ambulance Ordinance 751.1 and REMSA Policy 3201 prior to its operation.
4. The use and activation of Safety-Net EMS ambulance within each jurisdiction must be tracked by AMR and available for review at the request of the EMS Agency.
5. REMSA Duty Officer shall be notified immediately by first response agencies when Safety-Net Ambulance has been utilized within each jurisdiction.
6. All Safety-Net EMS responses will undergo a 100% CQI review by the EOA provider and first response agencies. Reviews will be reported quarterly to REMSA. Please submit reviews to REMSA_Clinical@rivco.org.

3204	ALS Interfacility Transport Service Provider Criteria
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **May 5, 2025**

PURPOSE
To define and establish criteria for permitting Advanced Life Support Interfacility Transport (ALS IFT) service providers within Riverside County.

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, ALSIFT 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:

c. ALS coordinator shall oversee initial and ongoing education and training for all medical personnel involved in the ALS IFT program.
d. Develop and maintain a REMSA approved ALS IFT CQI plan as defined by REMSA policies and procedures.
e. Assure that ALS IFT personnel adhere to BLS and ALS IFT Standing Orders approved by the REMSA Medical Director.
f. Assure that ALS IFT personnel adhere to REMSA protocols, policies and procedures.
g. 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.
h. 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.
i. ALS IFT ambulance staffing
i. Ambulance performing services under this policy shall be staffed according to Riverside County Ambulance Ordinance 756.1 – ALS Ambulance, REMSA policies, and REMSA EMS Plan.
j. 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.
k. 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.
l. Development of required reporting policies
m. 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:
i. 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;
ii. 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;
iii. EMS personnel are killed, or injured to the extent requiring hospitalization or care evaluation by a physician, while on duty;
iv. Patientcare equipment fails while in use, causing patient harm;
v. 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;
vi. Any changes to the geographic area coverage for ALS IFT service provider.
vii. 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.
viii. 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.
            (6) 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* and 7703 *REMSIS Authorization and Security*.

8. Administration Provisions
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 756.1 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.

3301	Medication Waiver Program
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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 he 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.

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

3302	Controlled Substances
	Operational Policy

Last Reviewed: **October 4, 2022**	Last Revised: **December 26, 2023**

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.

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

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

3303	Drug and Equipment List
	Operational Policy

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

PURPOSE

To set equipment requirements for Riverside County EMS Agency (REMSA) authorized PSFA, EMT, AEMT or EMT-P staffed light response, first response and ground transport operations.

APPLICATION

This policy applies to public safety first aid personnel (PSFA), 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.

Personal Documents	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
First Responder/PSFA Certificate	O	O	O	1	O	O	O	O	O	O
CA EMT Certificate	1	O	O	O	1	O	O	1	O	O
CA AEMT Certificate	O	1	O	O	O	1	O	O	1	O
CA EMT-P License	O	O	1	O	O	O	1	O	O	1
CPR for the "Professional Rescuer" or "Healthcare Provider" Card	1	1	1	1	1	1	1	1	1	1

ACLS Card	O	O	1	O	O	O	1	O	O	1
PALS, PEPP, or NAEMT-EPC Card	O	O	1	O	O	O	1	O	O	1
PHTLS, ITLS, or TPATC Card	O	O	1	O	O	O	1	O	O	1
Respirator Fit Card	O	O	O	O	O	O	O	O	O	O
TB Test Card	O	O	O	O	O	O	O	O	O	O
Vaccination Card	O	O	O	O	O	O	O	O	O	O

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, Cal OSHA Title 8 Section5199 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.
2. High visibility garments must meet 23 CFR 634, and ANSI / ISEA 107 (2010).
3. Medical exam gloves must meet 21 CFR 880.6250, or BS EN 455-2.

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.

Personal Protective Equipment	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Helmet	O	O	O	1	1	1	1	1	1	1
Hearing Protection	O	O	O	1	1	1	1	1	1	1
Multiple-Use Eye Protection	1	1	1	1	1	1	1	1	1	1
Respiratory Protection	1	1	1	1	1	1	1	1	1	1
Uniform Shirt/Pant or Jumpsuit	O	O	O	2	2	2	2	2	2	2
Uniform Cold Weather Outerwear	O	O	O	1	1	1	1	1	1	1
High Visibility Garment	O	O	O	1	1	1	1	1	1	1
Barrier Garment/Impermeable Gown	O	O	O	1	1	1	1	1	1	1
Medical Exam Glove	6	6	6	6	6	6	6	6	6	6

Work Glove	O	O	O	2	2	2	2	2	2	2
Multiple-Use Footwear	O	O	O	2	2	2	2	2	2	2
Single-Use Footwear Cover	O	O	O	2	2	2	2	2	2	2
Hand Sanitizer	O	O	O	1	1	1	1	1	1	1
Pocket Mask	O	O	O	1	1	1	1	1	1	1
Nerve Agent Antidote Kit (NAAK)	O	O	O	O	O	O	O	O	O	O
Surgical Mask	O	O	O	O	O	O	O	O	O	O
Sterile Glove	O	O	O	O	O	O	O	O	O	O
Gown	O	O	O	O	O	O	O	O	O	O

Personal Equipment

Personal equipment is listed per individual.

Personal Equipment	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Flashlight	O	O	O	1	1	1	1	1	1	1
Seatbelt Cutter	O	O	O	O	O	O	O	O	O	O
Stethoscope	O	O	O	1	1	1	1	1	1	1
Trauma Shears	O	O	O	1	1	1	1	1	1	1
Two-way Portable Radio	O	O	O	O	O	O	O	O	O	O
Window Punch	O	O	O	O	O	O	O	O	O	O

Incident Command System

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

Incident Command System	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Emergency Response Guidebook	O	O	O	1	1	1	1	1	1	1
Triage Tags	6	6	6	20	20	20	20	20	20	20
Field Operations Guide (ICS 420-1)	O	O	O	1	1	1	1	1	1	1
Packet of MCI/ICS Forms	O	O	O	1	1	1	1	1	1	1

Cervical Spine Stabilization & Splinting

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

Stabilization & Splinting	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Adjustable Pediatric C-Collar	O	O	O	X	2	2	2	2	2	2
Adjustable Adult C-Collar	1	1	1	X	2	2	2	2	2	2
Disposable Head Stabilizer	O	O	O	X	1	1	1	1	1	1
Long Spine Board	O	O	O	X	1	1	1	1	1	1
15' D-Ring Spine Board Strap	O	O	O	X	2	2	2	2	2	2
8 Point Plus Hook & Loop Spine Board Strap (Spider Strap)	O	O	O	X	O	O	O	O	O	O
Speed Clip Spine Board Straps (4 Speed Clip Straps per Board)	O	O	O	X	O	O	O	O	O	O
Medical Duct Tape	O	O	O	X	O	O	O	O	O	O
KED Type Extrication Device	O	O	O	X	1	1	1	1	1	1
Pediatric Stabilization Device	O	O	O	X	1	1	1	1	1	1
Scoop or "Special" Stretcher	O	O	O	X	O	O	O	O	O	O
Vacuum Mattress, Pump, and Supplies	O	O	O	X	O	O	O	O	O	O
Arm Splint	1	1	1	2	2	2	2	2	2	2
Leg Splint	O	O	O	2	2	2	2	2	2	2
Traction Splint(s) with Pediatric and Adult Capabilities	O	O	O	X	1	1	1	1	1	1

Assessment

Assessment equipment is listed per unit or vehicle. Length based pediatric resuscitation tapes must be commercially available and standardized.

Assessment	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Penlight	1	1	1	1	1	1	1	2	2	2
Trauma Shears	1	1	1	1	1	1	1	1	1	1
Stethoscope	1	1	1	1	1	1	1	2	2	2
Infant BP Cuff	O	O	O	X	O	O	O	O	O	O
Child BP Cuff	O	O	O	1	1	1	1	1	1	1

Adult BP Cuff	1	1	1	1	1	1	1	1	1	1
Large Adult BP Cuff	O	O	O	1	1	1	1	1	1	1
Thigh BP Cuff	O	O	O	X	O	O	O	O	O	O
Length Based Pediatric Resuscitation Tape	O	O	O	X	O	1	1	O	1	1
Measuring Tape	O	O	O	X	O	O	O	O	O	O
Calculator	O	O	O	X	O	O	O	O	O	O
Pulse Oximeter with Pediatric and Adult Probes, and Supplies	O	O	O	X	O	1	1	O	1	1
Glucometer with Lancets, Test Strips, and Supplies	X	1	1	X	O	1	1	O	1	1
Thermometer (non-rectal use only) with Supplies	1	1	1	X	O	O	O	O	O	O
Ring Cutter	O	O	O	O	O	O	O	O	O	O
Splinter Kit	1	1	1	O	O	O	O	O	O	O
Response Pack(s), Bag(s), or Case(s)	1	1	1	1	1	1	1	1	1	1

Suction

Suction equipment is listed per unit or vehicle.

Suction	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Manually Powered Portable Suction Unit with Collection Container and Supplies	1	1	1	O	O	O	O	1	O	O
Battery Powered Portable Suction Unit with Collection Container, Battery/Batteries, and Supplies	O	O	O	1	1	1	1	O	1	1
Wall Mount Suction with Collection Container and Supplies	O	O	O	O	O	O	O	1	1	1
Suction Tubing	O	O	O	1	1	1	1	2	2	2
Rigid or Semi-Rigid Suction Tip	O	O	O	1	1	1	1	2	2	2
Bulb Syringe	O	O	O	1	1	1	1	1	1	1
Suction Catheter 6 Fr.	O	O	O	X	O	O	O	O	O	O
Suction Catheter 8 Fr.	O	O	O	X	1	1	1	1	1	1
Suction Catheter 10 Fr.	O	O	O	X	1	1	1	1	1	1
Suction Catheter 12 Fr.	O	O	O	X	O	O	O	O	O	O
Suction Catheter 14 Fr.	O	O	O	X	1	1	1	1	1	1

Suction Catheter 16 Fr.	O	O	O	X	O	O	O	O	O	O
Suction Catheter 18 Fr.	O	O	O	X	O	O	O	O	O	O

BLS Airway

BLS airway equipment is listed per unit or vehicle.

BLS Airway	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Size 0 (50 mm) Oropharyngeal Airway (OPA)	O	O	O	O	O	O	O	O	O	O
Size 1 (60 mm) Oropharyngeal Airway (OPA)	O	O	O	1	1	1	1	1	1	1
Size 2 (70 mm) Oropharyngeal Airway (OPA)	O	O	O	O	O	O	O	O	O	O
Size 3 (80 mm) Oropharyngeal Airway (OPA)	O	O	O	1	1	1	1	1	1	1
Size 4 (90 mm) Oropharyngeal Airway (OPA)	1	1	1	O	O	O	O	O	O	O
Size 5 (100 mm) Oropharyngeal Airway (OPA)	1	1	1	1	1	1	1	1	1	1
14 Fr. Nasopharyngeal Airway (NPA)	O	O	O	O	O	O	O	O	O	O
16 Fr. Nasopharyngeal Airway (NPA)	O	O	O	O	O	O	O	O	O	O
18 Fr. Nasopharyngeal Airway (NPA)	O	O	O	O	O	O	O	O	O	O
20 Fr. Nasopharyngeal Airway (NPA)	O	O	O	1	1	1	1	1	1	1
22 Fr. Nasopharyngeal Airway (NPA)	O	O	O	O	O	O	O	O	O	O
24 Fr. Nasopharyngeal Airway (NPA)	O	O	O	O	O	O	O	O	O	O
26 Fr. Nasopharyngeal Airway (NPA)	O	O	O	O	O	O	O	O	O	O
28 Fr. Nasopharyngeal Airway (NPA)	O	O	O	O	O	O	O	O	O	O
30 Fr. Nasopharyngeal Airway (NPA)	O	O	O	1	1	1	1	1	1	1
32 Fr. Nasopharyngeal Airway (NPA)	O	O	O	O	O	O	O	O	O	O
34 Fr. Nasopharyngeal Airway (NPA)	O	O	O	O	O	O	O	O	O	O
36 Fr. Nasopharyngeal Airway (NPA)	O	O	O	O	O	O	O	O	O	O
Lubricating Jelly Packets	O	O	O	2	2	2	2	2	2	2

Laryngoscopy

Laryngoscopy equipment is listed per unit or vehicle.

Laryngoscopy	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Laryngoscope Handle with Batteries	X	X	1	X	X	X	1	X	X	1
Extra Batteries	X	X	O	X	X	X	2	X	X	2
0 Straight Blade	X	X	O	X	X	X	1	X	X	1
1 Straight Blade	X	X	O	X	X	X	1	X	X	1
2 Straight Blade	X	X	O	X	X	X	1	X	X	1
3 Straight Blade	X	X	O	X	X	X	1	X	X	1
4 Straight Blade	X	X	1	X	X	X	1	X	X	1
1 Curved Blade	X	X	O	X	X	X	O	X	X	O
2 Curved Blade	X	X	O	X	X	X	1	X	X	1
3 Curved Blade	X	X	O	X	X	X	1	X	X	1
4 Curved Blade	X	X	1	X	X	X	1	X	X	1
Extra Bulbs (if applicable to device)	X	X	2	X	X	X	2	X	X	2
Video Laryngoscope and Supplies	X	X	O	X	X	X	O	X	X	O
Pediatric Magill Forceps	X	X	O	X	X	X	1	X	X	1
Adult Magill Forceps	X	X	O	X	X	X	1	X	X	1

ALS Airway

ALS airway equipment is listed per unit or vehicle.

ALS Airway	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
6 mm Cuffed Endotracheal Tube	X	X	1	X	X	X	2	X	X	2
6.5 mm Cuffed Endotracheal Tube	X	X	O	X	X	X	O	X	X	O
7 mm Cuffed Endotracheal Tube	X	X	O	X	X	X	2	X	X	2
7.5 mm Cuffed Endotracheal Tube	X	X	1	X	X	X	O	X	X	O
8 mm Cuffed Endotracheal Tube	X	X	O	X	X	X	2	X	X	2

8.5 mm Cuffed Endotracheal Tube	X	X	O	X	X	X	O	X	X	O
9 mm Cuffed Endotracheal Tube	X	X	O	X	X	X	O	X	X	O
Size 3 - i-Gel Supraglottic Airway Device	X	X	1	X	X	X	1	X	X	1
Size 4 - i-Gel Supraglottic Airway Device	X	X	1	X	X	X	1	X	X	1
Size 5 - i-Gel Supraglottic Airway Device	X	X	1	X	X	X	1	X	X	1
Size 10 - Nasogastric / Orogastric Tube	X	X	1	X	X	X	1	X	X	1
or Size 12 - Nasogastric / Orogastric Tube	X	X	1	X	X	X	1	X	X	1
Size 14 - Nasogastric / Orogastric Tube	X	X	1	X	X	X	1	X	X	1
Size 16 - Nasogastric / Orogastric Tube	X	X	1	X	X	X	1	X	X	1
or Size 18 - Nasogastric / Orogastric Tube	X	X	1	X	X	X	1	X	X	1
Adult Endotracheal Intubation Stylet	X	X	1	X	X	X	1	X	X	1
Endotracheal Tube Introducer Stylet (Bougie)	X	X	O	X	X	X	1	X	X	1
Commercial Endotracheal Tube Securing Device	X	X	1	X	X	X	1	X	X	1

Ventilation

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

Ventilation	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Neonate Resuscitator Mask	O	O	O	1	1	1	1	1	1	1
Infant Resuscitator Mask	O	O	O	1	1	1	1	1	1	1
Pediatric Bag Valve Mask (BVM) Resuscitator Mask with O_2 Reservoir	O	O	O	1	1	1	1	1	1	1
Adult Bag Valve Mask (BVM) Resuscitator Mask with O_2 Reservoir	1	1	1	1	1	1	1	1	1	1
Manometer for BVM	1	1	1	O	2	2	2	2	2	2
Pediatric Colorimetric CO_2 Detector	O	O	O	O	O	1	1	O	1	1
Adult Colorimetric CO_2 Detector	O	1	1	O	O	1	1	O	1	1
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 cmH_2O Variable Valves	X	X	O	X	X	X	1	X	X	1
O2-RESQ™ Large Bi-Trac ED Mask	X	X	O	X	X	X	1	X	X	1
O2-RESQ™ 12.5 cmH_2O Valve	X	X	O	X	X	X	1	X	X	1

O2-RESQ™ 15 cmH2O Valve	X	X	O	X	X	X	1	X	X	1
O2-RESQ™ 20 cmH2O Valve	X	X	O	X	X	X	1	X	X	1
1.75-2-inch 18 ga IV Catheter for Needle Chest Decompression	X	X	2	X	X	X	2	X	X	2
3.25-inch 16 ga IV Catheter for Needle Chest Decompression	X	X	O	X	X	X	O	X	X	O
3.25-inch 14 ga IV Catheter for Needle Chest Decompression	X	X	2	X	X	X	2	X	X	2
One-way Flutter Valve for Needle Chest Decompression	X	X	O	X	X	X	O	X	X	O

AED

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

AED	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
AED with Cables, Battery/Batteries, and Supplies	1	1	1	1	1	1	O	1	1	O
Adult AED Pads	2	2	2	2	2	2	O	2	2	O
Pediatric AED Pads (or Pediatric Capability with Adult Pads)	O	O	O	1	1	1	O	2	2	O
Disposable Prep Razor	1	1	1	1	1	1	O	1	1	O

Resuscitation

Resuscitation equipment is listed per unit or vehicle.

Resuscitation	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Mechanical CPR Device with Supplies	O	O	O	X	O	O	O	O	O	O

ECG

ECG equipment is listed per unit or vehicle.

ECG	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
ECG Monitor with the following capabilities: • 12-Lead Acquisition & Transmission • Biphasic Defibrillation • Cardioversion • Real-time CPR Feedback • Transcutaneous Pacing • Waveform Capnography Must also have the following accessories: • Cables, Battery / Batteries, and Supplies	X	X	O	X	X	X	1	X	X	1

Automated Blood Pressure with Cables, Battery/Batteries, and Supplies	O	O	O	X	O	O	O	O	O	O
Adult Defibrillation Pad Set	X	X	O	X	X	X	2	X	X	2
Pediatric Defibrillation Pad Set	X	X	O	X	X	X	1	X	X	1
Adult ECG Electrodes	X	X	O	X	X	X	20	X	X	20
Pediatric ECG Electrodes	X	X	O	X	X	X	8	X	X	8
Disposable Prep Razor	O	O	O	O	O	O	1	O	O	1
Surgical Hair Clipper with Charger, and Supplies	X	X	O	X	X	X	O	X	X	O
Tincture of Benzoin Swabsticks	X	X	O	X	X	X	1	X	X	1

Oxygen (O_2)

O_2 equipment is listed per unit or vehicle. PSFA equipment requirements apply to REMSA authorized PSFA providers. Required O_2 must be carried in sufficient amounts:

Portable O_2

O_2 for at least 20 minutes @ 10 LPM, approximately:

- D Tank @ 1450 PSI
- Jumbo-D Tank @ 1000 PSI
- E Tank @ 925 PSI

Mounted O_2

O_2 for at least 60 minutes @ 10 LPM, approximately:

- M Tank @ 600 PSI
- G Tank @ 450 PSI
- H Tank @ 400 PSI

Oxygen	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Portable Oxygen System with O_2 Key, Liter Flow Regulator and Diameter Index Safety System Male (DISS-M) Connector	O	O	O	1	1	1	1	1	1	1
Spare Portable O_2 Tank	O	O	O	1	1	1	1	O	O	O
Wall Mount O_2 Regulator	O	O	O	O	O	O	O	2	2	2
Mounted Main O_2 Tank	O	O	O	O	O	O	O	1	1	1
O_2 Supply Hoses, Adaptors and Connectors	O	O	O	O	O	O	O	O	O	O
Infant Non-Rebreather (NRB) O_2 Mask	O	O	O	O	O	O	O	1	1	1
Pediatric Non-Rebreather (NRB) O_2 Mask	O	O	O	1	1	1	1	2	2	2
Adult Non-Rebreather (NRB) O_2 Mask	O	O	O	1	1	1	1	2	2	2
Infant Nasal Cannula	O	O	O	O	O	O	O	O	O	O
Pediatric Nasal Cannula	O	O	O	1	1	1	1	1	1	1
Adult Nasal Cannula	O	O	O	1	1	1	1	1	1	1

Wound Care

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

Wound Care	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
3X3 Sterile Gauze Sponge	O	O	O	O	O	O	O	4	4	4
4X4 Sterile Gauze Sponge	6	6	6	12	12	12	12	12	12	12
Gauze Sponge	O	O	O	O	O	O	O	O	O	O
Rigid Eye Shield (Example)	O	O	O	2	2	2	2	2	2	2
Eye Pad	O	O	O	O	O	O	O	O	O	O
Abdominal Pad	O	O	O	3	3	3	3	3	3	3
Trauma Dressing	4	4	4	2	2	2	2	2	2	2
Occlusive Dressing	2	2	2	2	2	2	2	2	2	2
Roller Gauze Bandage	2	2	2	6	6	6	6	6	6	6
Triangular Bandage	2	2	2	2	2	2	2	2	2	2
Hemostatic Dressing (EMSA approved only)	O	O	O	O	O	O	O	O	O	O
Combat-Application-Tourniquet (C-A-T) ®	2	2	2	2	2	2	2	2	2	2
Tourniquet	O	O	O	O	O	O	O	O	O	O
Non-Adherent Dressing	O	O	O	O	O	O	O	O	O	O
Self-Adherent Wrap	2	2	2	O	O	O	O	O	O	O
Elastic Wrap	O	O	O	O	O	O	O	O	O	O
Transpore™ Tape	1	1	1	2	2	2	2	2	2	2
Cloth Tape	2	2	2	2	2	2	2	2	2	2
Silk Tape	O	O	O	O	O	O	O	O	O	O
Disposable Cold Pack	3	3	3	2	2	2	2	6	6	6
Sterile Burn Sheet	2	2	2	2	2	2	2	2	2	2
1 Liter Normal Saline for Irrigation	O	O	O	2	2	1	1	2	2	2
Eye Wash, Bottle	1	1	1	O	O	O	O	O	O	O
Disposable OB Kit with Receiving Blanket and Head Cover	O	O	O	1	1	1	1	1	1	1

Vascular Access

Vascular access equipment is listed per unit or vehicle.

Vascular Access	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Constricting Band	X	2	2	X	X	2	2	X	2	2
IV Start Kit	X	O	O	X	X	O	O	X	O	O
Adhesive Band-Aid	O	O	O	3	3	3	3	3	3	3
IV Stabilization Dressing	X	2	2	X	X	O	O	X	O	O
IV Stabilization Splint	X	O	O	X	X	O	O	X	O	O
Alcohol Swab	X	6	6	X	X	12	12	X	12	12
Povidone Iodine Swab	X	4	4	X	X	4	4	X	4	4
ChloraPrep Swab	X	O	O	X	X	O	O	X	O	O
24 ga IV Catheter	X	O	O	X	X	2	2	X	2	2
22 ga IV Catheter	X	O	O	X	X	2	2	X	2	2
20 ga IV Catheter	X	2	2	X	X	2	2	X	2	2
18 ga IV Catheter	X	2	2	X	X	2	2	X	2	2
16 ga IV Catheter	X	2	2	X	X	2	2	X	2	2
14 ga IV Catheter	X	2	2	X	X	2	2	X	2	2
Powered IO Device with Pediatric Capability	X	O	O	X	X	1	1	X	1	1
Powered IO Device with Adult Capability	X	X	O	X	X	X	1	X	X	1
EZ-IO Power Driver	X	O	O	X	X	O	O	X	O	O
EZ-IO 15 ga / 15 mm – Pink Needle Set	X	O	O	X	X	O	O	X	O	O
EZ-IO 15 ga / 25 mm – Blue Needle Set	X	O	O	X	X	O	O	X	O	O
EZ-IO 15 ga / 45 mm – Yellow Needle Set	X	X	O	X	X	X	O	X	X	O
B.I.G. 18 ga – Red Pediatric IO Device	X	O	O	X	X	O	O	X	O	O
B.I.G. 15 ga – Blue Adult IO Device	X	X	O	X	X	X	O	X	X	O
Blood Collection Needle	X	O	O	X	X	O	O	X	O	O
Blood Collection Needle Holder	X	O	O	X	X	O	O	X	O	O

Blood Tubes	X	O	O	X	X	O	O	X	O	O
Bio-Hazard Lab Bag	X	O	O	X	X	O	O	X	O	O

Medication Administration

Medication administration equipment is listed per unit or vehicle.

Medication Administration	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Handheld Nebulizer with Mouthpiece, Reservoir, and Supply Tubing	X	O	O	X	X	2	2	X	2	2
Pediatric Nebulizer Mask	X	O	O	X	X	O	O	X	O	O
Adult Nebulizer Mask	X	O	O	X	X	1	1	X	1	1
Nebulizer Tee with Adaptors	X	O	O	X	X	1	1	X	1	1
Holding Chamber for MDI	X	O	O	X	X	O	O	X	O	O
MAD® Nasal-Mucosal Atomization Device	X	X	O	X	X	X	2	X	X	2
18 - 19 ga Hypodermic Needle	X	4	4	X	X	O	O	X	O	O
18 - 19 ga Filter Needle	X	O	O	X	X	O	O	X	O	O
Blunt IV Injection Cannula for Needleless System	X	O	O	X	X	O	O	X	O	O
21 ga X 1 - 1.5” Hypodermic Needle	X	O	O	X	X	2	2	X	O	2
23 ga X 1 - 1.5” Hypodermic Needle	X	O	O	X	X	2	2	X	2	2
25 ga X 1” Hypodermic Needle	X	2	2	X	X	2	2	X	2	2
1 mL TB Syringe	X	2	2	X	X	2	2	X	2	2
3 mL Syringe	X	O	O	X	X	2	2	X	2	2
5 mL Syringe	X	O	O	X	X	2	2	X	2	2
10 mL Syringe	X	2	2	X	X	2	3	X	2	3
20 mL Syringe	X	O	O	X	X	O	1	X	O	1
30 mL Syringe	X	O	2	X	X	O	2	X	O	2
or 60 mL Syringe	X	O	2	X	X	O	2	X	O	2
Carpuject® Holder	X	O	O	X	X	O	O	X	O	O
Saline Lock Extension Set	X	O	O	X	X	2	2	X	2	2

Three Way Stopcock	X	O	O	X	X	O	O	X	O	O
Luer Lock Adaptor	X	O	O	X	X	O	O	X	O	O
Volume Control Chamber IV Set	X	O	O	X	X	1	1	X	1	1
Flow Controller Extension set / "Dial-a-Flow"	X	X	O	X	X	X	1	X	X	1
60 drop / mL IV Set	X	O	O	X	X	O	O	X	O	O
10 drop / mL IV Set	X	2	2	X	X	2	2	X	2	2
Pressure Infusion Bag	X	O	O	X	X	1	1	X	1	1
IV Warmer with Supplies	X	O	O	X	X	O	O	X	O	O
Narcotic Storage	X	X	1	X	X	X	1	X	X	1

Blood Product Administration – LOSOP Required

Blood product administration equipment is listed per unit or vehicle. Par levels are left as "O" for first response and ground transport to support different agencies utilizing different apparatus for each LOSOP.

Blood Product Administration	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
AABB-approved cold storage refrigerator	X	X	X	X	X	X	O	X	X	O
Approved blood warming/rapid transfusing device	X	X	X	X	X	X	O	X	X	O
Blood administration tubing	X	X	X	X	X	X	O	X	X	O

POCUS – LOSOP Required

Ultrasound equipment is listed per unit or vehicle. Par levels are left as "O" for first response and ground transport to support different agencies utilizing different apparatus for each LOSOP.

POCUS	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Portable Ultrasound Device	X	X	X	X	X	X	O	X	X	O
Ultrasound Gel	X	X	X	X	X	X	O	X	X	O

Transportation

Transportation equipment is listed per vehicle. Restraints must be constructed of neoprene over nylon webbing with double hook and loop closure.

Transportation	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Ambulance Cot with 8+ Point Seat Belts	O	O	O	X	X	X	X	1	1	1
Cot Securing System	O	O	O	X	X	X	X	1	1	1
Commercial Child Restraint System	O	O	O	X	X	X	X	1	1	1
Collapsible (Folding) Stretcher	O	O	O	X	O	O	O	1	1	1
Stair Chair	O	O	O	X	O	O	O	O	O	O
Rescue Basket/Litter/Stretcher/Similar Device	O	O	O	X	O	O	O	O	O	O
Wrist Restraint	O	O	O	X	O	O	O	2	2	2
Ankle Restraint	O	O	O	X	O	O	O	2	2	2
Spit Sock (Patient Hood)	O	O	O	X	O	O	O	1	1	1

Waste Disposal

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

Waste Disposal	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Mounted Sharps Container	O	O	O	O	O	O	O	1	1	1
Portable Sharps Container	1	1	1	1	1	1	1	1	1	1
Covered Waste Container	O	O	O	O	O	O	O	1	1	1
Waste Bag	O	O	O	O	O	O	O	O	O	O
Biohazard Bag	2	2	2	2	2	2	2	2	2	2
Emesis Basin	O	O	O	O	O	O	O	1	1	1
Bed Pan	O	O	O	O	O	O	O	1	1	1
Urinal	O	O	O	O	O	O	O	1	1	1

Linen

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

Linen	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Blanket	O	O	O	O	O	O	O	2	2	2

Emergency Blanket	2	2	2	2	2	2	2	O	O	O
Towel	O	O	O	O	O	O	O	2	2	2
Stretcher Sheet	O	O	O	O	O	O	O	2	2	2
Pillow	O	O	O	O	O	O	O	2	2	2
Pillowcase	O	O	O	O	O	O	O	2	2	2

Documentation

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

Documentation	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Mobile ePCR System with: • Portable Touchscreen Computer • Magnetic Strip / Barcode Reader • ECG Monitor Connectivity • Dynamic transfer of live ePCR capable	O	O	O	O	1	1	1	1	1	1
Clipboard	O	O	O	1	1	1	1	1	1	1
Pen	1	1	1	1	1	1	1	1	1	1
Paper Release Forms	3	3	3	5	5	5	5	5	5	5
Pencil	1	1	1	O	O	O	O	O	O	O
Writing Pad	1	1	1	O	O	O	O	O	O	O
Light Response Program Inventory Sheet	1	1	1	O	O	O	O	O	O	O

Medications

Medications are listed per unit or vehicle. Of the authorized options, the preferred medication is in **bold** print.

Medications	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Acetaminophen 1000 mg/100 mL Vial or IV premix bag	X	X	O	X	X	X	1	X	X	1
Adenosine – 12 mg/4 mL Prefilled Syringe or Vial	X	X	O	X	X	X	2	X	X	2
or Adenosine — 6 mg/2 mL Prefilled Syringe or Vial	X	X	O	X	X	X	4	X	X	4
Albuterol 0.083% — 2.5 mg/3 mL Vial	X	O	O	X	X	3	3	X	3	3
or Albuterol — 90 mcg/1 Dose Metered Dose Inhaler/*May substitute vials & equipment*	X	1	1	X	X	O	O	X	O	O
or Levalbuterol – 1.25 mg/0.5 mL Vial	X	X	**A** (3)	X	X	X	**A** (3)	X	X	**A** (3)

or Levalbuterol – 1.25 mg/3 mL Vial	X	X	**A** (3)	X	X	X	**A** (3)	X	X	**A** (3)
or Levalbuterol – 0.63 mg/3 mL Vial	X	X	**A** (3)	X	X	X	**A** (3)	X	X	**A** (3)
or Levalbuterol – 0.31 mg/3 mL Vial	X	X	**A** (6)	X	X	X	**A** (6)	X	X	**A** (6)
or Albuterol with Ipratropium Bromide – 3 mg and 0.5 mg/3 mL Vial	X	X	**A**	X	X	X	**A**	X	X	**A**
Amiodarone — 150 mg/3 mL Vial	X	X	2	X	X	X	3	X	X	3
or Amiodarone — 900 mg/18 mL Vial	X	X	1	X	X	X	1	X	X	1
Anti-diarrheal Tablet – Special Program Approval Required	X	X	X	X	X	X	1	X	X	X
Aspirin — 81 mg/1 Tablet, Chewable Tablet in Packet	X	4	4	X	X	8	8	X	8	8
or Aspirin— 81 mg/1 Tablet Multi-dose Chewable Tab. Bottle	X	1	1	X	X	1	1	X	1	1
Atropine — 1 mg/10 mL Prefilled Syringe	X	X	1	X	X	X	1	X	X	1
or Atropine — 0.5 mg/5 mL Prefilled Syringe	X	X	2	X	X	X	2	X	X	2
or Atropine — 1 mg/1 mL Ampule or Vial	X	X	1	X	X	X	1	X	X	1
Atropine — 8 mg/20 mL Vial	X	X	O	X	X	X	1	X	X	1
or Atropine — 1 mg/1 mL Ampule or Vial	X	X	O	X	X	X	8	X	X	8
Calcium Chloride 10% — 1 g/10 mL Prefilled Syringe	X	X	O	X	X	X	1	X	X	1
Dextrose 10% — 25 g/250 mL IV Bag	X	1	1	X	X	2	2	X	2	2
or Dextrose 50% — 25 g/50 mL Prefilled Syringe or Vial	X	1	1	X	X	2	2	X	2	2
or Dextrose 25% — 2.5 g/10 mL Prefilled Syringe	X	10	10	X	X	20	20	X	20	20
or Dextrose 10% — 1 g/10 mL Prefilled Syringe	X	25	25	X	X	50	50	X	50	50
Diphenhydramine — 50 mg/1 mL Vial or Carpuject®	X	X	1	X	X	X	1	X	X	1
Epinephrine 1:1,000 — 1 mg/1 mL Vial or Ampule	X	1	1	X	X	1	1	X	1	1
or Epi. 1:1,000 — 10 mg/10 mL Vial	X	1	1	X	X	1	1	X	1	1
or Epi. 1:1,000 — 30 mg/30 mL Vial	X	1	1	X	X	1	1	X	1	1
or "EpiPen"/Auto-Injector. — 0.3 mg/ 0.3 mL	O	O	O	O	O	O	O	O	O	O
Epi. 1:10,000 — 1 mg/10 mL Prefilled Syringe	X	X	2	X	X	X	3	X	X	3
or Epi. 1:1,000 — 1 mg/1 mL Vial or Ampule	X	X	2	X	X	X	3	X	X	3
Glucagon/Glucagen — 1 mg/1 mL, Vial of Glucagon Powder + Vial of Diluent	X	1	1	X	X	1	1	X	1	1
Glucose Gel — 1 Container	1	1	1	X	1	1	1	1	1	1

Ipratropium Br.— 0.5 mg/2.5 mL Vial	X	X	O	X	X	X	1	X	X	1
Lidocaine 2% — 100 mg /5 mL Prefilled Syringe	X	X	O	X	X	X	1	X	X	1
or Lidocaine 2% — 400 mg/20 mL Vial	X	X	O	X	X	X	1	X	X	1
Ketorolac (Toradol) – 30 mg/mL Vial	X	X	O	X	X	X	1	X	X	1
Magnesium Sulfate - 5g/10mL Prefilled Syringe or Vial	X	X	O	X	X	X	1	X	X	1
or Magnesium Sulfate — 1 g/2 mL Vial	X	X	O	X	X	X	5	X	X	5
or Magnesium Sulfate - 4 g/100 mL IV Bag	X	X	O	X	X	X	1	X	X	1
Naloxone — 2 mg/2 mL Prefilled Syringe or Vial	X	1	1	X	LOSOP	4	4	LOSOP	4	4
or Naloxone — 4 mg/10 mL Vial	X	1	1	X	X	2	2	X	2	2
or Naloxone— 0.4 mg/1 mL Prefilled Syringe, Vial or Carpuject®	X	5	5	X	X	20	20	X	20	20
or Naloxone – 4 mg/0.1 mL, REMSA Approved Intranasal Delivery Device	X	X	X	X	LOSOP	X	X	X	X	X
Nitroglycerin — 0.4 mg/1 Dose, Multi-dose Spray or Bottle of Tab.	X	1	1	X	X	1	1	X	1	1
Nitro. Paste 2% — 1 g/1 Inch, Packet with Paper Applicators	X	X	O	X	X	X	2	X	X	2
or Nitro. Paste 2% — 30 g/1 Tube, with Paper Applicators	X	X	O	X	X	X	1	X	X	1
or Nitro. Paste 2% — 60 g/1 Tube, with Paper Applicators	X	X	O	X	X	X	1	X	X	1
Normal Saline 0.9% — 1000 mL IV Bag	X	1	1	X	X	2	2	X	2	2
or Normal Saline 0.9% — 500 mL IV Bag	X	2	2	X	X	4	4	X	4	4
or Normal Saline 0.9% — 250 mL IV Bag	X	4	4	X	X	8	8	X	8	8
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:

Controlled Substances	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
Fentanyl — 100 mcg/2 mL Ampule, Vial, or Carpuject®	X	X	1	X	X	X	1	X	X	1
or Fentanyl — 100 mcg/5 mL Ampule, Vial, or Carpuject®	X	X	1	X	X	X	1	X	X	1
or Fentanyl — 100 mcg/10 mL Ampule, Vial, or Carpuject®	X	X	1	X	X	X	1	X	X	1
Ketamine – 500 mg/10 mL Ampule, Vial or Carpuject®	X	X	O	X	X	X	1	X	X	1
or Ketamine – 50 mg/1 mL Ampule, Vial or Carpuject®	X	X	O	X	X	X	2	X	X	2
or Ketamine 200 mg/20 mL Ampule, Vial, or Carpuject®	X	X	O	X	X	X	1	X	X	1
or Ketamine 500 mg/5 mL Ampule, Vial, or Carpuject®	X	X	O	X	X	X	1	X	X	1
Midazolam — 5 mg/1 mL Ampule, Vial or Carpuject®	X	X	2	X	X	X	2	X	X	2
or Midazolam — 10 mg/2 mL Ampule, Vial, or Carpuject®	X	X	1	X	X	X	1	X	X	1
or Midazolam — 5 mg/5 mL Ampule or Vial	X	X	2	X	X	X	2	X	X	2
or Lorazepam — 4 mg/1 mL Ampule, Vial, or Carpuject®	X	X	**A**	X	X	X	**A**	X	X	**A**
or Lorazepam — 2 mg/1 mL Ampule, Vial, or Carpuject®	X	X	**A**	X	X	X	**A**	X	X	**A**
or Diazepam — 10 mg/2 mL Ampule, Vial, or Carpuject®	X	X	**A**	X	X	X	**A**	X	X	**A**
Morphine Sulfate — 10 mg/1 mL Ampule, Vial or Carpuject®	X	X	**A**	X	X	X	**A**	X	X	**A**
or Morphine Sulfate - 10 mg/10 mL Ampule or Vial	X	X	**A**	X	X	X	**A**	X	X	**A**

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.

CDC Medications	Light Response			First Response				Ground Transport		
	EMT	AEMT	EMT-P	PSFA	EMT	AEMT	EMT-P	EMT	AEMT	EMT-P
DuoDote Nerve Agent Antidote Kit	O	O	O	X	O	O	O	O	O	O
or Mark I Nerve Agent Antidote Kit	O	O	O	X	O	O	O	O	O	O

Cardiac Monitor Specification

Attributes/capabilities for Cardiac Monitor, Pacemaker, Defibrillator

Cardiac Monitor/Defibrillator/Pacemakers shall adhere to the below specifications and meet all current applicable and relevant REMSA policies/ protocols, guidelines and standards, including: American Heart Association (A.H.A.), American National Standards Institute (A.N.S.I.), American Society for Testing and Materials (A.S.T.M.), Association for the Advancement of Medical Instrumentation (A.A.M.I.), E.C.R.I. Institute, Federal Communications Commission (F.C.C.), Food and Drug Administration (F.D.A.).Health Insurance Portability and Accountability Act (H.I.P.A.A.), and National Fire Protection Association (N.F.P.A.).

Physical Attributes
Six (6) foot lead set with removable precordial lead connection
Multifunction cable with hands-free MFP capability
CPR diagnostic qualitative and quantitative feedback and reporting capability (*not optional – additional specification below)
A/C power adapter/battery charger - **Full functionality should be present while device is functioning with A/C power**
Lithium-ion batteries, two/device, must be smart batteries lasting minimum of 3 hours each
Battery charging device, minimum of 2 bay/bank charger. - **Charging support systems must recalibrate and test batteries in addition to charging.**
Minimum one (1) year EMS warranty
Biphasic waveform with hands-free defibrillation functionality with adult and pediatric capability. Energy setting options must be compatible with applicable REMSA protocols.
Functionality to operate in Automated External Defibrillator or Semi-Automated External defibrillator mode
Functionality to provide synchronized cardioversion at multiple age-appropriate energy levels. Energy setting options must be compatible with applicable REMSA protocols.
Adjustable and controllable amperage and rate for transthoracic pacing with adult and pediatric capability
Ability to operate in fixed, demand, and overdrive modes
Capability to detect and indicate presence of internal pacemaker
Capability to print field user machine test/internal diagnostic test results
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)
Programmable audio and visual alert systems for fatal arrhythmias, VF/VT at a minimum
Separate programmable alerts for biometric parameters of NiBP, heart rate, respiratory rate, etCO2, SpO2
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.
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
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 measure 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.

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. ECG transmission must not require any software / server purchase, or proprietary service to view, distribute.

Cardiopulmonary Resuscitation (CPR) diagnostics / feedback device must:
Measure high quality CPR performance feedback parameters 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 / improve performance of high quality CPR, 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.

Data Integration and Management continued:
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.
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. **1. All applicable REMSA Information Security policies and procedures must be followed during data transmissions, imports or other sharing methodologies.**

DEFINITIONS

California Code of Regulations, Title 22, Division 9, Prehospital Emergency Medical Services. (2019, January 1). Retrieved January 1, 2021, from https://emsa.ca.gov/wp-content/uploads/sites/71/2019/07/2019-EMS-Statute-Book.pdf

NEMSIS Version 3.5.0 Build 230317 Data Dictionary. (2023, March 17). Retrieved October 16, 2024, from https://nemsis.org/media/nemsis_v3/release-3.5.0/DataDictionary/PDFHTML/EMSDEMSTATE/index.html

REFERENCES

California Health and Safety Code - Division 2.5: Emergency Medical Services
California Code of Regulations, Title 22. Social Security, Division 9. Prehospital 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
ICS Position Manual, Fireline Emergency Medical Technician Paramedic [FEMP ICS223-11]
California Incident Command Certification System (CICCS) Qualification Guide

3304	Scene Management
Operational Policy	

Last Reviewed: **October 1, 2025**	Last Revised: **October 1, 2025**

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 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.

When a patient is identified, only through Emergency Medical Dispatch (EMD), as needing BLS level of care (Alpha (A) or Omega (O) determinant) and a BLS ambulance is dispatched, the first response agency paramedic will determine if the patient is appropriate for BLS level of care. If the first response paramedic deems the patient not appropriate for BLS care and transport, an ALS unit must be requested, or the first response paramedic must maintain patient care and accompany the BLS ambulance to provide the appropriate level of treatment. If any ALS interventions/skills are performed (identified as ALS patient management within REMSA Policy 4104 *Skills List*) or identified as being needed, the patient requires ALS transport.

If a patient receives BLS level response (BLS first response and ambulance) and is identified by providers as needing/benefiting from any ALS intervention/skills/monitoring (identified as ALS patient management within REMSA Policy 4104 *Skills List*), an ALS unit must be requested to support the needs of the patient. Similarly, if there is a disagreement on the level of care that is required for the patient (i.e. first response paramedic transferring care to a BLS level ambulance), and a conclusion cannot be made on scene, base hospital contact should be made to determine the appropriate level of transport.

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 three 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.

3305	EMS Surge/Multi Casualty Incident (MCI) Management
	Operational Policy

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

PURPOSE
To establish flexible medical management and documentation strategies for EMS Surge incidents and Multiple Casualty Incidents (MCIs) to improve patient outcomes. Management should focus on maximum resource allocation, triage of the patients (utilizing REMSA Policy 5301 *Trauma Triage Indicators*), patient distribution, clear communication, and prevention of unnecessary delays in patient care and transport. An MCI will be activated when there are ten (10) or more patients requiring transport or if deemed necessary by Incident Command.

EMS Surge Incident Management

1. EMS Surge incidents are events that may not overwhelm prehospital resources but have the potential to overwhelm hospital resources with multiple patients. Incidents with multiple patients that are not determined to be an MCI by the Incident Commander (IC) are also defined as an EMS Surge incident. Defined as:
   a. Three (3) or more ground or air transport resources are requested to respond to a single incident
   b. Multiple patients that are released at scene who may arrive at a hospital by private vehicle
   c. Incidents where there are two (2) or more patients meeting *REMSA 5301 Critical Trauma Patient Criteria*
2. EMS Surge incidents require early contact to the closest Level I/II Trauma base hospital (BH). Notification can be done by the first response apparatus (e.g. fire, ambulance, or other public safety) on scene or supervisor personnel enroute to the scene.
3. EMS Surge incidents shall be named using a naming convention consistent with the incident's geographic location.
4. EMS Surge incidents shall institute Incident Command System (ICS) as necessary. At minimum, Medical Communication (MedCom) Coordinator role shall be established for early communication with Trauma BH.

PATIENT TRANSPORTATION:
1. Treatment and transportation prioritization should be according to the seriousness of the patients' injuries.
2. Whenever possible, patients meeting REMSA 5301 *Critical Trauma Patient Criteria* shall be transported to a designated trauma receiving centers.
3. A single EMS transport unit may depart the scene with an immediate patient prior to initiating contact with the Level I/II Trauma Base Hospital (BH). If/when this occurs, the transport unit will contact Trauma BH with a full report and notify the BH that there will be the potential for more patients coming from the same scene.
   a. IC and/or MedCom shall be communicated with and notified that there has been a patient that was transported from scene.
   b. Any additional ambulance traffic leaving the scene shall be directed through MedCom

DOCUMENTATION:
A REMSA approved ePCR must be completed for each patient involved in the response. Additionally, Medcom is responsible for a single incident ePCR to provide an overview of the events and patient destination and disposition.

Multiple Casualty Incident (MCI) Scene Management

The ICS as defined by FIRESCOPE will be utilized at all MCIs. The IC has the overall responsibility for developing objectives and requesting the necessary resources required to mitigate the incident. ICS positions shall be filled as needed and directed by the IC. Riverside County Multi Patient Management Plan outlines job action sheets and levels of activation/notification for larger events.
Emergency responders shall perform triage using the following triage method:

- SALT (sort-assess-lifesaving interventions-treatment and/or transport): Used for adults, children, and special populations. Individual assessment begins with limited rapid lifesaving interventions. Allows for a quick global sorting of the patients so responders can more accurately identify patients who are not responding or have an obvious life threat. (SALT Triage Algorithm see Appendix A)

RESPONSE

The first on-scene responder unit will complete a rapid size-up of the incident. Upon arrival of the first public safety agency and IC establishment, the IC will determine if the incident is an EMS Surge event or if the incident needs to be declared an MCI. The public safety agency dispatch will be notified the incident is an MCI and request additional personnel and equipment as necessary. ICS shall be initiated and it will be determined by the IC if triage tags need to be utilized during the incident. Begin triage of victims using SALT and approved REMSA triage tags.

Red, yellow, green, and black/white colored flagging (i.e. "ribbon tags") may be used during EMS Surge and MCIs. During EMS Surge events the flagging may be used to identify or sort patients rapidly without the need to ultimately place triage tags. During an MCI the flagging may be used in place of a REMSA approved Triage Tag whenever it is beneficial for expediting patient care and transport (for example, a tactical response).

- If ribbon-tagging is used on the initial triage during a MCI, re-evaluation and re-triage must take place when the patients are moved into the Treatment Area to re-prioritize transport if needed.

<u>If the IC deems triage tags will be used for the incident, patients should not be transported without receiving an approved REMSA triage tag. Triage tags will be placed by the transporting unit when the patient is immediately loaded requiring immediate hospital care or when a patient is loaded with only a ribbon tag. The triage tag number will be reconciled with the receiving facility and ultimately MedCom.</u>

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.

- IC is responsible for the management of all incident operations.
- IC will assign the MedCom Coordinator position as soon as feasible in the incident, preferably to a paramedic.

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.

- IC has the authority to change assignments as they see fit.
- All on-scene providers will follow legal orders of/from the IC.

PATIENT TRANSPORTATION

1. The IC or his/her designee will designate an ambulance staging area.
2. 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.
3. Treatment and transportation prioritization should be according to the seriousness of the patients' injuries.
4. Wherever possible, patients meeting REMSA 5301 *Critical Trauma Triage Criteria* shall be transported to trauma receiving centers.
5. A single EMS transport unit may depart the scene with an immediate patient prior to initiating contact with the Level I/II Trauma BH. If/when this occurs, the transport unit will contact Trauma BH with a full report and notify the BH that there will be the potential for more patients coming from the same scene.
   a. IC and/or MedCom shall be communicated with and notified that there has been a patient that was transported from scene.
   b. Any additional ambulance traffic leaving the scene shall be directed through MedCom
6. The Transportation Unit Leader will notify the MedCom of departing units.
7. Departing units will contact the designated patient receiving center and provide a detailed patient report.
8. The Transportation Unit Leader will copy the information from the triage tag onto the *Multi-Casualty Recorder Worksheet* and confirm the destination with the ambulance crew.
9. During large MCIs where patient transport demands exhaust 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.
   a. Patients should be prioritized with higher acuity patients going via ALS ambulance and lower acuity patients going via BLS ambulance transport whenever possible.
   b. 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.
   c. 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.

10. 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.
    a. The IC is responsible for assuring patient safety when alternative transportation options are utilized.
    b. 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 REMSA-approved triage tags shall be used. The triage tag will be handled as follows:

1. 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.
2. The category half remaining on the triage tag must remain with the patient for identification.
3. The transport portion affixed to the top of the triage tag will be removed by the Transportation Unit Leader and documented with transport destination and mode of transportation with appropriate unit identifier.
4. Each transporting unit will complete a REMSA Approved ePCR for each patient transported from the incident.
    a. The transporting unit will upload image of triage tag and attach to their ePCR
5. Following the conclusion or resolution of the incident, the IC will be responsible for completion of all MCI documentation. Documentation will be attached to REMSA Approved ePCR for the incident.

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.

EMS SURGE/MCI COMMUNICATION:

1. All responding units will be informed of the channel and will use it for all incident radio communications.
2. Pre-notification by any first response apparatus (e.g. fire, ambulance, or other public safety) enroute or immediately upon arrival to a reported EMS Surge incident/MCI is strongly encouraged, even prior to official declaration of an event and established MedCom Coordinator.
    a. Early trauma base hospital notification is essential to managing EMS Surge incident/MCIs fluidly.
3. All base hospital communications must be done by the IC designated MedCom Coordinator, as soon as possible, to the single closest Level I/II Trauma BH.
    a. MedCom role must be filled by a paramedic whenever possible.
    b. MedCom's <u>initial</u> contact shall include:
        i. Identifying self as MedCom.
        ii. Name and location of the EMS Surge incident/MCI.
        iii. ETA to closest hospital and trauma center to establish a point of reference.
        iv. Scene description including any special circumstances.
        v. Estimated number of patients that may require transport (consider specialty care needs).
        vi. Request bed availability on ReddiNet, (Consider out-of-county hospital(s) for MCIs based on incident location)
    c. MedCom's <u>second</u> contact shall include:
        i. Current patient count by patient status (Immediate, Delayed, Minor, Expectant, or Deceased).
        ii. Receiving bed availability from the Trauma BH (use the *Multi-Casualty Hospital Resource Availability Worksheet* for all MCIs).
        iii. Transportation destination considerations: pediatrics, burn, trauma.
            (1) The Trauma BH will coordinate patient destination with MedCom during EMS Surge incidents, not MCIs.
            (2) Whenever possible, patients meeting REMSA 5301 *Critical Trauma Patient Criteria* shall be transported to a designated trauma receiving centers.
    d. (MCI ONLY) MedCom's <u>subsequent</u> contacts shall be consistent with the *Multi-Casualty Recorder Worksheet*. Subsequent contacts should be minimal.
        i. Patient Triage Tag Number
        ii. Patient Info: Age/Sex, chief complaint
        iii. Patient Status (Immediate, Delayed, or Minor)

iv. Ambulance Company & Unit ID Number
v. Hospital Destination
vi. Estimated Time of Arrival

e. MedCom's final contact shall include:
   i. Wrap up of the scene and final patient count with destinations (including deceased) for reconciliation of records.

4. Transporting ambulances shall notify the receiving hospital as soon as possible with a full patient report.

EMS SURGE/MCI HOSPITAL RESPONSIBILITIES

Initial contact from scene (or enroute to incident) will be as brief as possible and recognize that the contact is a notification only and that further details will be provided in subsequent contacts.

1. MICNs initial contact:
   a. Upon identification of EMS Surge incident/MCI, a dedicated MICN will be assigned to the event.
   b. Poll for bed availability on ReddiNet, consider specialty populations when polling.
      i. For MCI, utilize out of county facilities as needed/appropriate
2. MICNs second/subsequent contacts:
   a. Confirm patient count and status (Immediate, Delayed, Minor, Expectant, or Deceased)
   b. Provide MedCom with bed availability responses from ReddiNet
   c. Coordinate patient destination with MedCom for EMS Surge Incidents only
      i. Whenever possible, patients meeting REMSA 5301 *Critical Trauma Patient Criteria* shall be transported to trauma receiving centers.
   d. Utilize ReddiNet for notification of incoming ambulances to the designated receiving centers
      i. BHs and paramedic receiving centers will enter ambulance information upon contact into ReddiNet for patient tracking and reconciliation at the termination of the event.
3. MICNs final contact:
   a. Reconciliation of final patient count and destinations with MedCom
   b. End incident within ReddiNet
      i. BH and paramedic receiving hospitals will continue to enter patient information into ReddiNet

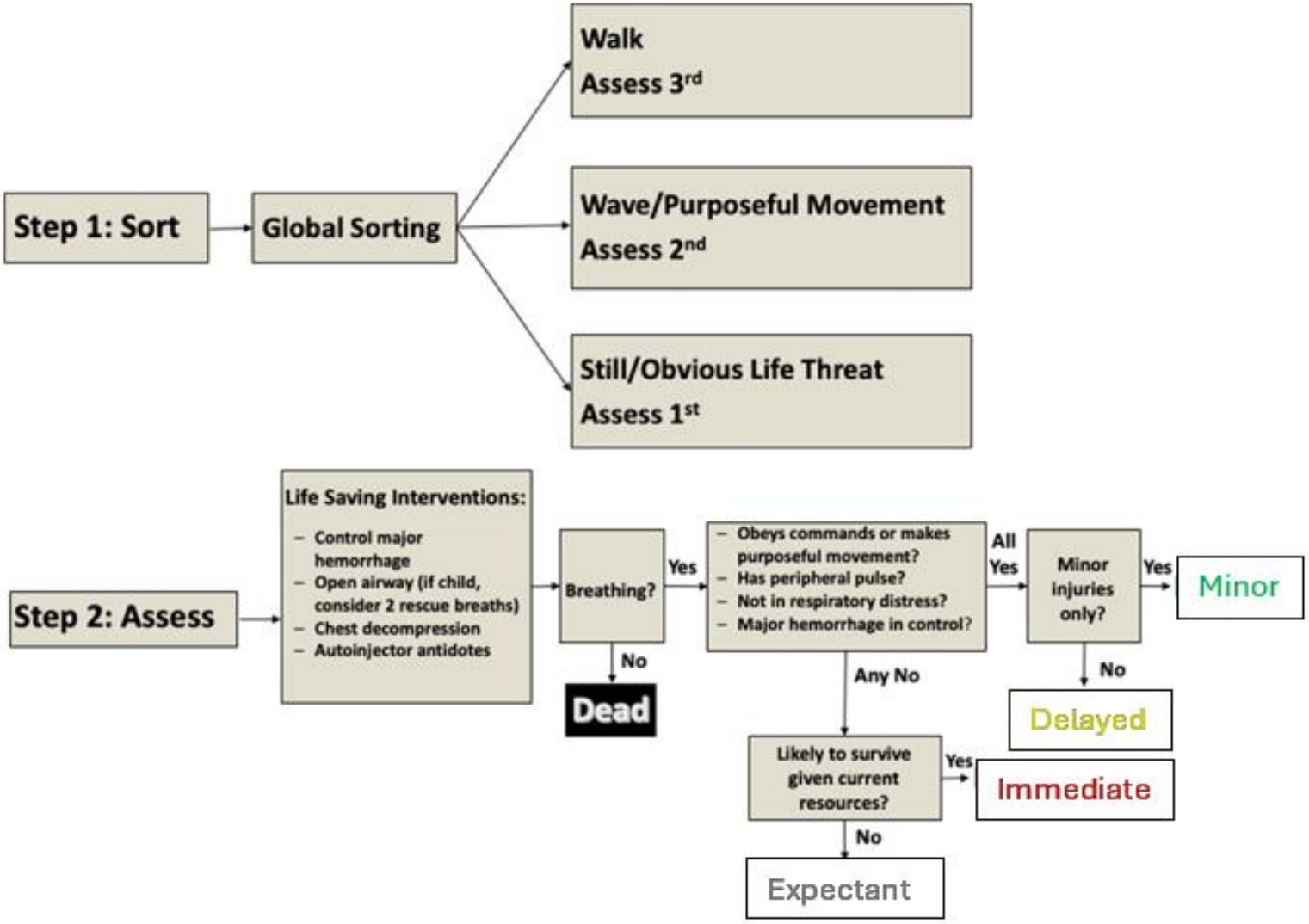
EMS SURGE/MCI CONTINUOUS QUALITY REVIEW AND IMPROVEMENT

Retrospective review of all available documentation including but not limited to ePCRs, Triage Tags, Base Tape(s) will be provided to both the provider's continuous quality improvement (CQI) coordinator and Base Hospital PLN within 5 days of the incident and a comprehensive review of any established Surge Event/MCI must be conducted. This review should include patient care/distribution, ePCR documentation, base tape review(s), and other review of submitted documents. Any outliers of the standard of care shall be reported to REMSA using protocol 7201. All declared MCIs will undergo 100% CQI by the service providers.

TRAINING

The Riverside County EMS Agency approved MCI Training Program for initial and annual recurrent training is required for all:

- ALS Providers
- BLS Providers
- Base Hospitals


Step 1: Sort
Global Sorting
Walk
Assess 3rd
Wave/Purposeful Movement
Assess 2nd
Still/Obvious Life Threat
Assess 1st
Step 2: Assess
Life Saving Interventions:
– Control major hemorrhage
– Open airway (if child, consider 2 rescue breaths)
– Chest decompression
– Autoinjector antidotes
Breathing?
Yes
No
Dead
– Obeys commands or makes purposeful movement?
– Has peripheral pulse?
– Not in respiratory distress?
– Major hemorrhage in control?
All Yes
Any No
Minor injuries only?
Yes
No
Minor
Delayed
Likely to survive given current resources?
Yes
No
Immediate
Expectant

3306	Physical Restraint and Transport
Operational Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **September 11, 2025**

PURPOSE
To set parameters for the use of physical restraint and transport of the restrained.

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.
        ii. If a 911 dispatched call results in a patient on a 5150 that requires transport by ambulance, they shall be transported to the closest emergency department.
    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.

4. Fully document use of restraints on the patient care report (PCR/ePCR).

3307	Emerging Viruses
Operational Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 26, 2023**

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.

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.ruhealth.org/sites/default/files/PH/Disease%20Control/docs/cmr_except_tb_dmv.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.

3309	Intranasal Naloxone Use by Public Safety First Aid Personnel
Operational Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2025**

PURPOSE

To establish the processes and procedures to allow for approved public safety first aid personnel (PSFA) to provide intranasal naloxone to patients with suspected acute narcotic overdose.

Training Standards

1. Agencies that employ PSFAs 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. PSFAs must be trained to the Public Safety First Aid Personnel and CPR standard as outlined in Title 22, Division 9, Chapter 2.3, Article 3, Section 100027.03 and maintain ongoing competencies and proficiencies as outlined by Section 100027.06
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 PSFAs 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. PSFAs 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 First Aid Personnel form, found here: https://forms.office.com/g/CaDY22ycFA

3310	"Leave Behind Naloxone" Kit Distribution by EMS Providers
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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

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.

3312	Assess and Refer
	Provisional Policy

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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:
  - Altered level of consciousness
  - Alcohol or drug ingestion that impairs decision making capacity
  - Abnormal or labored breathing or shortness of breath
  - Chest pain or discomfort of any kind
  - Hypoxia as indicated by low oxygen saturation of less than 94%
  - Significant tachycardia
  - 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 and the Referral Notification card (Appendix A): "*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.

REFERRAL NOTIFICATION

You have been assessed by paramedics from the 911 system and based on their assessment, your illness / injury does not meet the criteria for emergent transport by ambulance to an emergency department.

Please follow one of the recommendations below:

EMS Providers, check the box next to the recommendation that was provided:

☐ CONTACT YOUR MEDICAL INSURANCE PROVIDER'S NURSE ADVICE LINE
☐ FOLLOW UP WITH YOUR PRIMARY CARE PROVIDER / PERSONAL PHYSICIAN
☐ SEEK TREATMENT AT A LOCAL URGENT CARE OR CLINIC

When calling a Nurse advice line, please be sure to say the following:
"**I have already called 911 and have already been evaluated by paramedics. I do not require immediate care in an emergency department, and it was recommended that I should follow up with you**."

NURSE ADVICE CONTACT LINES

Aetna (24/7)		Anthem BlueCross	
Balance (by CCHP)		Blue shield	
Healthnet		IEHP	
Kaiser		LA Care Health Plan	
Molina		Sharp Health Plan (*after hours and weekends only*)	
Valley Health Plan		Western Health Advantage	

If you do not have health insurance, the Riverside County Department of Public Social Services can help. Visit https://rivcodpss.org/, call 1-877-410-8827 (M-F, 8a to 5p) to schedule an appointment or scan the QR code below:

For all other types of assistance, contact 2-1-1, or visit the Inland SoCal United Way, here: https://inlandsocaluw.org/, or scan the QR code below:

NOTIFICACIÓN DE REFERENCIA

Ha sido evaluado por paramédicos del sistema 911 y, según su evaluación, su enfermedad / lesión no cumple con los criterios para el transporte en ambulancia a un departamento de emergencias del hospital.

Siga una de las recomendaciones siguientes:

Proveedores de EMS, marque la casilla junto a la recomendación que se proporcionó:

☐ PÓNGASE EN CONTACTO CON LA LÍNEA DE ASESORAMIENTO DE ENFERMERAS DE SU PROVEEDOR DE SEGURO MÉDICO
☐ SEGUIMIENTO CON SU PROVEEDOR DE CUIDADO PRIMARIO / MÉDICO PERSONAL
☐ BUSQUE TRATAMIENTO EN UNA CLÍNICA O ATENCIÓN DE URGENCIA LOCAL

Cuando llame a una línea de asesoramiento de enfermería, asegúrese de decir lo siguiente: **"Ya llamé al 911 y los paramédicos ya me evaluaron. No necesito atención inmediata en un departamento de emergencias del hospital, y se recomendó que hiciera consulta con usted."**

LÍNEAS DE CONTACTO DE ASESORAMIENTO DE ENFERMERAS

Aetna (24/7)		Anthem BlueCross	
Balance (by CCHP)		Blue shield	
Healthnet		IEHP	
Kaiser		LA Care Health Plan	
Molina		Sharp Health Plan (*solo después de horas y fines de semana*)	
Valley Health Plan		Western Health Advantage	

Si no tiene seguro médico, el Departamento de Servicios Sociales Públicos del Condado de Riverside puede ayudar. Visite https://rivcodpss.org/, llame al 1-877-410-8827 (lunes a viernes, 8am a 5pm) para programar una cita o escanear el código QR a continuación:

Para asistencia addicional, comuníquese con 2-1-1, o visite Inland SoCal United Way, aquí: https://inlandsocaluw.org/, o escanee el código QR a continuación:

REFERRAL NOTIFICATION

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☐ FOLLOW UP WITH YOUR PRIMARY CARE PROVIDER / PERSONAL PHYSICIAN
☐ SEEK TREATMENT AT A LOCAL URGENT CARE OR CLINIC

When calling a Nurse advice line, please be sure to say the following:
"**I have already called 911 and have already been evaluated by paramedics. I do not require immediate care in an emergency department, and it was recommended that I should follow up with you**."

NURSE ADVICE CONTACT LINES

Aetna (24/7)	1-800-556-1555	Anthem BlueCross	1-800-224-0336
Balance (by CCHP)	1-888-243-8310	Blue shield	1-800-609-4166
Healthnet	1-800-893-5597	IEHP	1-888-244-4347
Kaiser	1-833-574-2273	LA Care Health Plan	1-800-249-3619
Molina	1-888-275-8750	Sharp Health Plan (*after hours and weekends only*)	1-800-359-2002
Valley Health Plan	1-855-348-9119	Western Health Advantage	1-877-793-3655

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Proveedores de EMS, marque la casilla junto a la recomendación que se proporcionó:

☐ PÓNGASE EN CONTACTO CON LA LÍNEA DE ASESORAMIENTO DE ENFERMERAS DE SU PROVEEDOR DE SEGURO MÉDICO
☐ SEGUIMIENTO CON SU PROVEEDOR DE CUIDADO PRIMARIO / MÉDICO PERSONAL
☐ BUSQUE TRATAMIENTO EN UNA CLÍNICA O ATENCIÓN DE URGENCIA LOCAL

Cuando llame a una línea de asesoramiento de enfermería, asegúrese de decir lo siguiente: **"Ya llamé al 911 y los paramédicos ya me evaluaron. No necesito atención inmediata en un departamento de emergencias del hospital, y se recomendó que hiciera consulta con usted."**

LÍNEAS DE CONTACTO DE ASESORAMIENTO DE ENFERMERAS

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3314	Nurse Navigation Field Referral
Administrative Policy	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

PURPOSE

To be used by Paramedics for stable patients who, after patient contact and assessment, could benefit from alternative care options determined by Nurse Navigation.

GENERAL CONSIDERATIONS

1. Complete a full paramedic assessment and document in the assessment panel of the ePCR.
2. Paramedic judgment indicates the patient does not require ALS level of care or emergent transport to ED.

NURSE NAVIGATION EXCLUSION CRITERIA

Patients (adult and pediatric) must have **none** of the following:

1. Unable to provide consent/absent legally responsible party (unaccompanied minor, skilled nursing/assisted living)
2. Acutely altered/confused/agitated patients (including secondary to substance use)
3. Suicidal/Homicidal ideations and/or auditory/visual hallucinations
4. In law enforcement custody or on a legally mandated hold
5. Pregnancy ≥ 20 weeks gestation (regardless of complaint)
6. Syncope
7. Seizures or postictal
8. Bed bound/non-ambulatory patients who require a specialty care van/ambulance for transport
9. Any patient requiring specialty care services (Trauma, Stroke, STEMI)
10. Brief Resolved Unexplained Event (BRUE)

NURSE NAVIGATION ELIGIBILITY

Screening criteria for Field Referral to Nurse Navigation:
Requires BLS level of care only with no anticipated interventions during transport.

AND

1. Adults have vital signs meeting guidelines:
   a. Heart Rate between 60-120 bpm
   b. Systolic BP between 90-180 mmHg
   c. Respiratory Rate between 10-22 bpm
   d. Oxygen Saturation ≥ 94% (or at baseline with no respiratory complaint)
   e. Blood glucose and temperature should be assessed if pertinent to patient condition.
2. Pediatrics have vital signs/presentation meeting guidelines:
   a. Heart Rate within normal age range/no signs poor perfusion and/or cyanosis
   b. Respiratory Rate within normal age range/no signs respiratory distress
   c. Blood pressure greater than or equal to [70 + (age x 2)]/no signs poor perfusion
   d. Oxygen Saturation ≥ 94%
   e. Blood glucose and temperature should be assessed if pertinent to patient condition

Pediatric Normal Vital Signs				
Age	RR	HR	Systolic	Diastolic
0-3 months	35-55	110-160	65-85	45-55
3-6 months	30-45	100-160	70-90	50-65
6-12 months	22-38	90-160	80-100	55-65
1-3 years	22-30	80-150	90-105	55-70
3-6 years	20-24	70-120	95-110	60-75
6-12 years	16-22	60-110	100-120	60-75
12+ years	12-20	60-100	110-135	65-85

NURSE NAVIGATION REFERRAL PROCEDURE

1. EMS crew will offer Field Nurse Navigation Services
   a. If the patient refuses or declines at any point, discontinue Nurse Navigation referral and follow appropriate REMSA policies and procedures for disposition.
2. EMS crew will contact the Nurse Navigation line. The provider will communicate and document within the electronic PCR:
   a. Patient Name/Legal Guardian Name
   b. DOB
   c. Address
   d. Chief Complaint
   e. Pertinent History of present illness
   f. Physical findings
   g. Vital Signs
3. EMS crew will place the patient in contact with the Nurse and stand by to assist as needed.
   a. EMS will remain on scene until an appropriate treatment plan, determined by Nurse Navigation, is agreed upon by the patient.
   b. At no time can the EMS providers on scene be directed to provide the patient with any ALS interventions by the Nurse Navigator.
   c. Nurse Navigation dispositions are protocol driven and will be determined by the Nurse while in communication with the patient. **At no time will the EMS crew request or expect a specific disposition**. If at any time, the patient does not agree with the recommendation, the care of the patient will be re-assumed by the paramedic on scene and transported to the closest most appropriate facility.

CQI REQUIREMENTS

All Nurse Navigation Field Referrals will undergo 100% CQI by the service providers.

4100	Introduction to Treatment Protocols
Treatment Protocol	

Last Reviewed: **November 30, 2022**	Last Revised: **July 1, 2026**

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.

APPLICATION

The REMSA treatment protocols must be adhered to by each part of the EMS System including the following personnel:

- Public Safety First Aid Personnel (PSFA)
- Emergency Medical Technician (EMT)
- Advanced Emergency Medical Technician (AEMT)
- Paramedic (EMT-P)
- Mobile Intensive Care Nurse (MICN)
- Base Hospital Physician (BHP)

PSFAs are non-EMT firefighters or peace officers and/or lifeguards functioning in the Riverside County EMS System. PSFAs who have completed either Cal Fire's PSFA First Aid and CPR Training Course, or peace officers and/or lifeguards a REMSA Approved First Aid and CPR course, must follow the REMSA treatment protocols as they were trained at the PSFA or First Aid/CPR level and may not operate beyond the REMSA approved PSFA 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.

PRINTING, RETENTION AND DISPLAY

All REMSA Treatment protocols are intended for color printing and hard copy retention in a binder using top loading sheet protectors. These protocols are also intended for electronic display in Adobe Portable Document Format (PDF) or through the REMSA authorized web application (found here: https://remsaapp.rivcoready.org/). Distribution is provided by means of the EMS Agency's official website(s).

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 PSFA, 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. 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 PSFAs.

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
4900 – Pediatrics

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.

IN ADDITION:

- **PREHOSPITAL PERSONNEL ARE NOT PERMITTED TO FOLLOW GIVEN ORDERS THAT ARE OUTSIDE OF THEIR SCOPE OF PRACTICE**

- **MAXIMUM SINGLE MEDICATION ADMINISTRATIONS FOR PEDIATRIC PATIENTS WILL NOT EXCEED THAT OF A MAXIMUM SINGLE MEDICATION ADMINISTRATION FOR ADULTS.**

4101	Universal Patient Care
Treatment Protocol	

Last Reviewed: **July 1, 2025**	Last Revised: **July 1, 2026**

PURPOSE

Facilitate appropriate initial assessment and management of any EMS patient and link to appropriate specific treatment protocols as directed by the findings within the Universal Patient Care Protocol. Perform assessments and interventions as noted below within the providers scope of practice.

Patient/Scene Management

1. Assess scene safety
   a. Evaluate for hazards to EMS personnel, patient, bystanders
   b. Safely remove patient from hazards prior to beginning medical care
   c. Determine the number of patients
   d. Determine mechanism of injury or potential source of illness
   e. Request additional resources if needed. Cancel, reduce, or increase priority of responding equipment as clinically indicated and operationally required
      i. Request air ambulance as clinically indicated and operationally required
      ii. Consider declaring an/a EMS Surge/Mass Casualty Incident (MCI), go to REMSA Protocol 3305 *EMS Surge/Multiple Patient Incident (MCI) Management*
2. Use appropriate personal protective equipment (PPE)
   a. Consider suspected or confirmed hazards on scene
   b. Consider suspected or confirmed highly contagious infectious disease (i.e. contact, droplet, or airborne)
3. Consider cervical spine stabilization and/or spinal precautions if traumatic injury is suspected

Primary Survey

Airway, breathing, circulation should be assessed; however, there may be circumstances to reprioritize and evaluate circulation, airway, breathing when significant hemorrhage is recognized. As clinically indicated, obtain the patients age and weight (reported by written document, patient/parent, or EMS estimation). Classify patient as pediatric if appearing or known to be 14 years of age or less.

1. Airway: assess for patency and open airway as clinically indicated
   a. Head tilt/chin lift
   b. Jaw thrust
   c. Suction as clinically indicated
   d. Consider the need for an airway adjunct or definitive airway (i.e. OPA, NPA, iGel, orotracheal intubation)
   e. Patients with laryngectomies or tracheostomies, remove all objects or clothing that may be obstructing the opening, suction as clinically indicated, maintain the flow of the prescribed oxygen and reposition the head and/or neck
2. Breathing:
   a. Evaluate rate, breath sounds, accessory muscle use, retractions, patient positioning, oxygen saturation
   b. Provide supplemental oxygen as clinically indicated for target O2 of 94-98% SPO2 and based on clinical presentation
   c. Evaluate ETCO2 as clinically indicated and per treatment policy requirements
3. Circulation:
   a. Control any major external hemorrhage (i.e. direct pressure, hemostatic gauze, tourniquet placement)
   b. Assess for pulse
      i. If none – go to REMSA Protocol 4405/4903 *Adult/Pediatric Medical Cardiac Arrest* or REMSA Protocol 4301/4902 *Adult/Pediatric Traumatic Shock/Injury/*Arrest) treatment protocols as applicable
      ii. Assess rate and quality of radial, brachial, and/or carotid as clinically indicated
      iii. Evaluate perfusion – skin color, temperature, moisture, and capillary refill

4. Disability:
   a. Evaluate patient responsiveness: Glasgow Coma Scale (GCS) or AVPU (Alertness, Verbal, Pain, Unresponsive). mLAPSS as clinically indicated.
   b. Evaluate gross motor and sensory function in all extremities
   c. For found/reported altered mental status or suspected stroke, obtain blood glucose level and treat as clinically indicated
   d. If acute stroke suspected – go to REMSA Protocol 4502 *Suspected Stroke*
5. Expose: removal of clothing and/or obstructions on patient as appropriate to complaint and physical exam requirements
   a. Be considerate of patient modesty
   b. Consider warming/cooling measures as appropriate and clinically indicated
6. Assess for urgency of transport if any critical injuries or illnesses are discovered during the primary survey
   a. Prior to transport: Consider need for specialty care destinations (i.e. Stroke, STEMI, Trauma) and contact REMSA authorized base hospital as required by REMSA protocols.
   b. Contact Level I/II Trauma base for any instances where multiple patients are present (EMS Surge/MCI) for early notification and patient distribution.

Insert treatment protocols for emergency stabilization of the patient when indicated early in the assessment. Follow clinically indicated treatment protocols when the patient requires emergency interventions within the providers scope of practice.

Secondary Survey

The performance of the secondary survey should not delay patient transport in critical patients. Secondary surveys should be tailored to the patient's presentation and chief complaint. Secondary survey should be completed after the primary survey has ruled out any immediate interventions that need to be performed on the patient based on assessment finding.

1. Head
   a. Pupils
   b. Ears
   c. Naso-oropharynx
   d. Skull and scalp
2. Neck
   a. Jugular venous distention
   b. Tracheal position
   c. Spinal tenderness
3. Chest
   a. Retractions
   b. Breath sounds
   c. Chest wall tenderness, deformity, crepitus, and excursion
4. Abdomen/Back
   a. Tenderness or bruising
   b. Abdominal distention, rebound, or guarding
   c. Spinal tenderness, crepitus, or step-offs
   d. Pelvic stability or tenderness
5. Extremities: evaluate all four extremities as indicated
   a. Pulses
   b. Edema
   c. Deformity/crepitus
6. Neurologic
   a. Mental status/orientation (if the patient has a history of an altered mental status, document if they are at baseline or not)
   b. Motor/sensory
7. Evaluate for medical equipment the patient may have (e.g. pacemaker/defibrillator, LVAD, insulin pump, dialysis fistula)

Insert treatment protocols for patient disposition. If during either the primary or secondary survey, critical findings are discovered, appropriate interventions should be performed within providers scope of practice as indicated in the appropriate treatment protocol. Follow operationally indicated treatment protocols when required for patient disposition and transport destination decisions.

Vital Signs/History

Obtain baseline vital signs (an initial full set of vital signs is required: pulse, blood pressure, respiratory rate, neurologic status assessment, pulse oximetry as indicated, waveform capnography as indicated)

1. Stable patients will have at least two sets of pertinent vital signs. Vital signs are taken 10 to 15 minutes apart and, if transported, taken shortly before arrival at the receiving facility. Vital signs may be taken more often as clinically indicated.
2. Critical patients will have vital signs taken every 5 minutes. Vital signs may be taken more often as clinically indicated.
3. Neurologic status assessment involves establishing baseline and then trending any change in patient neurologic status
   a. Glasgow Coma Scale (GCS) should be used to gather baseline and treading changes in the patient.
   b. If the patient is a suspected Stroke, mLAPSS is to be utilized and go to REMSA Protocol 4502 *Suspected Stroke*
4. Patients with cardiac or respiratory complaints:
   a. Pulse oximetry
   b. 12-Lead electrocardiogram (EKG) should be obtained promptly in patients with cardiac or suspected cardiac complaints when paramedic present
   c. Continuous cardiac monitoring on scene and throughout transport
   d. Waveform capnography to be used for patients with respiratory complaints (mandatory use on critical patients and those patients who require invasive airway management)
5. Patients with altered mental status:
   a. Check blood glucose. If low, go to REMSA Protocol 4201/4901 *Adult/Pediatric Symptomatic Hypoglycemia*
   b. Consider waveform capnography (mandatory use on critical patients and those patients who require invasive airway management)
6. Obtain **OPQRST** history:
   a. **O**nset of symptoms
   b. **P**rovocation: location; any exacerbating or alleviating factors
   c. **Q**uality of pain
   d. **R**adiation of pain
   e. **S**everity of symptoms: appropriate pain scale for age and patient's presentation
   f. **T**ime of onset and circumstances around onset
7. Obtain **SAMPLE** history:
   a. **S**ymptoms
   b. **A**llergies: medication, environmental, and foods
   c. **M**edications: prescription and over the counter; bring containers to ED if possible
   d. **P**ast medical history
      i. Look for medical alert tags, portable medical records, advanced directives
      ii. Look for medical devices/implants (e.g. dialysis shunts, insulin pumps, pacemaker, central venous access port, gastric tubes, urinary catheter)
      iii. For females of childbearing age, inquire about potential or recent pregnancy when applicable
   e. **L**ast oral intake
   f. **E**vents leading up to the 911 encounter
      i. In patients with syncope, seizure, altered mental status, or acute stroke, consider bringing the witness to the hospital or obtain their contact phone number to provide the receiving facility

Treatment and Interventions

Insert treatment protocols for patient disposition.

1. Administer oxygen as appropriate with a target of achieving 94-98% saturation and select the appropriate method of oxygen delivery to mitigate or treat hypercarbia associated with hypoventilation.
2. Place appropriate monitoring equipment as dictated by assessment findings; these may include:
   a. Continuous pulse oximetry
   b. Cardiac rhythm monitoring
   c. Waveform capnography or digital capnometry
3. Establish vascular access if indicated or in patients who are at risk for clinical deterioration (IO if unable to obtain IV access in two attempts). Consider the need for additional sites.
4. Monitor pain scale if appropriate
5. Reassess patient after any treatment or intervention and/or as clinically indicated

Insert treatment protocols for patient management. Follow clinically indicated treatment protocols and interventions when required for patient management within the providers scope of practice. If a Medical or Trauma patient doesn't fit a specific treatment protocol, make base station contact for further direction.

Transfer of Care

The content and quality of information provided during the transfer of patient care to another party is critical for seamless patient care and maintenance of patient safety. Ideally, a complete electronic medical record should be provided to the next caregiver at the time of transfer of care. If provision of the completed medical record is not possible at the time of transfer of care, a detailed verbal report should be provided to the next caregiver.

1. The information provided during the transfer of care should include, but not limited to:
   a. Patient's full name
   b. Age
   c. Chief complaint
   d. History of present illness/Mechanism of injury
   e. Past medical history
   f. Medications
   g. Allergies
   h. Vital signs with documented times
   i. Patient assessment, interventions, medications given by provider along with the timing and patient's response to such medications and interventions
2. The detailed verbal report provided at the time of transfer of care does not take the place of or negate the requirement for the provision of a complete electronic or written medical record of the care provided by the EMS personnel.

Patient Safety Considerations

1. Be aware of legal issues and patient rights as they pertain to and impact patient care (e.g. patients with functional needs or children with special healthcare needs)
2. Be aware of potential need to adjust management based on patient age and comorbidities, including medication dosages
3. The maximum weight-based dose of medication administration to a pediatric patient should not exceed the maximum adult dose
4. Consider air medical transport, if available, for patients with time-critical conditions where ground transport time exceeds 30 minutes

Performance Measures

1. Abnormal vital signs should be addressed and reassessed
2. Response to treatments and medication therapy should be documented including pain scale when applicable and reassessment if appropriate
3. Limit scene time for patients with time-critical illness or injury unless clinically indicated
4. Blood glucose level obtained when indicated
5. Compliance with provision of critical information during patient transfer of care
6. Appropriate utilization of air medical services

Documentation Elements

1. At least two sets of vital signs should be documented for every patient
2. All patient interventions and responses to care should be documented in the ePCR Actions Panel of the agency that provided the care (i.e., improved, not improved)
3. If a 4-Lead and/or 12-Lead is placed on the patient, the findings (i.e. rhythm strip, 12-Lead) **MUST** be uploaded or attached to the ePCR documentation
4. All major changes in clinical status including, but not limited to, vital signs and data from monitoring equipment, should be documented
5. Unification of ePCR, between/within agencies is highly encouraged

Key Considerations

1. **Pediatrics**: a patient appearing or known to be older than 29 days but less than or equal to 14 years of age. If the age is unknown, any patient 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.
   a. Use a weight-based assessment tool (length-based tape or other system) to estimate patient weight and guide medication therapy and adjunct choices.
   b. Consider using the pediatric assessment triangle (appearance, work of breathing, circulation) when first approaching a child to help with assessment.
2. **Geriatrics**: a patient appearing or known to be 65 years of age of more
   a. In these patients, medications can have prolonged effects if there is preexisting renal disease (i.e., on dialysis or a diagnosis of chronic renal insufficiency) or hepatic disease (i.e., severe cirrhosis or end-stage liver disease).
3. **Secondary Survey**: if the patient has critical primary survey problems, it may not be possible to complete. Every effort should be made to complete in route to the receiving facility.
4. **Critical Patients**: proactive patient management should occur simultaneously with assessment.
   a. Ideally, one provider should be assigned to exclusively monitor and facilitate patient-focused care
   b. Other than lifesaving interventions that prevent deterioration enroute, treatment and interventions should be initiated as soon as practical but should not impede extrication or delay transport to definitive care.

4102	Alternative Medications / Dosages
Operational Policy	

Last Reviewed: **February 17, 2023**	Last Revised: **July 1, 2023**

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.

Alternative Medications		**CDC Medications**	
Medication & Concentration	**Formula**	**Medication & Concentration**	**Formula**
Albuterol MDI 90 mcg / 1 puff	Adults: 2 metered doses (2 puffs) Pediatrics: • Weight = 14 kg (≈31 lbs) or less: **NOT PERMITTED**. • Weight = 15 kg (≈33 lbs) or more: 2 metered doses (2 puffs).	Atropine Autoinjector 2 mg / 0.7 mL	Adults: 2 mg (1 injection) IM. **MAY REPEAT PRN**. Pediatrics: **NOT PERMITTED**.
Atropine Autoinjector 2 mg / 0.7 mL	Adults: 2 mg (1 injection) IM. **MAY REPEAT PRN**. Pediatrics: **NOT PERMITTED**.	Atropine Autoinjector 1 mg / 0.7 mL	Adults: 2 mg (2 injections) IM. **MAY REPEAT PRN**. 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 1 mg / 0.7 mL	Adults: 2 mg (2 injections) IM. **MAY REPEAT PRN**. 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 0.5 mg / 0.7 mL	Adults: 2 mg (4 injections) IM. **MAY REPEAT PRN**. Pediatrics: 0.5 mg IM x2. **MAY REPEAT PRN**.

Medication & Concentration	Formula	Medication & Concentration	Formula
Atropine Autoinjector 0.5 mg / 0.7 mL	Adults: 2 mg (4 injections) IM. **MAY REPEAT PRN**. Pediatrics: 0.5 mg IM x2. **MAY REPEAT PRN**.	Diazepam-IM 10 mg / 2 mL	Adults: 5 mg (1 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**. • Patients weighing 15 kg or more (≈33 lbs): Preferred injection site is the deltoid. **MAX VOLUME PER INJECTION IS 1 mL**.
Diazepam–IV 10 mg / 2 mL	Adults: 2.5 mg (0.5 mL) IV Pediatrics: 0.05 mg / kg IV	Diazepam–IV 10 mg / 2 mL	Adults: 2.5 mg (0.5 mL) IV Pediatrics: 0.05 mg / kg IV
Diazepam-IM 10 mg / 2 mL	Adults: 5 mg (1 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**. • Patients weighing 15 kg or more (≈33 lbs): Preferred injection site is the deltoid. **MAX VOLUME PER INJECTION IS 1 mL**.	Diazepam Autoinjector 10 mg / 2 mL	Adults: 10 mg (1 injection) IM. **MAY REPEAT TWICE AT 15 MINUTE INTERVALS. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER**. Pediatrics: **NOT PERMITTED**.
Diazepam - IV Related to CPAP Mask 10 mg / 2 mL	Adults: 1 mg / 0.2 mL IV. Pediatrics: **NOT PERMITTED**.	DuoDote (NAAK) Autoinjector Atropine 2.1 mg / 0.7 mL & Pralidoxime 600 mg / 2 mL	Adults: 1 injection (both syringes) IM. **MAY REPEAT TWICE**. Pediatrics: **NOT PERMITTED**.
Diazepam Autoinjector 10 mg / 2 mL	Adults: 10 mg (1 injection) IM. **MAY REPEAT TWICE AT 15 MINUTE INTERVALS. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER**. Pediatrics: **NOT PERMITTED**.	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**.
DuoDote (NAAK) Autoinjector Atropine 2.1 mg / 0.7 mL & Pralidoxime 600 mg / 2 mL	Adults: 1 injection (both syringes) IM. **MAY REPEAT TWICE**. Pediatrics: **NOT PERMITTED**.	Midazolam (Seizalam) - IV 5 mg / 1 mL **OR** 50 mg / 10 mL	Adults: 2.5 mg (0.5 mL) IV. Pediatrics: 0.05 mg / kg IV.

Medication & Concentration	Formula	Medication & Concentration	Formula
Ketamine - IVPB 100 mg / 1 mL **OR** 10 mg / 1 mL	Adults: 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)**. **MAX SINGLE DOSE IS 30 MG.** Pediatrics: **NOT PERMITTED**.	Midazolam (Seizalam) - IM/IN 5 mg / 1 mL **OR** 50 mg / 10 mL	Adults: 5 mg (1 mL) IM/IN. Pediatrics: 0.1 mg / kg IM/IN
Ketamine - IN 100 mg / 1 mL **OR** 10 mg / 1 mL	Adults: 0.5 mg / kg IN. **MAY REPEAT ONCE**. **ADDITIONALADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. **MAX SINGLE DOSE IS 30 MG.** Pediatrics: **NOT PERMITTED**.	Pralidoxime - IM 1000 mg / 5 mL (in 20 mL vial)	Adults: 600 mg (3 mL) IM. **MAY REPEAT TWICE**. Preferred injection site is the lateral thigh. **MAX VOLUME PER INJECTION IS 3 mL AT THIS SITE**. Pediatrics: 20 mg / kg IM. **MAY REPEAT TWICE**. • 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–IV/IN 4 mg / 1 mL	Adults: 2.4 mg / 0.6 mL IV/IN. Pediatrics: 0.05 mg / kg IV/IN.	Pralidoxime - IVPB 1000 mg / 20 mL	Adults: 600 mg (12 mL) IVPB. Pediatrics: 20 mg / kg IVPB.
Lorazepam-IM 4 mg / 1 mL	Adults: 5.2 mg / 1.3 mL IM. Pediatrics: 0.1 mg / kg 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.		
Lorazepam Related to CPAP Mask 4 mg / 1 mL	Adults: 1.2 mg (0.3 mL) slow IV/IO push or IM/IN. Pediatrics: **NOT PERMITTED**.		

Medication & Concentration	Formula
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.

Medication & Concentration	Formula
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.**

Medication & Concentration	Formula
Pralidoxime - IM 1000 mg / 5 mL (in 20 mL vial)	Adults: 600 mg (3 mL) IM. **MAY REPEAT TWICE**. Preferred injection site is the lateral thigh. **MAX VOLUME PER INJECTION IS 3 mL AT THIS SITE**. Pediatrics: 20 mg / kg IM. **MAY REPEAT TWICE**. • 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.**
Pralidoxime - IVPB 1000 mg / 20 mL	Adults: 600 mg (12 mL) IVPB. Pediatrics: 20 mg / kg IVPB.

4103	Weight Conversion Matrix
	Treatment Protocol

Last Reviewed: **October 4, 2022**	Last Revised: **August 17, 2022**

Grey 4-5 kg	Pink 5-7 kg	Red 8-9 kg	Purple 10-12 kg	Yellow 12-14 kg	White 15-16 kg	Blue 17-21 kg	Orange 23-29 kg	Green 32-37 kg	Coal 40-42 kg	Magenta 42-46 kg	Maroon 46-49 kg
9 – 11 lbs	11 – 15 lbs	17 – 20 lbs	22 – 26 lbs	26 – 31 lbs	33 – 35 lbs	37 – 46 lbs	50 – 64 lbs	70 – 81 lbs	88 – 93 lbs	93 – 101 lbs	101 – 108 lbs

50 kg	52 kg	54 kg	57 kg	59 kg	61 kg	64 kg	66 kg	68 kg	70 kg	73 kg	75 kg
110 lbs	115 lbs	120 lbs	125 lbs	130 lbs	135 lbs	140 lbs	145 lbs	150 lbs	155 lbs	160 lbs	165 lbs

77 kg	79 kg	82 kg	84 kg	86 kg	88 kg	91 kg	93 kg	95 kg	98 kg	100 kg	102 kg
170 lbs	175 lbs	180 lbs	185 lbs	190 lbs	195 lbs	200 lbs	205 lbs	210 lbs	215 lbs	220 lbs	225 lbs

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
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)**					None	Repeat as clinically indicated. BG should always be evaluated and documented prior to allowing the patient to refuse treatment and/or transport
ECG APPLICATION AND MONITORING	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 • Palpitations • Unexplained diaphoresis • Dyspnea • Syncope, near syncope, or dizziness • Altered mental status • Epigastric pain • General weakness • Congenital heart problems		***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 ECG leads will impede immediate patient care needs	

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
ECG APPLICATION AND MONITORING (12-LEAD)	<u>Patients that present with the following signs and/or symptoms</u>: • 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		***MAY ASSIST WITH PLACEMENT OF LEADS BUT MAY NOT INTERPRET***	***MAY ASSIST WITH PLACEMENT OF LEADS BUT MAY NOT INTERPRET***		<u>Relative</u>: • Uncooperative patient • Life-threatening conditions • Applying and performing 12-lead will impede immediate patient care needs	<u>12-lead ECGs should be transmitted to a STEMI Receiving Center when</u>: • ASTEMI is suspected • A STEMI is identified on ECG monitor or interpreted by EMT-P ****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
INDWELLING DEVICE ACCESS (*<u>SHUNTS/GRAFTS /PORT-A-CATHS,ET AL.)</u>*	When fluid resuscitation or medications need to be provided and peripheral IV access **and** IO access is unobtainable	**NOT PERMITTED IN RIVERSIDE COUNTY**					

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
INTRAMUSCULAR INJECTION	• When unable to establish peripheral IV access for medication administration • When the desired route for administration of a medication is IM		***MAY ONLY ASSIST WITH THE USE OF PATIENT'S RX EPI- PEN***	***MAY ONLY ASSIST WITH THE USE OF PATIENT'S RX EPI- PEN***		When any of the following are found at the intended injection site: • Masses • Tenderness • Bruising • Infection • Abrasions • Swelling	• The preferred site in patients greater than or equal to 3 years of age is the deltoid (maximum of 1 ml volume) • The preferred site in patients less than or equal to 3 years of age is the vastus lateralis (maximum of 3 ml volume)
INTRANASAL NALOXONE (IN) ADMINISTRATION BY PUBLIC SAFETY FIRST AID PERSONNEL AND FIRST RESPONSE AGENCY BLS PROVIDERSINTHE ABSENCE OF ALS PROVIDERS	Respiratory depression/ arrest with suspected narcotic overdose	***REQUIRES REMSA APPROVAL***	***REQUIRES REMSA APPROVAL***			• Significant nasal trauma • Significant amount of blood or dried mucous discharge present in the nare(s)	PSFAs and first response agency EMTs in the absence of ALS providers working for agencies that are REMSA authorized to administer intranasal naloxone may provide 4 mg IN following procedures outlined in Policy 3309and in REMSA approved training
INTRANASAL MEDICATION ADMINISTRATION	• When unable to establish peripheral IV access for medication administration • When the desired route for administration of a medication is IN		***REQUIRES REMSA APPROVAL***			• Significant nasal trauma	• 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. • IN volume of 2.5 ml is ONLY approved for Tranexamic Acid treatment of epistaxis

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
INTRAOSSEOUS (IO) ACCESS	When unable to establish peripheral IV access for medication administration			***MAY ONLY INITIATE IO ACCESS IN PEDIATRIC PATIENTS***		• When able to establish peripheral vascular access • When a fracture exists at the insertion site • When there is difficulty clearly identifying the insertion site (absence of anatomical landmarks/ excess tissue/other problem) • When an infection is present at the insertion site • When there has already been a previous orthopedic procedure at the insertion site (IO attempt within last 48 hours/joint replacement/prosthetic)	IO access is considered the primary vascular access route in patients eight (8)years of age and younger <u>AEMTs may use:</u> • the EZ-IO Power Driver at the distal and proximal tibia **in pediatrics only** • the Waismed Bone Injection Gun (B.I.G.) at the proximal tibia **in pediatrics only** <u>EMT-Ps may use:</u> • the EZ-IO Power Driver at the distal and proximal tibia in adults & pediatrics and the proximal humerus (humeral head) in adults • the Waismed Bone Injection Gun (B.I.G.) at the proximal tibia in adults & pediatrics 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

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
INTRAOSSEOUS (IO) ACCESS: LIDOCAINE ADMINISTRATION FOR PAIN DURING IO INFUSION IN THE CONSCIOUS PATIENT	Pain during IO infusion in the conscious patient					None	**Adults**: 50 mg slow IO Pover 1 minute. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** **Pediatrics**: 0.5 mg/kg slow IOP over 1 minute. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
INTRAVENOUS ACCESS - EXTERNAL JUGULAR	When unable to establish peripheral IV access, or IO access, when medication administration or fluid resuscitation is required					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 • Havea VP shunt on the side of the intended insertion • Have obscured landmarks	Avoid using large bore catheters
INTRAVENOUS ACCESS - PERIPHERAL	Administration of medication(s), the need for fluid replenishment and/or anticipation of administration of either					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.

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
PAIN MANAGEMENT	• When a patient complains of a pain scale of 1 – 5 and would benefit from the administration of an analgesic • When patient has a pain scale of 6 – 10 with refusal of opioid (Fentanyl) and non-opioid (Ketamine) analgesics • When a patient has pain or myalgias associated with fever **NOTE: the administration of Acetaminophen and/or Ketorolac followed by the administration of Ketamine and/or Fentanyl is a standing order.**					Acetaminophen: • Known allergy to Acetaminophen • Acute ethanol intoxication • Acute Acetaminophen overdose • Known ingestion of 4 gm Acetaminophen in the last 24 hours • Known history of acute or severe liver disease Ketorolac: • Known allergy to Ketorolac or any NSAID • Active bleeding • Active wheezing • Current anticoagulation therapy • Head or multisystem trauma • History if GI bleeds or ulcers • History of gastric bypass surgery • History of renal disease or kidney transplant • Known or suspected pregnancy • Suspected sepsis and/or septic shock • Thoracic and/or abdominal trauma	• Acetaminophen and Ketorolac are **single dose** administrations **ADMINISTRATION OF ACETAMINOPHEN TO PEDIATRIC PATIENT LESS THAN 2 YEARS OF AGE IF NOT PERMITTED** **ADMINISTRATION OF KETOROLAC TO PEDIATRIC PATIENT LESS THAN 4 YEARS OF AGE IF NOT PERMITTED**

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
PAIN MANAGEMENT	When a patient complains of pain greater than 5/10 on the pain scale and would benefit from the administration of analgesics **NOTE: the administration of Fentanyl to its max dose followed by the administration of Ketamine – or vice versa – is a standing order.**					Fentanyl: • Sensitivity to opioids • Hypotension/systolic BP less than 90 mmHg Ketamine: • Pediatric patients (patients appearing to be 14 years of age or less) • Sensitivity to Ketamine • Pain/discomfort of suspected cardiac origin	• Vitals signs (ECG, SpO_2, and waveform/digital capnography) must be monitored throughout BLS and ALS interventions for pain management • The max single dose for Ketamine is 30 mg regardless of the route. **REPETITION OF ANY ANALGESIC AFTER ALL MAX DOSES HAVE BEEN ADMINISTERED REQUIRES A BASE HOSPITAL ORDER (BHO)** **ADMINISTRATION OF KETAMINE TO PEDIATRIC PATIENTS IS NOT PERMITTED**
SUPPLEMENTAL OXYGEN THERAPY	Pulse oximetry reading of less than 94% in the presence of shortness of breath	***REQUIRES REMSA APPROVAL***				• Pulse oximetry reading of greater than 94% • No complaint of shortness of breath	Titrate to maintain, or increase, SpO_2 to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD
VENOUS BLOOD SAMPLING	Obtaining IV access for the purpose of taking a venous blood sample at the request of law enforcement	**NOT PERMITTED IN RIVERSIDE COUNTY**					

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
AIRWAY MANAGEMENT SKILLS							
AIRWAY ADJUNCT – NASOPHARYNGEAL (NPA)	• Inadequate/ineffective positive pressure ventilations • Conscious patients who cannot tolerate an OPA	***REQUIRES REMSA APPROVAL***				• 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
AIRWAY ADJUNCT – OROPHARYNGEAL (OPA)	Inadequate/ineffective positive pressure ventilations	***REQUIRES REMSA APPROVAL***				• Patients with an intact gag reflex • Patients with a foreign body obstructing the airway	Nasopharyngeal airways (NPAs) are the preferred BLS adjunct
AIRWAY SUCTIONING	• Mucus, blood or foreign body obstruction in the airway • Low SpO_2 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	***REQUIRES REMSA APPROVAL***				None	3 mL of normal saline may be introduced during suctioning to loosen thickened secretions. **MAY REPEAT PRN**.

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
BAG VALVE MASK (BVM)/POSITIVE PRESSURE VENTILATIONS	Inadequate/ineffective respirations	***REQUIRES REMSA APPROVAL***				None	• All ALS provider agencies MUST use waveform/ digital capnography when providing rescue ventilations via BVM • Nasopharyngeal airways (NPAs) are the preferred BLS airway when providing rescue ventilations via BVM
CAPNOGRAPHY-COLORMETRICS	• For use if waveform/digital capnography is not working/unavailable/delayed • Can be used in conjunction with waveform/digital capnography. • Waveform/digital capnography remains the primary device for ETT placement conformation.					None	• A colormetric device may be used in conjunction with waveform/digital capnography but it does not take the place of waveform/digital capnography use • **In the event of waveform/ digital capnography failure/unavailable/delay use of a colormetric device is mandatory**

CAPNOGRAPHY-WAVEFORM/ DIGITAL	• 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
						None	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

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
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 **CPAP APPLICATION AND USE IN PEDIATRICS IS NOT PERMITTED**		***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 cmH2Oincrements, 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

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
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					Presence of facial trauma	
NASOGASTRIC TUBE PLACEMENT	To facilitate passive gastric decompression	NOT PERMITTED IN RIVERSIDE COUNTY					
OROGASTRIC TUBE PLACEMENT, ADULT	To facilitate passive gastric decompression after orotracheal intubation (OTI) or the insertion of an i-gel supraglottic airway device.					• 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.	• After successful **OTI**, insertion of an appropriately sized OG tube is **highly recommended.** • After successful placement of the **i-gel**, **immediate** 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.

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
OROGASTRIC TUBE PLACEMENT, PEDIATRIC	To facilitate passive gastric decompression after orotracheal intubation (OTI) or the insertion of an i-gel supraglottic airway device.				***REQUIRES REMSA HEMS LOSOP***		
INTUBATION-NASAL	When BLS airway management is inadequate and/or ineffective and orotracheal intubation is contraindicated or not possible	**NOT PERMITTED IN RIVERSIDE COUNTY**					

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
INTUBATION – OROTRACHEAL (OTI), ADULT	When BLS airway management is inadequate and/or ineffective					• When BLS airway management **is** adequate and/or effective • 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.	Passing the laryngoscope past the teeth with the intent of placing an ETT is considered an intubation attempt. After two (2) failed attempts, return to BLS airway management Utilize waveform/digital capnography immediately after orotracheal intubation to confirm correct placement of the ETT. Utilize a colormetric device if waveform/digital capnography is not working/unavailable/delayed 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 $ETCO_2$ levels is between 30 – 45 mmHg if ROSC is present. The target range for $ETCO_2$ levels is between 15 mmHg – 45 mmHg during CPR. After successful OTI, insertion of an appropriately sized OG tube is **highly recommended.**

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
INTUBATION – OROTRACHEAL (OTI), ADULT WITH INTRODUCER/ BOUGIE	When ETT placement/ orotracheal intubation assistance is needed due to a difficult airway					None	<u>The introducer is correctly placed when:</u> • It can be seen going through the vocal cords • Ratcheting of the tip can be felt on the tracheal rings as it is introduced and/or • When resistance is met after it has been advanced (the tip is at the carina). <u>If no resistance is encountered and the entire length of the introducer is inserted, the device is in the esophagus</u>
INTUBATION - OROTRACHEAL, PEDIATRIC/ NEONATE	When BLS airway management is inadequate and/or ineffective in the pediatric and/or neonate patient				***REQUIRES REMSA HEMS LOSOP***	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	
INTUBATION - STOMAL	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	**NOT PERMITTED IN RIVERSIDE COUNTY**					

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
i-gel/ SUPRAGLOTTIC AIRWAYDEVICE, ADULT	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 (x2 attempts) 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					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**, **immediate** insertion of an appropriately sized OG tube is **mandatory.**
i-gel/ SUPRAGLOTTIC AIRWAYDEVICE, PEDIATRIC	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				***REQUIRES REMSA HEMS LOSOP***		

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
PULSE OXIMETRY (SpO_2)	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 SpO_2 monitoring					None	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
RAPID SEQUENCE INTUBATION (RSI)	Facilitate a secure and definitive advanced airway through the use of sedation and paralytic agents in patients who have: • Failure to oxygenate • Failure to ventilate with BVM • Failure to protect their airway • Altered mental status (GCS less than 8 or demonstrating inability to protect airway) • Status Epilepticus • Expected course is likely to end in airway deterioration including airway swelling secondary to burn/inhalation/anaphylaxis/ hematoma, etc.				***REQUIRES REMSA HEMS LOSOP***	• Facial/neck injuries or anatomy which would preclude reasonable expectation of successful endotracheal intubation • Findings on the airway evaluation(s) which raise concerns over successful endotracheal intubation (consider BLS airway maneuvers and/or back up plan before RSI) • Epiglottitis	
VENTILATOR INITIATION AND MANAGEMENT	Initiation and management of: • Patient weight greater than 3 kg • Patient in need of CPAP or BiPAP • Patient in need of mechanical ventilation: 1. ETT or SGA 2. Manual ventilation time greater than ten (10) minutes				***REQUIRES REMSA HEMS LOSOP***	• Patients presenting with know or suspected auto PEEP (air trapping) • Patients with COPD or asthma • Patients with any air leak disease process (i.e. Pulmonary Interstitial Emphysema, Pneumothorax) • Uncuffed ETT's with significant leak	

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
CARDIAC CARE SKILLS							
AUTOMATED EXTERNAL DEFIBRILLATOR (AED)	Cardiac arrest					<u>The presence of:</u> • Palpable pulses • Spontaneous respirations • A DNR • A POLST • Attestation Form	AED patches should not be placed over implanted medical devices, jewelry, or transdermal medication patches
MANUAL DEFIBRILLATION	Ventricular fibrillation (VF) or pulseless ventricular tachycardia (VT) in the cardiac arrest patient					<u>The presence of:</u> • Palpable pulses • Spontaneous respirations • A DNR • A POLST • Attestation Form • Anon-shockable rhythm (NOT VF or VT)	<u>Settings</u>: **<u>Adults</u>**: Use manufacturer recommended joule settings **<u>Peds</u>**: 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.
MECHANICAL CPR DEVICE	Patients in cardiac arrest		***APPLICATION AND USE REQUIRES PROVIDER AGENCY TRAINING***			• Traumatic arrest or suspected traumatic cause of arrest • Patients **<u>not</u>** in cardiac arrest • Manufacturers contraindications	

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
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	Settings: **Adults**: Initial 100j Second 150j Subsequent200j **Peds**: Initial = 1 j/kg. Subsequent =2j/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.

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
TRANSCUTANEOUS CARDIAC PACING (TCP)	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** • Havea heart rate less than 60 **TRANSCUTANEOUSCARDIAC PACING OF PEDIATRIC PATIENTS REQUIRES A BASE HOSPITAL ORDER (BHO)**					• Children less than or equal to 12 years old (brady dysrhythmias in children are usually respiratory related) • Asystolic arrest, unless approved by a base hospital **(BHO)**	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. • Anterior-posterior placement of pacer pads is recommended to minimize pain and maximize current conduction. • 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). • Perform a 12-lead ECG prior to TCP only if such a delay does not cause harm to the patient. • Use IN/IM administration for Versed administration if warranted and if IV access is poor. • Do not delay TCP in patients with poor peripheral vasculature or in patients experiencing high-degree blocks (2nddegree Type II or 3rd degree)

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
VAGAL MANEUVERS	Patients experiencing symptomatic supraventricular tachycardia (SVT) who are exhibiting the following signs and symptoms of poor systemic 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					Relative: • Hypertension • Suspected acute MI • Suspected head/brain injury	• An ECG strip of Lead II should always be printed prior to, during and immediately after a vagal maneuver in order to capture any potential rhythm change(s) • Perform a 12-lead ECG prior to the patient attempting a vagal maneuver only if such a delay does not cause harm to the patient. • Do not delay cardioversion in an unstable patient presenting with signs and symptoms of poor perfusion.

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
TRAUMA CARE SKILLS							
CERVICAL SPINE IMMOBILIZATION	The patient complains of: • Spinal pain after a confirmed, or suspected, traumatic injury **OR** • 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					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	*****The long backboard (LBB) is an extraction 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 **OR** • When bleeding remains uncontrolled after application of a tourniquet					Manufacturers contraindications	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.	NOT PERMITTED IN RIVERSIDE COUNTY					

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
NEEDLE DECOMPRESSION/ THORACOSTOMY	<u>Signs and symptoms of tension pneumothorax:</u> • Air hunger • Chest pain • Elevated hemithorax without respiratory movement • Hypotension • Neck vein distension • Respiratory distress • Tachycardia • Unilateral absence of breath sounds • Cyanosis (late sign) • Tracheal deviation away from the side of the injury (late sign) <u>For unilateral decompression:</u> • Signs and symptoms of tension pneumothorax with compromised cardiac output AND rapidly progressing respiratory distress unrelieved by less invasive means <u>For bilateral decompression</u> • Cardiac arrest with known/suspected torso trauma					• When unable to positively identify the appropriate anatomical landmarks • When none of the listed indications are present	<u>Anterior approach:</u> • Second (2nd) intercostal space at the midclavicular line immediately above the third (3rd) rib (2 ICS @ MCL) • Third(3rd) intercostal space at the midclavicular line immediately above the fourth (4th) rib (3 ICS @ MCL) <u>Anterolateral approach</u>: • Fourth (4th) intercostal space at the anterior axillary line immediately above the fifth (5th) rib (4 ICS @ AAL) • Fifth (5th) intercostal space at the anterior axillary line immediately above the sixth (6th) rib (5 ICS @ AAL) <u>Lateral approach</u>: • Fourth (4th) intercostal space at the midaxillary line immediately above the fifth (5th) rib (4 ICS @ MAL) • Fifth (5th) intercostal space at the midaxillary line immediately above the sixth (6th) rib (5 ICS @ MAL)

SKILL	INDICATION(S)	PSFA	EMT	AEMT	EMT-P	CONTRAINDICATIONS	EXPECTATIONS
		BLS Patient Management		ALS Patient Management			
TOURNIQUET APPLICATION	Life-threatening hemorrhage when bleeding is uncontrolled after direct pressure has been applied					When bleeding is controlled after direct pressure has been applied	• Tourniquets must be approved for use by the Co- TCCC and the SWAT-T • Do not delay tourniquet application to extricate/ load patient, establish IVs, or other treatments • If the patient's condition allows, use a tourniquet prior to TXA administration is recommended • Pain management should be considered unless clinically contraindicated

4105	ALS Drug Index
	Treatment Protocol

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

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ACETAMINOPHEN (PARACETAMOL, TYLENOL)

CLASS:
- Analgesic, non-opioid

ACTION:
- Inhibits the cyclooxygenase (COX) pathways in the CNS, reducing their activity, producing an analgesic effect
- Inhibits the synthesis of prostaglandins in the CNS, leading to further analgesia and antipyresis
- ONSET= IV Infusion: 1-5 minutes
- DURATION= IV Infusion: 4-6 hours

INDICATION	DOSAGE/ROUTE
Pain scale of 1 – 5 (4204/4901) Pain scale of 6 – 10 with refusal of opioid (Fentanyl) and non-opioid (Ketamine) analgesics (4204/4901) Pain or myalgias associated with fever (4204/4901) Non-trauma related acute/chronic pain (4204/4901)	Adults: 1 gm IV, infused in 100 mL normal saline, administered over 15 minutes. Pediatrics: 15 mg/kg IV infusion, administered over 15 minutes. **MAX SINGLE DOSE IS 1 GM**. **ADMINISTRATION OF ACETAMINOPHEN TO PEDIATRIC PATIENTS LESS THAN 2 YEARS OF AGE IS NOT PERMITTED**.

CONTRAINDICATIONS:
- Known allergy to Acetaminophen
- Acute ethanol intoxication
- Acute Acetaminophen overdose
- Known ingestion of 4 gm Acetaminophen in the last 24 hours
- Known history of acute or severe liver disease

SIDE EFFECTS:
- Skin rash
- Hypersensitivity reactions
- Nephrotoxicity
- Nausea/vomiting
- Constipation
- Pruritis
- Abdominal pain

SPECIAL INFORMATION:
1. Pediatric patients weighing less than 36 kg/79.2 lbs. AND whose length falls within the range of any commercially available, standardized length-based pediatric resuscitation tape, require the use of a volume control chamber device for IV infusions.
2. Acetaminophen for adults and pediatrics is a single dose medication.

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

INDICATION	DOSAGE/ROUTE
Symptomatic supraventricular tachycardia (SVT) with Pulses (4403)	Adults: 12 mg rapid IVP/IOP. Follow immediately with 20 mL normal saline rapid IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. ****OR**** 12 mg mixed in a 20 ml syringe with 16 ml normal saline rapid IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. Pediatrics: 0.2 mg/kg rapid IVP/IOP. Follow immediately with 20 mL normal saline rapid IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. ****OR**** 0.2 mg/kg mixed in a 20 ml syringe with enough normal saline to fill remainder of 20 ml syringe rapid IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

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 blocks, 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 ventricular ectopy). These are generally not treated and are quickly self-limiting

SPECIAL INFORMATION:

1. 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.
2. Obtain ECG documentation before, during, and after giving Adenosine.
3. Transient arrhythmias (PVC's, PAC's, sinus bradycardia, AV block, sinus tach and possibly asystole) may be witnessed after administration
4. Discontinue administration if 2nd or 3rd degree block develops.
5. Adenosine will only convert SVT; it will not convert A-Fib or A-Flutter.
6. 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

INDICATIONS	DOSAGE/ROUTE
Suspected hyperkalemia associated with crush injuries (4301/4902) Suspected hyperkalemia associated with heat illness/ hyperthermia (4702)	**INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)** Adults and pediatrics: 2.5 mg (one pouch), nebulized.
Symptomatic dysrhythmia induced by End Stage Renal Disease (ESRD) (4403/4404)	Adults: 5 mg (two pouches), nebulized. **REPEAT CONTINUOUSLY UNTIL ARRIVAL AT EMERGENCY DEPARTMENT.** **ADMINISTRATION OF ALBUTEROL FOR ESRD-INDUCED DYSRHYTHMIA IN PEDIATRICS IS NOT PERMITTED**.
Bronchospasm (4406/4904) Bronchospasm associated with suspected toxic inhalation (4603) Bronchospasm associated with allergy and/or anaphylaxis (4704/4907)	Adults and pediatrics: 2.5 mg (one pouch), nebulized. **MAY REPEAT PRN**.

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, SpO_2, 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: 150 mg IV, infuse in 50-100 mL normal saline, administer over 10 minutes. Pediatrics: 5 mg/kg IV, infuse in 50-100 mL normal saline, administer over 10 minutes. **MAX SINGLE DOSE TO INFUSE IS 150 MG**.
Medical Cardiac arrest with VF or VT (4405/4903)	Adults: 300 mg IVP/IOP. **MAY REPEAT ONCE AT 150 MG 5 MINUTES AFTERFIRST (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 IVP/IOP. **MAX SINGLE DOSE IS 150 MG**.

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.
3. Pediatric patients weighing less than 36 kg/79.2 lbs. AND whose length falls within the range of any commercially available, standardized length-based pediatric resuscitation tape, require the use of a volume control chamber device for IV infusions.

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

INDICATIONS	DOSAGE/ROUTE
Symptomatic bradycardia with pulses (4404)	Adults: 1 mg IVP/IOP. **MAYREPEAT EVERY 3-5 MINUTES TO A MAX OF 3 MG**. **INITIAL AND REPEAT PEDIATRIC ADMINISTRATION REQUIRES A BASE HOSPITAL ORDER (BHO)**. Pediatrics: 0.02 mg/kg IVP/IOP. **MAX SINGLE DOSE IS 0.5 MG**.
Adult Medical Cardiac Arrest (4405)	**INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. Adults: 1 mg IVP/IOP. **ADMINISTRATION OF ATROPINE TO PEDIATRIC PATIENTS IN CARDIAC ARREST IS NOT PERMITTED**.
Nerve agent, organophosphate and carbamate poisoning (4604, 4605)	Adults: 1 mg (10 mL of prefilled syringe) IVP/IOP. **MAY REPEAT PRN.** ****OR**** 2 mg (5 mL of MDV) IM. **MAY REPEAT PRN**. Pediatrics: 0.02 mg/kg IVP/IOP. **MAX SINGLE DOSE IS 1 MG**. **MAY REPEAT PRN**. ****OR**** 0.05 mg/kg (MDV) IM. **MAX SINGLE DOSE IS 1 MG**. **MAY REPEAT PRN**.

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 ($CaCl_2$)

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 ventricular automaticity
- ONSET = 2-10 mins
- DURATION= 30-60 mins

INDICATIONS	DOSAGE/ROUTE
Suspected hyperkalemia associated with crush injuries (4301/4902) Suspected beta blocker or calcium channel blocker overdose (4601) Cardiac dysrhythmias associated with toxic exposure, inhalation, or ingestion (4603) Suspected hyperkalemia associated with heat illness/ hyperthermia (4702)	**INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).** Adults: 1 gm IV, infuse in50-100 mL normal saline, administer over 10 minutes. Pediatrics: 20 mg/kg IV, infuse in 50-100 mL normal saline, administer over 10 minutes.
Symptomatic dysrhythmia induced by End Stage Renal Disease (ESRD) (4403/4404)	Adults: 1 gm slow IVP administer over 5 minutes. **ADMINISTRATION OF CALCIUM CHLORIDE FOR ESRD-INDUCED DYSRHYTHMIA IN PEDIATRICS IS NOT PERMITTED**.
Medical Cardiac arrest with suspected hypocalcemia, hyperkalemia, hypermagnesemia, or calcium channel blocker overdose (4405/4903)	**INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).** Adults: 1 gm IVP/IOP. Pediatrics: 20 mg/kg IVP/IOP.
Medical Cardiac arrest in a known/suspected dialysis patient (4405/4903)	Adults: 1 gm IVP/IOP. **ADDITIONAL ADMINISTRATIONS REQUIRE ABASEHOSPITAL ORDER (BHO).** **INITIALANDREPEAT PEDIATRIC ADMINISTRATION REQUIRES A BASE HOSPITAL ORDER (BHO)**. Pediatrics: 20 mg/kg IVP/IOP.

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

SPECIAL INFORMATION:

1. **CALCIUM CHLORIDE USE IN KNOWN OR SUSPECTED END STAGE RENAL DISEASE (ESRD):**
   Patients at increased risk for hyperkalemia include those with a history, or clinical evidence of renal failure, missed dialysis, with ECG signs of hyperkalemia included peaked T-waves, wide QRS, bradycardia, tachycardia, long PR interval and absent P-waves. Initial assessment is critical along with ongoing assessments.
   - Documentation is required in the ePCR data fields.
   - Calcium chloride use for suspected ESRD patients is a single dose medication
2. Pediatric patients weighing less than 36 kg/79.2 lbs. AND whose length falls within the range of any commercially available, standardized length-based pediatric resuscitation tape, require the use of a volume control chamber device for IV infusions.

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

INDICATIONS	DOSAGE/ROUTE
ALS care providers: Symptomatic hypoglycemia: • Have a blood glucose less than 80 mg/dl in adults • Have a blood glucose less than 70 mg/dl in pediatrics • Have a blood glucose less than 60 mg/dl in neonates if greater than 48 hours old but less than 28 days old • Have a blood glucose less than 45 mg/dl in neonates less than 48 hours old (4201/4901)	Adults: 25 gm (D10%) IV/IO bolus or infusion. **MAY REPEAT PRN**. Neonates and Pediatrics: 5 mL/kg (D10%) IV/IO bolus or infusion. **MAY REPEAT PRN**.
Neonatal Resuscitation Post Delivery (4801)	**INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)** Neonates: 5 mL/kg (10% solution) IV/IO bolus or infusion.

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 D10% administration:
   - ➢ Altered LOC- reassess LOC and skins; recheck BGL if there is no improvement in symptoms
4. Pediatric patients weighing less than 36 kg/79.2 lbs. AND whose length falls within the range of any commercially available, standardized length-based pediatric resuscitation tape, require the use of a volume control chamber device for IV infusions.

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

INDICATIONS	DOSAGE/ROUTE
Nausea and/or Vomiting (4203/4901)	**INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).** Adults: 25-50 mg slow IVP/IOP or IM. Pediatrics: 1 mg/kg slow IVP/IOP. ****OR**** 2 mg/kg IM. **MAX SINGLE DOSE IVP/IOP/IM IS 50 MG**.
Overdose/Adverse Reaction: suspected dystonic reaction (4601) Allergy and/or Anaphylaxis (4704/4907)	Adults: 50 mg slow IVP/IOP or IM. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. Pediatrics: 1 mg/kg slow IVP/IOP. ****OR**** 2 mg/kg IM. **MAX SINGLE DOSE IVP/IOP/IM IS 50 MG**. **ADDITIONAL ADMINISTRATIONS REQUIREA 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 = IVP/IOP: 1-2 minutes, IM: 5-10 minutes
- DURATION= 5-10 minutes

INDICATIONS	DOSAGE/ROUTE
Shock unrelated to trauma (4202/4901) Shock related to trauma where cardiac arrest is imminent (4301/4902) Shock following ROSC (4405/4903) Shock associated with allergy and/or anaphylaxis (4704/4907) Shock associated with snakebite (4705) Shock associated with postpartum hemorrhage (4801)	Adults: Push Dose Epinephrine 0.01 mg (0.01 mg/mL concentration) IVP/IOP. **MAY REPEAT AS CLINICALLY INDICATEDEVERY 1-5 MIN TO MAINTAIN A SBP > 90** Pediatrics: Push Dose Epinephrine 0.01 mg (0.01 mg/ml concentration) IVP/IOP. **MAY REPEAT AS CLINICALLY INDICATED TO MAINTAIN A SBP > [70 + (AGE X2)]**
Medical Cardiac Arrest (4405/4903)	Adults: 1 mg (0.1 mg/mL concentration) IVP/IOP. **MAY REPEAT EVERY 5 MINUTES TO A MAX OF 5 MG. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** Pediatrics: 0.01 mg/kg (0.1 mg/mL concentration) IVP/IOP. **MAY REPEAT EVERY 5 MINUTES TO A MAX OF FIVE (5) ADMINISTRATIONS.** **INITIAL AND REPEAT ADMINISTRATIONS FOR NEONATE REQUIRE A BASE HOSPITAL ORDER (BHO).** Neonates: Epinephrine 0.01 mg/kg (0.1 mg/mL concentration) IVP/IOP.

For moderate to severe upper airway disease/croup (Stridor or Barky Cough) (4904)	Pediatrics: Nebulized Epinephrine 0.5 mg/kg (1 mg/ml) 1:1000, mixed with NS for minimum volume 3 ml. **MAX SINGLE DOSE EPI IS 5 MG. ADMINISTRATION OF NEBULIZED EPINEPHRINE TO PEDIATRIC PATIENTS GREATER THAN 8 YEARS OF AGE IS NOT PERMITTED**.
Shock following ROSC WHEN PATIENT'S SYSTOLIC BP IS LESS THAN 90 MMHG (4405)	Adults: 0.4 mg (1 mg/mL concentration) IV, infused in 100 mL normal saline ****OR**** 0.2 mg(1 mg/mL concentration) IV, 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, TOACHIEVE OR MAINTAIN SYSTOLIC BP OF 90 MMHG OR GREATER** • Begin infusion at 1 mcg/min (15 ml/hr) **OR** 1.33mcg/min(20ml/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 ASYSTOLIC 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 INFUSION UNTIL A SYSTOLIC BP OF 90 MMHG OR GREATER IS ATTAINED** **ADMINISTRATION OF EPINEPHRINE BY IV INFUSION TO PEDIATRIC PATIENTS IS NOT PERMITTED**
Respiratory distress (4406/4904)	**INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)**. Adults: 0.3 mg (1 mg/mL concentration) IM. Pediatrics: 0.01 mg/kg (1 mg/mL concentration) IM. **MAX SINGLE DOSE IS 0.3 MG.**

Suspected Anaphylaxis (4704/4907)	Adults: 0.3 mg (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).**
Pediatric Medical Cardiac Arrest (4903) Neonatal Resuscitation Post Delivery (4801)	**INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)** Neonates: 0.01 mg/kg (0.1 mg/mL concentration) IVP/IOP

CONTRAINDICATIONS

- (Relative) tachycardia
- Not indicated in traumatic arrest

CONTRAINDICATIONS (INFUSION)

- Administration via IO route
- Patients 14 years of age or younger
- Shock due to trauma
- ROSC after traumatic arrest
- Unable to obtain a systolic BP
- Unable to use a Dial-a-Flow

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 O_2 saturation
   - Respiratory distress--monitor lung sounds, respiratory rate, SpO_2, capnography, ECG and pulse
4. Nebulized Epinephrine use for severe upper airway disease/croup is a single dose medication.

FENTANYL

CLASS:
- Opioid (Synthetic)

ACTION:
- Binds with stereospecific receptors at many sites within the CNS.
- Increases pain thresholds and alters pain reception.
- ONSET = IVP/IOP: within seconds, IM/IN: 7-8 minutes
- DURATION = IVP/IOP: 30-60 minutes, IM/IN: 1-2 hours

INDICATIONS	DOSAGE/ROUTE
Pain associated with: • Non-trauma related acute/chronic pain (4204/4901) • Acute traumatic injury or injuries (4301/4902) • Suspected ACS with persistent chest discomfort unresponsive to Nitroglycerin (4401) • Burns (4701/4906) • Frostbite (4703) • Snakebite (4705)	Adults: 50 mcg slow IVP/IOP 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 IVP/IOP or IM/IN. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
Discomfort associated with transcutaneous cardiac pacing: TCP (4404)	Adults: 50 mcg slow IVP/IOP 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 IVP/IOP or IM/IN.
Pain following ROSC (4405)	**INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)** Adults: slow IVP/IOP 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, SpO_2 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

INDICATIONS	DOSAGE/ROUTE
ALS care providers: Symptomatic hypoglycemia: • Have a blood glucose less than 80 mg/dl in adults • Have a blood glucose less than 70 mg/dl in pediatrics • Have a blood glucose less than 60 mg/dl in neonates if greater than 48 hours old but less than 28 days old • Have a blood glucose less than 45 mg/dl in neonates less than 48 hours old WHEN UNABLE TO ADMINISTER IV/IO DEXTROSE (4201/4901)	Adults: 1 mg IM. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** Pediatrics and neonates: Weight = 21 kg (≈46 lbs) or less: 0.5 mg IM. Weight = 22 kg (≈48 lbs) or more: 1 mg IM. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.
Suspected esophageal food impaction (4406/4904)	**INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)**. Adults:1 mg IVP/IOP or IM. Pediatrics: Weight = 21 kg (≈46 lbs) or less: 0.5 mg IVP or IM. Weight = 22 kg (≈48 lbs) or more: 1 mg IVP or IM.
Suspected beta blocker or calcium channel blocker overdose (4601)	**INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).** Adults: 1 mg IVP/IOP or IM. Pediatrics: 50 mcg/kg, IVP/IOP or IM.
Neonatal Resuscitation Post Delivery (4801)	**WHEN UNABLE TO ADMINISTER IV/IO DEXTROSE** **INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** Neonates: Weight = 21kg (≈48 lbs) or less: 0.5 mg IM

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, neonates post-delivery).
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.

INDICATIONS	DOSAGE/ROUTE
BLS and ALS care providers: Symptomatic hypoglycemia: • Have a blood glucose less than 80 mg/dl in adults • Have a blood glucose less than 70 mg/dl in pediatrics • Have a blood glucose less than 60 mg/dl in neonates if greater than 48 hours old but less than 28 days old • Have a blood glucose less than 45 mg/dl in neonates less than 48 hours old (4201, 4801/4901)	**PATIENT MUST BE ALERT AND COOPERATIVE (ADULTS), WITH GAG REFLEXES INTACT.** Adults: Glucose Gel(oral) 15 gm (1 tube) PO. **MAY REPEAT PRN**. Neonates and Pediatrics: Glucose Gel (oral/buccal) PO AS TOLERATED. **MAY REPEAT PRN TO ACHIEVE AND/ OR MAINTAIN CORRESPONDING AGEAPPROPRIATE BLOOD GLUCOSE LEVEL**

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

INDICATION	DOSAGE/ROUTE
Bronchospasm (4406/4904)	Adults and Pediatrics: 0.5 mg (one pouch), mixed with one (1) pouch of Albuterol, then nebulized. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

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, SpO_2, 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 = IV Infusion: within 30 seconds, IN: 5-10 minutes
- DURATION= IV Infusion: approximately 10 minutes, IN: 30-60 minutes

INDICATIONS	DOSAGE/ROUTE
Pain associated with: • Non-trauma related acute/chronic pain (4204) • Adult acute traumatic injury or injuries (4301) • Burns (4701) • Frostbite (4703) • Snakebite (4705)	Adults: 0.3 mg/kg IV, infuse in 50-100 mL Normal Saline, administer over 5 minutes. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. ****OR**** 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**.

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, SpO_2 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.

KETOROLAC (TORADOL)

CLASS:
- Nonsteroidal anti-inflammatory (NSAID)

ACTION:
- Inhibits the cyclooxygenase (COX) pathways in the CNS, reducing their activity, producing an analgesic effect
- Inhibits the synthesis of prostaglandins in the CNS, leading to further analgesia and antipyresis
- ONSET = IVP/IOP: 1-5 minutes, IM: 10 minutes
- DURATION= 4-6 hours

INDICATIONS	DOSAGE/ROUTE
Pain scale of 1 – 5 (4204/4901) Pain scale of 6 – 10 with refusal of opioid (Fentanyl) and non-opioid (Ketamine) analgesics (4204/4901) Pain or myalgias associated with fever (4204/4901) Non-trauma related acute/chronic pain (4204/4901)	Adults: 15 mg slow IVP/IOP ****OR**** 30 mg IM Pediatrics: 0.5 mg/kg slow IVP/IOP or IM. **MAX SINGLE DOSE IS 15 MG**. **ADMINISTRATION OF KETOROLAC TO PEDIATRIC PATIENTS LESS THAN 4 YEARS OF AGE IS NOT PERMITTED**.

CONTRAINDICATIONS:
- Known allergy to Ketorolac or any NSAID
- Active bleeding
- Active wheezing
- Current anticoagulation therapy
- Head or multisystem trauma
- History of GI bleeds or ulcers
- History of gastric bypass surgery
- History of renal disease or kidney transplant
- Known or suspected pregnancy
- Suspected sepsis and/or septic shock
- Thoracic and/or abdominal trauma

SIDE EFFECTS:
- Swelling of the face, fingers, lower legs, ankles and/or feet
- Ecchymosis
- Hypertension
- Acute rash and/or pruritis

SPECIAL INFORMATION:
Ketorolac for adults and pediatrics is a single dose medication.

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

INDICATIONS	DOSAGE/ROUTE
Pain during IO infusion in the conscious patient	Adults: 50 mg slow IOP over 1 minute. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** Pediatrics: 0.5 mg/kg slow IOP over 1 minute. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
Symptomatic tachycardia with pulses (4403) Medical Cardiac arrest with VF or VT WHEN AMIODARONE IS UNAVAILABLE (4405/4903)	**INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)**. Adults: 1 mg/kg slow IVP/IOP followed by the second dose (0.5 mg/ kg) 8-10 minutes later, to a max of 3 mg/kg. Pediatrics: 1 mg/kg slow IVP/IOP followed by the second dose (1 mg/kg) 8-10 minutes later.

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

INDICATIONS	DOSAGE/ROUTE
Medical Cardiac arrest with VF or VT WHEN ASSOCIATED WITH TORSADES DE POINTES / POLYMORPHIC VT (4405/4903)	**INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)**. Adults: 2 gm slow IVP/IOP. Pediatrics: 50 mg/kg slow IVP/IOP.
Asthma exacerbation unresponsive to Albuterol and Ipratropium breathing treatments (4406/4904) Cardiac dysrhythmias associated with toxic exposure, inhalation, or ingestion (4603)	**INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)**. Adults: 2 gm/4 mL slow IVP/IOP. Pediatrics: 50 mg/kg IV, infuse in 50-100 mL normal saline, administer over 10 minutes.
Suspected pre-eclampsia or eclampsia (4801)	5 gm IV, infuse in 50-100 mL normal saline, administer over 10 minutes. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. **OR** 5 gm (10 mL) IM. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

CONTRAINDICATIONS:

- Heart block
- Recent myocardial infarction

SIDE EFFECTS:

- Constipation
- Flushing
- General
- Muscle Weakness
- Headache
- Lethargy
- Nausea/Vomiting
- Palpitations

SPECIAL INFORMATION:

1. Magnesium IV infusion may be given prophylactically for suspected eclampsia
2. With IV infusion 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.
4. Pediatric patients weighing less than 36 kg/79.2 lbs. AND whose length falls within the range of any commercially available, standardized length-based pediatric resuscitation tape, require the use of a volume control chamber device for IV infusions.

MIDAZOLAM (VERSED)

CLASS:

- Benzodiazepine

ACTION:

- CNS depressant
- Produces retrograde amnesia then sedation
- Stops and prevents seizures
- ONSET = IVP/ IOP or IN: 2-5 minutes, IM: 15 minutes
- DURATION= 1-4 hours

INDICATIONS	DOSAGE/ROUTE
Amnesic effect in the conscious VAD patient prior to synchronized cardioversion (4402)	**CONSIDER**: 2.5 mg slow IVP/IOP. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. ****OR**** 5 mg IM/IN. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.
Amnesic effect prior to synchronized cardioversion (4403) Amnesic effect prior to Transcutaneous Cardiac Pacing (TCP) (4404)	Adults: 2.5 mg slow IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** ****OR**** 5 mg 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: 0.1 mg/kg slow IVP/IOP. ****OR**** 0.2 mg/kg IM/IN.
Anxiety following ROSC (4405) Shivering associated with heat illness/hyperthermia (4703)	**INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)** Adults: 1 mg slow IVP/IOP or IM/IN. **ADMINISTRATION OF MIDAZOLAM TO PEDIATRIC PATIENTS FOR POST-ROSC ANXIETY OR HEAT ILLNESS-RELATEDSHIVERING IS NOT PERMITTED**.

Anxiety related to the use of CPAP (4406)	Adults: 1 mg slow IVP/IOP 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 (4501/4905) 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 (4602)	Adults: 2.5 mg slow IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** ****OR**** 5 mg IM/IN. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** Pediatrics: 0.1 mg/kg slow IVP/IOP. **MAY REPEAT ONCE AFTER 5 MINUTES**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** ****OR**** 0.2 mg/kg IM/IN. **MAY REPEAT ONCE AFTER 5 MINUTES**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
Eclampsia unresponsive to Magnesium Sulfate administration (4801)	**INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)** 2.5 mg slow IVP/IOP ****OR**** 5 mg IM/IN.

Patients requiring chemical restraint when physical restraints are ineffective and who pose an immediate danger to themselves or others, due to a suspected traumatic brain injury (4301/4902)	**INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)**. Adults: 2.5 mg slow IVP/IOP. **OR** 5 mg IM/IN Pediatrics: 0.1 mg/kg slow IVP/IOP **OR** 0.2 mg/kg 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 SpO_2 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= IVP or IN: 1-2 minutes, IM: 2-5 minutes
- DURATION = IVP or IN: 30-60 minutes, IM: longer

INDICATION	DOSAGE/ROUTE
REMSA Authorized Public Safety Personnel **AND first response agency BLS providers in the absence of ALS providers – LOSOP Approval Required** Respiratory depression/respiratory arrest with suspected narcotic overdose (4601)	**MAY REPEAT ONCE**. Use REMSA approved intranasal administration device with REMSA approved pre-loaded dose
Agency LOSOP Approval Required for BLS Providers Respiratory depression/respiratory arrest with suspected narcotic overdose (4601) Pediatric General Medical (4901) Pediatric Medical Cardiac Arrest (4903)	Adults: 1 mg IVP/IOP or IM/IN. **MAY REPEAT PRN. TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS OR PUPILLARY CONSTRICTION** Pediatrics: 0.1 mg / kg IVP/IOP/IM/IN. **MAX SINGLE DOSE IS 1 MG. MAY REPEAT PRN. TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS OR PUPILLARY CONSTRICTION** Neonates: Naloxone 0.1 mg/kg IVP/IOP/IM/IN. **MAX SINGLE DOSE IS 1 MG. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**
Neonatal Resuscitation Post Delivery (4801)	Neonates: Naloxone 0.1 mg/kg IVP/IOP/IM/IN. **MAX SINGLE DOSE IS 1 MG. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

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 relapses; as long as opioid is still in the patient's system, be prepared to continue administrations
2. Assessing effectiveness of Narcan:
   - ➢ increase in LOC, respiratory status, SpO_2 and pupil response

   Effective against:

Codeine	Darvon	Demerol	Dilaudid
Fentanyl	Heroin	Lomotil	Methadone
Morphine	Nubain	Oxycontin	Paragoric
Percodan	Stadol	Talwin	Vicodin

NITROGLYCERIN (NTG, NITRO)

CLASS:
- Nitrate

ACTION:
- Relaxes systemic venous & arterial vessels causing vasodilatation thereby:
  - Decreases preload & afterload
  - Decreases myocardial workload.
  - Decreases myocardial O_2consumption.
- Dilates coronary arteries
- ONSET = 2 minutes
- DURATION= 30-60 minutes

INDICATIONS	DOSAGE/ROUTE
Suspected ACS (4401) Dyspnea with suspected CHF (4406)	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**** 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**.

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)

INDICATIONS	DOSAGE/ROUTE
Loosen thickened secretions during suctioning (4104)	3 mL **MAY REPEAT PRN**.
Shock unrelated to Trauma (4202/4403/4405/4701/4702/4801/4901) Traumatic Shock/Injury/Arrest (4301/4902) Suspected hyperkalemia associated with crush injuries (4301/4902) Shock following ROSC (4405/4903) Hyperthermia or heat illness symptoms related to severe agitation/aggression/distress (4602) Significant burns (4701/4906) Heat illness/hyperthermia (4702) Hypothermia (4703) Allergy and/or Anaphylaxis (4704/4907) Pediatric General Medical (4901)	Adults: 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TOA MAX ADMINISTRATION OF 2 L**. Pediatrics: 20 mL/kg IV/IO bolus. Use a volume control chamber device for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.** Neonates: 10 ml/kg IV/IO rapid infusion. Use a volume control chamber device for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED**
Neonatal Resuscitation Post Delivery (4801)	Neonates: 10 ml/kg IV/IO rapid infusion. Use a volume control chamber device for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.**
Hemodynamically unstable VAD patient (4402)	**CONSIDER**: 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L**.

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.**
3. **Pediatric patients weighing less than 36 kg/79.2 lbs. AND whose length falls within the range of any commercially available, standardized length-based pediatric resuscitation tape, require the use of a volume control chamber device for IV infusions.**

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 = IVP: 2-3 minutes, IM: 10-15 minutes, PO: 20 -30 minutes
- DURATION= 1.5 – 2 hours

INDICATIONS	DOSAGE/ROUTE
Nausea and/or vomiting (4203/4901)	Adults: 4 mg PO (1 ODT). **MAY REPEAT TWICE TO MAX 12 MG**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. ****OR**** 4 mg slow IVP/IOP 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 LESSTHAN 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 ABASEHOSPITAL ORDER (BHO)**. ****OR**** 0.1 mg/kg slow IVP/IOP or IM. **MAX SINGLE DOSE IS 4 MG**. **MAY REPEAT TWICE TO MAX 12 MG**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

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 Torsade 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, $NaHC0_3$)

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	DOSAGE/ROUTE
Suspected hyperkalemia associated with crush injuries (4301/4902) Altered mental status and/or dysrhythmia with suspected cyclic antidepressant overdose (4601) Suspected hyperkalemia associated with heat illness/ hyperthermia (4602/4702)	**INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).** Adults: 50 mEq slow IVP/IOP Pediatrics: 1 mEq/kg slow IVP/IOP
AFTER THE ADMINISTRATION OF CALCIUM CHLORIDE: Symptomatic dysrhythmia induced by End Stage Renal Disease (ESRD) (4403/4404)	**BASE HOSPITAL ORDER (BHO) REQUIRED PRIOR TO ADMINISTRATION. FLUSH INTRAVENOUS LINE WITH 10-20ml NS PRIOR TO ADMINISTRATION.** Adults: 50mEq slow IVP/IOP. **ADMINISTRATION OF SODIUM BICARBONATE FOR ESRD-INDUCED DYSRYTHMIA IN PEDIATRICS IS NOT PERMITTED.**
Medical Cardiac arrest with suspected metabolic acidosis, hyperkalemia, or tricyclic antidepressant overdose (4405/4903)	Adults: 50 mEq IVP/IOP. **MAY REPEAT ONCE. ADDITIONAL ADMINISTRATIONS REQUIRE ABASE HOSPITAL ORDER (BHO).** **INITIAL AND REPEAT NEONATE AND PEDIATRIC ADMINISTRATION REQUIRES A BASE HOSPITAL ORDER (BHO).** Neonates and Pediatrics: 1 mEq/kg IVP/IOP.
Neonatal Resuscitation Post Delivery (4801)	**INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** Neonates: 1 mEq/kg IVP/IOP.

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	DOSAGE/ROUTE
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 (4301)	Adults: 2 gm slow IVP/IOP, administered over 1 minute. ****OR**** Tranexamic Acid (TXA) 1 gm (10 ml) IM. **MUST REPEAT 1 GM IVP/IOP, ONCE IV HAS BEEN ESTABLISHED, TOTAL 2 GM** **MAX DOSE IS 2 GM** **ADMINISTRATION OF TRANEXAMIC ACID (TXA) TO PEDIATRIC PATIENTS IS NOT PERMITTED**.
For postpartum hemorrhage within three (3) hours of time of birth, with signs and symptoms of hemorrhagic shock (EBL > 500 mL) with systolic BP less than 90 mmHg ****OR**** Significant hemorrhage with heart rate ≥ 120 (4801)	Adults: 1 gm slow IVP/IOP, administered over 1 minute. **ADMINISTRATION OF TRANEXAMIC ACID (TXA) TO PEDIATRIC PATIENTS IS NOT PERMITTED**.
For epistaxis hemorrhage within three (3) hours of onset and NOT controlled by BLS intervention (4202)	Adults: 250mg (2.5ml) atomized IN into bleeding naris. **MAY REPEAT ONCE AFTER FIFTEEN (15) MINUTES FOR CONTINUED SIGNIFICANT HEMORRHAGE** **ADMINISTRATION OF TRANEXAMIC ACID (TXA) TO PEDIATRIC PATIENTS IS NOT PERMITTED**.

CONTRAINDICATIONS:

- Any form of shock NOT related to trauma, postpartum hemorrhage or epistaxis (i.e. GI bleeding, varicose veins, etc.)
- Traumatic injuries that occurred more than three (3) hours prior
- Signs and symptoms of hemorrhagic shock but vital signs do not meet the specified criteria
- Epistaxis: pregnancy, known allergy, known nasopharyngeal or oral malignancy, nasal trauma
- 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
3. IV infusion is the preferred administration route; IO infusion or IM route should only be used when IV access is unable to be obtained.
4. Total max dose of TXA for treatment of traumatic hemorrhagic shock is 2 gm; one (1) dose slow IVP/IOP (2 gm) **OR** one (1) dose IM (1 gm) and one dose IVP (1 gm) for a total of 2 gm
5. TXA use for postpartum hemorrhage is a single dose medication (1 gm).

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

4108	Do Not Attempt Resuscitation Discontinue Resuscitation
Treatment Protocol	

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2025**

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.
  9. Neonates delivered before 22 weeks gestation **WITH** no signs of life.
     - If unknown gestational age look for:
       - Eyelids fused shut
       - Foot length less than 40 mm (1.5 inches)
       - Transparent skin
       - Weight less than 2 pounds
       - Low muscle tone

- **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

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).

7. May remove invasive medical devices at the direction of the Coroner's Office
8. Remain at scene until released by LE
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

10. **When the decision not to attempt/to discontinue resuscitation has been made during transport**

    a) Stop in a safe location without crossing county lines
    b) Comfort and care for any survivors present
    c) Contact the County of Riverside Coroner's Office, give report, and answer all applicable questions
    d) Follow the Coroner's directions for:
        - Disposition
        - Notification of local law enforcement
    e) 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

4109	Ambulance Patient Offload Delay
Treatment Protocol	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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.)

4110	End of Life Care
Treatment Protocol	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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. <u>EMS Prehospital DNR</u>
   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. <u>DNR Medallion, Bracelet or Necklace</u>
   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 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.
    - 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.

4201	Adult Symptomatic Hypoglycemia
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

BLS Patient Management	ALS 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, 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 **Symptomatic hypoglycemia:** • Have a blood glucose less than 80 mg/dl in adults **BLS and ALS care providers** **PATIENT MUST BE ALERT AND COOPERATIVE (ADULTS), WITH GAG REFLEXES INTACT.** Adults: Glucose Gel (oral) 15 gm (1 tube) PO**. MAY REPEAT PRN.**	• Interpret and continuously monitor ECG, vital signs and SpO_2 • **For symptomatic hypoglycemia with blood glucose less than 80 mg/dL in adults** Adults: Dextrose 25 gm (D10%) IV/IO bolus or infusion. **MAY REPEAT PRN**. • **For symptomatic hypoglycemia with blood glucose less than 80 mg/dL in adults WHEN UNABLE TO ADMINISTER DEXTROSE** Adults: Glucagon 1 mg IM. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

Patient Disposition

- **CONTACT A SINGLE BASE HOSPITAL FOR ANY PATIENT THAT REFUSES TRANSPORT FOLLOWING THE INITIATION OF ANY ALS TREATMENT**

4202	Adult Shock Unrelated to Trauma
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

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
    - **Epistaxis**: apply direct pressure to bridge of nose. Suction as needed, should not allow patient to swallow blood
- **Oxygen**
  As clinically indicated. Titrate to maintain, or increase, SpO_2 to a minimum of 94%. A range of 88-92% is acceptable for patients with a history of COPD
- 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

  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, SpO_2 and waveform/digital capnography

  Perform, interpret, and transmit 12L 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 Epistaxis hemorrhage within three (3) hours of onset and NOT controlled by BLS intervention**
  Adults: Tranexamic Acid (TXA) 250 mg (2.5 ml) atomized IN into bleeding naris. **MAY REPEAT ONCE AFTER FIFTEEN (15) MINUTES FOR CONTINUED SIGNIFICANT HEMORRHAGE**

  ADMINISTRATION OF TRANEXAMIC ACID (TXA) TO PEDIATRIC PATIENTS IS NOT PERMITTED
- **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**.

  Adults: Epinephrine Push Dose 0.01 mg (0.01 mg/mL concentration) IVP/IOP. **MAY REPEAT AS CLINICALLY INDICATED EVERY 1-5 MIN TO MAINTAIN A SBP > 90**
- **INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS REQUIRE A BASE HOSTPIAL ORDER (BHO)**
  For hemorrhagic shock due to non-traumatic injury with SBP < 70 mmHg or unable to obtain BP

  ****OR****

  SBP <90 AND HR ≥ 110 (SI>1.2)

  ****OR****

	Hypovolemic/hemorrhagic arrest witnessed by EMS Adults: LTO+WB 1 Unit warmed and infused **OR** Adults: pRBCs 2 Units warmed and infused If blood administration criteria persist, administer an additional unit of LTO+WB or pRBCs

4203	Adult Nausea and/or Vomiting
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

BLS Patient Management	ALS 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, 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	• 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 when applicable • **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 IV solution slow IVP/IOP/IM. **MAY REPEAT TWICE TO MAX 12 MG**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. --- **INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS REQUIRE A BASE HOSPITAL ORDER (BHO).** Adults: Diphenhydramine 25-50 mg slow IVP/IOP/IM.

4204	Adult Pain Management
	Treatment Protocol

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

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, 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 (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, SpO_2 and waveform/digital capnography

For non-trauma related acute/chronic pain

- **For a pain scale of 1 – 5**

****OR****

Pain scale of 6 – 10 with refusal of opioid (Fentanyl) and non-opioid (Ketamine) analgesics

****OR****

Pain or myalgias associated with fever

Adults: Acetaminophen 1 gm IV, infused in 100 ml normal saline, administered over 15 minutes.

Adult: Ketorolac 15 mg slow IVP/IOP or 30 mg IM

- **For pain scale 6 – 10**
  Adults: Fentanyl 50 mcg slow IVP/IOP 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).**

	Adults: Ketamine 0.3 mg/kg IV, 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**.

4301	Adult Traumatic Shock/Injury/Arrest
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

BLS Patient Management	ALS Patient Management
• **Establish, maintain, and ensure cervical spine stabilization, as clinically indicated, when NSAID criteria is met** ○ **N**euro deficits ○ **S**pinal Tenderness ○ **A**ltered Mental Status ○ **I**ntoxication ○ **D**istracting 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 it 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, SpO_2 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	• Interpret and continuously monitor ECG, vital signs, waveform, digital capnography, and SpO_2 • 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 • **For pain associated with acute traumatic injury or injuries** Adults: Fentanyl 50 mcg slow IVP/IOP 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**. --- Adults: Ketamine 0.3 mg/kg IV, infused 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.** • **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**.

- 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

- **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 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 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

- **If the patient is in traumatic cardiac arrest with known/suspected torso trauma**

  THEN

  Perform bilateral chest decompression

- **For traumatic injuries within three (3) hours signs and symptoms of hemorrhagic shock with systolic BP less than 90 mmHg**

  ****OR****

  Significant hemorrhage with heart rate ≥ 120

  ****OR****

  Uncontrolled bleeding despite tourniquet application

  Adults: Tranexamic Acid (TXA) 2 gm slow IVP/IOP, administered over 1 minute.

  ****OR****

  Tranexamic Acid (TXA) 1 gm (10 ml) IM. **MUST REPEAT 1 GM IVP/IOP, ONCE IV HAS BEEN ESTABLISHED, TOTAL 2 GM**

  MAX DOSE IS 2 GM

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 LEVEL I OR LEVEL II TRAUMA 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 hemorrhagic shock due to severe traumatic injury with SBP < 70 mmHg or unable to obtain BP**

  ****OR****

  SBP <90 AND HR ≥ 110 (SI>1.2)

  ****OR****

  Traumatic arrest witnessed by EMS

  Adults: LTO+WB 1 Unit warmed and infused

  OR

  Adults: pRBCs 2 Units warmed and infused
  If blood administration criteria persist, administer an additional unit of LTO+WB or pRBCs

- **For persistent shock due to trauma when cardiac arrest is imminent AFTER Normal Saline, TXA, and chest decompression as indicated:**
  Adults: Epinephrine Push Dose 0.01 mg (0.01 mg/mL concentration) IVP/IOP. **MAY REPEAT AS CLINICALLY INDICATED EVERY 1-5 MIN TO MAINTAIN A SBP > 90**

- **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**.

- **INITIAL AND REPEAT ADMINISTRATIONS OF ALBUTEROL, CALCIUM CHLORIDE, AND SODIUM BICARBONATE FOR SUSPECTED HYPERKALEMIA ASSOCIATED WITH CRUSH INJURIES IN ADULTS REQUIRES A BASE HOSPITAL ORDER (BHO)**

  Adults: Albuterol 2.5 mg/3 mL (one pouch), nebulized.

  Adults: Calcium Chloride 1 gm IV, infused in 50-100 ml normal saline, administered over 10 minutes.

  Adults: Sodium bicarbonate 50 mEq IVP/IOP

- **INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

  Patients requiring chemical restraint when physical restraints are ineffective and who pose an immediate danger to themselves or others, due to a suspected traumatic brain injury

  Adults: Midazolam 2.5 mg slow IVP/IOP.

  ****OR****

  Midazolam 5 mg IM/IN

  Traumatic Arrest:

- **For Adult blunt traumatic arrest**
  - If the patient meets the criteria outlined in REMSA Policy 4108 *Do Not Attempt Resuscitation/Discontinue Resuscitation*: **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.**
  - Otherwise, **IMMEDIATELY INITIATE** transport to the closest **Level I** or **Level II** trauma center.

- **Adult penetrating traumatic arrest:**
  - If the patient meets the criteria outlined in REMSA Policy 4108 *Do Not Attempt Resuscitation/Discontinue Resuscitation*: **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, **IMMEDIATELY INITIATE** transport to the closest **Level I** or **Level II** trauma center.

- **Note: CPR should not impede procedural interventions in patients with traumatic cardiac arrest**
- **Epinephrine is not indicated in Traumatic Arrests. If suspected medical cause of arrest, go to REMSA Policy 4405 *Medical Cardiac Arrest***

Patient Disposition

- Attempt to limit scene time to ten (10) minutes or less when Trauma Trigae Criteria has been met. Do not delay transport with nonessential treatment or non-entrapped, transport ready, critical trauma patients.
- Do not delay contacting a Level I/II Trauma Base Hospital for critical trauma patients.
- **CONTACT A SINGLE LEVEL I OR II TRAUMA BASE STATION FOR: ANY CTP AND/OR EMS SURGE/MASS CASUALTY INCIDENT (MCI)**
- **CONTACT A SINGLE BASE HOSPITAL FOR: ANY PATIENT THAT HAS BEEN SEXUALLY ASSULTED OR INCIDENTS WHEN LAW ENFORCEMENT REQUESTS AN "OK TO BOOK" EXAM**

4401	Suspected Acute Coronary Syndrome (ACS)
	Treatment Protocol

Last Reviewed: **October 4, 2022**	Last Revised: **September 13, 2024**

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, 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

- 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 OFASPIRINTOPEDIATRIC 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 OFNITROGLYCERIN TOPEDIATRIC PATIENTS IS NOT PERMITTED**. • **For suspected ACS with persistent chest discomfort unresponsive to Nitroglycerin** Adults: Fentanyl 50 mcg slow IVP/IOP 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 ABASE HOSPITAL ORDER (BHO)**.

4402	Mechanical Circulatory Support Devices
	Treatment Protocol

Last Reviewed: **July 23, 2024**	Last Revised: **September 13, 2024**

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

Ventricular Assist Device (VAD)	Total Artificial Heart (TAH)
Usually pulseless	Pulsatile
ECG shows native heart rhythm	ECG is meaningless because there is no heart
Do **NOT** administer NTG	NTG may be administered for systolic blood pressure greater than 140 mmHg
May perform chest compressions for a cardiac rhythm of VF, VT, or asystole	Do **NOT** perform chest compressions
May cardiovert, externally pace, or defibrillate	Do **NOT** cardiovert, externally pace, or defibrillate
Must auscultate the left upper quadrant of the patient's abdomen for the "hum" of the VAD	The TAH's Freedom Driver is audible without a stethoscope, making a "galloping" type of sound
Will usually have an ICD	Will not have an ICD
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	Blood pressure is obtainable utilizing a normal sphygmomanometer

BLS Patient Management	ALS 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	• 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, 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

- **CONTACT A SINGLE BASE HOSPITAL AS SOON AS POSSIBLETOGIVETHEM TIME TOCONTACT 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 slow IVP/IOP. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

  ****OR****

  Midazolam 5 mg IM/IN. **ADDITIONAL ADMINISTRATIONS REQUIRE ABASEHOSPITAL 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

4403	Symptomatic Tachycardia with Pulses
	Treatment Protocol

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2025**

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, 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

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
  - ASTEMI 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 rapid IVP/IOP. Follow immediately with 20 mL normal saline rapid IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

  ****OR****

  Adenosine 12 mg mixed in a 20 ml syringe with 16 ml normal saline rapid IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

  Pediatrics: Adenosine 0.2 mg/kg rapid IVP/IOP. Follow immediately with 20mL normal saline rapid IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

  ****OR****

  Adenosine 0.2 mg/kg mixed in a 20 ml syringe with enough normal saline to fill remainder of 20 ml syringe rapid IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

- **For symptomatic tachycardia with pulses**
  INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)

  Adults: Amiodarone 150 mg IV, infuse in 50- 100 mL normal saline, administer over 10 minutes.

  Pediatrics: Amiodarone 5 mg/kg IV, infuse in 50-100 mL normal saline, administer over 10 minutes. **MAX SINGLE DOSE TO INFUSE IS 150 MG**

  INITIALAND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Lidocaine 1 mg/kg slow IVP/IOP 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 IVP/IOP followed by the second dose (1 mg/kg) 8-10 minutes later.

- **Symptomatic dysrhythmia induced by End Stage Renal Disease (ESRD)**
  Adults: Calcium Chloride 1gm slow IVP, administered over 5 minutes.

  ****AND****

  Albuterol 5 mg, **REPEAT CONTINUOUSLY UNTIL ARRIVAL AT EMERGENCY DEPARTMENT.**

  ****THEN****

  INITIALADMINISTRATIONREQUIRES A BASE HOSPITAL ORDER (BHO).
  Sodium Bicarbonate 50mEqslow IVP.

  ADMINISTRATION OF CALCIUM CHLORIDE, ALBUTEROL, AND SODIUM BICARBONATE FOR SYMPTOMATIC DYSRHYTHMIA INDUCED BY ESRD IN PEDIATRICS IS NOT PERMITTED

- **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 amnesic effect prior to synchronized cardioversion** Adults: Midazolam 2.5 mg slow IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** ****OR**** Midazolam 5 mg IM/IN. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** **INITIALANDREPEAT PEDIATRICADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. Pediatrics: Midazolam 0.1 mg/kg slow IVP/IOP. ****OR**** Midazolam 0.2 mg/kg IM/IN. • **Synchronized cardioversion for symptomatic SVT or VT with pulses** Adults: ○ Initial shock – 100j ○ Second shock – 150j ○ Subsequent shocks – 200j **MAY REPEAT PRN AT 200j** **SYNCHRONIZED CARDIOVERSION OF PEDIATRIC PATIENTS REQUIRES ABASE HOSPITAL ORDER (BHO)**. Pediatrics: ○ Initial shock – 1 j/kg ○ Subsequent – 2 j/kg

4404	Symptomatic Bradycardia with Pulses
	Treatment Protocol

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2025**

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, 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

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 including digital & waveform capnography, and SpO2

  Perform, interpret, and transmit 12-lead ECG(s), as clinically indicated, when:
  - A STEMI is suspected
  - ASTEMI 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 IVP/IOP. **MAY REPEAT EVERY 3-5 MINUTES TO A MAX OF 3 MG**.

  INITIAL AND REPEAT PEDIATRIC ADMINISTRATION REQUIRES A BASE HOSPITAL ORDER (BHO).
  Pediatrics: Atropine 0.02 mg/ kg IVP/IOP. **MAX SINGLE DOSE IS 0.5 MG**.
- **Symptomatic dysrhythmia induced by End Stage Renal Disease (ESRD)**
  Adults: Calcium Chloride 1gm slow IVP, administered over 5 minutes.

  ****AND****

  Albuterol 5 mg, **REPEAT CONTINUOUSLY UNTIL ARRIVAL AT EMERGENCY DEPARTMENT.**

  ****THEN****

  INITIAL ADMINISTRATION REQUIRES A BASE HOSPITAL ORDER (BHO).
  Sodium Bicarbonate 50mEq slow IVP.

  ADMINISTRATION OF CALCIUM CHLORIDE, ALBUTEROL, AND SODIUM BICARBONATE FOR SYMPTOMATIC DYSRHYTHMIA INDUCED BY END STAGE RENAL DISEASE (ESRD) IN PEDIATRICS IS NOT PERMITTED

	• **For amnesic effect prior to Transcutaneous Cardiac Pacing (TCP)** Adults: Midazolam 2.5 mg slow IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. ****OR**** Midazolam 5 mg IM/IN. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. **INITIALANDREPEAT PEDIATRICADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. Pediatrics: Midazolam 0.1 mg/kg slow IVP/IOP. ****OR**** Midazolam 0.2 mg/kg IM/IN. • **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 slow IVP/IOP 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 AFTER100 MCG REQUIREABASE HOSPITAL ORDER (BHO)**. **INITIALANDREPEAT PEDIATRICADMINISTRATION REQUIRES A BASE HOSPITAL ORDER (BHO)**. Pediatrics: Fentanyl 1 mcg/kg slow IVP/IOP or IM/IN.

Patient Disposition

- **CONTACT A SINGLE BASE HOSPITAL FOR ALL PEDIATRIC PATIENTS EXPERIENCING SYMPTOMATIC BRADYCARDIA**

4405	Adult Medical Cardiac Arrest
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

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 SpO_2 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

ALS Patient Management

- **Ensure HP CPR is being performed according to current REMSA training and standards**
  Attach, interpret, and continuously monitor $EtCO_2$, (digital and waveform) If $EtCO_2$ 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

  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 $EtCO_2$. Utilize waveform/digital capnography immediately after orotracheal intubation to confirm correct placement of the ETT. Utilize a colormetric device if waveform/digital capnography is not working/unavailable/delayed:
  - 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

- **For known or suspected submersion incidents in the presence of 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

- **Analyze AED as soon as possible**
  - Defibrillate when indicated
  - Resume CPR immediately after each defibrillation
  - Reanalyze AED every 2 minutes and defibrillate when indicated

- **Recognize ROSC when one of the following signs is observed**
  1. ECG rhythm and skin signs improve
  2. $EtCO_2$ 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: iGel**
  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.

  INSERTION OF THE IGEL 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 iGel, as clinically indicated.

  Attach, interpret, and continuously monitor $EtCO_2$.

- **For passive gastric decompression after OTI or iGel insertion: Orogastric (OG) tube**
  - After successful **OTI**, insertion of an appropriately sized OG tube is **highly recommended**.
  - After successful placement of the **iGel**, insertion of an appropriately sized OG tube is **MANDATORY**.

- **For cardiac arrest**
  Adults: Epinephrine 1 mg (0.1 mg/mL concentration) IVP/IOP. **MAY REPEAT EVERY 5 MINUTES TO A MAX OF 5 MG (50 mL)**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
Adults: Atropine 1 mg IVP/IOP.

- **For cardiac arrest with ventricular fibrillation (VF) or ventricular tachycardia (VT)**
  Adults: Amiodarone 300 mg IVP/IOP. **MAY REPEAT ONCE AT 150 MG 5 MINUTES AFTER FIRST (1ST) DOSE, TO A MAX OF 450 MG**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

- **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 IVP/IOP followed by the second dose (0.5 mg/kg) 8-10 minutes later, to a max of 3 mg/kg.

- **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 slow IVP/IOP.

- **For cardiac arrest with suspected metabolic acidosis, hyperkalemia, or tricyclic antidepressant overdose** Adults: Sodium Bicarbonate 50 mEq IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

- **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 IVP/IOP.

- **For cardiac arrest in a known/suspected dialysis patient**
  Adults: Calcium Chloride 1 gm IVP/IOP.
  ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

- **Upon ROSC:**
  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 shock following ROSC**
  Adults: Normal saline 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L**.

Adults: Epinephrine Push Dose 0.01 mg (1 mL, 0.01 mg/mL concentration) IVP/IOP. **MAY REPEAT AS CLINICALLY INDICATED EVERY 1-5 MIN TO MAINTAIN A SBP > 90**

WHEN PATIENT'S SYSTOLIC BP IS LESS THAN 90 MMHG:

EPINEPHRINE INFUSION

Adults: Epinephrine 0.4 mg (1:1,000) IV, infused in 100 mL normal saline

****OR****

Epinephrine 0.2 mg (1:1,000) IV, 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) **OR** 1.33 mcg/min (20 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

- **For anxiety following ROSC**
  INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

  Adults: Midazolam 1 mg slow IVP/IOP or IM/IN.

- **For pain following ROSC**
  INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Fentanyl slow IVP/IOP 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.

	• **For <u>MEDICAL</u> cardiac arrest patients, discontinue 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

Patient Disposition

- **OHCA WITH ROSC PATIENTS OF UNKNOWN OR SUSPECTED CARDIAC ETIOLOGY SHALL BE TRANSPORTED TO THE CLOSEST STEMI CENTER (SRC)**
- **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**
- **Consider transporting patients with an obvious, non-cardiac etiology to the closest receiving facility**

4406	Adult Respiratory Distress
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

BLS Patient Management	ALS Patient Management
• **Establish, maintain, and ensure:** A. A patent and easily managed airway. Use manual maneuvers (head-tils/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 vis 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) as clinically indicated • **Oxygen** As clinically indicated. Titrate to maintain, or increase, SpO2 to a minimum of 94% • Position the patient as clinically indicted for safety, comfort, and to meet the physiological requirements • **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 • **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"	• 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, 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-identified or ○ The patient's cardiac rhythm is atypical or difficult to interpret • **For bronchospasm** Adults: Albuterol 2.5 mg/3 mL (one pouch), nebulized. **MAY REPEAT PRN**. Adults: 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. • **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 slow IVP/IOP.

- **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 suspected esophageal food impaction**
  INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Glucagon 1 mg IVP/IOP or IM.

- **For dyspnea with suspected CHF**
  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).

- **For severe respiratory distress suggestive of:**
  - **CHF exacerbation**
  - **COPD exacerbation**
  - **Asthma exacerbation**
  - **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)**

  Evaluate the patient for
  - Normalizing of inspiratory-to-expiratory time ratio (i.e. 1:2)
  - Increasing SpO2
  - 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 HOSPTITAL FOR DIRECTION. • **For anxiety related to the use of CPAP** Adults: Midazolam 1 mg slow IVP/IOP 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)**

4501	Adult Seizures
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

BLS Patient Management	ALS 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, 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 • Obtain and evaluate blood glucose • Protect the patient from injury. Loosen restrictive clothing. Do not forcibly restrain. Preserve privacy	• 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 • **For continuous or recurrent tonic-clonic seizures unrelated to eclampsia** Adults: Midazolam 2.5 mg slow IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. ****OR**** Midazolam 5 mg IM/IN. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

4502	Suspected Stroke
	Treatment Protocol

Last Reviewed: **October 4, 2022**	Last Revised: **September 13, 2024**

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, 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

- 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

mLAPSS Criteria	Yes	No	
1. Age over 17 years? *age 17 years and under presenting as a suspected stroke, consider transporting to the closes stroke center.			
2. No prior history of seizures			
3. LKWT within 24 hours?			
4. Patient was ambulatory at baseline prior to event?			
5. Blood glucose between 60 and 400?			
6. Exam (look for obvious asymmetry):	Normal/Bilaterally	Right	Left
• Facial Smile/Grimace	☐	- Droop - Normal	- Droop - Normal
• Grip	☐	- Weak Grip - Normal	- Weak Grip - Normal
	☐	- No Grip - Normal	- No Grip - Normal
• Arm Weakness	☐	- Drifts Down - Normal	- Drifts Down - Normal
	☐	- Falls Down Rapidly - Normal	- Falls Down Rapidly - Normal

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

4601	Overdose/Adverse Reaction
	Treatment Protocol

Last Reviewed: **October 4, 2022**	Last Revised: **September 13, 2024**

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, SpO_2 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**
  Naloxone IN ONLY. **MAY REPEAT ONCE**. Use REMSA approved administration device with REMSA approved pre-loaded dose.

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, SpO_2 and waveform/digital capnography

- **For respiratory depression/respiratory arrest with suspected narcotic overdose**
  Adults: Naloxone 1 mg IVP/IOP or IM/IN. **MAY REPEAT PRN**. **TITRATE TO IMPROVEMENT OF RESPIRATORYDEPRESSION, NOT RESOLUTION OF AMS**.

  Pediatrics: Naloxone 0.1 mg/kg IVP/IOP or IM/IN. **MAX SINGLE DOSE IS 1 mg**. **MAY REPEAT PRN**. **TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS**.

- **For suspected dystonic reaction**
  Adults: Diphenhydramine 50 mg slow IVP/IOP or IM. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

  Pediatrics: Diphenhydramine 1 mg/kg slow IVP/IOP.

  ****OR****

  Diphenhydramine 2 mg/kg IM. **MAX SINGLE DOSE IS 50 MG**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

LOSOP required for BLS providers

- **For respiratory depression/respiratory arrest with suspected narcotic overdose**
  Adults: Naloxone 1 mg IN ONLY. **MAY REPEAT PRN. TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS.**

  Pediatrics: Naloxone 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 suspected betablocker or calcium channel blocker overdose**
  INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Calcium Chloride 1 gm IV, infuse in 50-100 mL normal saline, administer over 10 minutes.

  Pediatrics: Calcium Chloride 20 mg/kg IV, infuse in 50-100 mL normal saline, administer over 10 minutes.

  INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Glucagon 1 mg IVP/IOP or IM.

  Pediatrics: Glucagon 50 mcg/kg, IVP/IOP or IM.

- **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 slow IVP/IOP.

  Pediatrics: Sodium Bicarbonate 1 mEq/kg slow IVP/IOP.

4602	Behavioral Emergencies
Treatment Protocol	

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

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, SpO_2 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, SpO_2 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 IM/IN. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

  ****OR****

  Midazolam 2.5 mg slow IVP/IOP. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

  Pediatrics: Midazolam 0.2 mg/kg IM/IN. **MAY REPEAT ONCE AFTER 5 MINUTES**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

  ****OR****

  Midazolam 0.1 mg/kg slow IVP/IOP. **MAY REPEAT ONCE AFTER 5 MINUTES**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

- **For hyperthermia or heat illness symptoms related to severe agitation/aggression/distress**
  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 suspected hyperkalemia associated with heat illness/hyperthermia** **INITIALANDREPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)**. Adults: Sodium Bicarbonate 50 mEq slow IVP/IOP. Pediatrics: Sodium Bicarbonate 1 mEq/kg slow IVP/IOP.

Patient Disposition

If a 911 dispatched call results in a patient on a 5150 that requires transport by ambulance, they shall be transported to the closest emergency department.

4603	Toxic Exposure, Inhalation, or Ingestion
	Treatment Protocol

Last Reviewed: **October 4, 2022**	Last Revised: **September 13, 2024**

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, SpO_2 and waveform / digital capnography

- **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

- **For suspected toxic ingestion**
  INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Milk or Potable Water PO

- **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 IV, infuse in 50-100 mL normal saline, administer over 10 minutes.

  Pediatrics: Calcium Chloride 20 mg/kg IV, infuse in 50-100 mL normal saline, administer over 10 minutes.

- **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, SpO_2 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

INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).

Adults: Magnesium Sulfate 2 gm slow IVP/IOP.

Pediatrics: Magnesium Sulfate 50 mg/kg IV, infuse in 50-100 mL normal saline, administer over 10 minutes.

4604	Exposure to Nerve Agents, Organophosphates or Carbamates

Treatment Protocol

Last Reviewed: **October 4, 2022**	Last Revised: **July 10, 2025**

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, SpO_2 and waveform / digital capnography

- **For symptomatic nerve agent, organophosphate, or carbamate exposure**
  Adults: Atropine 1 mg (10 mL of prefilled syringe) IVP/IOP. **MAY REPEAT PRN.**

  ****OR****

  Atropine 2 mg (5 mL of MDV) IM. **MAY REPEAT PRN**.

  Pediatrics: Atropine 0.02 mg/kg IVP/IOP. **MAX SINGLE DOSE IS 1 MG**. **MAY REPEAT PRN**.

  ****OR****

  Atropine 0.05 mg/kg IM. **MAX SINGLE DOSE IS 1 MG**. **MAY REPEAT PRN**.

• **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, SpO_2 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 • **<u>For self-administration</u> 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**.	

4605	Mass Exposure to Nerve Agents, Organophosphates or Carbamates

Treatment Protocol

Last Reviewed: **October 4, 2022**	Last Revised: **July 10, 2025**

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, SpO_2 and waveform/digital capnography

- **For symptomatic nerve agent, organophosphate, or carbamate exposure**
  INITIALANDREPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS VIA IV OR IO REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Atropine 2 mg(5 mL of MDV) IM. **MAY REPEAT PRN**.

  Pediatrics: Atropine 0.05 mg/kg IM. **MAX SINGLE DOSE IS 1 MG**. **MAY REPEAT PRN**.

- **For seizures associated with nerve agent, organophosphate, or carbamate exposure**
  INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS VIA IV OR IO OR IN REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Midazolam 5 mg 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)**.

- **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, SpO_2 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**.

- **For symptomatic nerve agent, organophosphate, or carbamate exposure WHEN A CDC CHEMPACK HAS BEEN DEPLOYED**
  Adults: Pralidoxime 600 mg IM. **MAY REPEAT TWICE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

  Pediatrics: Pralidoxime 20 mg/kg IM. **MAY REPEAT TWICE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

  ****OR****

  INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS VIA IV INFUSION REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Pralidoxime 600 mg (20 mL pre-mixed infusion) IV Infusion.

  Pediatrics: Pralidoxime 20 mg/kg (20 mL pre-mixed infusion) IV Infusion.

- **For seizures associated with nerve agent, organophosphate, or carbamate exposure WHEN A CDC CHEMPACK HAS BEEN DEPLOYED**
  Diazepam 10 mg (1 auto-injector) IM. **MAY REPEAT TWICE AT 15 MINUTE INTERVALS**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

  ADMINISTRATION OF DIAZEPAM VIA AUTOINJECTOR TO PEDIATRIC PATIENTS IS NOT PERMITTED.

  ****OR****

  Adults: Diazepam 5 mg 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)**.

AtroPen 1 mg (1 mg /0.7 mL) Weight = 14 kg (≈31 lbs) or less: **PEDIATRIC ADMINISTRATION IS NOT PERMITTED**. Weight = 15 kg (≈33 lbs) or more: 1 mg IM. **MAY REPEAT PRN**. **ADMINISTRATION OF 2 MG /0.7 mL ATROPEN TO PEDIATRIC PATIENTS IS NOT PERMITTED**.	

4701	Adult Burns
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

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, 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

- 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)

- Remove and bag patient's clothing, jewelry, etc., paying special attention to preventing binding and constriction

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

- **For significant burns**
  Adults: Normal Saline 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L**.

- **For pain associated with burns**
  Adults: Fentanyl 50 mcg slow IVP/IOP 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)**.

  Adults: Ketamine 0.3 mg/kg IV, 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

- **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)

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. Patients with major burns can be stabilized at any prehospital receiving center and then transferred as indicated.

- 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 circumference burns
  - High voltage electrical burns
  - Burns in combination with significant pre-existing medical conditions

4702	Heat Illness / Hyperthermia
Treatment Protocol	

Last Reviewed: **October 4, 2022**	Last Revised: **September 13, 2024**

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, 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

- **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 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 (one pouch), nebulized

  INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Calcium Chloride 1 gm IV, infuse in 50-100 mL normal saline, administer over 10 minutes.

  Pediatrics: Calcium Chloride 20 mg/kg IV, infuse in 50-100 mL normal saline, administer over 10 minutes.

  INITIAL AND REPEAT ADMINISTRATIONS FOR ADULTS AND PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Sodium Bicarbonate 50 mEq slow IVP/IOP.

  Pediatrics: Sodium Bicarbonate 1 mEq/kg slow IVP/IOP.

- **For shivering associated with heat illness/ hyperthermia**
  INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Adults: Midazolam 1 mg slow IVP/IOP or IM/IN.

  ADMINISTRATION OF MIDAZOLAM TO PEDIATRIC PATIENTS FOR HEAT ILLNESS-RELATED SHIVERING IS NOT PERMITTED.

4703	Frostbite/ Hypothermia
	Treatment Protocol

Last Reviewed: **October 4, 2022**	Last Revised: **September 13, 2024**

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, 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

- Preserve the patient's body heat by covering them with warm blankets

- Attach ECG leads to the patient when a paramedic is present

- **Remove from cold**
  Remove wet clothing and dry the patient, wrapping them with warm, dry blankets then move them to a heated environment. Individually wrap, cover, and protect areas of cold injured tissue; do not rub

  Obtain a baseline temperature and note the method: tympanic, temporal, axillary, or touch

  Rough handling may precipitate cardiac arrhythmia(s) in the severely hypothermic patient

ALS Patient Management

- **For hypothermia**
  Adults: Warmed normal saline 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L**.

  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 pain associated with frostbite**
  Adults: Fentanyl 50 mcg slow IVP/IOP 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 AFTER100 MCG REQUIRE ABASE HOSPITAL ORDER (BHO)**.

  Pediatrics: Fentanyl 1 mcg/kg slow IVP/IOP or IM/IN. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

  Adults: Ketamine 0.3 mg/kg IV, 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**. **ADDITIONALADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

  THEMAXSINGLE DOSE FOR EITHERROUTE IS 30 MG.

  ADMINISTRATION OFKETAMINE TOPEDIATRIC PATIENTS IS NOT PERMITTED.

4704	Adult Allergy and/or Anaphylaxis
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

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, SpO_2 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, SpO_2 and waveform/digital capnography

- **For suspected allergy and/or anaphylaxis**
  Adults: Diphenhydramine 50 mg slow IVP/IOP or IM. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

- **For bronchospasm associated with allergy and/or anaphylaxis**
  Adults: Albuterol 2.5 mg (one pouch), nebulized. **MAY REPEAT PRN**.

- **For suspected anaphylaxis**
  Adults: Epinephrine 0.3 mg (1 mg/mL concentration) IM. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

- **For shock associated with allergy and/or anaphylaxis**
  Adults: 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLYINDICATED TO A MAX ADMINISTRATION OF 2 L**.

Adults: Epinephrine Push Dose 0.01 mg (0.01 mg/mL concentration) IVP/IOP. **MAY REPEAT AS CLINICALLY INDICATED EVERY 1-5 MIN TO MAINTAIN A SBP > 90**

4705	Snakebite
Treatment Protocol	

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2025**

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, SpO_2 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: Normal Saline 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLYINDICATED TOA 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.**

  Adults: Epinephrine Push Dose 0.01 mg (0.01 mg/mL concentration) IVP/IOP. **MAY REPEAT AS CLINICALLY INDICATED EVERY 1-5 MIN TO MAINTAIN A SBP > 90**

  Pediatrics: Epinephrine Push Dose 0.01 mg (0.01 mg/ml concentration) IVP/IOP. **MAY REPEAT AS CLINICALLY INDICATED TO MAINTAIN A SBP > [70 + (AGE X2)]**

- **For pain associated with a snakebite**
  Adults: Fentanyl 50 mcg slow IVP/IOP 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 ABASE HOSPITAL ORDER (BHO).**

  Pediatrics: Fentanyl 1 mcg/kg slow IVP/IOP or IM/IN. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

	Adults: Ketamine 0.3 mg/kg IV, 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**. **ADDITIONALADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. **THEMAXSINGLE DOSE FOR EITHERROUTE IS 30 MG.** **ADMINISTRATION OFKETAMINE TOPEDIATRIC 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

4801	Obstetrical Emergencies/Newborn Deliveries
Treatment Protocol	

Last Reviewed: **July 1, 2025**	Last Revised: **July 1, 2026**

PRE-DELIVERY	
BLS Patient Management	ALS Patient Management
• **Establish, maintain, and ensure:** A. Patent airway. Oropharyngeal suction and/or airway adjuncts (OPA/NPAs) as clinically indicated B. O2 Saturation C. O2 and/or ventilate as clinically indicated D. If delivery is not imminent, transport in position of comfort, preferably on left side E. If the delivery is suspected to be imminent, allow the patient to remain in a position of comfort, visualize the perineum, and determine if there is time to transport F. If delivery is imminent (crowning, bulging of perineum, and/or pushing), stay on scene and prepare to assist with delivery • **Oxygen** As clinically indicated. Titrate to maintain, or increase, SpO_2 to a minimum of 94%. If the mother is experiencing complications, increase oxygen flow rate so that SpO_2 greater than or equal to 98%.	• 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 cardiac rhythm, BP, and SpO_2. Waveform/digital capnography and blood glucose as clinically indicated • **For suspected pre-eclampsia or eclampsia** *Standing order: may be given prophylactically* Magnesium Sulfate 5 gm IV, infuse in 50- 100 mL Normal Saline, administer over 10 minutes. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. ****OR**** Magnesium Sulfate 5 gm (10 ml) IM. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. • **For eclamptic seizures unresponsive to Magnesium Sulfate INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. Midazolam 2.5 mg slow IVP/IOP ****OR**** Midazolam 5 mg IM/IN.

DELIVERY
BLS and ALS
• **Routine Delivery** A. Placenta should deliver within 10-30 minutes. Do not wait on scene. Place placenta in a plastic bag and transport with mother. B. If infant is vigorous, wait 60 seconds after delivery, then clamp cord at approx. 3 inches and 4 inches, cut in between clamps. C. If neonate is not vigorous, clamp cord and begin resuscitation
• **Prolapsed Cord** A. Elevate mother's hips with pillows B. Insert gloved hand into vagina, with gentle pressure, lift presenting part off cord C. Transport immediately while retaining this position. Do not remove hand until relieved by hospital D. Covered exposed cord with saline-soaked gauze • **Breech Presentation** A. Expedite transport to the nearest facility with OB services B. Position the mother as clinically indicated (left lateral recumbent with legs/hips elevate or knees to chest) • **Nuchal Cord (Cord wrapped around neck)** A. Slip cord over the head and off the neck B. If cord is tightly wrapped around the neonates neck and unable to remove, clamp and cut cord

MOTHER POST-DELIVERY	
BLS Patient Management	ALS Patient Management
• Controlled bleeding using appropriate measures, as clinically indicated A. Massage fundus vigorously B. Baby to breast C. High-flow O2	• **For shock associated with postpartum hemorrhage** Adults: Normal Saline 250 mL IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED TO A MAX ADMINISTRATION OF 2 L**. Adults: Push Dose Epinephrine 0.01 mg (0.01 mg/mL concentration) IVP/IOP. **MAY REPEAT AS CLINICALLY INDICATED EVERY 1-5 MIN TO MAINTAIN A SBP > 90** • **For postpartum hemorrhage within three (3) hours of time of birth, with signs and symptoms of hemorrhagic shock (EBL > 500 mL) with systolic BP less than 90 mmHg** ****OR**** **Significant hemorrhage with heart rate ≥ 120** Adults: Tranexamic Acid (TXA) 1 gm slow IVP/IOP, administered over 1 minute. **ADMINISTRATION OF TRANEXAMIC ACID (TXA) TO PEDIATRIC PATIENTS IS NOT PERMITTED**.

	• **For hemorrhagic shock due to postpartum hemorrhage with SBP < 70 mmHg or unable to obtain BP** ****OR**** **SBP <90 AND HR ≥ 110 (SI>1.2)** ****OR**** **Hypovolemic/hemorrhagic arrest witnessed by EMS** Adults: LTO+WB 1 Unit warmed and infused **OR** Adults: pRBCs 2 Units warmed and infused If blood administration criteria persist, administer an additional unit of LTO+WB or pRBCs

NEONATE POST-DELIVERY/RESUSCITATION

BLS Patient Management	ALS Patient Management
• Dry, stimulate and then swaddle in a dry receiving blanket and head cover. Place with the mother as clinically indicated	• Establish, maintain, and ensure peripheral IV and/or IO access for emergency stabilization Consider the need for additional sites as clinically indicated
	For Neonatal Resuscitation Post Delivery • **When required, ensure high performance 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 Neonates: Normal Saline 10 ml/kg IV/IO rapid infusion. Use a volume control chamber device for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.** **PATIENT MUST BE ALERT WITH GAG REFLEXES INTACT** Neonates: Glucose Gel (buccal) PO AS TOLERATED. MAY **REPEAT PRN TO ACHIEVE AND/OR MAINTAIN CORRESPONDING AGE APPROPRIATE BG LEVEL** **INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** Neonates: Dextrose 5 mL/kg (10% solution) IV/IO bolus or infusion.

APGAR	*0*	*1*	*2*
Appearance	Blue	Pink Core / Blue Extremities	Pink
Pulse	Absent	Slow	Fast
Grimace	Absent	Weak	Strong
Activity	Absent	Weak	Strong
Respirations	Absent	Weak	Strong

- Assess using the APGAR scoring system at 1 minute and 5 minutes. Based on APGAR scores, presentation, and clinical assessment:
  - Suction mouth first then nose only if signs of obstruction by secretions present
  - Monitor SpO_2 while attached to the right upper extremity (a preductal location)
  - Provide blow-by oxygen as indicated
  - If APGAR at 5 minute check is 7 or less, assess blood glucose level. If blood glucose is less than 45 mg/dl, treat for hypoglycemia.

PATIENT MUST BE ALERT WITH GAG REFLEXES INTACT
Neonates: Glucose Gel (buccal) PO AS TOLERATED.
MAY REPEAT PRN TO ACHIEVE AND/OR MAINTAIN CORRESPONDING AGE APPROPRIATE BG LEVEL

IF HR LESS THAN 100 BPM OR POOR RESPIRATORY RATE, EFFORT, OR PERSISTENT CENTRAL CYANOSIS

- Administer oxygen and stimulate for 30 seconds.
- If no response, assist ventilations with PPV and supplemental oxygen at a rate of 40-60 breaths per minute.

IF HR LESS THAN 60 BPM

- Assist ventilations with PPV and supplemental oxygen at a rate of 40-60 breaths per min
- Organize the resuscitation team and perform high performance CPR according to current REMSA training and standards with a 3:1 compression ratio at a rate of 120/min

  Ensure high performance CPR by utilizing assigned roles and tasks during resuscitation (i.e., Pit Crew CPR)
  - Emphasize correct hand placement, compression depth (1/3" – 1/2") and rate (120/min) with complete chest recoil
  - Minimize interruption of chest compressions
  - Avoid hyperventilation

WHEN UNABLE TO ADMINISTER IV/IO DEXTROSE
INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
Neonates: Weight = 21kg (≈48 lbs) or less: Glucagon 0.5 mg IM

INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
Neonates: Epinephrine 0.01 mg/kg (0.1 mg/mL concentration) IVP/IOP.

Neonates: Naloxone 0.1 mg/kg IVP/IOP/IM/IN. **MAX SINGLE DOSE IS 1 MG.**
ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).

INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
Neonates: Sodium Bicarbonate 1 mEq/kg IVP/IOP.

DISCONTINUING RESUSCIATION OF A NEONATAL PATIENT REQUIRES A BASE HOSPITAL PHYSICIAN ORDER (BHPO)

Patient Disposition

- **CONTACT A SINGLE BASE HOSPITAL FOR ALL OBSTETRICAL DELIVERIES WITH ANY COMPLICATION OF CHILDBIRTH AND PATIENTS EXPERIENCING PRE-ECLAMPSIA/ECLAMPSIA**
- Do not attempt resuscitation on the neonate if they are younger than 22 weeks gestation **WITH** no signs of life after delivery.
  - Neonates delivered before 22 weeks gestation have a low chance of survival. If mother is encountered in labor with a gestational age younger than 22 weeks, in many instances the neonate will not survive.
  - If gestation age is unknown, findings of less than 22 weeks are:
    - Eyelids fused shut
    - Foot length less than 40 mm (1.5 inches)
    - Transparent skin
    - Weight less than 2 pounds
    - Absent muscle tone

4901	Pediatric General Medical
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

PURPOSE

To provide standing order assessments/treatment modalities for pediatric patient complaints not addressed within adult treatment protocols. The care and treatment of a newborn (< 48 hours) neonatal patient should refer to *REMSA Protocol 4801 Obstetrical Emergencies/Newborn Deliveries*. For all pediatric treatment policies, the neonatal patient will be referenced as a neonate greater than (>) 48 hours but less than (<) 29 days old. Pediatric protocols shall be utilized for patients up to and including 14 years of age. Applicable adult protocols may be utilized when there is not a pediatric protocol appropriate to the patient's complaint or condition. Prehospital personnel shall consult with the base station hospital for additional direction as needed.

Medical Considerations

BLS Patient Management	ALS 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, SpO_2 to a minimum of 94%. Do not hyperventilate. • Position the patient as clinically indicated for safety, comfort, and to meet the physiologic requirements	• 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 Neonates: Normal Saline 10 ml/kg IV/IO bolus. Use a volume control chamber device for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED** Pediatrics: Normal Saline 20 ml/kg IV/IO bolus. Use a volume control chamber device for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED** • **For respiratory depression/respiratory arrest with suspected narcotic overdose** Neonates: Naloxone 0.1 mg/kg IVP/IOP/IM/IN. **MAX SINGLE DOSE IS 1 MG. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).** Pediatrics: Naloxone 0.1 mg/kg IVP/IOP/IM/IN. **MAX SINGLE DOSE IS 1 MG. MAY REPEAT PRN. TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS.**

Symptomatic Hypoglycemia

BLS Patient Management	ALS Patient Management
Symptomatic hypoglycemia ranges: • Have a blood glucose less than 70 mg/dl in pediatrics • Have a blood glucose less than 60 mg/dl in neonates if greater than 48 hours old but less than 28 days old • Have a blood glucose less than 45 mg/dl in neonates less than 48 hours old **BLS and ALS Care Providers:** **PATIENTS MUST BE ALERT AND COOPERATIVE, WITH GAG REFLEXES INTACT** **Pediatrics and Neonates**: Glucose Gel (oral/buccal) PO AS TOLERATED. **MAY REPEAT PRN TO ACHIEVE AND/OR MAINTAIN CORRESPONDING AGE APPROPRIATE BLOOD GLUCOSE LEVEL**	• Interpret and continuously monitor ECG, vital signs, SpO2, and waveform/digital capnography • **For symptomatic hypoglycemia below ranges (see BLS management)** Neonates and Pediatrics: Dextrose 5 ml/kg (D10%) IV/IO bolus or infusion. **MAY REPEAT PRN.** • **For symptomatic hypoglycemia below ranges (see BLS management) WHEN UNABLE TO ADMINISTER DEXTROSE** Neonates and Pediatrics: 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)**
Patient Disposition	
• **CONTACT A SINGLE BASE HOSPITAL FOR ANY PATIENT/PARENT/GUARDIAN THAT REFUSES TRANSPORT FOLLOWING THE INITIATION OF AN ALS TREATMENT**	

Brief Resolved Unexplained Event (BRUE)

• Event that occurs in an infant less than (<) 1 year of age. Observer reports a sudden, brief (< 1 minute, typically < 20/30 seconds), and now resolved episode of:
  - Cyanosis or pallor
  - Absent, decreased, or irregular breathing
  - Marked change in tone (hyper- or hypotonia)
  - Altered level of responsiveness

BLS Patient Management	ALS Patient Management
Determine severity, nature and duration of episode • Was the child awake or sleeping • Were resuscitative measures taken Obtain complete medical history Perform a full physical assessment Always consider non-accidental trauma Check blood glucose • If hypoglycemic, refer to *Symptomatic Hypoglycemia* (above)	• Interpret and continuously monitor ECG, vital signs, SpO2, and waveform/digital capnography
Patient Disposition	
• **CONTACT A SINGLE BASE HOSPITAL FOR ANY PARENT THAT REFUSES TRANSPORT FOLLOWING AN EVALUATION OF A PATIENT PRESENTING WITH BRUE**	

Pain Management

BLS Patient Management	ALS Patient Management
• Attempt to calm and reduce anxiety. Utilize ice PRN. Immobilize and splint affected area(s) as clinically indicated • Assess patients' pain scale using age-appropriate scales. • Attach ECG leads to the patient when a paramedic is present • **VITAL SIGNS MUST BE MONITORED THRGOUHOUT BLS AND ALS INTERVENTIOSN FOR PAIN MANAGEMENT**	**Special consideration must be given to the type of pain, the patients' 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** • Interpret and continuously monitor ECG, vital signs, SpO2, and waveform/digital capnography **For non-trauma related acute/chronic pain** • **For pain scale 1 – 5** **** OR **** **Pain scale 6-10 with refusal of opioid (Fentanyl)** **** OR **** **Pain or myalgias associated with fever** Pediatrics: Acetaminophen 15 mg/kg IV infusion administered over 15 minutes. **MAX SINGLE DOSE IS 1 GM** **ADMINISTRATION OF ACETAMINOPHEN TO PEDIATRIC PATIENTS LESS THAN 2 YEARS OF AGE IS NOT PERMITTED** --- Pediatrics: Ketorolac 0.5 mg/kg slow IVP/IOP or IM. **MAX SINGLE DOSE IS 15 MG** **ADMINISTRATION OF KETOROLAC TO PEDIATRIC PATIENTS LESS THAN 4 YEARS OF AGE IS NOT PERMITTED** • **For pain scale 6 – 10** Pediatrics: Fentanyl 1 mcg/kg slow IVP/IOP or IM/IN. Patients systolic BP must be greater than or equal to [70 + (age x 2)] at the time of administration. **MAY REPEAT ONCE IN 5-10 MIN, DEPENDENT ON PAIN SEVERITY. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**

Nausea and Vomiting

BLS Patient Management	ALS Patient Management
• Attach ECG leads to the patient when a paramedic is present	• Interpret and continuously monitor ECG, vital signs, SpO2, and waveform/digital capnography when applicable • **For nausea and/or vomiting** **ADMINISTRATION OF ODANSETRON ODT TO PATIENTS WEIGHING LESS THAN 10 KG (≈ 22 LBS) IS NOT PERMITTED** Pediatrics: Weight = 10 kg or greater: Ondansetron 4 mg PO (1 ODT). **MAY REPEAT TO A MAX OF 12 MG**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)** **** OR **** Ondansetron 0.1 mg/kg slow IVP/IOP/IM. **MAX SINGLE DOSE IS 4 MG. MAY REPEAT TWICE. ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)** --- **INITIAL AND REPEAT ADMINISTRATIONS FOR PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)** Pediatrics: Diphenhydramine 1 mg/kg slow IVP/IOP **** OR **** Diphenhydramine 2mg/kg IM. **MAX SINGLE DOSE FOR IVP/IOP/IM IS 50 MG.**

Shock Unrelated to Trauma

BLS Patient Management	ALS Patient Management
• 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 the left lateral position. *Consider the cause of shock and act as indicated by REMSA policies, protocols, and standards*	• Interpret and continuously monitor ECG, vital signs, SpO2, and waveform/digital capnography • Perform, interpret, and transmit 12-lead ECG(s) as clinically indicated • **For shock unrelated to trauma** Neonates: Normal Saline 10 ml/kg IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED** Pediatrics: Normal Saline 20 ml/kg IV/IO bolus. **MAY REPEAT AS CLINICALLY INDICATED** --- Pediatrics: Epinephrine Push Dose 0.01 mg (0.01 mg/ml concentration) IVP/IOP. **MAY REPEAT AS CLINICALLY INDICATED EVERY 1-5 MIN TO MAINTAIN A SBP > [70 + (AGE X 2)]**

4902	Pediatric Traumatic Shock/Injury/Arrest
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

BLS Patient Management

- **Establish, maintain, and ensure cervical spine stabilization, as clinically indicated, when NSAID criteria is met**
  - **N**euro deficits
  - **S**pinal Tenderness
  - **A**ltered Mental Status
  - **I**ntoxication
  - **D**istracting 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 it 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, SpO_2 to a minimum of 94%.

- 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, waveform, digital capnography, and SpO_2

- 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

- **For pain associated with acute traumatic injury or injuries**
  Pediatrics: Fentanyl 1 mcg/kg slow IVP/IOP or IM/IN. Patients systolic BP must be greater than or equal to [70 + (AGE X2)] mmHg at the time of administration. **MAY REPEAT ONCE IN 5-10 MINUTES**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).**

- **For shock due to trauma**
  Neonates: Normal saline 10 mL/kg IV/IO bolus. Use a volume control administration set for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.**

  Pediatrics: Normal saline 20 mL/kg IV/IO bolus. Use a volume control administration set for accurate dosing. **MAY REPEAT 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)

- 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:
  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

AND

rapidly progressing respiratory distress unrelieved by less invasive means

THEN

Perform unilateral chest decompression

- **If the patient is in traumatic cardiac arrest with known/suspected torso trauma**

THEN

Perform bilateral chest decompression

- **For persistent shock due to trauma when cardiac arrest is imminent AFTER Normal Saline and chest decompression as indicated:**
  Pediatrics: Epinephrine Push Dose 0.01 mg (0.01 mg/ml concentration) IVP/IOP. **MAY REPEAT AS CLINICALLY INDICATED TO MAINTAIN A SBP > [70 + (AGE X2)]**

- **For suspected hyperkalemia associated with crush injuries**
  Pediatrics: Normal Saline 20 mL/kg IV/IO bolus. Use a volume control administration set for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.**

- **INITIAL AND REPEAT ADMINISTRATIONS OF ALBUTEROL, CALCIUM CHLORIDE, AND SODIUM BICARBONATE FOR SUSPECTED HYPERKALEMIA ASSOCIATED WITH CRUSH INJURIES IN PEDIATRICS REQUIRES A BASE HOSPITAL ORDER (BHO)**

  Pediatrics: Albuterol 2.5 mg/3 mL (one pouch), nebulized.

  Pediatrics: Calcium Chloride 20 mg/kg IV, infused in 50-100 ml normal saline, administered over 10 minutes.

  Pediatrics: Sodium Bicarbonate 1 mEq/kg IVP/IOP.

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 LEVEL I OR LEVEL II TRAUMA 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

- **INITIAL AND REPEAT ADMINISTRATIONS FOR PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO).**
  Patients requiring chemical restraint when physical restraints are ineffective and who pose an immediate danger to themselves or others, due to a suspected traumatic brain injury
  Pediatrics: Midazolam 0.1 mg/kg slow IVP/IOP

  ****OR****

  Midazolam 0.2 mg/kg IM/IN.

  Traumatic Arrest:

- **For Pediatrics traumatic arrest**
  - If the patient has signs of life and transport time is reasonable, **IMMEDIATELY INITIATE** transport to the closest **Level I** or **Level II** trauma center**.**

  A Trauma Base Hospital Physician Order (BHPO) is required to discontinue resuscitation.

- **Note: CPR should not impede procedural interventions in patients with traumatic cardiac arrest**

- **Epinephrine is not indicated in Traumatic Arrests. If suspected medical cause of arrest, go to REMSA Policy 4405 *Medical Cardiac Arrest***

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 or non-entrapped, transport ready, critical trauma patients.
- Do not delay contacting a trauma base hospital for critical trauma patients
- **CONTACT A SINGLE LEVEL I OR II TRAUMA BASE STATION FOR: ANY CTP AND/OR EMS SURGE/MASS CASUALTY INCIDENT (MCI)**
- **CONTACT A SINGLE BASE HOSPITAL FOR: ANY PATIENT THAT HAS BEEN SEXUALLY ASSULTED OR INCIDENTS WHEN LAW ENFORCEMENT REQUESTS AN "OK TO BOOK" EXAM**

4903 Pediatric Medical Cardiac Arrest

Treatment Protocol

Last Reviewed: **July 1, 2026** | Last Revised: **July 1, 2026**

BLS Patient Management

- **If you are resuscitating a newly delivered Neonate, please refer to REMSA Policy 4801 *Obstetrical Emergencies/Newborn Deliveries***

- **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 SpO_2 of 94% or greater but do not hyperventilate.
  Leading cause of arrest in pediatrics less than 1 year of age is respiratory related.

- 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**
  Neonate:
  IF HR LESS THAN 100 BPM OR POOR RESPIRATORY RATE, EFFORT, OR PERSISTENT CENTRAL CYANOSIS
  A. Administer oxygen and stimulate for 30 seconds.
  B. If no response, assist ventilations with PPV and supplemental oxygen at a rate of 40-60 breaths per minute.

ALS Patient Management

- **Ensure HP CPR is being performed according to current REMSA training and standards**
  Attach, interpret, and continuously monitor $EtCO_2$, (digital and waveform) If $EtCO_2$ 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
  Neonates and Pediatrics: defibrillate initially at 2 j/kg, all subsequent defibrillations at 4 j/kg.

  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.

- **For cardiac arrest**

  INITIAL AND REPEAT ADMINISTRATIONS FOR NEONATE REQUIRE A BASE HOSPITAL ORDER (BHO).
  Neonates: Epinephrine 0.01 mg/kg (0.1 mg/mL concentration) IVP/IOP.

  Pediatrics: Epinephrine 0.01 mg/kg (0.1 mg/mL concentration) IVP/IOP. **MAY REPEAT EVERY 5 MINUTES TO A MAX OF FIVE (5) ADMINISTRATIONS.**

- **For cardiac arrest with ventricular fibrillation (VF) or ventricular tachycardia (VT)**

  INITIAL AND REPEAT PEDIATRIC ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Pediatrics: Amiodarone 5 mg/kg IVP/IOP. **MAX SINGLE DOSE IS 150 MG.**

IF HR LESS THAN 60 BPM

- Assist ventilations with PPV and supplemental oxygen at a rate of 40-60 breaths per min
- Organize the resuscitation team and perform high performance CPR according to current REMSA training and standards with a 3:1 compression ratio at a rate of 120/min
  - Ensure high performance CPR by utilizing assigned roles and tasks during resuscitation (i.e., Pit Crew CPR)
  - Emphasize correct hand placement, compression depth (1/3 chest diameter) and rate (120/min) with complete chest recoil
  - Minimize interruption of chest compressions
  - Avoid hyperventilation

Pediatric:

- Ensure High Performance (HP) CPR by utilizing assigned roles and tasks during resuscitation (i.e., Pit Crew CPR)
- Emphasize correct hand placement, compression depth (1/3 chest diameter) and rate (100-120 bpm) with complete chest recoil
- Minimize interruption of chest compressions
- Ventilate at a rate of 12 -20 breaths per minute. Avoid hyperventilation

- **For known or suspected submersion incidents in the presence of 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

- **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

- **For cardiac arrest with ventricular fibrillation (VF) or ventricular tachycardia (VT) WHEN AMIODARONE IS UNAVAILABLE**

  INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Pediatrics: Lidocaine 1 mg/kg slow IVP/IOP followed by the second dose (1 mg/kg) 8-10 minutes later.

- **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).
  Pediatrics: Magnesium Sulfate 50 mg/kg slow IVP/IOP.

- **For cardiac arrest with suspected metabolic acidosis, hyperkalemia, or tricyclic antidepressant overdose**

  INITIAL AND REPEAT NEONATE AND PEDIATRIC ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Neonates: Sodium Bicarbonate 1 mEq/kg IVP/IOP.

  Pediatrics: Sodium Bicarbonate 1 mEq/kg IVP/IOP.

- **For cardiac arrest with suspected hypocalcemia, hyperkalemia, hypermagnesemia, or calcium channel blocker overdose**

  INITIAL AND REPEAT ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Pediatrics: Calcium Chloride 20 mg/kg IVP/IOP.

- **For cardiac arrest in a known/suspected dialysis patient**

  INITIAL AND REPEAT PEDIATRIC ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO).
  Pediatrics: Calcium Chloride 20 mg/kg IVP/IOP.

- **For suspected narcotic overdose:**

  Neonates: Naloxone 0.1 mg/kg IVP/IOP/IM/IN. **MAX SINGLE DOSE IS 1 MG.**
  ADDITIONAL ADMINISTRATIONS FOR NEONATE REQUIRE A BASE HOSPITAL ORDER (BHO).

  Pediatrics: 0.1 mg/ kg IVP/IOP/IM/IN. **MAX SINGLE DOSE IS 1 MG. MAY REPEAT PRN. TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS OR PUPILLARY CONSTRICTION**

	• **For shock following ROSC** Neonates: Normal Saline 10 ml/kg IV/IO rapid bolus. Use a volume control administration set for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.** Pediatrics: Normal Saline 20 ml/kg IV/IO rapid bolus. Use a volume control administration set for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.** --- Pediatrics: Epinephrine Push Dose 0.01 mg (1 ml, 0.01 mg/ml concentration) IVP/IOP. **MAY REPEAT AS CLINICALLY INDICATED TO MAINTAIN A SBP > [70 + (AGE X2)]** **DISCONTINUING RESUSCITATION OF A NEONATE OR PEDIATRIC PATIENT REQUIRES A BASE HOSPITAL PHYSICIAN ORDER (BHPO).**

Patient Disposition

- **OHCA WITH ROSC PATIENTS SHALL BE TRANSPORTED TO THE CLOSEST RECEIVING CENTER**

4904	Pediatric Respiratory Distress
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

BLS Patient Management	ALS Patient Management
• **Establish, maintain, and ensure:** A. A patent and easily managed airway. Use manual maneuvers (head-tils/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 vis 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% • Position the patient as clinically indicted for safety, comfort, and to meet the physiological 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	• 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, vital signs, SpO2, and waveform/digital capnography Perform, interpret, and transmit 12-lead ECG(s), as clinically indicated • **For bronchospasm** Pediatrics: Albuterol 2.5 mg/3 ml (one pouch), nebulized. **MAY REPEAT PRN** 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 moderate to severe upper airway disease/croup (Stridor or Barky Cough)** If suspected allergic reaction refer to REMSA Policy 4704 *Allergy and/or Anaphylaxis* Pediatrics: Nebulized Epinephrine 0.5 mg/kg (1 mg/ml) 1:1000, mixed with NS for minimum volume 3 ml. **MAX SINGLE DOSE EPI IS 5 MG. ADMINISTRATION OF NEBULIZED EPINEPHRINE TO PEDIATRIC PATIENTS GREATER THAN 8 YEARS OF AGE IS NOT PERMITTED**

- **For airway obstruction/possible foreign body**
  - Administer abdominal thrusts
  - Infants less than one (1) year: alternate repeated five (5) back slaps and five (5) chest thrusts
  - After obstruction is relieved, administer O2 as clinically indicated
  - If patient is unresponsive, begin CPR starting with compressions (30)
  - If apneic, attempt ventilations (2). If no chest rise and fall or unable to ventilate, continue compressions and ventilations until relieved or able to ventilate or arrival at hospital
  - Continue to confirm that pulses are present and reassess every two (2) minutes.

- **For respiratory distress of suspected pulmonary origin**
  Assist the patient/parent 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

- **For severe respiratory distress**
  INITIAL AND REPEAT ADMINISTRATIONS FOR PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)
  Pediatrics: Epinephrine 0.01 mg/kg (1 mg/ml concentration) IM. **MAX SINGLE DOSE IS 0.3 MG**

- **For asthma exacerbation unresponsive to Albuterol and Ipratropium breathing treatments**
  INITIAL AND REPEAT ADMINISTRATIONS FOR PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)
  Pediatrics: Magnesium Sulfate 50 mg/kg IV, infuse in 50-100 ml normal saline, administered over 10 minutes

- **For airway obstruction/possible foreign body**
  A. Perform BLS interventions
  B. If obstruction persists and unable ventilate, attempt visualization and removal of visible foreign body with Magill forceps and attempt to ventilate

- **For suspected esophageal food impaction**
  INITIAL AND REPEAT ADMINISTRATIONS FOR PEDIATRICS REQUIRE A BASE HOSPITAL ORDER (BHO)
  Pediatrics:
  Weight = 21 kg (≈46 lbs) or less: Glucagon 0.5 mg IVP/IOP or IM
  Weight = 22 kg (≈48 lbs) or more: Glucagon 1 mg IVP/IOP or IM

4905	Pediatric Seizures
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

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 (NPA/OPA) 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, SpO_2 to a minimum of 94%.

- 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 excess clothing and provide cooling measures for patients if they are febrile (most common between 6 months and 4 years of age)

- Obtain and evaluate blood glucose and provide treatment as indicated, see REMSA Protocol 4901 *Pediatric General Medical (Symptomatic Hypoglycemia)*

- Protect the patient from injury. Loosen restrictive clothing. Do not forcibly restrain. Preserve privacy

ALS Patient Management

- Don't delay treating prolonged seizure activity (> 5 minutes) by starting an IV. IM/IN medication route is the preferred method.

- 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, vital signs, SpO2, and waveform/digital capnography

- **For continuous or recurrent tonic-clonic seizures or active non-traumatic seizure activity**
  Pediatrics: Midazolam 0.1 mg/kg slow IVP/IOP. **MAY REPEAT ONCE AFTER 5 MINUTES**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

  ****OR****

  Midazolam 0.2 mg/kg IM/IN. **MAY REPEAT ONCE AFTER 5 MINUTES**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

Patient Disposition

- **CONTACT A SINGLEBASE HOSPITAL FOR ANY REFUSAL INVOLVING A NON-EMANCIPATED MINOR. THE REFUSAL MUST BE MADE BY THE PARENT, PARENTAL DESIGNEE, OR GUARDIAN**.

4906	Pediatric Burns
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

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, SpO_2 to a minimum of 94%.

- 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)

- **INFANTRULE 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

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

- **For significant burns**
  Neonates: Normal Saline 10 ml/kg IV/IO bolus. Use a volume control administration set for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED**

  Pediatrics: Normal Saline 20 mL/kg IV/IO bolus. Use a volume control administration set for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.**

- **For pain associated with burns**
  Pediatrics: Fentanyl 1 mcg/kg slow IVP/IOP or IM/IN. **MAY REPEAT ONCE**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**.

- **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)

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. Patients with major burns can be stabilized at any prehospital receiving center and then transferred as indicated.

- 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 circumference burns
  - High voltage electrical burns
  - Burns in combination with significant pre-existing medical conditions

4907	Pediatric Allergy and/or Anaphylaxis
Treatment Protocol	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

BLS Patient Management	ALS 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 (NPA/OPA) 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, SpO_2 to a minimum of 94%. • Assist the patient/patient's parent or guardian with administration of the child's physician prescribed Epi-pen or other appropriate medication(s). Record the self-administration in the ePCR as, "Self-administered", clarifying if it was the patient's parent or guardian in the narrative section. • 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	• 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, SpO_2 and waveform/digital capnography • **For suspected allergy and/or anaphylaxis** Pediatrics: Diphenhydramine 1 mg/kg slow IVP/IOP. ****OR**** Diphenhydramine 2 mg/kg IM. **MAX SINGLE DOSE FOR IVP/IOP/IM IS 50 MG**. **ADDITIONAL ADMINISTRATIONS REQUIRE A BASE HOSPITAL ORDER (BHO)**. • **For bronchospasm associated with allergy and/or anaphylaxis** Pediatrics: Albuterol 2.5 mg (one pouch), nebulized. **MAY REPEAT PRN**. • **For suspected anaphylaxis** 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 shock associated with allergy and/or anaphylaxis** Neonates: 10 ml/kg IV/IO Normal Saline. Use a volume control chamber device for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.** Pediatrics: 20 ml/kg IV/IO bolus Normal Saline. Use a volume control chamber device for accurate dosing. **MAY REPEAT AS CLINICALLY INDICATED.** --- Pediatrics: Epinephrine Push Dose 0.01 mg (0.01 mg/ml concentration) IVP/IOP. **MAY REPEAT AS CLINICALLY INDICATED TO MAINTAIN A SBP > [70 + (AGE X2)**

5101	EMT AED Service Provider
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

PURPOSE
To authorize and regulate emergency medical technician (EMT) Automated External Defibrillator (AED) service providers.

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.

5102	Public Safety AED Service Provider
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2025**

PURPOSE
To comply with the California Code or Regulations, Title 22, Division 9, Chapter 2.3, Article 3, 100027.05.

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.

5201	EMS Aircraft Operations, Equipment and Personnel
Administrative Policy	

Last Reviewed: **April 4, 2026**	Last Revised: **July 1, 2026**

PURPOSE
To establish policies for Emergency Medical Service (EMS) aircraft operations, equipment, and personnel responding to incidents within Riverside County.

GENERAL PROVISIONS
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 EMS Aircraft pursuant to Division 9, Chapter 7, 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 7.

No person or organization shall provide or hold themselves out as providing prehospital Air Ambulance or Air Rescue services unless that person or organization has aircraft which have been classified by REMSA or in the case of the California Highway Patrol, California Department of Forestry, California National Guard, and the EMS Authority.

EMS AIRCRAFT CLASSIFICATIONS
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 responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has a minimum of two (2) attendants certified or licensed to provide ALS care.

Rescue Aircraft
An 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.

1. ALS Rescue Aircraft: a rescue aircraft whose medical flight crew has at a minimum one attendant accredited and licensed in ALS care.
2. BLS Rescue Aircraft: a rescue aircraft whose medical flight crew has at minimum one attendant certified as an EMT.

Air Rescue Service
An air service used for emergencies, including search and rescue.

Requirements

EMS Aircraft Operations
EMS aircraft must be authorized by REMSA in order to provide prehospital patient transport within the jurisdiction of REMSA.

A request from a designated dispatch center shall be deemed as authorization of aircraft operated by the California Highway Patrol, Department of Forestry, National Guard or the Federal Government.

1. EMS Aircraft Permits:
   Any EMS aircraft provider seeking authorization to provide EMS in Riverside County, regardless of their base of flight operations, will comply with all applicable Riverside County ordinances and REMSA policies and procedures, applicable sections of the California Code of Regulations Title 22, and pertinent F.A.A. regulations. Nothing in this policy supersedes or negates compliance with federal regulations.
   a. Air Ambulance Service Providers:
      i. Must secure a written agreement with REMSA. This document is meant to ensure service consistent with REMSA policies and practices.
      ii. Have sufficient cabin space to accommodate two patients and two attendants with a clear view and full body access to either patient.
      iii. Air Ambulance providers applying for a permit will provide and maintain proof of full accreditation by the Commission on Accreditation of Medical Transport Systems (CAMTS).
   b. Air Rescue Aircraft Providers (agreement and approval ONLY):
      i. Must secure a written agreement with REMSA. This document is meant to ensure service consistent with REMSA policies and practices.
      ii. REMSA must authorize any ALS/BLS Air Rescue Aircraft wishing to provide ALS/BLS services within Riverside County
      iii. The Air Rescue Aircraft must provide care consistent with its certification level.
         1. ALS Air Rescue Aircraft shall operate under REMSA ALS policies and protocols
         2. BLS Air Rescue Aircraft shall operate under REMSA BLS policies and protocols
2. Unable to Respond:
   If for any reason, other than scheduled maintenance or being engaged in an emergency response activity, an authorized EMS Aircraft is not, or will not, be able to provide immediate response for an emergency prehospital response, 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 using this FORM, documenting this event to REMSA that includes:
      i. Date and time of occurrence.
      ii. Brief description of the circumstances preventing contracted compliance, including staffing.
      iii. Total down time for the aircraft before returning to full contractual obligations.
      iv. Measures taken to ensure that this situation does not occur again
   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 (when applicable), in Riverside County, per the REMSA Policy 2201 *Radio Communication Standard*.
4. Patient Care and Responsibility:
   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.
   a. 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).
   b. A comprehensive record will be initiated and completed on a County approved ePCR platform for every patient that a member of the flight crew assumes primary medical responsibility for. An electronic ePCR will be completed on the REMSIS designated platform in accordance with REMSA Policy 7701 *Patient Care Record* for any dispatched incident. 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. Communicable Disease Control:
   The EMS Aircraft 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.
7. EMS Aircraft Utilization:
   a. Air Rescue Aircraft:
      i. When EMS providers are unable to access the patient by ground or access to patient by ground is difficult and would delay patient contact/care
      ii. Dispatched or requested when specialty care services are needed (i.e. hoist operations, skid extractions, basket rescues, remote terrain access)
   b. Air Ambulance:
      i. Incidents 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
      ii. Air transportation is the most expedient transportation available to transport the patient to the most appropriate medical treatment facility; or
      iii. 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:
   a. Each EMS Aircraft Service Provider will cooperate with REMSA in connection with annual and random aircraft inspections of medical equipment, supplies, personnel, and records.
2. EMS Aircraft Drug and Equipment List
   a. A drug and equipment list will be approved by the Physician Advisor of the EMS Aircraft Provider and REMSA.
      i. BLS/ALS Air Rescue Aircraft and Air Ambulance drug and equipment list shall be maintained and stocked, at minimum, according to the approved service level identified in REMSA Policy 5202 *HEMS Drug and Equipment List*.
   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. 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. Air Ambulances:
   a. One paramedic who is licensed in California and accredited to work in Riverside County and who possesses current CPR, ACLS/ALS, PHTLS/ITLS/TPATC, and PALS/ALS PEPP/NAMET-EPC 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/ALS, PHTLS/ITLS/TPATC, and PALS/ALS PEPP/NAEMT-EPC 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 a REMSA approved Air Ambulance Attendant course.
   d. Alternative Staffing for Air Ambulance:

i. A Physician licensed in the state of California with recent Emergency Department experience may be substituted for the paramedic, the RN, or both.
ii. A Registered Nurse (RN) currently licensed in the state of California who possesses current CPR, ACLS, BTLS or PHTLS/ITLS/TPATC, and PALS/PEPP/NAEMT-EPC 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.
iii. The minimum required staffing may be met by utilizing a combination of any of the aforementioned categories of personnel.

2. Air Rescue Services:
   a. BLS Air Rescue: one attendant certified as an EMT.
   b. ALS Air Rescue: one paramedic who is licensed in California and accredited to work in Riverside County and who possesses current CPR, ACLS/ALS, PHTLS/ITLS/TPATC, and PALS/ALS PEPP/NAMET-EPC certification.
3. Physician Advisor:
   All Air Ambulance or ALS Rescue Aircraft 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 or ALS Rescue Aircraft Service Provider.
4. Scope of Practice:
   a. All paramedics employed by EMS Aircraft providers 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 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 7 (Prehospital EMS Aircraft Regulations).
   a. 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 Air 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
   c. Radio contact can be made via the Riverside County Intercom System.
2. EMS Aircraft Requests:
   a. Notification to the Riverside County Fire Department ECC from an incident in which EMS Aircraft transport will be initiated shall be done by the Incident Commander, their designee, or an EMS provider (coordinating with the Incident Commander). 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, EMS Surge/MCI)
   b. 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
   c. The ECC will request from the air transport provider:
      i. An ETA to the incident
   d. The ETA and any additional information with be relayed back to the ground provider
   e. 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)
iii. Upon the ECC's relay of this information to the air transport provider, all further communications between ground and air will occur directly.

Data Collection/Continuous Quality Improvement

1. Comply with REMSA requirements for documentation, data collection and reporting as outlined in REMSA 7701 *Patient Care Records*
2. EMS Aircraft provider scene calls will be reviewed by each permitted provider and REMSA to evaluate appropriate utilization
3. Consistent with Title 22, Chapter 10 Data and Quality Assurance, EMS Aircraft providers will develop and participate in the CQI program and plan submission with REMSA as outlined in REMSA 7101 *CQI System*.

5202	Drug and Equipment List - HEMS
	Administrative Policy

Last Reviewed: **April 9, 2026**	Last Revised: **July 1, 2026**

PURPOSE
To set equipment and medication requirements for Riverside County EMS Agency (REMSA) authorized EMS Aircraft operations.

APPLICATION
This policy applies specifically to Riverside County EMS Aircraft (helicopter) ALS/BLS/transport providers that employ Riverside County accredited, Emergency Medical Technicians (EMT), 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 certified EMS Aircraft 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."
- Equipment/medications authorized by HEMS Unified Scope of Practice for Advanced Paramedic LOSOP approval is identified by a "LOSOP"

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.

Personal Documents	Air Rescue		Air Transport
	BLS	ALS	ALS
CA EMT	1	O	O
CAEMT-P License	O	1	1
CPR for the "Professional Rescuer" or "Healthcare Provider" Card	1	1	1
ACLS or ALS Card	O	1	1
PALS, PEPP, or NAEMT-EPC Card	O	1	1

PHTLS, ITLS, or TPATC Card	O	1	1
Respirator Fit Card	O	O	O
TB Test Card	O	O	O
Vaccination Card	O	O	O

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 Section5144 Respiratory Protection, Cal OSHA Title 8 Section5199 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.
5. High visibility garments must meet 23 CFR 634, and ANSI / ISEA 107 (2010).
6. Medical exam gloves must meet 21 CFR 880.6250, or BS EN 455-2.

PPE must meet the CAMTS criteria.

Personal Protective Equipment	Air Rescue		Air Transport
	BLS	ALS	ALS
Helmet	O	O	O
Hearing Protection	O	O	O
Multiple-Use Eye Protection	1	1	1
Respiratory Protection	1	1	1
Uniform Shirt / Pant or Jumpsuit	1	1	1
Uniform Cold Weather Outerwear	1	1	1
High Visibility Garment	1	1	1
Barrier Garment	O	O	O
Medical Exam Glove	6	6	6
Work Glove	O	O	O
Multiple-Use Footwear	2	2	2
Single-Use Footwear Cover	O	O	O
Hand Sanitizer	1	1	1

Pocket Mask	O	O	O
Nerve Agent Antidote Kit (NAAK)	O	O	O
Surgical Mask	O	O	O
Sterile Glove	O	O	O
Gown	O	O	O

Personal Equipment

Personal equipment is listed per individual.

Personal Equipment	Air Rescue		Air Transport
	BLS	ALS	ALS
Flashlight	O	O	O
Penlight	O	O	O
Seatbelt Cutter	O	O	O
Trauma Shears	O	O	O
Two-way Portable Radio	O	O	O
Window Punch	O	O	O

Incident Command System

Each item must be the most current revision.

Incident Command System	Air Rescue		Air Transport
	BLS	ALS	ALS
Emergency Response Guidebook	1	1	1
Triage Tags	O/P	O/P	O / P
Field Operations Guide (ICS 420-1)	O	O	O
Packet of MCI/ICS Forms	O/P	O/P	O / P

Cervical Spine Stabilization & Splinting

Stabilization & Splinting	Air Rescue		Air Transport
	BLS	ALS	ALS
Adjustable Pediatric C-Collar	2	2	2
Adjustable Adult C-Collar	2	2	2
Disposable Head Stabilizer	1	1	1
Long Spine Board	O	O	O
15' D-Ring Spine Board Strap	O	O	O
8 Point Plus Hook & Loop Spine Board	O	O	O
Speed Clip Spine Board Straps (4 Speed Clip Straps per Board)	O	O	O
Medical Duct Tape	O	O	O
KED Type Extrication Device	O	O	O
Pediatric Stabilization Device	1	1	1
Scoop or "Special" Stretcher	O	O	O
Vacuum Mattress, Pump, and Supplies	O	O	O
Arm Splint	1	1	1
Leg Splint	1	1	1
Traction Splint(s) with Pediatric and Adult Capabilities	1	1	1

Assessment

Assessment	Air Rescue		Air Transport
	BLS	ALS	ALS
Stethoscope	2	2	2
Infant BP Cuff	O	O	O
Child BP Cuff	1	1	1
Adult BP Cuff	1	1	1

Thigh BP Cuff	O	O	O
Length Base Pediatric Resuscitation Tape	O	1	1
Measuring Tape	O	O	O
Calculator	O	O	O
Pulse Oximeter with Pediatric and Adult Probes, and Supplies	O	1	1
Glucometer with Lancets, Test Strips, and Supplies	O	1	1
Thermometer (non-rectal use) w/ Supplies	O	O	O
Ring Cutter	O	O	O
Splinter Kit	O	O	O
Response Pack(s), Bag(s), or Case(s)	1	1	1

Suction

Suction	Air Rescue		Air Transport
	BLS	ALS	ALS
Manually Powered Portable Suction Unit with Collection Container and Supplies	O	O	O
Battery Powered Portable Suction Unit with Collection Container, Battery /	1	1	1
Wall Mount Suction with Collection Container and Supplies	O	0	0
Suction Tubing	1	1	1
Rigid or Semi-Rigid Suction Tip	1	1	1
Bulb Syringe	1	1	1
Suction Catheter 6 Fr.	1	1	1
Suction Catheter 8 Fr.	1	1	1
Suction Catheter10 Fr.	O	O	O
Suction Catheter12 Fr.	1	1	1
Suction Catheter14 Fr.	1	1	1
Suction Catheter16 Fr.	O	O	O

Suction Catheter18 Fr.	1	1	1

BLS Airway

BLS Airway	Air Rescue		Air Transport
	BLS	ALS	ALS
Size 00 (40 mm) Oropharyngeal Airway (OPA)	1	1	1
Size 0 (50 mm) Oropharyngeal Airway (OPA)	1	1	1
Size 1 (60 mm) Oropharyngeal Airway (OPA)	1	1	O
Size 2 (70 mm) Oropharyngeal Airway (OPA)	1	1	O
Size 3 (80 mm) Oropharyngeal Airway (OPA)	1	1	1
Size 4 (90 mm) Oropharyngeal Airway (OPA)	1	1	O
Size 5 (100 mm) Oropharyngeal Airway (OPA)	1	1	1
14 Fr. Nasopharyngeal Airway (NPA)	O	O	O
16 Fr. Nasopharyngeal Airway (NPA)	O	O	O
18 Fr. Nasopharyngeal Airway (NPA)	O	O	O
20 Fr. Nasopharyngeal Airway (NPA)	1	1	1
22 Fr. Nasopharyngeal Airway (NPA)	O	O	1
24 Fr. Nasopharyngeal Airway (NPA)	O	O	O
26 Fr. Nasopharyngeal Airway (NPA)	O	O	1
28 Fr. Nasopharyngeal Airway (NPA)	O	O	O
30 Fr. Nasopharyngeal Airway (NPA)	1	1	1
32 Fr. Nasopharyngeal Airway (NPA)	O	O	O
34 Fr. Nasopharyngeal Airway (NPA)	O	O	1
36 Fr. Nasopharyngeal Airway (NPA)	O	O	O
Lubricating Jelly Packets	2	2	2

Laryngoscopy

Laryngoscopy	Air Rescue		Air Transport
	BLS	ALS	ALS
Laryngoscope Handle with Batteries	X	1	1
Extra Batteries	X	2	2
0 Straight Blade	X	1	1
1 Straight Blade	X	1	1
2 Straight Blade	X	1	1
3 Straight Blade	X	1	1
4 Straight Blade	X	1	1
1 Curved Blade	X	O	O
2 Curved Blade	X	1	1
3 Curved Blade	X	1	1
4 Curved Blade	X	1	1
Extra Bulbs (if applicable to device)	X	1	1
Video Laryngoscope and Supplies	X	O	O
Pediatric Magill Forceps	X	1	1
Adult Magill Forceps	X	1	1

ALS Airway

ALS Airway	Air Rescue		Air Transport
	BLS	ALS	ALS
2.5 mm Cuffed Endotracheal Tube	X	X	LOSOP
3.0 mm Cuffed Endotracheal Tube	X	X	LOSOP
3.5 mm Cuffed Endotracheal Tube	X	X	LOSOP
4.0 mm Cuffed Endotracheal Tube	X	X	LOSOP

4.5 mm Cuffed Endotracheal Tube	X	X	LOSOP
5.0 mm Cuffed Endotracheal Tube	X	X	LOSOP
5.5 mm Cuffed Endotracheal Tube	X	1	1
6 mm Cuffed Endotracheal Tube	X	1	1
6.5 mm Cuffed Endotracheal Tube	X	1	1
7 mm Cuffed Endotracheal Tube	X	1	1
7.5 mm Cuffed Endotracheal Tube	X	1	1
8 mm Cuffed Endotracheal Tube	X	1	1
8.5 mm Cuffed Endotracheal Tube	X	O	O
9 mm Cuffed Endotracheal Tube	X	O	O
Size 1 i-Gel Supraglottic Airway	X	X	LOSOP
Size 1.5 i-Gel Supraglottic Airway	X	X	LOSOP
Size 2 i-Gel Supraglottic Airway	X	X	LOSOP
Size 2.5 i-Gel Supraglottic Airway	X	X	LOSOP
Size 3 i-Gel Supraglottic Airway	X	1	1
Size 4 i-Gel Supraglottic Airway	X	1	1
Size 5 i-Gel Supraglottic Airway	X	1	1
Size 1 LMA Supreme Supraglottic Airway	X	X	LOSOP
Size 1.5 LMA Supreme Supraglottic Airway	X	X	LOSOP
Size 2 LMA Supreme Supraglottic Airway	X	X	LOSOP
Size 2.5 LMA Supreme Supraglottic Airway	X	X	LOSOP
Size 3 LMA Supreme Supraglottic Airway	X	X	LOSOP
Size 4 LMA Supreme Supraglottic Airway	X	X	LOSOP
Size 5 LMA Supreme Supraglottic Airway	X	X	LOSOP
Size 6 – Nasogastric/Orogastric Tube	X	X	LOSOP
Size 10 - Nasogastric/Orogastric Tube	X	1	1

Size 12 - Nasogastric/Orogastric Tube	X	1	1
Size 14 – Nasogastric/Orogastric Tube	X	1	1
Size 16 - Nasogastric/Orogastric Tube	X	1	1
or Size 18 - Nasogastric/Orogastric Tube	X	1	1
Adult Endotracheal Intubation Stylet	X	1	1
Endotracheal Tube Introducer Stylet (Bougie)	X	1	1
Commercial Endotracheal Tube Securing Device	X	1	1

Ventilation

Ventilation	Air Rescue		Air Transport
	BLS	ALS	ALS
Neonate Resuscitator Mask	1	1	1
Infant Resuscitator Mask	1	1	1
Pediatric Bag Valve Mask (BVM) Resuscitator Mask	1	1	1
Adult Bag Valve Mask(BVM) Resuscitator Mask	1	1	1
Manometer for BVM	1	1	2
Pedi. Colorimetric CO_2 Detector	O	1	1
Adult Colorimetric CO_2 Detector	O	1	1
Ventilator with Associated Supplies	X	X	LOSOP
O2-RESQ™ CPAP Device with Flow Generator and Circuit, one (1) Medium Bi-Trac ED Mask, Head Strap and one (1) eacg 5/7.5/10 cmH2O Variable Valves	X	1	O
O2-RESQ™ 12.5 cmH_2O Valve	X	1	O
O2-RESQ™ 15cmH_2O Valve	X	1	O
O2-RESQ™ 20cmH_2O Valve	X	1	O
1.75-2-inch 18 ga IV Catheter for Needle Chest Decompression	X	2	2
3.25-inch 16 ga IV Catheter for Needle Chest Decompression	X	O	O

3.25-inch 14 ga IV Catheter for Needle Chest Decompression	X	2	2
One-way Flutter Valve for Needle Chest Decompression	X	O	O

AED

AED	Air Rescue		Air Transport
	BLS	ALS	ALS
AED with Cables, Battery/Batteries, and Supplies	1	0	O
Adult AED Pads	2	0	O
Pediatric AED Pads (or Pediatric Capability with Adult Pads)	1	O	O
Disposable Prep Razor	1	1	1

Resuscitation

Resuscitation	Air Rescue		Air Transport
	BLS	ALS	ALS
Mechanical CPR Device with Supplies	O	O	O

ECG

ECG	Air Rescue		Air Transport
	BLS	ALS	ALS
ECG Monitor with: • Biphasic Defibrillation • Cardioversion • 12-Lead acquisition & transmission • Waveform Capnography • Transcutaneous Pacing • Cables, Battery/Batteries, and Supplies	X	1	1
Automated Blood Pressure with Cables, Battery/Batteries, and Supplies	X	1	1
Adult Defibrillation Pad Set	X	2	2
Pediatric Defibrillation Pad Set	X	1	1

Adult ECG Electrodes	X	20	20
Pediatric ECG Electrodes	X	8	8
Disposable Prep Razor	O	1	1
Surgical Hair Clipper with Charger, and Supplies	X	O	O
Tincture of Benzoin Swabsticks	X	O	O

Oxygen

Portable Oxygen
O_2 for at least 20 minutes @ 10 LPM, approximately:

- D Tank @ 1450 PSI
- Jumbo-D Tank @ 1000 PSI
- E Tank @ 925 PSI

Mounted Oxygen
O_2 for at least 60 minutes @ 10 LPM, approximately:

- M Tank @ 600 PSI
- G Tank @ 450 PSI
- H Tank @ 400 PSI

Oxygen	Air Rescue		Air Transport
	BLS	ALS	ALS
Portable O_2 System with: • Oxygen Key • Liter Flow Regulator • Diameter Index Safety System Male Connector (DISS-M)	1	1	1
Spare Portable O_2 Tank	O	O	O
Wall Mount O_2 Regulator	O	0	1
Mounted Main O_2 Tank	O	1	1
O_2 Supply Hoses, Adaptors and Connectors	O	O	O
Infant Non-Rebreather (NRB) O_2 Mask	1	1	1
Pediatric Non-Rebreather (NRB) O_2 Mask	2	2	2
Adult Non-Rebreather (NRB) O_2 Mask	2	2	2
Infant Nasal Cannula	O	O	O
Pediatric Nasal Cannula	1	1	1
Adult Nasal Cannula	1	1	1

Wound Care

REMSA approved tourniquets include those recommended by the Co-TCCC and the SWAT-T.

Wound Care	Air Rescue		Air Transport
	BLS	ALS	ALS
3X3 Sterile Gauze Sponge	O	O	O
4X4 Sterile Gauze Sponge	6	6	P
Gauze Sponge	O	O	O
Rigid Eye Shield (Example)	O	O	O
Eye Pad	O	O	O
Abdominal Pad	O	O	O
Trauma Dressing	4	4	1
Chest Seal	O	O	2
Occlusive Dressing	2	2	O
Roller Gauze Bandage	2	2	2
Triangular Bandage	2	2	O/P
Hemostatic Dressing (EMSA approved only)	O	O	O
Combat-Application-Tourniquet (C-A-T) ®	2	2	1
Tourniquet	O	O	O
Non-Adherent Dressing	O	O	O
Self-Adherent Wrap	O	O	O
Elastic Wrap	O	O	O
Transpore™ Tape	1	1	2
Cloth Tape	2	2	2
Silk Tape	O	O	O
Disposable Cold Pack	3	3	P
Sterile Burn Sheet	1	1	1

1 Liter Normal Saline for Irrigation	1	1	1
Eye Wash, Bottle	O	O	O
Disposable OB Kit with Receiving Blanket and Head Cover	1	1	1

Vascular Access

Vascular Access	Air Rescue		Air Transport
	BLS	ALS	ALS
Constricting Band	X	2	2
IV Start Kit	X	O	O
Adhesive Band-Aid	O	3	3
IV Stabilization Dressing	X	2	O
IV Stabilization Splint	X	O	O
Alcohol Swab	X	12	12
Povidone Iodine	X	4	4
ChloraPrep Swabs / Sponges	X	2	2
24 ga IV Catheter	X	2	2
22 ga IV Catheter	X	2	2
20 ga IV Catheter	X	2	2
18 ga IV Catheter	X	2	2
16 ga IV Catheter	X	2	2
14 ga IV Catheter	X	2	2
Powered IO Device with Pediatric Capability	X	1	1
Powered IO Device with Adult Capability	X	1	1
EZ-IO Power Driver	X	1	1
EZ-IO15ga /15 mm Pink Needle Set	X	1	1
EZ-IO15ga /25 mm Blue Needle Set	X	1	1

EZ-IO 15 ga /45 mm Yellow Needle Set	X	1	1
B.I.G. 18 ga Red Pediatric IO Device	X	O	O
B.I.G. 15 ga Blue Adult IO Device	X	O	O
Blood Collection Needle	X	O	O
Blood Collection Needle Holder	X	O	O
Blood Tubes	X	O	O
Bio-Hazard Lab Bag	X	O	O

Medication Administration

Medication Administration	Air Rescue		Air Transport
	BLS	ALS	ALS
Handheld Nebulizer with Mouthpiece, Reservoir, and Supply Tubing	X	1	1
Pediatric Nebulizer Mask	X	1	O/P
Adult Nebulizer Mask	X	1	1
Nebulizer Tee with Adaptors	X	1	1
Holding Chamber for MDI	X	O	O
MAD® Nasal-Mucosal Atomization Device	X	2	2
18 -19 ga Hypodermic Needle	X	4	O/P
18 - 19 ga Filter Needle	X	4	4
Blunt IV Injection Cannula for Needleless System	X	O	O
21 ga X 1 - 1.5” Hypodermic Needle	X	1	1
23 ga X 1 - 1.5” Hypodermic Needle	X	O	O
25 ga X 1” Hypodermic Needle	X	1	1
1 mL TB Syringe	X	1	1
3 mL Syringe	X	2	2
5 mL Syringe	X	2	2

10 mL Syringe	X	2	2
20 mL Syringe	X	1	1
30 mL Syringe	X	2	O/P
60 mL Syringe	X	2	O/P
Carpuject® Holder	X	O	O
Saline Lock Extension Set	X	2	2
Three Way Stopcock	X	O	O
Luer Lock Adaptor	X	O	O
Volume Control Chamber IV Set	X	2	O
IV Pump	X	X	1
60 drop / mL IV Set	X	2	O
10 drop / mL IV Set	X	2	1
Pressure Infusion Bag	X	1	1
IV Warmer with Supplies	X	O	1
Narcotic Storage	X	1	1

Transportation

Transportation	Air Rescue		Air Transport
	BLS	ALS	ALS
Ambulance Cot with 8+Point Seat Belts	O	O	1
Cot Securing System	O	O	1
Commercial Child Restraint System	O	O	1
Collapsible (Folding) Stretcher	O	O	O
Stair Chair	O	O	O
Rescue Basket / Litter / Stretcher / Similar Device	1	1	O
Wrist Restraint*	O	O	2

Ankle Restraint*	O	O	2
Spit Sock (Patient Hood)	O	O	O

Waste Disposal

Waste Disposal	Air Rescue		Air Transport
	BLS	ALS	ALS
Mounted Sharps Container	O	0	1
Portable Sharps Container	1	1	1
Covered Waste Container	O	O	O
Waste Bag	O	O	O
Biohazard Bag	1	1	1
Emesis Basin	O	O	O
Bed Pan	O	O	O
Urinal	O	O	O

Linen

Linen	Air Rescue		Air Transport
	BLS	ALS	ALS
Blanket	1	1	1
Emergency Blanket	2	2	O
Towel	O	O	O
Stretcher Sheet	O	O	O
Pillow	O	O	O
Pillowcase	O	O	O

Documentation

Documentation	Air Rescue		Air Transport
	BLS	ALS	ALS
Mobile PCR System with: • Portable Touchscreen Computer • Magnetic Strip / Barcode Reader • ECG Monitor Connectivity • Mobile Internet Access	1	1	1
Clipboard	1	1	1
Pen	1	1	1
Paper Release Forms	3	3	5
Pencil	O	O	O
Writing Pad	O	O	O
Light Response Program Inventory Sheet	O	O	O

Medications

Of the authorized options, the preferred medication is in **bold** print.

Medications	Air Rescue		Air Transport
	BLS	ALS	ALS
Acetaminophen 1000 mg / 100 mL Vial or IV premix bag	X	1	1
Act. Charcoal — 50 g/ 240 mL Container	X	O	O
Or Act. Charcoal — 25 g/ 120 mL Container	X	O	O
Adenosine — 12 mg/ 4 mL Prefilled Syringe or Vial	X	2	2
or Adenosine — 6 mg / 2 mL Prefilled Syringe or Vial	X	4	4
Albuterol 0.083% — 2.5 mg/ 3 mL Vial	X	3	3
Albuterol — 90 mcg/ 1 Dose Metered Dose Inhaler. *May substitute vials & equipment*	X	O	O
Amiodarone — 150 mg/ 3 mL Vial	X	3	3
or Amiodarone — 900 mg / 18 mL Vial	X	1	1
Aspirin — 81 mg/ 1 Tab Chewable Tablet in Packet	X	8	8
or Aspirin — 81 mg / 1 Tab, Multi-dose Chewable Tab Bottle	X	1	1

Atropine — 1 mg/ 10 mL Prefilled Syringe	X	1	1
or Atropine— 0.5 mg / 5 mL Prefilled Syringe	X	2	2
or Atropine — 1 mg / 1 mL Ampule or Vial	X	1	1
Atropine — 8 mg / 20 mL Vial	X	1	O
or Atropine — 1 mg / 1 mL Ampule or Vial	X	8	O
Calcium Chloride 10% — 1 g/ 10 mL Prefilled Syringe	X	1	1
Dextrose 10% — 25 g/ 250 mL IV Bag	X	1	1
or Dextrose 50%— 25 g / 50 mL Prefilled Syringe or Vial	X	1	1
or Dextrose 25% — 2.5 g/ 10 mL Prefilled Syringe	X	10	10
or Dextrose 10%— 1 g / 10 mL Prefilled Syringe	X	25	25
Diphenhydramine — 50 mg / 1 mL Vial, or Carpuject®	X	1	1
Epi. 1:1,000 — 1 mg / 1 mL Ampule	X	1	1
O r Epi. 1:1,000 — 30 mg / 30 mL Vial	X	1	1
or "EpiPen" / Auto-Injector. — 0.3 mg / 0.3 mL	X	O	O
Epi. 1:10,000 — 1 mg/ 10 mL Prefilled Syringe	X	3	3
or Epi. 1:1,000 — 1 mg / 1 mL Ampule	X	3	3
or Epi. 1:1,000 — 30 mg / 30 mL Vial	X	1	1
Etomidate – 20mg/10 ml Vial	X	X	LOSOP
Glucagon — 1 mg / 1 mL Vial of Powder + Vial of Diluent	X	1	O
Glucose Gel— 1 Container	X	1	O
Ipratropium Br.— 0.5 mg/ 2.5 mL Vial	X	1	1
Ketorolac (Toradol) – 30 mg / mL Vial	X	1	1
Lidocaine 2% — 100 mg / 5 mL Prefilled Syringe	X	1	1
or Lidocaine 2% — 400 mg / 20 mL Vial	X	1	1
Magnesium Sulfate — 5 g/ 10 mL Prefilled Syringe or Vial	X	1	1
or Magnesium Sulfate— 1 g / 2 mL Vial	X	5	5
or Magnesium Sulfate - 4 g / 100 mL Bag	X	1	1
Naloxone — 2mg/ 2mL Prefilled Syringe or Vial	X	4	1
or Naloxone — 4 mg / 10 mL Vial	X	2	1
or Naloxone— 0.4 mg / 1 mL Prefilled Syringe, Vial or Carpuject®	X	5	5
Nitroglycerin — 0.4 mg / 1 Dose Multi-dose Spray or Bottle or Tab.	X	1	1
Nitro. Paste 2% — 1 g/ 1 Inch	X	2	O

Packet with Paper Applicators			
or Nitro. Paste 2% — 30 g / 1 Tube with Paper Applicators	X	1	O
or Nitro. Paste 2% — 60 g / 1 Tube with Paper Applicators	X	1	O
Normal Saline 0.9% — 1000 mL IV Bag	X	2	2
or Normal Saline 0.9% — 500 mL IV Bag	X	4	4
or Normal Saline 0.9% — 250 mL IV Bag	X	8	8
Normal Saline 0.9% — 50 mL IV Bag	X	1	O/P
Normal Saline 0.9% — 10 mL Prefilled Syringe or Vial	X	2	2
Ondansetron — 4mg/ 2mL Prefilled Syringe or Vial	X	1	1
or Ondansetron — 40 mg / 20 mL Vial	X	1	1
Ondansetron — 4 mg / 1 Tab Oral Disintegrating Tablet	X	1	O
Rocuronium – 50 mg/5 ml Vial	X	X	LOSOP
So. Bicarb. 8.4% - 50 mEq / 50 mL Prefilled Syringe or Vial	X	1	1
or So. Bicarb. 8.4% -10 mEq / 10 mL Prefilled Syringe or Vial	X	1	5
Tranexamic Acid 1 gram/10 mL Vial	X	1	1

Controlled Substances

Of the authorized options, the preferred medication is in **bold** print. Minimum par levels required at all times.

Controlled Substances	Air Rescue		Air Transport
	BLS	ALS	ALS
Fentanyl — 100 mcg / 2 mL Ampule, Vial, or Carpuject®	X	1	1
or Fentanyl — 100 mcg/ 5 mL Ampule, Vial, or Carpuject®	X	O	O
or Fentanyl— 100 mcg / 10 mL Ampule, Vial, or Carpuject®	X	O	O
Ketamine – 500 mg / 10 mL Ampule, Vialor Carpuject®	X	1	2
or Ketamine – 50 mg/1 mL Ampule, Vial or Carpuject®	X	2	O
or Ketamine 200 mg / 20 mL Ampule, Vial, or Carpuject®	X	1	O
or Ketamine 500 mg / 5 mL Ampule, Vial, or Carpuject®	X	1	O
Midazolam — 5 mg / 1 mL Ampule, Vialor Carpuject®	X	2	2
or Midazolam— 10 mg / 2 mL Ampule, Vial, or Carpuject®	X	1	O
or Midazolam— 5 mg/ 5 mL Ampule or Vial	X	2	O

or Lorazepam— 4 mg / 1 mL Ampule, Vial, or Carpuject®	X	A	O
or Lorazepam— 2 mg / 1 mL Ampule, Vial, or Carpuject®	X	A	O
or Diazepam — 10 mg / 2 mL Ampule, Vial, or Carpuject®	X	A	O
Morphine Sulfate — 10 mg / 1 mL Ampule, Vial or Carpuject®	X	A	O
or Morphine Sulfate- 10 mg / 10 mL Ampule or Vial	X	A	O

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.

CDC Medications	Air Rescue		Air Transport
	BLS	ALS	ALS
DuoDote Nerve Agent Antidote Kit	O	O	O
or Mark I Nerve Agent Antidote Kit	O	O	O

Cardiac Monitor Specification

Attributes/capabilities for Cardiac Monitor, Pacemaker, Defibrillator

Cardiac Monitor/Defibrillator/Pacemakers shall adhere to the below specifications and meet all current applicable and relevant REMSA policies/ protocols, guidelines and standards, including: American Heart Association (A.H.A.), American National Standards Institute (A.N.S.I.), American Society for Testing and Materials (A.S.T.M.), Association for the Advancement of Medical Instrumentation (A.A.M.I.), E.C.R.I. Institute, Federal Communications Commission (F.C.C.), Food and Drug Administration (F.D.A.).Health Insurance Portability and Accountability Act (H.I.P.A.A.), and National Fire Protection Association (N.F.P.A.).

Physical Attributes
Six (6) foot lead set with removable precordial lead connection
Multifunction cable with hands-free MFP capability
CPR diagnostic qualitative and quantitative feedback and reporting capability (*not optional – additional specification below)
A/C power adapter/battery charger - Full functionality should be present while device is functioning with A/C power
Lithium-ion batteries, two/device, must be smart batteries lasting minimum of 3 hours each
Battery charging device, minimum of 2 bay/bank charger. - Charging support systems must recalibrate and test batteries in addition to charging.
Minimum one (1) year EMS warranty
Biphasic waveform with hands-free defibrillation functionality with adult and pediatric capability. Energy setting options must be compatible with applicable REMSA protocols.
Functionality to operate in Automated External Defibrillator or Semi-Automated External defibrillator mode
Functionality to provide synchronized cardioversion at multiple age-appropriate energy levels. Energy setting options must be compatible with applicable REMSA protocols.
Adjustable and controllable amperage and rate for transthoracic pacing with adult and pediatric capability
Ability to operate in fixed, demand, and overdrive modes
Capability to detect and indicate presence of internal pacemaker
Capability to print field user machine test/internal diagnostic test results

Display, select and/or cascade multiple waveforms simultaneously (e.g.: paddles/MFP, Lead I, Lead II, Lead III, capnography, SpO2 Photoplethysmography (pleth) – all are required as options for display)
Programmable audio and visual alert systems for fatal arrhythmias, VF/VT at a minimum
Separate programmable alerts for biometric parameters of NiBP, heart rate, respiratory rate, etCO2, SpO2
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.
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
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 measure 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)
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.

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:
Measure high quality CPR performance feedback parameters 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 / improve performance of high quality CPR, 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. 1. All applicable REMSA Information Security policies and procedures must be followed during data transmissions, imports or other sharing methodologies.

5203	HEMS Unified Scope of Practice Advanced Paramedic
Operational Policy LOSOP	

Last Reviewed: **January 6, 2025**	Last Revised: **July 1, 2025**

PURPOSE

To establish a uniform approach to patient care delivered by qualified transport paramedics throughout Riverside County and California.

PROGRAM REQUIREMENTS

All HEMS providers seeking to use Advance Practice Paramedics in Riverside County must have approval from REMSA prior to deploying participating EMS personnel. The application for approval and renewal can be found **HERE**.
Once approved, program effective and expiration dates will be documented on a REMSA-provided approval letter.

Definitions

1. **CAMTS**: Commission on Accreditation of Medical Transport Systems
2. **CAMTS Emergency Critical Care (ECC) Level Certification**: CAMTS recognizes both the Critical Care Paramedic (CCP-C) and the Certified Flight Paramedic (FP-C) for the ECC accreditation level. These CAMTS ECC levels also require a qualified nurse partner and are required for programs participating in this local optional scope of practice - *see CAMTS 11th edition Accreditation Standard pg 3.4*
3. **CCP-C:** A Critical Care Paramedic:
   - Is educated and trained in critical care transport (this scope of practice is in accordance with the standards prescribed in Title 22, Division 9, Chapter 3.3 of the California Code of Regulations)
   - Holds current CCP certification through the Board for Critical Care Transport Paramedic Certification (BCCTPC)
   - Has a valid California paramedic license
   - Is currently accredited by REMSA
   - Practices within a Qualified Transport Program (QTP)

   A **CCP-C in training** must take the CCP-C exam within six (6) months and pass the exam by the end of their (1st) first year with their QTP
4. **EMS Medical Director Association of California (EMDAC)**: An advisory group to the EMS Authority on issues of scope of practice
5. **FP-C:** A Certified Flight Paramedic:
   - Is educated and trained in critical care transport and flight medicine
   - Holds current FP-C certification by the Board for Critical Care Transport Paramedic Certification (BCCTPC)
   - Has a valid California paramedic license
   - Is currently accredited by REMSA
   - Practices within a Qualified Transport Program (QTP)

   The FP-C examination consists of 125 questions and takes 2.5 hours to complete.
6. **FP-C in training:** These paramedics have completed the QTP's initial academy training and are fully functional paramedics for the program, but they have not yet completed their FP-C testing / certification. The FP-C in training must take the FP-C exam within six (6) months and pass the exam by the end of their first (1st) year with the QTP.
7. **Local Optional Scope of Practice (LOSOP):** The performance or monitoring of procedures, or the administration of medications, that are not included in the basic statewide scope of practice. The REMSA Medical Director, in collaboration with EMDAC and the Director of the California Emergency Medical Services Authority (EMSA), must approve these procedures/medications. Paramedics must be trained and tested to demonstrate competence in performing the additional procedures and administering the additional medications.
8. **Qualified Flight Paramedic:** A licensed, and REMSA accredited, paramedic that meets the requirements for participation in this local optional scope of practice (LOSOP) program. These qualified FP-C or CCP-C paramedics have at least three (3) years of critical care experience and have completed the QTP's initial academy training and fall into one of these categories:

- FP-C
- FP-C in training
- CCP-C
- CC-P in training
    - with additional education in flight and altitude physiology
    - are currently working for an agency that has a QTP and
    - Are paired with a Qualified Transport Nurse as required in the "ECC level" of CAMTS 11th edition standards.

9. **Qualified Transport Program (QTP):** any aeromedical transport program that has met the requirements to participate in this LOSOP program by meeting CAMTS ECC accreditation (if an aeromedical program) as outlined in the 11th edition and demonstrates the required training, education, competencies, QI and Medical Direction required.
10. **Qualified Transport Nurse:** A registered nurse with at least three (3) years of critical care experience, who has completed the QTP training and is working toward one of the following certifications:
    - CCRN – Certified Critical Care Nurse
    - CEN – Certified Emergency Nurse
    - CFRN – Certified Flight Nurse
    - CTRN – Certified Transport Nurse

    The qualified transport nurse must be employed by, and practicing with, a QTP. *(For aeromedical nurses, see CAMTS 11th edition Accreditation Standard pg 3.6)*
11. **Qualified Transport Program Medical Director:** The QTP Medical Director is Board certified, or eligible, in Emergency Medicine by the American Board of Emergency Medicine or the American Board of Osteopathic Medicine. If the Medical Director directs an aeromedical service, they must meet CAMTS ECC level requirements for Medical Director.
12. **Qualified Transport Program Physician:** A physician who is affiliated with the QTP as an associate or consultant and is not the Medical Director, but is Board certified, or eligible, by an American Board of Medical Specialties board in emergency medicine or in the specialty appropriate for the scope of service (e.g, pediatrics, critical care). For aeromedical services, they must meet all CAMTS requirements for Medical Director.

Overview

This unified scope of practice provides a standardized approach for qualified paramedics who practice on rotor or fixed wing aircraft. With its use, this LOSOP will allow a uniform practice environment for QTP teams that remains consistent throughout California and across regional boundaries. As a result, patients will receive the best critical care possible. QTPs (aeromedical) that cross regional boundaries may qualify for participation in this LOSOP with REMSA approval.

Paramedic Unified Scope of Practice procedures include:

1. Pediatric intubation
2. RSI (rapid sequence induction) medication administration, including: sedatives, paralytics, analgesics, and induction agents
3. Supraglottic airway devices
4. Ventilator initiation, maintenance and management

To participate in this LOSOP, QTPs must:

1. Be CAMTS ECC certified (aeromedical transport program)
2. Provide enhanced training, education and competency verification consistent with the requirements of this LOSOP, of the CAMTS 11th edition ECC level, and as necessary for the FP-C/CCP-C. Submission and verification of educational programs as specified in the Appendix are required.
3. Provide all four (4) paramedic unified scope of practice procedures, appropriate Quality Improvement (QI) and all REMSA required metrics, providing a uniform report approved by EMDAC and delivered biannually to all LEMSAs.
4. Have a Medical Director that is Board certified, or eligible, in Emergency Medicine by the American Board of Emergency Medicine or the American Board of Osteopathic Medicine. If the Medical Director directs an aeromedical service, they must meet CAMTS ECC level requirements for Medical Director

To participate in this LOSOP, qualified paramedics must:

1. Be employed by a CAMTS accredited QTP during any transports where these optional scope procedures are performed
2. Be partnered with a qualified transport nurse, qualified program medical director or qualified program physician during transport when these optional scope procedures are performed
3. Be currently accredited by REMSA
4. Remain competent/proficient in these four (4) unified scope of practice procedures by passing the competency testing noted in each skill verification form located in the LOSOP HEMS Unified Scope Advanced Paramedic Skills Competency Verification (SCV) Form, or REMSA approved provider competency forms, with the frequency required and noted here:

Pediatric Intubation	Quarterly
Rapid Sequence Induction	Quarterly
Supraglottic Airway	Quarterly
Ventilator Management	Annually

5. Must have completed a minimum of two hundred (200) hours of requisite QTP training and meet the requirements as outlined in definitions for one of the following:
   a. CCP-C in training
   b. FP-C in training
   c. CCP-C
   d. FP-C

Medical Control

Medical control shall remain the primary responsibility of REMSA and it will be documented as such within the REMSA approved QTPs policies and procedures:

1. Online medical direction via direct conversation between the qualified transport teams and qualified transport program Medical Director
2. Online medical direction will occur as described in any and all applicable REMSA treatment protocols
3. Offline medical direction through the QTP policies and procedures as approved by REMSA
4. Offline medical direction will occur as described in the policies, procedures, scope of practice and LOSOP (as documented in this policy) that have been approved by REMSA
5. During an interfacility transport, online medical direction may be obtained from the sending or receiving physician if on duty at a designated base hospital

Quality Improvement (QI) Program

1. To ensure on-going QI, data analysis, and performance improvement, the QI program must be a collaborative process between EMDAC, REMSA and the QTP
2. The QTP will provide EMDAC and REMSA with a standardized database report consistent with current national guidelines
3. QI reporting will be delivered biannually and will include all pertinent aspects of service and care surrounding the four (4) procedures in this LOSOP as well other critical care bundles
4. The following QI reports will be submitted to REMSA and EMDAC on a scheduled basis (biannually), to include at minimum, the following system-wide aggregate data:
   a. Pediatric intubation (frequency, success and adverse events)
      - Percent of successful placements by age
        i. Numerator: # successful attempts = yes, Denominator: # of patients in whom ETI placement was attempted (defined as placement of a laryngoscope with intent of performing ETI)
      - Percent of first-attempt successes
        i. Numerator: # successful attempts = yes with attempts =1, Denominator: # of patients in whom ETI placement was attempted
      - Percent of each complication (emesis, trauma, hypoxia, dislodgement) and percent of total complications

i. Numerator: # with complication = yes, Denominator: # of patients in whom ETI placement was attempted

- Median time to insertion (if collected)

b. RSI (rapid sequence induction) medication administration, including: sedatives, paralytics, analgesics, and induction agents
   - Metrics to gauge success shall be the same as above (4a – Pediatric intubation)

c. Supraglottic airways (SGA): Frequency as primary and rescue airway, success and adverse events.
   - Percent used as a primary airway versus a rescue airway
   - Percent of successful placements by age
     i. Numerator: # successful attempts = yes, Denominator: # of patients in whom SGA placement was attempted
   - Percent of first-attempt successes
     i. Numerator: # successful attempts = yes with attempts =1, Denominator: # of patients in whom SGA placement was attempted
   - Percent of each complication (emesis, trauma, hypoxia, dislodgement) and percent of total complications
     i. Numerator: # with complication = yes, Denominator: # of patients in whom SGA placement was attempted
   - Median time to insertion (if collected)

d. Ventilator initiation, maintenance, and management: Frequency and adverse events

5. Data collection will be consistent with the EMDAC derived metrics for endotracheal intubation and supraglottic airway placement:
   a. Pediatric intubation and RSI:
      i. Rescue device? – yes/no/not documented
      Rescue device is defined as a device used after failure of the initial device attempted for secondary airway management, after bag-mask-ventilation.
      ii. Successful placement? – yes/no/not documented
      Successful placement is defined as the ability to ventilate the patient with minimal or no air leak, confirmed primarily with $ETCO_2$ measurement with capnography. Secondary confirmation methods include visible chest rise during ventilation and air movement on pulmonary auscultation.
      iii. Number of attempts – numeric in integers/not documented
      Attempt is defined as insertion of the laryngoscope in the mouth with the purpose of ETI.
      iv. Time to insertion *(optional)* – numeric in seconds/not documented
      Time to insertion is defined as the time from insertion of the laryngoscope into the mouth for the first (1^{st}) attempt until the time of the first successful ventilation with minimal or no air leak.
      v. Complications
         - Regurgitation/emesis? – yes/no/not documented
         Regurgitation/emesis is defined as the presence of gastric contents noted in the oropharynx or on device during or after placement.
         - Bleeding/trauma? – yes/no/not documented
         Bleeding/trauma is defined as the presence of blood noted in the oropharynx or on the device during or after placement, or any abrasion, laceration, dental trauma or other trauma occurring during placement or repositioning of the device. This excludes bleeding or trauma present prior to attempted device placement.
         - Hypoxia? – yes/no/not documented
         Hypoxia is defined as any oxygen saturation measurement less than or equal to 90% during or after placement in a patient previously normoxic prior to placement.
         - Dislodgement? – yes/no/not documented
         Dislodgement is defined as loss of the ability to adequately ventilate the patient after successful placement was achieved
         - Cardiovascular effects? – yes/no/not documented

If yes:

Hypotension?	*yes/no/not documented*
Bradycardia?	*yes/no/not documented*
Cardiopulmonary arrest?	*yes/no/not documented*

vi. If dislodgement occurred after initial placement, was secondary placement successful? – yes/no/not documented/not applicable

Successful secondary placement is defined as the ability to ventilate the patient with minimal or no air leak, after dislodgement and replacement of the same device, confirmed primarily with $ETCO_2$ measurement with capnography. Secondary confirmation methods include visible chest rise during ventilation and air movement on pulmonary auscultation.

b. Supraglottic airway:

i. Rescue device? – yes/no/not documented

Rescue device is defined as a device used after failure of the initial device attempted for secondary airway management, after bag-mask-ventilation.

ii. Successful placement? – yes/no/not documented

Successful placement is defined as the ability to ventilate the patient with minimal or no air leak, confirmed primarily with $ETCO_2$ measurement with capnography. Secondary confirmation methods include visible chest rise during ventilation and air movement on pulmonary auscultation.

iii. Number of attempts – numeric in integers/not documented

Attempt is defined as insertion of the laryngoscope in the mouth with the purpose of ETI.

iv. Time to insertion *(optional)* – numeric in seconds/not documented

Time to insertion is defined as the time from insertion of the laryngoscope into the mouth for the first (1^{st}) attempt until the time of the first successful ventilation with minimal or no air leak.

v. Complications

- Regurgitation/emesis? – yes/no/not documented
  Regurgitation/emesis is defined as the presence of gastric contents noted in the oropharynx or on device during or after placement.
- Bleeding/trauma? – yes/no/not documented
  Bleeding/trauma is defined as the presence of blood noted in the oropharynx or on the device during or after placement, or any abrasion, laceration, dental trauma or other trauma occurring during placement or repositioning of the device. This excludes bleeding or trauma present prior to attempted device placement.
- Hypoxia? – yes/no/not documented
  Hypoxia is defined as any oxygen saturation measurement less than or equal to 90% during or after placement in a patient previously normoxic prior to placement.
- Dislodgement? – yes/no/not documented
  Dislodgement is defined as loss of the ability to adequately ventilate the patient after successful placement was achieved
- Cardiovascular effects? – yes/no/not documented
  If yes:

Hypotension?	*yes/no/not documented*
Bradycardia?	*yes/no/not documented*
Cardiopulmonary arrest?	*yes/no/not documented*

vi. If dislodgement occurred after initial placement, was secondary placement successful? – yes/no/not documented/not applicable

Successful secondary placement is defined as the ability to ventilate the patient with minimal or no air leak, after dislodgement and replacement of the same device, confirmed primarily with $ETCO_2$ measurement with capnography. Secondary confirmation methods include visible chest rise during ventilation and air movement on pulmonary auscultation.

Training and Education Program, Skills and Competency Evaluations for Unified Optional Scope of Practice
Overview and Goals: (see LOSOP HEMS Unified Scope Advanced Paramedic Skill Competency Verification Form or other competency forms as approved by REMSA. All competency verification shall be tracked by the provider and submitted annually within their CQIP.)

This unified scope policy carries a goal of delivering proficient critical care paramedics, who have completed all the requirements for FP-C or CCP-C certification, with respect to these four (4) optional scope procedures. This will be accomplished through assurance that qualified programs are held to the highest recognized standard in the industry – CAMTS ECC level accreditation.

Qualified programs must also ensure that all FP-C or CCP-C paramedics utilizing these unified scope skills are certified within the first two (2) years, and that FP-C or CCP-C trainees, once they complete the education, will attempt the certification exam within six (6) months with certification required by one (1) year of employment.

CAMTS ECC certification also requires that an FP-C or CCP-C paramedic operate concurrently with a critical care nurse partner with one (1) of the following certifications: certified emergency nurse (CEN), certified critical care nurse (CCRN), certified flight nurse (CFRN) or certified transport (CTRN).

CAMTS also demands rigorous attention to maintaining the highest standards in medical care, transport program reliability / safety and quality improvement. CAMTS ECC Certification requires passing a 2-3 day survey every two (2) years. The CAMTS ECC requirements set the threshold as high as possible for paramedics participating in this optional scope of practice.

Specific Objectives:

1. Enhanced training, competency verification, and quality improvement for paramedics utilizing the unified scope shall be provided by the QTP
2. All qualified paramedics will participate in a structured orientation and educational process including, but not limited, to the following:
    a. Initial training academy following the core curriculum content from the following certifications, CCP-C and/or FP-C:
        i. Flight Physiology (only required for flight transport programs)
            a. Identify causes of hypoxia
            b. Relate the stages of hypoxia to patient condition and treatment
            c. Take corrective measures to prevent altitude related hypoxia
            d. Identify signs of barometric trauma
            e. Identify stressors related to transport (including thermal, humidity, noise, vibration, or fatigue related conditions)
            f. Take corrective action for patient stressors related to transport
            g. Relate the relevant gas laws to patient condition and treatment
            h. Identify immediate causes of altitude related conditions in patients
            i. Identify immediate causes of altitude related conditions as they affect the air medical crew
            j. Provide interventions to prevent the adverse effects of altitude changes during patient transport
        ii. Advanced Airway Management
            a. Identify the indications for basic and advanced airway management
            b. Demonstrate advanced airway management techniques in both adult and children
                1. Determine the appropriate laryngoscope blade type and size.
                2. Determine appropriate endotracheal tube size
                3. Demonstrate technique for securing the endotracheal tube
                4. Demonstrate confirmation of endotracheal tube placement
                5. Demonstrate appropriate troubleshooting techniques for poor response to intubation
                6. Discuss the management of complications of intubation.
            c. Administer appropriate medications for airway management.
            d. Identify the indications and contraindications for specific airway interventions
            e. Implement the appropriate airway algorithms

f. Perform alternative airway management techniques
g. Outline indications and contraindications for these techniques
h. Manage complications of alternative airway technique
i. Monitor airway management and ventilation.
j. Discuss the importance and the requirement of continuous waveform End Tidal CO_2 capnography during transport.
k. Perform post-intubation management
l. Identify causes of hypoxia
m. Relate the stages of hypoxia to patient condition and treatment
n. Take corrective measures to prevent altitude related hypoxia
o. Identify stressors related to transport (including thermal, humidity, noise, vibration, or fatigue-related conditions)
p. Take corrective action for patient stressors related to transport
q. Relate the relevant gas laws to patient condition and treatment
r. Identify immediate causes of altitude related conditions in patients (flight transport programs only)
s. Identify immediate causes of altitude related conditions as they affect the air medical crew (flight transport programs only)
t. Provide interventions to prevent the adverse effects of altitude changes during patient transport (flight transport programs only)

iii. Ventilation initiation, maintenance, and management:
a. Respiratory pathophysiology
b. Recognition of respiratory failure (hypercapnia and hypoxia)
c. Basic ventilator function
d. Ventilation and oxygenation of the critically ill medical and trauma patient
e. Discuss the implementation of ventilation settings to react to the patient's condition

b. Preceptorship with preceptor "sign-off" of various required aspects of critical care. This includes all procedures in the unified scope of practice.
i. This may require skills demonstration on manikins, dynamic human patient simulators, animals or cadavers
ii. Initial airway education and training: no less than five (5) infant (birth to one year), (5) pediatric (age 14 years and below), and (5) adult intubations (live, cadaver, animal lab, or dynamic Human Patient Simulators (HPS) are acceptable). Airway management experiences to include alternative airway management: **direct laryngoscopy, video laryngoscopy, pediatric airway specific issues, utilization of the bougie, and supraglottic airways (SGAs)**

c. All qualified paramedics will become either FP-C or CCP-C certified by the end of their first (1st) year
d. The QTP will provide on-going training, education, and skills competency verification that will help ensure patient safety and quality improvement (the programs will use a proactive, concurrent, and retrospective approaches).
i. Training will occur at least quarterly and include psychomotor, cognitive, and affective competency-based assessments for the unified scope procedures.
ii. Ongoing airway education and training: No less than one (1) infant, pediatric, and adult successful intubations (live, cadaver, HPS or mannequin) per quarter (calendar or fiscal year). Airway management experiences for each type of airway adjuncts listed within the programs' protocols. Quarterly vetted intubation experience is required.

3. Participation in Quality Improvement plans.

5301	Trauma Triage Indicators and Destination
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

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.

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 RESUSCITATE OR 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 4701/4906 *Adult/Pediatric 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 *EMS Surge/Mass Casualty Incident (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
- Infant respiratory rate less than 20
- Systolic BP less than 90 mmHg
- Geriatric patient (65 years or older) with a systolic BP less than 100 mmHg

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.

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

5302	Continuation of Trauma Care
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 27, 2022**

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

Trauma Triage Continuation of Care	
Critical Trauma Patient Needs Immediate Higher Level of are ED to ED	**Trauma Patient, needs Higher Level of Care to In-House Trauma Services**
Vital Signs	
Respiratory Compromise Systolic BP less than 90 • If greater than 70 y/o, systolic BP less than 100 GCS less than or equal to 13	Within Normal Limits
CNS	
Penetrating/depressed skull injury Open injury with or without CSF leak Deteriorating GCS or changes in neurological status	Stable Spinal Cord Injury Any head injury w/ combined face, chest, abdomen, or pelvis
CHEST	
Widened mediastinum on initial XRAY Penetrating injury	Major chest wall injury or pulmonary contusion Prolonged ventilator requirements
ABDOMEN/PELVIS	
Any injury w/ associated Shock (systolic BP less than 90)	Unstable pelvic ring
EXTREMITIES	
Any injuries w/ associated shock (systolic BP less than 90)	Open long bone fracture Crush injuries or prolonged ischemia Loss of distal pulses

MULTI SYSTEM	
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.

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

5303	Trauma Patient Registry Form (Non-Trauma Centers)
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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).

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: https://rivcoready.org/sites/g/files/aldnop181/files/2023-11/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.

5304	Trauma Center Standards
	Administrative Policy

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

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.

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 6 – Critical and Specialty Care Programs, for the requested level of designation.
3. Verification from the American College of Surgeons (ACS) (Level I, II, III and III-N Trauma Centers)
   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 receival of letter.
   b. Level IV trauma centers must remain in compliance with the current American College of Surgeons Standards.
4. A trauma center may be designated under a provisional status. If the trauma center fails to obtain ACS verification under the provisional status, hospital will revert back to previous level trauma center prior to the provisional designation.
5. Participation in the trauma data management system and commitment to provide additional data as required by REMSA and/or the Trauma Audit Committee.
6. Current written agreement with REMSA for designation as a Trauma Center to provide services in Riverside County.
7. Additional requirements for designation may be stipulated by the REMSA Medical Director.

Designation Renewal

1. The trauma center may be re-designated after satisfactory review of written documentation and a site survey by REMSA personnel/designees. 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.
2. The trauma center must remain compliant with all requirements listed in Title 22, Division 9, Chapter 6 – Critical and Specialty Care Programs.
3. 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: (Level I, II, III and III-N Trauma Centers)
      i. A full-time registered nurse who is designated by the hospital, committed to the trauma program, 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, II, III and III-N Trauma Centers)
      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 6 – Critical and Specialty Care Programs
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, II, III and III-N Trauma Centers) or must comply with the current ACS standards for Level IV trauma centers.
   b. The hospital shall have established protocols for triage and diagnosis following field notification of an inbound suspected trauma patients.
   c. The hospital shall have a single call activation system to activate the 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 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.
   h. Unless designated by the local emergency medical services agency, no health care facility shall advertise in any manner or otherwise hold itself out to be designated as a trauma center, pediatric trauma receiving center, or trauma receiving hospital.
2. Additional requirements for Level IV trauma centers:
   a. A written transfer agreement with a 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. Any changes to key Trauma Receiving Center personnel must be reported to REMSA by the following business day. Written notification of new personnel must be submitted to REMSA 10 (ten) business days to include:
   a. Trauma Program Medical Director
   b. Trauma Program Director/Program Manager

5305	Pediatric Trauma Center Standards
	Administrative Policy

Last Reviewed: **April 11, 2023**	Last Revised: **July 1, 2026**

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.

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 6.1 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 receival 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.
6. Additional requirements for designation may be stipulated by the REMSA Medical Director.

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 6.1 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 6.1
      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

5306	Pediatric Receiving Center Standards
Administrative Policy	

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

PURPOSE

To establish standards for the designation of an acute care hospital as a Pediatric Receiving Center (PedRC). These standards ensure that pediatric patients accessing the 9-1-1 system who meet defined pediatric triage criteria are transported to an appropriately designated Pediatric Receiving Center.

PEDIATRIC RECEIVING CENTER DEFINITIONS

Pediatric Receiving Center (PedRC)

A Pediatric Receiving Center is a licensed general acute care hospital (GACH) with, at minimum, a permit for standby, basic, or comprehensive emergency services, formally designated by the Local EMS Agency (LEMSA) as a Basic, General, Advanced, or Comprehensive Pediatric Receiving Center.

Pediatric Patient

A pediatric patient is defined as a person less than 15 years of age.

LEVELS OF PEDIATRIC RECEIVING CENTERS

Basic Pediatric Receiving Center

A GACH meeting the minimum requirements of this section may be designated by the LEMSA as a Basic Pediatric Receiving Center (Title 22, Chapter 6, Specialty Care Programs, Emergency Medical Care for Children).

General Pediatric Receiving Center

A GACH meeting the requirements of this section may be designated by the LEMSA as a General Pediatric Receiving Center.

Advanced Pediatric Receiving Center

A GACH meeting the requirements of this section may be designated by the LEMSA as an Advanced Pediatric Receiving Center.

Comprehensive Pediatric Receiving Center

A GACH meeting the minimum requirements of this section may be designated by the LEMSA as a Comprehensive Pediatric Receiving Center.

DESIGNATION BY REMSA AS A PEDIATRIC RECEIVING CENTER

Initial designation by the Riverside County EMS Agency (REMSA) as a Pediatric Receiving Center requires submission of an application, a site survey, and verification of the following:

1. Current participation in the EMS system as a Prehospital Receiving Center (PRC).
2. Compliance with all standards and requirements contained in this policy.
3. Compliance with all applicable requirements in Title 22, Division 9, Chapter 6, Subchapter 4 – Critical and Specialty Care Programs, for the level of designation requested.
4. Licensed PICU and NICU by the California Department of Public Health (CDPH) *(advanced and comprehensive only).*
   a. If license is pending, the hospital shall submit proof of certification to REMSA within 30 days of receipt.
   b. Continued designation requires ongoing certification; renewal documentation must be submitted to REMSA at least 30 days prior to expiration.
5. Enrollment and active participation in the REMSA data management system, including submission of additional data as required by REMSA and/or the Pediatric Advisory Committee (PAC).
6. A current written agreement with REMSA for designation as a Pediatric Receiving Center serving Riverside County.
7. Completion of a satisfactory application review, documentation review, and initial site survey conducted by REMSA personnel or designees.
8. Additional requirements for designation may be stipulated by the REMSA Medical Director.

Designation Renewal

1. Pediatric Receiving Centers may be re-designated following satisfactory review of required documentation and a site survey by REMSA personnel or designees.
2. Re-designation occurs every five (5) years. REMSA will conduct Pediatric Center audits every three (3) years.

HOSPITALS DESIGNATED BY REMSA AS PEDIATRIC RECEIVING CENTERS

Hospitals designated by REMSA as Pediatric Receiving Centers must:

1. Be a licensed general acute care hospital recognized by REMSA as a pre-hospital receiving center.
2. Comply with all requirements in California Code of Regulations, Title 22, Chapter 6, Subchapter 4, Article 2 – Critical and Specialty Care Programs.

Staffing Requirements

Pediatric Receiving Centers shall staff the following positions:

1. Pediatric Medical Director:
   a. A board-certified emergency medicine physician, or a qualified specialist in pediatrics or family medicine, with active emergency department privileges and demonstrated competency in resuscitation of pediatric patients from neonates through adolescents
2. Pediatric Emergency Care Coordinator (PECC):
   a. The PECC shall:
      i. Be a California-licensed registered nurse.
      ii. Have a minimum of two years of pediatric or emergency nursing experience within the previous five years.
      iii. Demonstrate competency in pediatric resuscitation across all age groups (neonates through adolescents).
      iv. Maintain current American Heart Association Pediatric Advanced Life Support (PALS) certification.
      v. Participate in ongoing pediatric-specific continuing education, including pediatric physiology.
      vi. Participate in pediatric performance improvement and patient safety activities.
      vii. PECCs within REMSA designated Base Hospitals should coordinate with the Prehospital Liaison Nurse (PLN) for EMS data, education, outreach, and quality improvement.

   Basic and General are only required to have one position and may utilize a qualified physician or nurse.

3. Pediatric Team: (Composition varies by level of designation; e.g., PECC = Medical Director + RN for Advanced/Comprehensive; single PECC, for Basic/General).
   a. The multidisciplinary pediatric team shall:
      i. Provide oversight of the emergency department pediatric quality improvement program.
      ii. Serve as liaison to hospital-based pediatric care committees.
      iii. Serve as liaison to other Pediatric Receiving Centers, the LEMSA, base hospitals, prehospital providers, and neighboring hospitals.
      iv. Facilitate pediatric emergency department continuing education and competency evaluation for ED staff.
      v. Coordinate pediatric disaster preparedness activities.
      vi. Ensure implementation of family-centered care practices.

Data Collection and Submission

PedRC/EMSC patient care data elements shall be selected by REMSA. Data elements are subject to change and appropriate notification will be given to designated facilities.

1. PedRCs must:
   a. Provide loop closure and outcome data to EMS providers for all transported pediatric patients via the REMSIS ePCR system.
   b. Submit data quarterly and within 90 days of discharge to REMSA for submission to the EMS Authority.

System participation

1. The Pediatric Emergency Care Coordinators (PECCs), Pediatric Medial Directors and other specified individuals as identified shall actively participate as members of the Pediatric advisory Committee and other related committees.

2. Maintain compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality, and a disclosure-protected review of selected pediatric cases.

Reporting Requirements

1. Pediatric receiving center shall notify REMSA in writing of any failure to meet these Pediatric Receiving Center Standards within ten (10) business days.
2. Changes to key Pediatric Receiving Center personnel shall be reported to REMSA within ten (10) business days to include:
   a. Pediatric Medical Director
   b. Pediatric Emergency Care Coordinator (PECC)
   c. Pediatric Team (if applicable)

Pediatric Receiving Center Designation Level Comparison Overview of Requirements:

Requirement Category	Basic PedRC	General PedRC	Advanced PedRC	Comprehensive PedRC
Licensed GACH	✓	✓	✓	✓
Emergency Services Permit (Standby/Basic/Comprehensive)	✓	✓	✓	✓
Pediatric Medical Director	Optional (MD or RN PECC)	Optional (MD or RN PECC)	**Required**	**Required**
Full time Pediatric Emergency Care Coordinator (PECC – RN)	Recommended	Recommended	**Required**	**Required**
Pediatric Team (Multidisciplinary)	Optional	Recommended	**Required**	**Required**
Pediatric Resuscitation Competency (All ED Staff)	✓	✓	✓	✓
Participation in REMSA Data System	✓	✓	✓	✓
Pediatric QI Program	✓	✓	✓	✓
Pediatric Disaster Preparedness	✓	✓	✓	✓
CDPH Licensed PICU & NICU	Not required	Not required	**Required**	**Required**
Meets Title 22, Ch. 6 Requirements	✓	✓	✓	✓

5401	STEMI Center Standards
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

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.

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 6 Article 2- 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.
8. Additional requirements for designation may be stipulated by the REMSA Medical Director.

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, GWTG, 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 Chapter 6, Article 2 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.
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 **OR** Primary Heart Attack Center (PHAC) certification level or higher from The Joint Commission (TJC).
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.

5402	Continuation of STEMI Care
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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.

5501	Tactical EMS Operations
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **December 27, 2023**

PURPOSE
To establish policies and procedures for all EMS personnel who participate in, and respond to, tactical EMS (TEMS) events in Riverside County.

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 through submission of the Tactical EMS Program Roster.

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.*

MEDICATIONS	BLS Par	ALS Par
Albuterol 2.5 mg with Atrovent 0.5 mg MDI		1
Aspirin chewable 81 mg tablets		1 bottle
Atropine Sulfate		1
Dextrose 50% 25 gm pre-filled syringe		1
Diphenhydramine 50 mg		2
Epinephrine 1:1,000 1 mg		2
Epinephrine 1:10,000 1 mg (*or equivalent*)		2
Glucagon 1 mg		1
Naloxone 2 mg pre-filled syringe		2
Nerve Agent Antidote (DuoDote)(*optional*)		1
Nitroglycerine 0.4 mg SL spray or tablets (*tablets to be discarded 90 days after opening*)		1
Normal Saline 500 mL		2
Normal Saline 10 mL prefilled syringe ("flush")		2
Ondansetron 4 mg IV / IM / ODT		4
Tranexamic Acid (TXA) 1 gm		1

CONTROLLED SUBSTANCES	BLS Par	ALS Par
Midazolam		20 mgs
Fentanyl		200 - 400 mcg
Ketamine		120 - 1000 mg

AIRWAY EQUIPMENT	BLS Par	ALS Par
Bag valve mask (BVM)	1	1
End tidal CO_2 (*device may be integrated into BVM*)		1
Endotracheal Tubes - 6.0 and/or 6.5, 7.0 and/or 7.5, and 8.0 and/or 8.5, with stylet		1 each
ET tube holder		1
Laryngoscope kit		1
Nasopharyngeal airways (NPA)	1 set	1 set
Needle thoracostomy kit		1
Suction (handheld)	1	1

MONITORING IV / NEEDLES / SYRINGES	BLS Par	ALS Par
AED (*optional)*	1	
Blood pressure cuff	1	1
ECG monitor		1
IO device and needles		1
IV catheters 14 / 16 / 18 / 20 gauge		1 each
IV start kit		1
IV tubing		1
Pulse oximeter (*optional*)		1
Saline Lock		2
Stethoscope	1	1
Syringes 3 cc / 5 cc / 10 cc		1 each

DRESSINGS / SPLINTS	BLS Par	ALS Par
Chest seal and flutter valve		1
CoTCCC - recommended tourniquet system	1	1
Elastic compression dressing	1	1
Latex free gloves	1	1
N95 mask	1	1
Occlusive dressing	1	1
Roller bandage	1	1
Splint - semi-ridged moldable	1	1
Sterile gauze pads	1	1
Tape	1	1
Trauma dressing	1	1
Trauma shears	1	1
Triangle bandage	1	1
Hemostatic impregnated gauze non-exothermic, i.e., Combat Gauze (*optional*)	2	2

MISCELLANEOUS EQUIPMENT	BLS Par	ALS Par
Litter	1	1
Personal protection equipment (PPE)	1	1
Triage tags	10	10
Tactical light	1	1
Eyewear	1	1
Rescue blanket	1	1
Self-heating blanket (*optional*)	1	1

5601	Nerve Agent Antidote Kit (NAAK) Training
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **October 23, 2024**

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.

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 First Aid Personnel (PSFA), 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 PSFA, 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:

- The PSFA may not administer the NAAK or AtroPen® to patients unless approved through REMSA Policy #1104.
- 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.
- The EMT-P may administer Atropine and Pralidoxime (2-PAM) Chloride so long as it is 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).

5602	Basic Life Support Trailer Deployment
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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

5603	CHEMPACK Deployment
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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 the with 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-present 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 A1 - EMS CHEMPACK Container Inventory - 454 Patient Capacity				
ITEMS	**Unit Pack**	**Cases**	**QTY**	**COLOR**
Mark 1 auto-injector	240	5	1200	**YELLOW**
Atropine Sulfate 0.4mg/mL 20mL	100	1	100	**BLUE**
Pralidoxime 1gm inj 20mL	276	1	276	**RED**
AtroPen® 0.5 mg	144	1	144	**PURPLE**
AtroPen® 1.0 mg	144	1	144	**GRAY**
Diazepam 5mg/mL auto-injector	150	2	300	**GREEN**
Diazepam 5mg/mL vial, 10mL	25	2	50	**ORANGE**
Sterile water for injection (SWFI) 20mL	100	2	200	**WHITE**
Sensaphone® 2050	1	1	1	
Satco C DEA Container	1	1	1	

TABLE A2 - Hospital CHEMPACK Container Inventory – 1000 Patient Capacity				
ITEMS	**Unit Pack**	**Cases**	**QTY**	**COLOR**
Mark 1 auto-injector	240	2	480	**YELLOW**
Atropine Sulfate 0.4mg/mL 20mL	100	9	900	**BLUE**
Pralidoxime 1 gm inj 20 mL	276	10	2760	**RED**
AtroPen® 0.5 mg	144	1	144	**PURPLE**
AtroPen® 1.0 mg	144	1	144	**GRAY**
Diazepam 5 mg/mL auto-injector	150	1	150	**GREEN**
Diazepam 5 mg/mL vial, 10 mL	25	26	650	**ORANGE**
Sterile water for injection (SWFI) 20 mL	100	28	2800	**WHITE**
Sensaphone® 2050	1	1	1	
Satco C DEA Container	1	1	1	

Tables B, C, & D: EMS CHEMPACK CONTAINER BREAKDOWN SCHEDULES

TABLE B - EMS CHEMPACK Container Breakdown Schedule - 450 Patients			
ITEMS	**UNIT QTY**	**CASES TO ISSUE**	**COLOR**
Mark 1 auto-injector	1200	5	**YELLOW**
Atropine Sulfate 0.4mg/mL 20mL	100	1	**BLUE**
Pralidoxime 1 gm inj 20 mL	276	1	**RED**
AtroPen® 0.5 mg	144	1	**PURPLE**
AtroPen® 1.0 mg	144	1	**GRAY**
Diazepam 5 mg/mL auto-injector	300	2	**GREEN**
Diazepam 5 mg/mL vial, 10 mL	50	2	**ORANGE**
Sterile water for injection (SWFI) 20 mL	200	2	**WHITE**

TABLE C - EMS CHEMPACK Container Breakdown Schedule - 250 Patients			
ITEMS	**UNIT QTY**	**CASES TO ISSUE**	**COLOR**
Mark 1 auto-injector	720	3	**YELLOW**
Atropine Sulfate 0.4mg/mL 20mL	100	1	**BLUE**
Pralidoxime 1 gm inj 20 mL	276	1	**RED**
AtroPen® 0.5 mg	144	1	**PURPLE**
AtroPen® 1.0 mg	144	1	**GRAY**
Diazepam 5 mg/mL auto-injector	150	1	**GREEN**
Diazepam 5 mg/mL vial, 10 mL	25	1	**ORANGE**
Sterile water for injection (SWFI) 20 mL	100	1	**WHITE**

TABLE D - EMS CHEMPACK Container Breakdown Schedule - 125 Patients			
ITEMS	**UNIT QTY**	**CASES TO ISSUE**	**COLOR**
Mark 1 auto-injector	480	2	**YELLOW**
Atropine Sulfate 0.4mg/mL 20mL	100	1	**BLUE**
Pralidoxime 1 gm inj 20 mL	276	1	**RED**
AtroPen® 0.5 mg	144	1	**PURPLE**
AtroPen® 1.0 mg	144	1	**GRAY**
Diazepam 5 mg/mL auto-injector	150	1	**GREEN**
Diazepam 5 mg/mL vial, 10 mL	25	1	**ORANGE**
Sterile water for injection (SWFI) 20 mL	100	1	**WHITE**

Tables E, F, & G: HOSPITAL CHEMPACK CONTAINER BREAKDOWN SCHEDULES

TABLE E - Hospital CHEMPACK Container Breakdown Schedule – 500 Patients			
ITEMS	**QTY**	**CASES TO ISSUE**	**COLOR**
Mark 1 auto-injector	240	1	**YELLOW**
Atropine Sulfate 0.4mg/mL 20mL	500	5	**BLUE**
Pralidoxime 1 gm inj 20 mL	1380	5	**RED**
AtroPen® 0.5 mg	144	1	**PURPLE**
AtroPen® 1.0 mg	144	1	**GRAY**
Diazepam 5 mg/mL auto-injector	150	1	**GREEN**
Diazepam 5 mg/mL vial, 10 mL	375	15	**ORANGE**
Sterile water for injection (SWFI) 20 mL	1400	14	**WHITE**

TABLE F - Hospital CHEMPACK Container Breakdown Schedule – 250 Patients			
ITEMS	**QTY**	**CASES TO ISSUE**	**COLOR**
Mark 1 auto-injector	480	2	**YELLOW**
Atropine Sulfate 0.4mg/mL 20mL	300	3	**BLUE**
Pralidoxime 1 gm inj 20 mL	828	3	**RED**
AtroPen® 0.5 mg	144	1	**PURPLE**
AtroPen® 1.0 mg	144	1	**GRAY**
Diazepam 5 mg/mL auto-injector	150	1	**GREEN**
Diazepam 5 mg/mL vial, 10 mL	175	7	**ORANGE**
Sterile water for injection (SWFI) 20 mL	700	7	**WHITE**

TABLE G - Hospital CHEMPACK Container Breakdown Schedule – 125 Patients			
ITEMS	**QTY**	**CASES TO ISSUE**	**COLOR**
Mark 1 auto-injector	480	2	**YELLOW**
Atropine Sulfate 0.4mg/mL 20mL	300	3	**BLUE**
Pralidoxime 1 gm inj 20 mL	828	3	**RED**
AtroPen® 0.5 mg	144	1	**PURPLE**
AtroPen® 1.0 mg	144	1	**GRAY**
Diazepam 5 mg/mL auto-injector	150	1	**GREEN**
Diazepam 5 mg/mL vial, 10 mL	175	7	**ORANGE**
Sterile water for injection (SWFI) 20 mL	700	7	**WHITE**

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 H - Hospital CHEMPACK Recommended Ancillary Supplies				
ITEM	**UNIT OF ISSUE**	**HOSPITAL QTY**	**DOPH/PHEPR***	**HOST SITE****
NAR Saline Lock Kit Kit Includes: -adult IV catheter 18 ga x 1.25” -10 cc luer-lock syringe -18 ga x 1.5” needle -locking saline plug -constricting band -securing device -cleaning/ dressing supplies	200/case	5 cases	2 cases	3 cases
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

ITEM	**1000 PATIENTS** (up to 25% peds)	**500 PATIENTS** (up to 25% peds)	**250 PATIENTS** (up to 25% peds)	**125 PATIENTS** (up to 25% peds)	**60 PATIENTS** (up to 25% peds)
NAR Kits	5 cases	3 cases	2 cases	1 case	½ case
Saline mini bag	28 cases	14 cases	7 cases	4 cases	2 cases
Peds IV Catheter	5 cases	3 cases	2 cases	1 case	1 case
IV Administration Set	20 cases	10 cases	5 cases	3 cases	2 cases

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

Hospital monitors situation and sends status reports to PHEPR via normal communication channels at appropriate intervals

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.

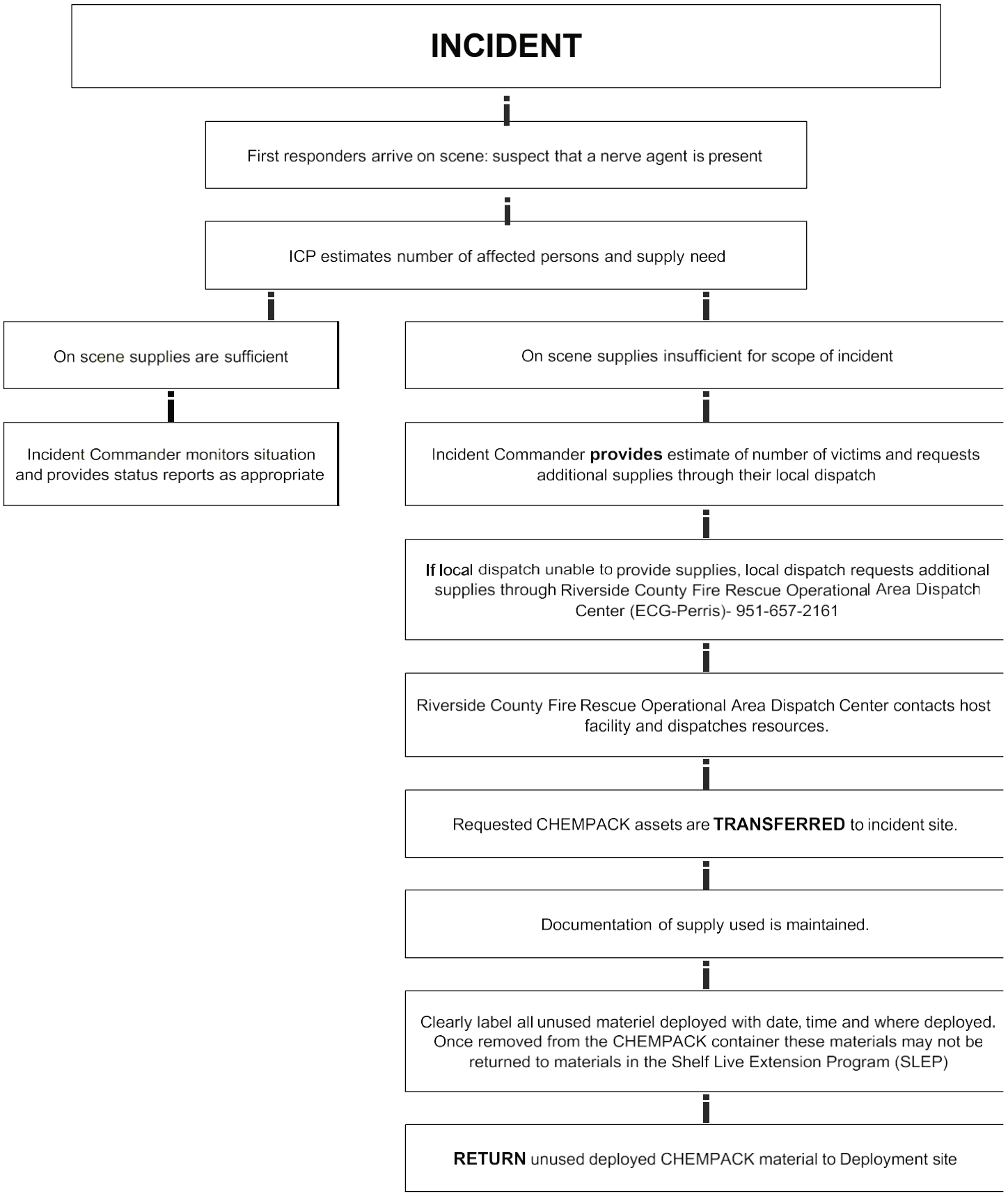
Non-impacted storage facilities **PREPARE** CHEMPACK for access and transport of selected items to requesting hospital/s (standby)

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 DES who will notify; State Warning Center & State Emergency Operations Center

FIELD CHEMPACK DEPLOYMENT ALGORITHM



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

The following controlled Substances have been removed from_____
for delivery to _____

Hospital- Diazepam 5mg/ml 10 ml vials (25 per box) Number of Boxes_____
EMS- Diazepam 5mg/ml auto-injector (150 per box) Number of Boxes_____

Name & Shield Number of courier _____ Signature _____
Date _____ Time_____

PART B- Delivery of Diazepam to Location #1

The following controlled Substances have been removed from_____
for delivery to _____

Hospital- Diazepam 5mg/ml 10 ml vials (25 per box) Number of Boxes_____
EMS- Diazepam 5mg/ml auto-injector (150 per box) Number of Boxes_____

Name & Shield Number of courier _____ Signature _____
Date _____ Time_____

PART C- Delivery of Diazepam to Location #2

The following controlled Substances have been removed from_____
for delivery to _____

Hospital- Diazepam 5mg/ml 10 ml vials (25 per box) Number of Boxes_____
EMS- Diazepam 5mg/ml auto-injector (150 per box) Number of Boxes_____

Name & Shield Number of courier _____ Signature _____
Date _____ Time_____

PART D- Delivery of Diazepam to Location #3

The following controlled Substances have been removed from_____
for delivery to _____

Hospital- Diazepam 5mg/ml 10 ml vials (25 per box) Number of Boxes_____
EMS- Diazepam 5mg/ml auto-injector (150 per box) Number of Boxes_____

Name & Shield Number of courier _____ Signature _____
Date _____ Time_____

CALIFORNIA DEPARTMENT OF HEALTH SERVICES

CHEMPACK TRACKING

RELEASE AND RECEIPT OF MATERIEL

CHEMPACK LOCATION: **CHEMPACK ID NUMBER:** **Release Date:**	**Unit Total**	**Cases Total**
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:

5701	Stroke Center Standards
	Administrative Policy

Last Reviewed: **May 4, 2023**	Last Revised: **July 1, 2026**

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.

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 6, Article 3- 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.
7. Additional requirements for designation may be stipulated by the REMSA Medical Director.

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.
      ii. 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 stoke 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

5702	Continuation of Stroke Care
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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.

5801	Prehospital Ultrasound (POCUS)
Treatment Policy LOSOP	

Last Reviewed: **May 16, 2024**	Last Revised: **January 16, 2025**

PURPOSE

Paramedics approved by REMSA may, while on duty with a participating provider agency, use agency provided portable ultrasound devices as an additional means of patient assessment. Ultrasound exams will be focused and limited to identification of findings of concern (FOC) as specified.

General Considerations

1. FOCs are specific ultrasonographic findings that give rise to suspicion for an active pathologic process warranting further assessment and evaluation.
2. FOCs indicate suspicion of a condition, not confirmation, unless verified by a physician on review of the exam images and/or patient evaluation.
   - Paramedics may make use of ultrasound FOC to improve resuscitative efforts and as a means of verifying absent cardiac activity when terminating resuscitation in the field.
   - Paramedics should communicate FOC to patients and the receiving emergency department to facilitate FOC verification and ongoing care.
   - Patients will be informed that if an exam does not reveal a FOC that the paramedic is unable to exclude underlying illness or injury.
   - Required reporting and documentation shall be completed for all ultrasound exams performed or attempted.
3. Perform primary and secondary assessments as clinically indicated.
   - If patient meets specialty destination criteria for STEMI care, proceed with treatment(s) and transport in accordance with REMSA Policy 4401 (*Suspected Acute Coronary Syndrome*).
   - If patient meets specialty destination criteria for stroke care, proceed with treatment(s) and transport in accordance with REMSA Policy 4502 (*Suspected Stroke*).
   - If patient meets specialty destination criteria for trauma care, proceed with treatment(s) and transport in accordance with REMSA Policy 5301 (*Trauma Triage Indicators and Destination*).
4. **Do not delay transport while attempting to complete an ultrasound; it may be performed during transit.**
5. For patients meeting indications for exams as follows, inform patient of intended use of ultrasound as an additional assessment tool. Paramedics must explain that the exam will evaluate for FOC and that the exam will not be used to confirm the absence of a medical condition.
6. The only REMSA approved POCUS device is the Butterfly IQ (https://www.butterflynetwork.com/education)

Inclusion Criteria

1. **Cardiac: Adult** and **Pediatric** patients in cardiac arrest
   - Adjunct assessment for cardiac activity during scheduled pulse checks
   - Use as adjunct in termination of resuscitation is limited to **adult patients only**
2. **Abdominal Right Upper Quadrant:** Adult (15 yrs or greater) blunt or penetrating trauma to chest and/or abdomen
   - Adjunct for detection of intra-abdominal bleeding
3. **Pulmonary:** Adult (15 yrs or greater) Presentation concerning for tension pneumothorax
   - Absent or decreased breath sounds **AND**
   - Signs of hemodynamic compromise (shock)

Refusal of Treatment and Transport

Ultrasound may be used as an adjunct tool for assessment in patients refusing treatment and transport to evaluate for FOC.

- A release of liability, or refusal of treatment, is not required when patients refuse an ultrasound exam.
- Base hospital personnel may not order an ultrasound exam as a required element of evaluation prior to supporting a patient's request to refuse treatment and/or transport.

Use of REMSA Policy 4107 (*Refusal of Treatment and/or Transport*) will not be affected by patient's who refuse an ultrasound exam.

Base Hospital

- Base Hospitals may consider reported ultrasound findings for decision making in consultation with the Base Hospital Physician. For transported patients, visual presentation of acquired images to receiving emergency department physician upon arrival is strongly encouraged. This shall be documented in the patient care record.
- MICNs/Base Hospital Physicians may confirm if paramedic is trained and equipped with ultrasound. If confirmed, they may request use of ultrasound under this policy.
- MICN will document paramedic ultrasound status of EMS crew and if ultrasound was or was not attempted if indicated.

Documentation/CQI

- All use of paramedic ultrasound will be recorded in the Actions Panel of the patient care record.
- EMS crews shall record the performing paramedic, patient complaint, exam type and findings for QI review.
- The EMS Coordinator for participating agencies shall utilize REMSIS ImageTrend and review 100% of cases and participate with quarterly scheduled case review sessions.
- CQI of Ultrasound usage must be included in the agency CQI plan.
- All scans must be loaded to the Butterfly Cloud and labeled appropriately for QI review
- Participating agencies shall log all ultrasound use cases and maintain internal records for individual performing paramedics along with the type of exam, exam FOC identified and whether these were validated on physician review.
- Logs shall be provided to REMSA upon request and as scheduled in coordination with REMSA.

5802	Community Assessment and Transport Team (CATT) Pilot Program
Administrative Policy	

Last Reviewed: **October 6, 2021**	Last Revised: **July 1, 2025**

PURPOSE
To establish a program to refer individuals who are experiencing a crisis to approved destinations and resources through the use of a Community Assessment and Transport Team (CATT).

Initial Requirements

Personnel

1. Emergency Medical Technicians: will meet all training, license, and certification requirements per REMSA policy.
2. Behavioral Health Specialist or Clinical Therapist: will meet all training, license, and certification requirements per Riverside University Health System – Behavioral Health (RUHS – BH) policy.
3. All CATT personnel will receive at least eighty (80) hours of training on:
   a. EMS Specific Curriculum
      i. CPR, AED, naloxone administration, basic first aid and bleeding control
   b. Crisis intervention curriculum:
      i. De-escalation techniques, crisis health assessments, community resources and client navigation
   c. All other training as required by RUHS - BH and/or REMSA.

Vehicles

All vehicles will be agreed upon by REMSA and Ambulance Contractor prior to use in this program. These vehicles will conform to the highest standards for crash safety ratings and passenger safety systems. An interior partition or barrier will be installed in the vehicle to provide separation between the driver and passenger compartments for vehicle occupant safety. All vehicle exterior colors, lettering, graphics, and markings will be approved by REMSA.

Equipment

Vehicles utilized by CATT personnel will be considered **Light Response** for the purposes of determining the appropriate standard equipment and minimum quantities that must be carried. Refer to REMSA policy #3303 (Drug and Equipment List).

Additional equipment for CATT personnel will include naloxone, a glucometer, and a pulse oximeter.

Continuous Requirements

In addition to the maintenance of personnel, vehicle and equipment criteria listed above, Contractor will ensure the following criteria are also continuously met:

Documentation

A REMSA electronic patient care report (ePCR) will be completed for every incident as outlined in REMSA Policy #7701 (Patient Care Records).

CQI

1. Provide targeted continuing education activities to further the knowledge base of the field personnel who provide care as part of this program.
2. Develop criteria for evaluation of field personnel who provide care as part of this program, to include, but not be limited to:
   a. Timely audits for 100% of ePCRs for CATT unit.
   b. Direct observation, as needed.
   c. Routine quarterly and annual performance evaluations.
   d. Design of corrective action plans for individual deficiencies.

3. Develop a process for identifying trends in the quality of field care by:
    a. Submitting reports as specified by REMSA
    b. Designing and participating in educational offerings based on problem identification and trend analysis.
    c. Making approved changes in internal policies and procedures to comply with REMSA policies.
    d. Track and report all requests for and utilization of CATT unit

Procedure for Requesting CATT Unit Response

For an individual in crisis, law enforcement or EMS personnel on scene will determine, if the individual would benefit from a response by CATT team and will contact Ambulance Contractor Dispatch Center directly to request CATT unit response. Ambulance Contractor will manage all requests for, and aspects of, CATT unit deployment. CATT Unit Response Time should be less than thirty (30) minutes from the time the available unit is notified by dispatch (eTimes.03) to the time the unit arrives on scene (eTimes.06). Exceptions on the time requirement are made due to circumstances limiting availability of the CATT unit (e.g., already deployed on another call, after hours request, or remote location).

Before placing an individual on a WIC 5150 or 5585 hold, attempts should be made by law enforcement to request a CATT unit response.

Procedures for CATT Personnel

Change in patient condition or recognition of a life-threatening illness or injury

An ALS Ambulance will be requested immediately if at any time during the patient encounter, a life-threatening illness or injury is recognized or if there is a change in patient condition.

For respiratory depression or respiratory arrest with suspected narcotic overdose, an ALS ambulance shall be requested immediately, and CATT personnel shall administer naloxone according to the treatment algorithm below:

Adults: Naloxone 1 mg IN ONLY. MAY REPEAT PRN. TITRATE TO IMPROVEMENT OF RESPIRATORY DEPRESSION, NOT RESOLUTION OF AMS.

All other patients

1. On arrival at the scene, a crisis assessment and health screening will be performed by CATT personnel. This screening will include, but not be limited to:
    a. A crisis assessment and triage by a licensed clinician
    b. A review of the individual's past medical history, allergies, and current medications
    c. Obtaining baseline vital signs to include, but not be limited to heart rate, respiratory rate, blood pressure, SpO2 level, blood glucose and pain severity level.
2. Based on assessment findings, a determination will be made if the individual is appropriate for transport or referral by CATT unit.

Individuals That May Be Appropriate for Transport by CATT Unit

The following individuals may be eligible for transport by CATT unit if they meet all (ALL) criteria listed below:

1. Have current capacity to make medical decisions or with written parental consent if patient is a minor
2. Are cooperative, compliant, not requiring restraints, and able to ambulate without assistance
3. Are negative for any signs/symptoms of life-threatening illness or injury

Approved Destinations

As determined by the results of the crisis assessment and health screening, an appropriate destination will be chosen by the Clinical Therapist based on bed availability, patient coverage and patient preferences if any. If the individual has no preference, the destination will be the closest appropriate facility. All destinations must be approved by Riverside County Mental Health Crisis Services and Riverside County EMS Agency. Examples of possible destinations include, but are not limited to, Crisis Residential Treatment Facilities, emergency departments, Mental Health Urgent Care Centers (MHUC), Psychiatric Emergency Services, shelters, sobering centers, and Veteran Affairs.

5803	Healthcare Accessibility Resource Team (HART) Program
Administrative Policy	

Last Reviewed: **June 18, 2024**	Last Revised: **June 18, 2024**

PURPOSE

This policy establishes the Healthcare Accessibility Resource Team Program (HART), a collaborative model which pairs Emergency Medical Technicians (EMTs) with Community Health Workers (CHWs), to deliver comprehensive follow-up and community health services across Riverside County. This team can provide EMS patients with post-discharge care to support high-frequency EMS system utilizers and aims to reduce hospital readmission rates and re-entry into the 911 system, thereby improving efficiency and patient outcomes across the healthcare system.

Personnel and Training Requirements

1. **Emergency Medical Technicians (EMTs):** Continue to meet all existing training, license, and certification requirements per Riverside County EMS Agency (REMSA) policies.
2. **Community Health Workers (CHWs):** Continue to meet all existing training, license, and certification requirements as required by Riverside University Health System Public Health (RUHS-PH) policies.
3. **Cooperative Training for EMTs and CHWs with HART may include:**
    - Understanding of local health resources and referral systems.
    - Collaborative patient care approaches.
    - Skills in patient engagement and communication.
    - Data sharing and privacy compliance.

Operational Requirements

- **Staffing Model**: Each team will consist of one EMT and one CHW.
- **Data sharing:** Case lists for follow-up purposes will be compiled from individuals encountering the 911 system and sent to the teams securely.
- **Supervision**: A designated HART program supervisor to oversee the EMT, clinical operations, ensure adherence to patient care protocols, and continuous quality improvement.
- **Equipment and Resources**: Utilize vehicles equipped with necessary medical and educational materials to facilitate on-site patient education and health interventions.

Patient Care Guidelines

- **Follow-Up Care Guidelines**: Develop specific guidelines for follow-up visits, which include assessment of recovery progress, medication adherence, and identification of any new or ongoing health needs.
- **Data Reporting**: Implement a system for recording and sharing patient care data between EMTs, CHWs, and other healthcare care providers, respecting patient privacy and HIPAA data security standards.

Quality Improvement

- **Performance Metrics:** Regular evaluations of the HART program's impact on reducing hospital readmissions, improving patient satisfaction, and enhancing overall community health metrics.
- **Community Feedback**: Incorporate feedback mechanisms for patients and community stakeholders to continuously adapt the program to meet community needs better.

Integration with Existing Services

- **911 and Emergency Services**: Ensure that the HART program will notify and integrate with the 9-1-1 system, should the patient require an ambulance and/or higher level of medical care.
- **Partnerships with Healthcare Facilities:** Forge relationships with hospitals, clinics, and other healthcare entities to create a seamless continuum of care for patients transitioning between different care settings.

6101	Prehospital Receiving Centers
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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 HAvBED 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.

6102	Hospital Emergency Services Reduction Impact Assessment
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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.

6103	Ambulance Diversion
Administrative Policy	

Last Reviewed: **November 30, 2022**	Last Revised: **July 1, 2024**

PURPOSE
To describe the criteria and processes for the diversion of ground and air ambulances in Riverside County.

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) and/or the applicable user guide (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).

6104	APOD Ambulance Redirection
	Administrative Policy

Last Reviewed: **November 30, 2022**	Last Revised: **December 1, 2023**

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.

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”

Cancelation 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.”

6201	Base Hospital Designation and Criteria
Administrative Policy	

Last Reviewed: **May 16, 2024**	Last Revised: **July 1, 2026**

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.

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. The 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 system updates related to 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. The Base Hospital shall provide evidence of compliance with all criteria in this policy. A site visit may be performed at the discretion of REMSA.

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, Emergency Department Nursing Director, Disaster Coordinator, or the Prehospital Liaison Nurse (PLN). It is the responsibility of the PLN to provide this notification. In the event the PLN is unable to, the Base Hospital Medical Director or the Emergency Department Nursing Director will notify REMSA of the changes.

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 (CE) Provider and 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 ReddiNet, 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. 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. 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.
9. Comply with REMSA Ambulance Diversion policy as set forth in the current REMSA policy manual.

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.
   e. Attend at least two (2) of Riverside County's Prehospital Medical Advisory Committee (PMAC) meetings per year; one (1) of which will include the meeting held during the third quarter of the year. If unable to attend a meeting, they are responsible for having a replacement base hospital physician to represent their agency.
   f. In the event the Base Hospital Medical Director steps down from this role, a new Base hospital Medical Director meeting criteria 1a-d must be identified within ten (10) business days of the change.

2. The Base Hospital Medical Director or 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 as needed.
   b. Establish a continuous quality improvement (CQI) program that complies with the requirements of California Title 22, Division 9, Chapter 10, 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, in collaboration with other involved agencies or organizations.
   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 an orientation to the Riverside County EMS system, including a protocol test.
   i. Provide annual policy updates to Base Hospital physicians to ensure understanding of new and updated EMS policies being implemented during the policy update period.
   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 Base Hospital Medical Director prior to being assigned responsibility for providing base hospital orders and medical direction.
   b. Attend at least 50% of internal Base Hospital Emergency Department meetings where minutes and attendance are taken and REMSA topics are presented and discussed. PMAC meetings are considered as attendance if attending for the Base Hospital Medical Director.
   c. Annually attend policy updates, during the policy update cycle, by the PLN or the Base Hospital Medical Director to review changes in REMSA policies, protocols, and procedures to ensure understanding of new and updated EMS policies being implemented.
   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. The PLN cannot perform the roles of a coordinator for any of the specialty care programs, either in a full-time or interim capacity.

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 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. If 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 must be notified of changes in PLN staffing within ten (10) business 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. 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.

h. Monitor protocol compliance by field personnel and report deviations from REMSA protocols to the appropriate prehospital provider agency(s) and REMSA.
i. 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.
j. 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.
k. 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 and issues identified through the CQI process.
    c. Performance evaluations once per MICN reauthorization cycle.
    d. Other appropriate documentation.
l. Coordinate with prehospital care providers for presenting reviews/field care audits/Base Hospital meetings a minimum of two times per year per Base Hospital. Review all information/data to be presented at BH meetings prior to meeting for appropriateness and within the scope of the paramedics.
m. Ensure dedicated MICN staffing 24/7, 365 days per year and report to REMSA when dedicated MICN staffing is unavailable.

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 assigned as the dedicated MICN, a position which will have primary responsibility, without any other patient care assignment, for providing Base Hospital Orders to prehospital personnel. Additional MICN staffing is necessary to provide back up to the dedicated MICN. The PLN should not be used as the dedicated MICN for the shift.
3. MICN shall meet the criteria in REMSA Policy 1209 *MICN Authorization* and/or REMSA Policy 1210 *MICN Reauthorization*.
4. MICN shall attend at least one (1) base hospital meeting annually offered at their sponsored base station.

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. Provide necessary Emergency Preparedness and base hospital equipment to the Emergency Department as specified by REMSA. Have and agree to utilize County Public Safety Enterprise Communication (PSEC) system, as specified by REMSA, to ensure the capability of direct two-way voice communication for online medical direction.

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 REMSIS MICN Base Hospital contact record for every prehospital contact into the base. This record will utilize documentation software, as specified by REMSA. Retain the original record as required by applicable state and federal laws. The Base Hospital will make available any of the records when a CQI request is made by prehospital providers and/or REMSA.

a. In the event downtime procedures are utilized, all non-electronic documentation must be retained in accordance to state and federal laws. The Base Hospital will make available any of the records when a CQI request is made by prehospital providers and/or REMSA.

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, EMS Surge/Multi Casualty Incident (MCI) 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. Annually review/archive the list of physicians authorized to provide Base Hospital orders to prehospital personnel who have been oriented to EMS policies; the date(s) of such orientation compared to date of hire and date of annual policy update.
5. Actively participate in REMSA's data system.

Hospital Policies / Agreements

1. Have a written agreement, which is reviewed every three (3) years, with the LEMSA indicating the concurrence of hospital administration, medical staff, and emergency department staff to meet the requirements for program participation as specified in Title 22, Paramedic Base Hospital, and REMSA policies and procedures.
2. The Base Hospital shall have a continuous quality improvement (CQI) plan, which assists REMSA with monitoring of EMS operations. CQI plans will be reviewed internally on an annual basis and submitted annual on December 1 with any updates. Fully reviewed and updated CQI plans will be submitted every three (3) years in alignment with their audit year and approved by REMSA. Tri-annual updates 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

6202	EMS Fellow On Scene
Administrative Policy	

Last Reviewed: **November 30, 2022**	Last Revised: **July 1, 2026**

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.)

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/a EMS Surge/MCI, REMSA Policy 3305 *EMS Surge/Multiple Casualty Incident (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.

6203E	Special Event Designated Base Hospital - EAST
Provisional Policy	

Last Reviewed: **January 1, 2025**	Last Revised: **July 1, 2026**

PURPOSE

The purpose of this provisional policy is to identify the Riverside County EMS Agency (REMSA) designated base hospital that will be responsible for determining the destinations for patients originating from the identified events (below).

EVENT

Coachella Valley Music & Arts Festival 81-800 Avenue 51, Indio, CA 92201	**April 9, 2026 @ 0900 – April 13, 2026 @ 1200**
Coachella Valley Music & Arts Festival 81-800 Avenue 51, Indio, CA 92201	**April 16, 2026 @ 0900 – April 20, 2026 @ 1200**
Stagecoach Festival 81-800 Avenue 51, Indio, CA 92201	**April 23, 2026 @ 1200 – April 27, 2026 @1200**
Head Trip 81-800 Avenue 51, Indio, CA 92201	**October 9, 2026 @ 1200 – October 12, 2026 @ 1200**

OBLIGATION OF THE DESIGNATED BASE HOSPITAL

Desert Regional Medical Center (DRMC) will function as the designated base hospital for the events named in this provisional policy, with all on-line medical direction and patient destination assignments coordinated by their Mobile Intensive Care Nurse (MICN) personnel.

1. DRMC will designate and dedicate, at a minimum, one (1) REMSA-authorized MICN to answer calls originating from the events listed in this policy for the duration of each event.
2. DRMC will use the MCI module in the ReddiNet to coordinate and track all patient destination assignments.

In the event that DRMC is unable to meet their obligations as the designated base hospital for any reason, REMSA may assign the above functions to a different Riverside County Base Hospital.

OBLIGATIONS OF PREHOSPITAL PROVIDERS

1. The transporting paramedic will, prior to leaving the event site, contact DRMC to receive a destination assignment.
   a. During true MCI events, the task of contacting DRMC will be delegated to MEDCOM (REMSA Policy 3305 *EMS Surge/MCI)*.
   b. During true MCI events, transport ambulances shall notify the receiving hospital as soon as possible with full patient report (REMSA Policy 3305 *EMS Surge/MCI)*.
2. On arrival at the assigned destination, the transporting paramedic will advise the receiving hospital staff that the patient(s) originated from one of the events listed above.

OBLIGATIONS OF RECEIVING HOSPITALS

1. The designated landing zone (LZ) for helicopter operations will be the helipad located on the campus of John F. Kennedy Memorial Hospital.
   a. Should air transport be clinically indicated, DRMC will be contacted first to determine the appropriate patient destination.
2. All Riverside County receiving hospitals will use and monitor the MCI module in the ReddiNet to track patients being transported from the above events to their facilities.
   a. Hospitals will log patients in the ReddiNet and enter all pertinent patient data.

POLICY TERMINATION

The effective and expiration dates for this policy will align with the dates of the events listed above.

6203W	Special Event Designated Base Hospital - WEST
Provisional Policy	

Last Reviewed: **January 1, 2025**	Last Revised: **April 24, 2025**

PURPOSE

The purpose of this provisional policy is to identify the Riverside County EMS Agency (REMSA) designated base hospital that will be responsible for determining the destinations for patients originating from the identified events (below).

EVENT

Southern California Air Show @ March ARB 14560 2nd Street, Moreno Valley CA, 92518	**April 12, 2025 @ 0700 – April 14, 2025 @ 0700**
Starbase Festival 17801 Lake Perris Drive, Perris CA, 92571	**April 24, 2025 @1700 – April 27 @1900**
Temecula Balloon and Wine Festival 37701 Warren Rd, Winchester, CA 92596	**June 20, 2025 @ 0700 – June 23, 2025 @ 0700**

OBLIGATION OF THE DESIGNATED BASE HOSPITAL

Riverside University Health System – Medical Center (RUHS) will function as the designated base hospital for the events named in this provisional policy, with all on-line medical direction and patient destination assignments coordinated by their Mobile Intensive Care Nurse (MICN) personnel.

1. RUHS will designate and dedicate, at a minimum, one (1) REMSA-authorized MICN to answer calls originating from the events listed in this policy for the duration of each event.
2. RUHS will use the MCI module in the ReddiNet to coordinate and track all patient destination assignments.

In the event that RUHS is unable to meet their obligations as the designated base hospital for any reason, REMSA may assign the above functions to a different Riverside County base hospital.

OBLIGATIONS OF PREHOSPITAL PROVIDERS

1. The transporting paramedic will, prior to leaving the event site, contact RUHS to receive a destination assignment.
   a. During true MCI events, the task of contacting RUHS will be delegated to MEDCOM (REMSA Policy 3305 *EMS Surge/MCI)*.
   b. During true MCI events, transport ambulances shall notify the receiving hospital as soon as possible with full patient report (REMSA Policy 3305 *EMS Surge/MCI)*.
2. On arrival at the assigned destination, the transporting paramedic will advise the receiving hospital staff that the patient(s) originated from one of the events listed above.

OBLIGATIONS OF RECEIVING HOSPITALS

1. All Riverside County receiving hospitals will use and monitor the MCI module in the ReddiNet to track patients being transported from the above events to their facilities.
   a. Hospitals will log patients in the ReddiNet and enter all pertinent patient data.

POLICY TERMINATION

The effective and expiration dates for this policy will align with the dates of the events listed above.

6301	Specialty Care Center Designation
	Administrative Policy

Last Reviewed: **July 1, 2026**	Last Revised: **July 1, 2026**

PURPOSE

To establish standards for the designation, re-designation, and de-designation, of specialty care centers (Trauma, STEMI, Stroke, and Pediatric Receiving Center) in Riverside County. Additional requirements may be stipulated by the REMSA Medical Director.

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 REMSA Policy 5304 *Trauma Center Standards* for more information regarding designation requirements.

- Applicants requesting consideration to be designated as a Pediatric receiving center in Riverside County must refer to REMSA Policy 5306 *Pediatric Receiving 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 REMSA 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 REMSA Policy 5701 *Stroke Center Standards* for more information regarding designation requirements.

REMSA approved accreditation/certification/verifying entities:

STEMI	Stroke	Trauma
American College of Cardiology (ACC) **OR** Primary Heart Attack Center (PHAC)	Joint Commission (TJC) **OR** Det Norske Veritas (DNV) **OR** Accreditation Commission for Healthcare (ACHC)	American College of Surgeons (ACS) *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) with verifying entities
- 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, Chapter 6 for the specific requested program, and the standards and requirements listed in all applicable REMSA policies (5304, 5306, 5401, and/or 5701)
2. Successfully pass an audit performed by REMSA
3. Achieve re-accreditation/recertification/reverification by one (1) of the verifying entities (as applicable):

STEMI	Stroke	Trauma
American College of Cardiology (ACC) **OR** Primary Heart Attack Center (PHAC)	Joint Commission (TJC) **OR** Det Norske Veritas (DNV) **OR** Accreditation Commission for Healthcare (ACHC)	American College of Surgeons (ACS) *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, Chapter 6
2. Failed to comply with current REMSA policy as outlined in policies 5304, 5306, 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, data requirements, audit findings and/or recommendations provided by REMSA.
2. Are in gross default of material obligation as specified in their agreement with REMSA.
3. (Trauma Centers only) Fail to obtain ACS verification if currently under a provisional designation. Hospital will then revert back to previous level trauma center prior to the provisional designation.

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.

6401	Interfacility Transfer
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

PURPOSE
To serve as the utilization standard for all patient transfers between acute care facilities within Riverside County.

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)]

3. 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.
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 <u>at the opening only</u> 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. Acetaminophen
        ii. Intropin (Dopamine)
        iii. Isoproterenol (Isuprel)

iv. KCl of ≤ 40mEq/1000cc
v. Morphine Sulfate
vi. 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 756.1 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/NAEMT-EPC 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/NAEMT-EPC certification.
    ii. 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/NAEMT-EPC 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/NAEMT-EPC 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, SpO_2, 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.

IV FLUID & MEDICATION ADMINISTRATION AND MONITORING	BLS	ALS	CCT	Air
Infusion Pump	No	No	Yes	Yes
Titration of IV Infusion to effect	No	No	Yes	Yes
ACLS Medications	No	Yes	Yes	Yes
Any Medications	No	No	Yes	Yes
Acetaminophen	No	Yes	Yes	Yes
Blood/Blood Products	No	No	Yes	Yes
Chemotherapeutic Agents	**No**	**No**	**No**	**No**
D5/0.2% NS IV (no meds)	Yes	Yes	Yes	Yes
D5/0.45% NS IV (no meds)	Yes	Yes	Yes	Yes
D5/0.9% NS IV (no meds)	Yes	Yes	Yes	Yes
D5W/IV (no meds)	Yes	Yes	Yes	Yes
Intropin (Dopamine)	No	Yes	Yes	Yes
Ionosol T	Yes	Yes	Yes	Yes
Isoproterenol (Isuprel)	No	Yes	Yes	Yes
KCl of > 40 mEq/1000 cc	No	Yes	Yes	Yes
Lactated Ringers	Yes	Yes	Yes	Yes
Morphine Sulfate	No	Yes	Yes	Yes
NaCl 0.225%	Yes	Yes	Yes	Yes
NaCl 0.45%	Yes	Yes	Yes	Yes
NaCl 0.9%	Yes	Yes	Yes	Yes
Narcotic Analgesic (PCA pump)	Yes	Yes	Yes	Yes
Nutritional IV	No	No	Yes	Yes
Xylocaine HCL (Lidocaine)	No	Yes	Yes	Yes
AIRWAY MONITORING AND PROCEDURES	**BLS**	**ALS**	**CCT**	**Air**
Bi-PAP (Bi Level) Ventilation*	No	No	Yes	Yes
Capnography (Continuous CO2 monitoring)	No	Yes	Yes	Yes
Combitube (insertion)	No	No	Yes	Yes
Combitube (monitoring)	No	No	Yes	Yes
C-PAP (Continuous)	No	Yes	Yes	Yes
Cricothyrotomy (Surgical / Needle) (initiate)	No	No	Yes	Yes
Endotracheal Tube (initiate)	No	Yes	Yes	Yes
King Airway (initiate)	No	No	Yes	Yes
Nasotracheal Intubation*	No	No	Yes	Yes
Pulse Oximetry	Yes	Yes	Yes	Yes
Rapid Sequence Intubation (RSI)*	No	No	No	Yes
Tracheostomy	Yes	Yes	Yes	Yes
Tracheostomy (Deep Suctioning)	No	Yes	Yes	Yes
Tracheostomy (Stoma Suctioning)	Yes	Yes	Yes	Yes
Ventilator	No	No	Yes	Yes
ARTERIAL & VENOUS ACCESS AND MONITORING	**BLS**	**ALS**	**CCT**	**Air**

Arterial Lines to keep intact	No	No	Yes	Yes
Arterial Venous Sheaths	No	No	Yes	Yes
Broviac/Hickman Catheters	Yes	Yes	Yes	Yes
Central Line (monitoring)	No	Yes	Yes	Yes
Central Line placement (Femoral)	No	No	No	Yes
Central Line placement (Subclavian)	No	No	No	Yes
Central Venous Access (Long Term)	Yes	Yes	Yes	Yes
CVP or Central Venous Pressure Lines	No	No	Yes	Yes
Dialysis shunts (access)	No	No	Yes	Yes
Dialysis shunts with complications (monitor)	No	No	Yes	Yes
Heplock (monitor)	Yes	Yes	Yes	Yes
Intraosseous (initiate)	No	Yes	Yes	Yes
Intraosseous (monitor)	Yes	Yes	Yes	Yes
Peripheral IV (insertion)	No	Yes	Yes	Yes
Peripheral IV (monitoring)	Yes	Yes	Yes	Yes
PICC Lines (access)	No	Yes	Yes	Yes
PICC Lines (monitor)	Yes	Yes	Yes	Yes
Porta-Caths (access)	No	Yes	Yes	Yes
Porta-Caths (monitor)	Yes	Yes	Yes	Yes
Pulmonary Artery Lines (Swan Ganz Cath.) (monitoring)	No	No	Yes	Yes
Pulmonary Artery Lines to keep intact	No	No	Yes	Yes
Saline lock (initiate)	No	Yes	Yes	Yes
Saline lock (monitor)	Yes	Yes	Yes	Yes
CARDIAC MONITORING AND PROCEDURES	**BLS**	**ALS**	**CCT**	**Air**
Automatic External Defibrillation*	Yes	Yes	Yes	Yes
Cardioversion	No	Yes	Yes	Yes
ECG (monitoring)	No	Yes	Yes	Yes
ECG (12-lead) (initiate and interpret)	No	Yes	Yes	Yes
Hemodynamic Monitoring	No	No	Yes	Yes
IABP or Intra-Aortic Balloon Pump	No	No	Yes	Yes
Manual Defibrillation	No	Yes	Yes	Yes
CARDIOTHORACIC MONITORING AND PROCEDURES	**BLS**	**ALS**	**CCT**	**Air**
Chest Tube Insertion*	No	No	No	Yes
Chest Tube to Suction	No	No	Yes	Yes
Chest Tube to Water Seal	No	Yes	Yes	Yes
Needle Thoracostomy (initiate)	No	Yes	Yes	Yes
Pericardiocentesis*	No	No	No	Yes
CATHETER / TUBE ACCESS AND MONITORING	**BLS**	**ALS**	**CCT**	**Air**
Abdominal Tube (G-tube, J-tube, Peg, JP, etc.)	Yes	Yes	Yes	Yes
Foley Catheters	Yes	Yes	Yes	Yes
Nasogastric Tube (Clamped)	Yes	Yes	Yes	Yes
Nasogastric Tube (Suction Required)	No	Yes	Yes	Yes
Orogastric Tube (Clamped)	No	Yes	Yes	Yes
Orogastric Tube (Suction Required)	No	Yes	Yes	Yes

NEURO / CRANIAL MONITORING	BLS	ALS	CCT	Air
ICP or Intracranial Pressure Lines	No	No	Yes	Yes
Ventriculostomy	No	No	Yes	Yes
OTHER PROCEDURES AND MONITORING	**BLS**	**ALS**	**CCT**	**Air**
Blood Glucose Monitoring (Capillary)	Yes	Yes	Yes	Yes
Escharotomy* (monitoring)	No	No	No	Yes
Fetal Monitoring (External)	No	No	No	Yes
Wound Vac	Yes	Yes	Yes	Yes

7101	CQI System
Administrative Policy	

Last Reviewed: **October 10, 2024**	Last Revised: **October 9, 2025**

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.

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 designated CQI Coordinators, and EMS Training Leads 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 1 of the same year. Section VI of the CQI Plan (*Annual CQI Update*) will be due by January 31. All CQI plans will follow the EMSA #166 CQI model guidelines.

EMS Continuous Quality Improvement Leadership Team (CQILT)

1. Prepare and follow-up, as appropriate, for CQILT meetings.
2. Disseminate the information discussed at CQILT meetings to the represented group.
3. Maintain responsibility for monitoring, collecting CQI data on, reporting on, and evaluating state, local, and optional EMS System indicators from the EMS providers and hospitals within the jurisdiction of the Riverside County EMS Agency.
4. Identify and develop Riverside County EMS specific indicators for system evaluation.
5. Re-evaluate, expand upon, and improve local and state required EMS system indicators annually or as needed.
6. Prepare plans for improving the Riverside County EMS Agency's CQI program.
7. Establish a mechanism to incorporate input from EMS provider advisory groups for the development of performance improvement plan templates.
8. Recommend the chartering of Quality Task Forces and review of their reports.
9. Seek and maintain relationships with all EMS participants.

The EMS CQILT meets quarterly. Results from CQI 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 presented to the CQILT who performs an RCA. Once that is completed, the issue is disseminated to the Stroke System, STEMI System, or Trauma Audit Committee (TAC) to discuss more thoroughly with the specialty committees. Once the group has reached consensus on the issue, their recommendations are presented back to the CQILT. Outputs of the CQILT include, but are not limited to, data for reporting on RivCoReady.org/REMSA.

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 in order to 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.
7. Participate in the Incident Review Process.
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. Attendance at CQILT meetings: Invited agency educators / CQI coordinators should attend a minimum of two (2) CQILT meetings per calendar year; one (1) of which should include the meeting held during the first quarter of the calendar year.
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 of prehospital 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. Attendance at CQILT meetings: Invited agency educators / CQI coordinators should attend a minimum of two (2) CQILT meetings per calendar year; one (1) of which will include the meeting held during the first quarter of the calendar year.
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 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

7102	Unusual Occurrence Submission, Process, and Review (Clinical)
Administrative Policy	

Last Reviewed: **July 5, 2023**	Last Revised: **January 1, 2025**

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 HERE** to submit incidents is mandatory.

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

1. 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

1. Non-compliance with treatment protocols or policies with or without the potential for patient harm.
2. 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.
  - 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 and by submitting all applicable supporting documents.** Policy 7102 Reporting Form can be found **HERE**.

Level B

1. Once an occurrence is identified by the Reporting Party, immediate notification to the agency's Designated Agent/Coordinating Party is required. The Coordinating Party is then required to notify REMSA's CQI Coordinator **within five (5) business days** by phone, email, **AND** online submission form **HERE**. Each Coordinating Party is required to submit their supporting documents, listed below, **within five (5) business days** of initial notification to REMSA.
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
3. Dispatch log of events
4. Remediation/education delivered (Record(s) of Conversation, summations, PIP, CEP, or equivalent)
5. BH recording(s)
6. Patient outcome from receiving facility

Hospital reporting

1. BH recording(s) and log notes
2. MICN or RN narrative(s)
3. MD dictation
4. Patient outcome
5. 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 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). 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.

7701	Patient Care Records
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2026**

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 data elements required by REMSA.

System Requirements
The ImageTrend 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 Data Standards Committee 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) and the Riverside Emergency Management Service Information Systems (REMSIS). 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.

Submission of ePCR to REMSIS
All records created outside of the REMSIS ImageTrend platform will be considered a "third party" import and are required to meet the documentation requirements as established by the REMSIS Schematron which can be found at rivcoready.org/remsa. Each agency administrator is responsible in maintaining compliance with this standard. As such, agencies not on the REMSIS provided documentation software are required to monitor the export of their records to REMSIS and correct any "Errors" preventing export within seven (7) days of recognition. Administrators are encouraged to correct "Warnings", but there will not prevent export of the record in question.

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 3.5 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/a EMS Surge/MCI, a minimum of one (1) operational (MEDCOM) ePCR must be completed by the first responder agency with the required MCI form(s) or worksheet(s) attached within the ePCR.

- Each transporting unit is required to initiate and complete a treatment/patient contact 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).

7702	REMSIS Authorization and Security
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **January 30, 2026**

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.

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 or acted as the online medical direction as documented by the prehospital provider.
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 (CEMSIS).
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/MICN – 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 or MICNs working in the hospital.
   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.

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 720 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 License/Certification/Authorization expiration dates are require to be up to date to access REMSIS. Any user that has an expired credential in any capacity will be denied access until their License/Certification/Authorization is updated.
5. Provider organizations and their Administrators are the primary contact that are responsible for troubleshooting password resets and lockouts. REMSA Duty Officers are the last resort in resolving these issues identified by filed providers.
6. 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 shall have hardware devices (computer, iPads, etc.) provided by their respective agency or organization. At no time shall a personal, home device, or third-party device be used to access the REMSIS platform
5. 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
6. All employees accessing any device connected to REMSIS shall receive initial and annual training in data security and protection of patient health information.
7. 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

7703	Continuous Quality Improvement Module
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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).

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.

7704	+EMS & SAFR
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2023**

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.

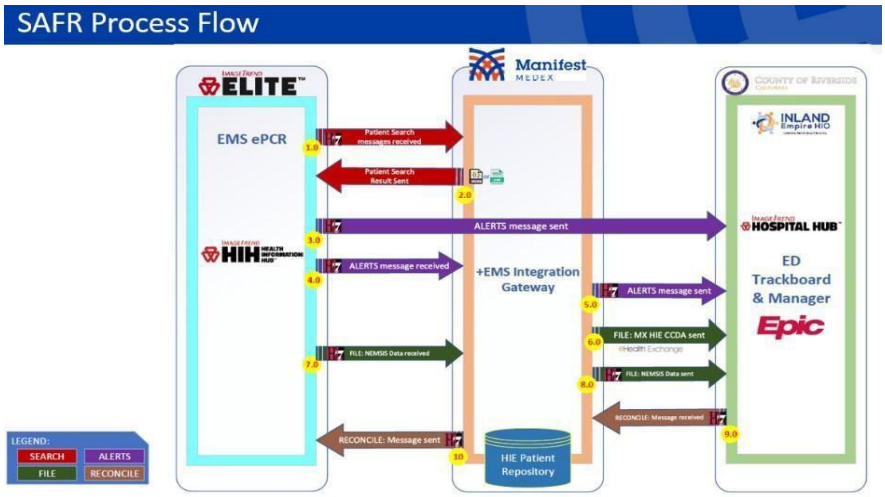
APPLICATION

This policy applies to the following:

Prehospital Receiving Facilities	Ground Transport Providers
Corona Regional Medical Center	American Medical Response – Riverside County (*includes the Desert Cities, Hemet, and Riverside Operations*)
Desert Regional Medical Center	Riverside County Fire Department
Inland Valley Medical Center	
John F. Kennedy Memorial Hospital	
Loma Linda Medical Center – Murrieta	
Parkview Community Hospital Medical Center	
Rancho Springs Medical Center	
Riverside University Health System – Medical Center	
Temecula Valley Hospital	

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.



8101	Resource List
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **May 12, 2026**

Riverside County Agencies

	Organization	Address	Phone 1	Phone 2	Phone 3	URL
1	EMS Agency	450 E. Alessandro Blvd, Riverside, CA 92508	(951) 358-5029	(951) 712-3342- Duty Officer		www.rivcoready.org/remsa
2	Em. Mgmt.- Operations	450 E. Alessandro Blvd, Riverside, CA 92508	(951) 358-7100	(951) 312-5167- Duty Officer		https://www.rivcoready.org
3	Em. Mgmt.- Preparedness	450 E. Alessandro Blvd, Riverside, CA 92508	(951) 358-7100			www.rivcophepr.org
4	Fire Department	210 W San Jacinto Ave, Perris, CA 92570	(951) 940-6900			www.rvcfire.org
5	Sheriff's Department	4095 Lemon St, Riverside, CA 92501	(800) 950-2444			www.riversidesheriff.org
6	Coroner's Bureau	800 S Redlands Ave, Perris, CA 92570	(951) 443-2300	(760) 863-8311 - Indio		www.riversidesheriff.org
7	Environmental Health	4065 County Cir Dr, Riverside, CA 92503	(888) 722-4234	(951) 782-2968 – after hours/holidays		www.rivcoeh.org
8	Mental Health	4095 County Cir Dr, Riverside, CA 92503	(888) 768-4968	(951) 509-2499 - ETS	(951) 686-4357 – HELP Line Suicide	www.rcdmh.org
9	Public Health	4065 County Cir Dr, Riverside, CA 92503	(951) 358-5000	(951) 358-5122- DOC (when activated)		www.rivcoph.org
10	Disease Control	4065 County Cir Dr, Riverside, CA 92503	(951) 358-5107			www.rivcodiseasecontrol.org
11	Injury Prevention	4065 County Cir Dr, Suite 207, Riverside, CA 92503	(951) 358-7171			www.rivcoips.org
12	Public Social Services	4060 County Cir Dr, Riverside, CA 92503	(951) 358-3000	(800) 491-7123- Adult Abuse Hotline	(800) 442-4918- Child Abuse Hotline	http://dpss.co.riverside.ca.us/

First Response Agencies

	Organization	Address	Phone	URL	BLS	ALS	Notes
1	Blythe Volunteer Fire Department	201 N Commercial St, Blythe, CA 92225	(760) 922-6117	www.cityofblythe.ca.gov	X		Volunteer Agency
2	Calimesa Fire Department	908 Park Avenue, Calimesa, CA 92320	(909) 795-9801	www.cityofcalimesa.net	X		Municipal Agency
3	Canyon Lake Fire Department	31516 Railroad Canyon Road, Canyon Lake, CA	(951) 244-2955	http://canyonlakeca.gov/clfd		X	Municipal Agency
4	Cathedral City Fire Department	32100 Desert Vista Rd, Cathedral City, CA 92234	(760) 770-8200	www.cathedralcityfire.org		X	Authorized ALS transport service
5	Chuckawalla Fire Department	19025 Wiley's Well Rd, Blythe, CA 92225	(760) 922-5300 Ext. 7700	www.cdcr.ca.gov	X		Federal Agency
6	Corona Fire Department	735 Public Safety Way, Corona, CA 92882	(951) 736-2220	www.coronaca.gov		X	Municipal Agency
7	Hemet Fire Department	510 E Florida Ave, Hemet, CA 92543	(951) 765-2450	www.hemetca.gov		X	Municipal Agency
8	Idyllwild Fire Protection District	54160 Maranatha Dr, Idyllwild-Pine Cove, CA 92549	(951) 659-2153	www.idyllwildfire.com		X	Authorized BLS & ALS transport services
9	MARB Fire Department	64508 St, March Air Reserve Base, CA 92518	(951) 655-2075	www.march.afrc.af.mil	X		Federal Agency
10	Morongo Fire Department	12700 Pumarra Road, Banning, CA 92220	(951) 755-5315	morongonation.org/fire		X	Tribal Agency
11	Murrieta Fire and Rescue	41825 Juniper Street, Murrieta, 92562	(951) 304-3473	www.murrietaca.gov/Fire		X	Municipal Agency
12	Palm Springs Fire Department	300 El Cielo Rd, Palm Springs, CA 92262	(760) 323-8181	www.palmspringsca.gov		X	Municipal Agency
13	Pechanga Fire Department	48240 Pechanga Rd, Temecula, CA 92592	(951) 506-5332	www.pechanga-nsn.gov		X	Tribal Agency
14	Riverside City Fire Department	3401 University Ave, Riverside, CA 92504	(951) 826-5321	www.riversideca.gov/fire/		X	Riverside County Contracted Fire Agency
15	Riverside County Fire Department	210 West San Jacinto Ave, Perris, CA 92570	(951) 940-6900	www.rvcfire.org		X	Two areas with authorized ALS transport services
16	Soboba Fire Department	23121 Soboba Rd, San Jacinto, CA 92583	(951) 654-1092	www.soboba-nsn.gov	X		Tribal Agency
17	US BLM	1201 Bird Center Dr, Palm Springs, CA 92262	(760) 833-7100	www.blm.gov	X		Federal Agency
18	US CBP- Blythe	16870 W Hobson way, Blythe, CA 92225	(760) 922-6715	www.cbp.gov	X		Federal Agency
19	USFS- Cleveland	10845 Rancho Bernardo Rd, San Diego, CA 92127	(858) 673-6180	www.fs.fed.us	X		Federal Agency
20	USFS- San Bernardino	602S Tippecanoe Ave, San Bernardino, CA 92408	(909) 383-5651	www.fs.fed.us	X		Federal Agency

Ground Transport Services

	Organization	Address	Phone	URL	BLS	ALS	CCT	Notes
1	Advantage Ambulance	6180 Quail Valley Ct, Riverside, CA 92507	(866) 962-3826	www.advantageambulancesd.com	X		X	BLS & CCT Transport service
2	AMR- Desert Cities/ Blythe	1111 Montalvo Way, Palm Springs, CA 92262	(760) 883-5100	www.amr.net/	X	X	X	Contracted ALS Ground Transport Provider
3	AMR- Hemet	208 E Devonshire Ave, Hemet, CA 92543	(951) 765-3900	www.amr.net/	X	X	X	Contracted ALS Ground Transport Provider
4	AMR - Riverside	879 Marlborough Ave, Riverside, CA 92507	(951) 782-5200	www.amr.net/	X	X	X	Contracted ALS Ground Transport Provider
5	Care Medical Transport	8605 Indiana Ave., Riverside, CA 92504	(858) 653-4500	https://careambulancesd.com/	X		X	BLS & CCT Transport services
6	Cathedral City FD	32100 Desert Vista Rd, Cathedral City, CA 92234	(760) 770-8200	www.cathedralcityfire.org		X		BLS & authorized ALS first response agency
7	Cavalry	423 Jenks Circle Suite 213, Corona, CA 92880	(951) 278-3700	www.cavalryems.com	X		X	BLS & CCT Transport service
8	Idyllwild FPD	54160 Maranatha Dr, Idyllwild-Pine Cove, CA 92549	(951) 659-2153	www.idyllwildfire.com	X	X		BLS & authorized ALS first response agency
9	Lifeline Ambulance	6605 E Washington Blvd, Commerce, CA 90040	(800) 700-9344	www.lifeline-ems.com	X			*Kaiser PICU/NICU Transports Only
10	Lynch	2950 La Jolla Street, Anaheim, CA 92806	(800) 347-3262	www.lynchambulance.com	X*			*Children's Hospital of Orange County calls only.
11	Primary Ambulance	2050 E La Cadena Dr. Suite #H, Riverside, CA 92507	(888) 353-9556	https://premieramb.com/	X		X	BLS & CCT Transport service
12	PRN	1240 Bradley Ave, Sylmar, CA 91342	(818) 810-3600	www.prnambulance.com	X*			*Kaiser PICU/NICU Transports Only
13	Riverside County FD - Coves	44400 Town Center Way, Palm Desert, CA 92260	(760) 346-6234	www.rvcfire.org	X	X		BLS & authorized ALS first response agency
14	Riverside County FD - Indio	46990 Jackson St, Indio, CA 92201	(760) 347-0726	www.rvcfire.org	X	X		BLS & authorized ALS first response agency
15	Symbiosis/Symons	1801 Orange Tree Ln#130, Redlands, CA 92374	(866) 728-3548	www.symonsambulance.com	X		X	BLS & CCT Transport service

Air Transport Services

	Organization	Address	Phone	URL	BLS	ALS	CCT	Notes
1	Mercy Air 10	17240 W Hobsonway, Blythe, CA 92225	(619) 346-6349	www.airmethods.com		X	X	Helicopter transport service
2	Mercy Air 18	86400 Lightning St., Thermal, CA 92274	(760) 828-8570	www.airmethods.com		X	X	Helicopter transport service
2	CHP- Air Rescue	56-855 Liberator Ln, Thermal, CA 92274	(760) 984-5300	www.chp.ca.gov		X		Helicopter transport service
4	REACH Air 9	1111 Airport Rd, Imperial, CA 92251	(760) 670-6659	www.reachair.com		X	X	Helicopter transport service
5	REACH Air 81	79880 Avenue 42, Hangar B, Bermuda Dunes, CA 92203	(760) 834-9251	www.reachair.com		X	X	Helicopter transport service

EMS Training

	Organization	Address	Phone 1	Phone 2	URL	PSFA/FR	EMT	AEMT	EMT-P	MICN	EMS CE
1	California Baptist University	3532 Monroe St, Riverside, CA 92504	(951) 323-4379		www.calbaptist.edu		X				
2	College of the Desert	43-500 Monterey Ave, Palm Desert, CA 92260	(760) 776-7313		www.collegeofthedesert.edu		X		X		
3	Health Pro EMT Training	2900 Adams Street Suite C5, Riverside, CA 92504	(951) 370-1617		www.hpemt.org		X				X
4	High Desert Medical College	31625 De Portola Rd Suite 200, Temecula, CA 92592	(951) 365-5390		www.hdmc.edu		X				
5	Moreno Valley College	20629 11th Street, Riverside, CA 92518	(951) 571-6300		www.mvc.edu		X		X	Closed	X
6	Mt. San Jacinto College	28237 La Piedra Road., Menifee, CA 92584	(951) 672-6752	(951) 487-6752	www.msjc.edu		X				X
7	Murrieta Valley High School (HS Only)	42200 Nighthawk Way, Murrieta, CA 92562	(951) 696-1408 ext. 5813				Closed				
8	National College of Technical Instruction	895 Marlborough Ave#100, Riverside, CA 92507	(951) 384-7813		https://ncti.edu		X		X		
9	Orange Vista High School (HS Only)	1400 E Orange St, Perris, CA 92571	(951) 490-4660				Closed				
10	Palo Verde College	1 College Drive, Blythe, CA 92225	(760) 921-5444		www.paloverde.edu		X				
11	Riverside County Office of Education (HS Only)	3939 13th St, Riverside, CA 92501	(951) 826-6535				Closed				
12	Southern California EMS Training	21440 Lemon Street, Wildomar, CA 92595	(951) 304-0099		www.emttrainingca.com		X				X
13	West Coast EMT	1960 Chicago Ave Suite D19, Riverside, CA 92507	(714) 558-9604		www.westcoastemt.com		X				

Riverside County Hospitals

							Trauma			Stroke						
	Facility	Address	Phone	ED Phone	Recorded Line	BH	Adult	PEDS	STEMI	Primary	Comp.	OB	NICU	PICU	DTMF
1	Corona Regional	800 S Main St, Corona, CA 92882	(951) 737-4343	(951) 736-6241	(951) 736-6320					X					120
2	Desert Regional	1150 N Indian Canyon Dr, Palm Springs, CA 92262	(760) 323-6511	(760) 323-6521	(760) 323-4723	X	Level I		X		X	X	X		210
3	Eisenhower	39000 Bob Hope Dr, Rancho Mirage, CA 92270	(760) 340-3911	(760) 837-8016	(760) 568-4197	X	Level IV		X	X		X	X		250
4	Hemet Valley	1117 E Devonshire Ave, Hemet, CA 92543	(951) 652-2811	(951) 766-6464	(951) 925-6335										130
5	Inland Valley	36485 Inland Valley Dr, Wildomar, CA 92595	(951) 677-1111	(951) 677-9773	(951) 677-0833	X	Level II			X					150
6	JFK Memorial	47111 Monroe St, Indio, CA 92201	(760) 347-6191	(760) 775-8111	(760) 342-3011	X	Level IV		X	X		X			220
7	Kaiser Moreno Valley	27300 Iris Avenue, Moreno Valley, CA 92555	(951) 243-0811	(951) 251-6565	(951) 251-6055					X		X	X		340
8	Kaiser Riverside	10800 Magnolia Ave, Riverside, CA 92505	(951) 353-2000	(951) 353-3790	(951) 353-3373					X		X	X		440
9	Loma Linda - Murrieta	28062 Baxter Rd, Murrieta, CA 92563	(951) 290-4000	(951) 704-1725	(951)704-1734				X			X	X		320
10	Menifee Global	28400 McCall Blvd, Menifee, CA 92585	(951) 679-8888	(951) 672-7190	(951) 672-7191										360
11	Palo Verde	250 N 1st St, Blythe, CA 92225	(760) 922-4115	(760) 921-5235	(760) 921-5144										110
12	Parkview	3865 Jackson St, Riverside, CA 92503	(951) 688-2211	(951) 352-5666	(951) 352-5642					X		X	X		160
13	Rancho Springs	25500 Medical Center Dr, Murrieta, CA 92562	(951) 696-6000	(951) 696-6161	(951) 696-6035					X		X	X		420
14	Riverside Community	4445 Magnolia Ave, Riverside, CA 92501	(951) 788-3000	(951) 788-3200	(951) 683-8671	X	Level I		X		X	X	X		170
15	RUHS-MC	26520 Cactus Ave, Moreno Valley, CA 92555	(951) 486-4000	(951) 486-5650	(951) 486-4137	X	Level I	X		X		X	X	X	180
16	San Gorgonio	600 N Highland Springs Blvd, San Gorgonio, CA 92220	(951) 845-1121	(951) 769-2121	(951) 769-2175					X		X			230
17	Temecula Valley	31700 Temecula Pkwy, Temecula, CA 92592	(951) 331-2200	(951) 331-2280	(951) 331-2242				X		X				550

Out of County Hospitals

					Trauma			Stroke					
	Facility	County	Address	Phone	Adult	PEDS	Burn	Primary	Comp.	STEMI	OB	NICU	PICU
1	Arrowhead Regional	San Bernardino	400 N. Pepper Ave., Colton, CA 92324	(909) 580-1000	X		X		X		X	X	
2	CHOC- Orange (Main)	Orange	1201 W. La Veta Ave, Orange, CA 92868	(714) 509-9095		X						X	X
3	Kaiser–Anaheim	Orange	3440 E. La Palma Avenue, Anaheim, CA 92806	(714) 644-2880							X	X	
4	Kaiser– Fontana	San Bernardino	9961 Sierra Avenue, Fontana, CA 92335	(909) 427-5000				X			X	X	X
5	Kaiser– Ontario	San Bernardino	2295 S. Vineyard Ave., Ontario, CA 91761	(888) 750-0036				X					
6	Loma Linda (Main)	San Bernardino	11234 Anderson St., Loma Linda, CA 92354	(909) 558-4444	X	X			X	X	X	X	X
7	OC Global	Orange	1001 N. Tustin Ave, Santa Ana, CA 92705	(714) 953-3339	X		X			X	X	X	
8	Providence Mission Hospital	Orange	27700 Medical Center Rd, Mission Viejo, CA 92691	(949) 365-2202	X	X			X	X			X
9	Redlands Community*	San Bernardino	350 Terracina Blvd., Redlands, CA 92373	(909) 335-5500				Thromb.			X	X	
10	UCI Medical Center	Orange	101 The City Drive South, Orange, CA 92868	(714) 456-5705	X	X	X		X	X	X	X	

*Redlands Community Hospital is thrombectomy capable only

Legend

BH - Base Hospital	OB - Obstetrical Services	NICU - Neonatal Intensive Care Unit	PICU - Pediatric Intensive Care Unit

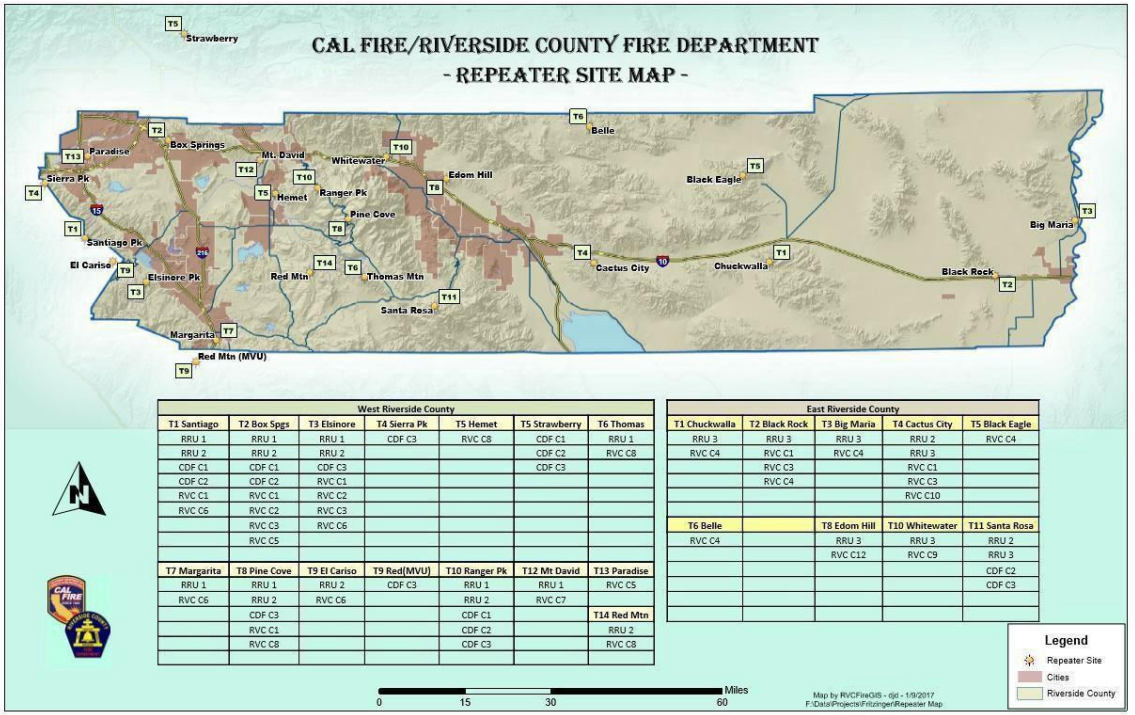
CAL FIRE RRU GPH/DPH PORTABLE RADIOS

Group 1 RVC West
Group 2 RVC East
Group 3 RRU Wildland
Group 4 Mutual Aid West
Group 5 Mutual Aid East
Group 6 RVC TAC's
Group 7 BDU / BDC
Group 8 MVU North
Group 9 MVU South
Group 10 EMS / RSO Mutual Aid
Group 11 2014 S.O.L.A.R. Com Plan
Group 12 USFS/LAC/Mutual Aid
Group 13 P.R.O.S. Com Plan
Group 14 Incident
Group 15 Incident
Group 16 CDF, CMD's & Units 11-21
Group 17 Units 21-33
Group 18 Units 33-43
Group 19 Units 43-46, CDF TAC's 1-14
Group 20 CDF TAC's 14-31, NIFC TAC's
Group 21 FSR5, NIFC CMD's FED A/A or A/G
Group 22 USFS Forest Nets
Group 23 BLM Nets, Air to Grounds
Group 24 OES, VTAC's, VFIRE's
Group 25

ALL CHANGES FROM THE LAST LOAD WILL BE IN RED

STANDARD 32 CTCSS TONES

T 1	110.9	T 17	67.0
T 2	123.0	T 18	71.9
T 3	131.8	T 19	74.4
T 4	136.5	T 20	77.0
T 5	146.2	T 21	79.7
T 6	156.7	T 22	82.5
T 7	167.9	T 23	85.4
T 8	103.5	T 24	88.5
T 9	100.0	T 25	91.5
T 10	107.2	T 26	94.8
T 11	114.8	T 27	97.4
T 12	127.3	T 28	118.8
T 13	141.3	T 29	173.8
T 14	151.4	T 30	179.9
T 15	162.2	T 31	186.2
T 16	192.8	T 32	203.5



8201	Emergency Medical Care Committee
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

PURPOSE
To define the membership, rules of operation, and functions of the local Emergency Medical Care Committee (EMCC).

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 supervisorial 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.

8202	Prehospital Medical Advisory Committee
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **May 13, 2024**

PURPOSE

To describe the function and composition of the Prehospital Medical Advisory Committee (PMAC); including its rules of operation.

The Prehospital Medical Advisory Committee

The function of the PMAC is to provide guidance and expertise to the County of Riverside EMS Agency (REMSA) related to the administrative, operational, and functional prehospital delivery of Emergency Medical Services, and to enhance coordination and cooperation between the multiple EMS providers who deliver care to the residents and visitors of Riverside County.

PMAC serves as an advisory committee to the REMSA Medical Director and will be open to the public.

PMAC will:

1. Provide specialized advice to the REMSA Medical Director in carrying out the agency's statutory responsibilities to develop written medical protocols;
2. Provide specialized advice to the REMSA Medical Director in carrying out the agency's statutory responsibilities to maintain medical control of the EMS system;
3. Provide physician representatives to the REMSA Emergency Medical Care Committee (EMCC) for the approval of EMS prehospital treatment modalities, procedures or pharmacologic treatments;
4. Provide communication and coordination between REMSA and regional EMS system partners;
5. Provide other specialized subject matter expertise as deemed necessary and appropriate.

PMAC MEMEBERSHIP

Active (voting) membership will consist of:

Position	#	Appointing Authority
Base Hospital Physician	1	REMSA
Non-Base Hospital Physician	1	REMSA
Non-Base Hospital RN	1	REMSA
Pediatric Critical Care Physician	1	REMSA
Stroke Hospital Coordinator – RN	1	Stroke Committee
STEMI Hospital Coordinator – RN	1	STEMI Committee
Prehospital Liaison Nurse (PLN)	1	PLN Chair
Trauma Program Medical Director	1	Trauma Advisory Committee
Public Transport Medical Director	1	Fire Chief's Association
Private Transport Medical Director	1	REMSA
Fire Department Medical Director	1	Fire Chief's Association
EMS Officers	1	Fire Chief's Association
Public Transport Medical Rep (Paramedic/RN)	1	Fire Chief's Association
Private Transport Medical Rep (Paramedic/RN)	1	Ambulance Association
Non-Transport Agency Rep (Paramedic/RN)	1	Fire Chief's Association
Riverside County Police Association	1	RCLEAAA
Tribal Partner Representative	1	Tribal Chief's
Private Air Transport Medical Director	1	Riverside County Permitted Air Transport Providers
EMS Training Program Representative	1	EMS Training Program Providers

Ex-officio members (non-voting members) will include:

1. The County Director of Public Health / Health Officer,
2. The REMSA Medical Director or designee,
3. The REMSA Administrator,
4. The Deputy REMSA Administrator,
5. Representatives from other Riverside County departments/agencies (e.g. EMD, Behavioral Health, etc.),
6. The Emergency Department Physician Director(s) or their physician designees from out-out-county acute care hospitals impacted by Riverside County residents,

Each position will be selected by the appointing authority above and individual agencies can only fill no more than two (2) positions. It is expected that each member should attend a minimum 75% of meetings each year or the appointing authority will be contacted to request a new representative be appointed.

The voting 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 three (3) year term. Elections will be at the last meeting of the third-year term. 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. A quorum for voting is defined by four (4) physicians, two (2) hospital-based nurses and three (3) field representatives from EMS being present at the meeting. The position of Chairperson, or Vice Chair in the absence of the Chairperson, is a non-voting position except in cases where a tie vote must be broken. The Chairperson shall also serve as the elected representative to REMSA Emergency Medical Care Committee (EMCC).

REMSA staff will provide support for the PMAC, including but not limited to, the scheduling and recording of meetings, developing agendas, supplying needed background/research information, and the dissemination of information generated from PMAC.

The PMAC will meet at least quarterly unless otherwise determined by the Chair and Vice Chair.

8203	Trauma Audit Committee
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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.

8204	Trauma Program Managers Committee
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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.

8205	Prehospital Liaison Nurse's Committee
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

PURPOSE
To establish an advisory committee to REMSA and subcommittees on EMS system issues.

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.

8206	Stroke System Advisory Committee
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

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 rivcorready.org.

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.

8207	STEMI System Advisory Committee
Administrative Policy	

Last Reviewed: **October 4, 2022**	Last Revised: **July 1, 2023**

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.

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 rivcoready.org.

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.

8208	Data Standards Advisory Committee
	Administrative Policy

Last Reviewed: **October 4, 2022**	Last Revised: **December 1, 2023**

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.

REMSA Data Standards Committee

1. 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.

2. The Committee reports to:
   a. REMSA
   b. The EMS Agency Administrator
   c. The EMS Agency Medical Director

3. 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.

4. 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

5. 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.

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.

   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.

7. Committee Documentation:
   Meeting minutes will be kept by REMSA and will be made available to committee members upon request.

8. 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.

8301	Policy Review Process
	Administrative Policy

Last Reviewed: **October 10, 2024**	Last Revised: **October 23, 2024**

PURPOSE
To describe the Riverside County EMS Agency's (REMSA) policy review process.

DEFINITIONS
Consensus
A mutual agreement that is determined by the Prehospital Medical Advisory Committee (PMAC) designated members in attendance at the time of a motion.. Each appointed member will get one (1) vote when a motion is made, and votes are tallied.

Qualifying Motion / Vote
A formal proposal, or indication of a choice, made by an individual outside of the agency, department, or organization that made a proposal. The purpose of requiring votes to be "qualified" is to ensure that there is a shared interest in furthering discussion of, and giving attention to, a proposal.

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 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.

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 first aid 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 to the EMS system, to improve the delivery of prehospital care services through the monitoring, reviewing, and evaluating of the systems 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 a System Advisory.

Annual Policy Review Schedule

REMSA's policy review process is facilitated through 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.

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, 2025, REMSA will initiate and maintain the policy and protocol review process as follows:

- **September PMAC**: In addition to all new business and standing agenda items, representatives of an agency, department, or organization, may propose modifications to any policy or protocol that they believe would benefit from modification.
    - **Beginning 2025**: Agencies, departments, and organizations that would like to propose a policy and/or protocol change at the next year's September PMAC may submit their proposals to REMSA throughout the calendar year for inclusion on the September PMAC agenda. The deadline for these submissions is three (3) weeks prior to the September PMAC of the current year. This allows time for specialty care review of proposed policy changes (i.e., STEMI, Stroke, and/or Trauma) following the September PMAC. Regardless of when a proposal is submitted, an objective and factually sound presentation is still required at the September PMAC. Presentation proposals will be emailed to remsa_clinical@rivco.org.
    - **Required Outline for Submission**: REMSA requires that the proposing agency, department, or organization make a brief presentation that consists of objective, empirical data that validates their proposal. Presentations must include, at a minimum, draft policy and/or protocol language that includes "Current language" (i.e., what the policy/protocol looks like now), "Proposed language" (i.e., what it could/should/might look like based on the aforementioned proposal), and a "Purpose" statement (i.e., the reason why the proposal should be adopted by the system).
    - **December PMAC**: Following the September PMAC meeting, and after any specialty care reviews (if applicable), the policy changes will be presented again at the December PMAC for review of any recommended changes and final review and/or approval.

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 to determine if the proposal should be addressed at a specialty care committee or move forward to the December PMAC.
    - × 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.

- If the consensus vote to allow the proposal to proceed to specialty care committee/December PMAC is greater than 50% + 1 of the PMAC designated members in attendance, the proposal will move forward.
- If the consensus vote to allow the proposal to proceed to specialty care committee/December PMAC is less than 50% of the PMAC designated members in attendance, 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.

Period Between September and December PMAC: Proposed policy and/or protocol language that affects specialty care programs will be discussed within the corresponding specialty care committee prior to EMS system discussion at the following December PMAC. These advisory committees reserve the right to modify any/all proposed language presented to them prior to providing an adoption recommendation to the REMSA Medical Director, so that it aligns with all current and recognized medical standards and best practices.

Due to this review schedule, items that are not carried into the specialty care review will not have the opportunity to be addressed again until the next September PMAC meeting.

- **December PMAC:** In addition to all new business and standing agenda items, all proposals that were reviewed at a specialty care committee (TAC, STEMI, or Stroke) will be addressed openly with the committee. All proposals from the September PMAC will be reviewed at the December PMAC.

  Motion to Discuss Further: In addition to all new business and standing agenda items, all specialty care review proposals will be addressed openly with the committee.
  - 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 PMAC designated members in attendance, pending REMSA Medical Director approval, REMSA will begin producing the necessary educational content for the EMS system the day after the December PMAC.
  - If the consensus vote to recommend adoption of the proposal is less than 50% of the PMAC designated members in attendance, it will be considered moot, and no further time will be spent addressing it.

  Proposals that are being addressed at the December PMAC have already received qualifying motions through the previous September PMAC. Anyone participating at the December PMAC may make a Motion to Discuss Further 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 the December PMAC, as evidenced by a consensus vote to formally adopt, will need to be re-addressed at the next September PMAC 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/release educational content no later than April 1. Agency, department, and organization trainers are required to participate in these meetings in order to receive all PUC-related training materials. Hybrid and/or virtual meeting options will not be available; these meetings will be held in-person only. If an agency, department, or organization's regular trainer/educator is unable to attend for any reason, a delegate from their agency, department, or organization must attend in their place.

- **January through 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.

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 open comments at the September PMAC occurring during the triennial review period in order to provide meaningful feedback to the REMSA Medical Director at that following PMAC.