COASTAL VALLEYS EMS AGENCY

ADMINISTRATIVE POLICY MANUAL
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Latest changes version released April 11, 2024

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LEMSA ADMINISTRATION AND ORGANIZATION

POLICY NO: **1000** PAGE 1 OF 1

REVISED DATE: October 1, 2020

APPROVED: Bryan Cleaver, EMS Administrator; Dr. Mark Luoto, EMS Medical Director

AUTHORITY: California Health and Safety Code, Division 2.5 EMS, SECTION 1797.204

1000.1 PURPOSE

a. To identify the organizational structure of the Local Emergency Medical Services Agency.
b. The Coastal Valleys EMS Agency (LEMSA) is responsible for the planning, implementation, and evaluation of the emergency medical system within the region. This system, as defined in Division 2.5 of the California Health and Safety Code, consists of "... an organized pattern of readiness and response services based on public and private agreements and operational procedures." The LEMSA, housed within the Sonoma County Department of Health Services, is comprised of an administrator, medical director and staff members.
c. The EMS Agency phone number is: (707)565-6501
d. The EMS Agency FAX number is: (707)565-6510
e. The EMS Agency email address is: coastalvalleysemsagency@sonoma-county.org
f. The EMS Agency website: https://www.coastalvalleysems.org/
g. EMS Agency Duty Officer 24/7 contact via REDCOM Dispatch Center at (707)568-5933. Request the on-call EMS Agency Duty Officer.

1000.2 EMS AGENCY STAFF

LEMSA Medical Director:	Mark Luoto MD, FACEP
LEMSA Administrator:	Bryan Cleaver
LEMSA Trauma/CARES Coordinator	Joanne Chapman, RN
EMS Coordinator Sonoma	James Salvante
EMS Coordinator, Mendocino	Jen Banks
ALS Coordinator-Regional MHOAC	Carly Sullivan
LEMSA Epidemiologist	Lucinda Gardner
ALS Coordinator Special Projects	Thomas Hinrichs
LEMSA Administrative Aide Certifications	Kristina Griffith

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MEDICAL CONTROL-LEMSA (EMS) MEDICAL DIRECTOR

POLICY NO: **1001**

REVISED DATE: October 1, 2020

APPROVED: Bryan Cleaver, EMS Administrator; Dr. Mark Luoto, EMS Medical Director

AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.202 and 1798. California Code of Regulations, Title 22, Division 9, Sections 100144, 100146, 100147, 100169

1001.1 PURPOSE

a. To define the role of the Medical Director of the Coastal Valleys EMS Agency (LEMSA) with respect to EMS medical control

1001.2 DEFINITION

a. "Medical control" means the medical management of the EMS System.

1001.3 POLICY

a. The Medical Director of the LEMSA shall establish and maintain medical control in the following manner:
   1. Approve and annually review the EMS Agency policies and procedures to assure medical control of the EMS System. These shall include at a minimum:
      a) Readily accessible treatment protocols that encompass the EMT(BLS) and Advanced EMT and Paramedic (ALS) scope of practice.
      b) The development of, and ongoing monitoring of, a comprehensive, system-wide Continuous Quality Improvement and Assurance Program and its Incident Event Review Process.
      c) Transport and transfer policies (air and ground).
      d) Policies regarding applications for additional AED, EMR, EMT, Advanced EMT, Paramedic providers and training programs.
   2. Certification and recertification of EMT personnel and verification and local accreditation of Paramedics.
   3. Establishment of standards of due process regarding the suspension and revocation of EMT and Paramedic certificates/accreditation.
   4. Evaluate and review any EMT or Paramedic training program. Review and recommend actions to the LEMSA Administrator, including any application for new programs, providers or centers.

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5. Evaluate and review any EMS dispatch center. Review and recommend actions to the LEMSA Administrator, including any application for new programs, providers or centers.
6. Evaluate and review any provider of EMS services. Review and recommend actions to the LEMSA Administrator, including any application for new programs, providers or centers.
7. Evaluate and review receiving facilities, base hospitals and specialty care centers designations. Review and recommend actions to the LEMSA Administrator, including any application for new programs, providers or centers.

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ON-LINE MEDICAL DIRECTOR

POLICY NO: **1002** PAGE 1 OF 2

REVISED DATE: October 1, 2020

APPROVED: Bryan Cleaver, EMS Administrator; Dr. Mark Luoto, EMS Medical Director

AUTHORITY: Health and Safety Code, Division 2.5, Sections 1707.90, 1798, 1798.2, 1798.102, 1798.104. California Code of Regulations, Title 22, Division 9, Sections 100144, 100146,

1001.1 PURPOSE

a. To define the role of the Medical Director of the Coastal Valleys EMS Agency (LEMSA) with respect to EMS medical control

1001.2 DEFINITION

a. "Medical control" means the medical management of the EMS System.

1001.3 POLICY

a. The Medical Director of the LEMSA shall establish and maintain medical control in the following manner:
   1. Approve and annually review the EMS Agency policies and procedures to assure medical control of the EMS System. These shall include at a minimum:
      a) Readily accessible treatment protocols that encompass the EMT(BLS) and Advanced EMT and Paramedic (ALS) scope of practice.
      b) The development of, and ongoing monitoring of, a comprehensive, system-wide Continuous Quality Improvement and Assurance Program and its Incident Event Review Process.
      c) Transport and transfer policies (air and ground).
      d) Policies regarding applications for additional AED, EMR, EMT, Advanced EMT, Paramedic providers and training programs.
   2. Certification and recertification of EMT personnel and verification and local accreditation of Paramedics.
   3. Establishment of standards of due process regarding the suspension and revocation of EMT and Paramedic certificates/accreditation.
   4. Evaluate and review any EMT or Paramedic training program. Review and recommend actions to the LEMSA Administrator, including any application for new programs, providers or centers.

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5. Evaluate and review any EMS dispatch center. Review and recommend actions to the LEMSA Administrator, including any application for new programs, providers or centers.
6. Evaluate and review any provider of EMS services. Review and recommend actions to the LEMSA Administrator, including any application for new programs, providers or centers.
7. Evaluate and review receiving facilities, base hospitals and specialty care centers designations. Review and recommend actions to the LEMSA Administrator, including any application for new programs, providers or centers.

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SCENE MANAGEMENT AND AUTHORITY

POLICY NO: **1003** PAGE 1 OF 2

REVISED DATE: October 1, 2020

APPROVED: Bryan Cleaver, EMS Administrator; Dr. Mark Luoto, EMS Medical Director

AUTHORITY: Health and Safety Code, Division 2.5, EMS, Sections 1798, 1798.6 and

California Code of Regulations, Title 22, Division 9, Section 100169

1003.1 POLICY

a. At the scene of a **non-disaster** medical emergency the following will occur:

1003.2 AUTHORITY FOR MEDICAL EMERGENCY SCENE MANAGEMENT

a. Authority for patient health care management in an emergency shall be vested in that licensed and/or certified health care professional, which may include any paramedic or other prehospital emergency medical personnel, at the scene of an emergency who is most medically qualified specific to the provision of rendering emergency medical care. If no licensed or certified health care professional is available, the authority shall be vested in the most appropriate medically qualified representative of public safety agencies who may have responded to the scene of the emergency.

1. Notwithstanding the above, authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority. The scene of an emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition. Priority shall be placed upon the interests of those persons exposed to the more serious and immediate risks to life and health. Public safety officials shall consult emergency medical services personnel or other authoritative health care professionals at the scene in the determination of relevant risks (Health and Safety Code 1798.6).
2. In the event that both transport and non-transport emergency medical services personnel are on the scene with the same qualifications, patient health care management will rest with the CVEMSA permitted emergency ambulance service transport provider. The first arriving paramedic shall initiate care and shall transfer care to the transport provider as soon as the “task at hand” is completed (i.e. Assessment, starting IV, etc.). All prehospital personnel shall cooperate with one another to ensure rapid and efficient care and transport of all patients per *Administrative Policy 4008-Turnover of Patient Care.* Documentation via the ePCR of care provided by all performing providers is essential.

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3. Medical management at the scene of a medical emergency includes:
   a) Medical Assessment.
   b) Medical aspects of extrication and all movement of the patient(s).
   c) Medical care.
   d) Patient destination decisions per CVEMSA Administrative Policy 7007- Point of Entry.
   e) Transport code.
4. The assignment of responsibility for patient care management in the CVEMSA System is based on resources available on scene, listed below, from the lowest level to highest level, with the emergency ambulance service transport provider paramedic having the highest level of responsibility for patient care management (medical):
   a) First responder-EMR
   b) Non-transport EMT-I;
   c) Transport EMT-I;
   d) Non-transport Paramedic;
   e) Transport Paramedic.

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EMERGENCY MEDICAL CARE COMMITTEE
LEMSA COMMITTEES

POLICY NO: **1004** PAGE 1 OF 2

REVISED DATE: October 1, 2020

APPROVED: Bryan Cleaver, EMS Administrator; Dr. Mark Luoto, EMS Medical Director

AUTHORITY: Health and Safety Code, Division 2.5, EMS, Sections 1797.204 & 1797.220

1004.1 POLICY/PURPOSE/ AUTHORITY

a. This policy defines the respective County Emergency Medical Care Committee (EMCC) responsibilities. The respective County EMCC membership shall abide by their EMCC Bylaws.

b. Health & Safety (HS) Code, Division 2.5, Sections 1797.270: "An emergency medical care committee (EMCC) may be established in each county in this State…."

c. HS 1797.272: "The county board of supervisors shall prescribe the membership, and appoint the members, of the emergency medical care committee…."

d. HS 1797.276. "Every emergency medical care committee shall, at least annually, report to the
Authority, and the Local EMS Agency its observation and recommendations relative to its review of the ambulance services, emergency medical care, first aid practices, programs for training people in cardiopulmonary resuscitation and lifesaving first aid techniques, and public participation in such programs in that county. The EMCC shall submit its observation and recommendations to the respective County Board of Supervisors which it serves, and shall act in an advisory capacity to the County Board of Supervisors and to the LEMSA, on all matters relating to emergency medical services as directed by the Board of Supervisors."

1004.2 APPLICATION AND RESPONSIBILITIES

a. HS 1797.274. "The emergency medical care committee shall, as least annually, review the operations of each of the following:"

   1. Ambulance services operating within the county.
   2. Emergency medical care offered within the county, including programs for training large numbers of people in cardiopulmonary resuscitation and lifesaving first aid techniques.
   3. First aid practices in the county.

1004.3 CVEMSA COMMITTEES

a. The following committees meet on a routine basis, and their input is instrumental to the LEMSA. For information on membership and current meeting location, dates and times visit

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the EMS Agency website at www.coastalvalleysems.org or contact the EMS Agency at (707)565-6501.

1. Medical Advisory (MAC) - Comprised of representatives from all EMS providers. This committee advises the LEMSA and the EMS Medical Director on prehospital medical care. It provides a forum for communication between all agencies.
2. Trauma Advisory (TAC) - Membership is comprised of physicians and nurses and represents participants in the trauma care system. This committee reviews the appropriateness of trauma care provided throughout the trauma system and reviews patient outcomes to identify system issues for improvement.
3. Continuous Quality Improvement (CQI) - This committee oversees the delivery of prehospital medical services in the LEMSA. All system participants have a member on the committee(s) who monitors, reviews and evaluates prehospital care delivery and efficacy.
4. Aircraft - This committee oversees and advises on compliance with agreements, responses, staffing, coordination, medical care and other issues unique to emergency medical and rescue aircraft integration in the LEMSA.
5. Provider Compliance - This committee meets to review all aspects of performance criteria contained in ambulance Exclusive Operating Agreements and all other provider contracts or agreements.

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POLICY DEVELOPMENT PROCESS

POLICY NO: **1005** PAGE 1 OF 2

REVISED DATE: October 1, 2020

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: Health and Safety Code, Division 2.5, EMS, Sections 1797.204 & 1797.220

California Code of Regulations, Title 22, Division 9

1005.1 PURPOSE

a. The purpose of this policy is to provide a mechanism for policy development including medical and administrative policies and procedures as well as EMS system standards and guidelines.

1005.2 POLICY

a. The development of EMS policies, procedures, standards and guidelines, hereafter referred to as policies, shall:
    1. Include a mechanism for the initiation of a draft document.
    2. Provide a mechanism for adequate internal staff review and input on draft document(s).
    3. Provide a mechanism for review and input of the draft document by the impacted external groups and EMCC members.
    4. Receive final approval from the EMS Administrator and Medical Director.
    5. Allow for the development of emergency policies/Special Memos by the EMS Medical Director for the immediate protection of the public health and safety.

b. Format:
    1. A standard policy format shall be maintained.

c. Process
    1. Prehospital care policies will routinely be reviewed and revised as needed. This process will be initiated by the LEMSA following the steps outlined in this policy. Suggestions for new policies or revisions will be considered from any interested agency or individual.
    2. A LEMSA staff member will draft policy and submit to all staff for internal review. The internal review period will be twenty-one (21) days, unless modified by the LEMSA Administrator. LEMSA staff will review and make comments and submit revised content.
    3. The LEMSA Administrator and Medical Director will review and approve the revised draft policy for external review. The draft policy will be made available to County EMCC

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members and all stakeholders, as determined by the responsible LEMSA staff, for a sixty day (60) external comment period. Extension of the public comment period can occur as needed to ensure adequate participation.

4. All draft policies approved for external review shall be placed on the LEMSA Website.
5. After the close of the external review period, the policy author will review and make appropriate revisions to the draft policy.
6. The revised draft policy will be re-submitted to LEMSA staff for final review. If necessary, an internal or external workshop will be scheduled to discuss the proposed policy.
7. Approved policies shall be dispersed to all parties affected with an indicated implementation date providing advance notice of no less than thirty (30) days.

d. Treatment Policy Revisions Prior to Scheduled Review

1. In order to keep pace with changes in professional clinical standards and practices, such as with ACLS, PALS, and other accepted guidelines, the LEMSA Medical Director may make changes to treatment policies prior to the scheduled review date. These revisions will be limited to significant changes in treatment standards. Such changes will be made only after consultation with applicable committees in each county.

e. Policy Revision/Implementation not Subject to Public Review

1. Revision or implementation of policies based solely on compliance with statute and/or regulations may occur without the public review process as outlined above. Such determination will be made by the LEMSA Administrator and Medical Director.

f. Provider Policies

1 No EMS service provider shall develop or institute a patient care policy/protocol that conflicts with any CVEMSA policy/protocol. This does not apply to EMS Aircraft treatment protocols developed by individual providers for their RN or other higher level of care personnel.

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COUNTY EVALUATORS AND PRECEPTORS

POLICY NO: **2007** PAGE 1 OF 1

EFFECTIVE DATE: 04-01-00
REVISED DATE:

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: California Health and Safety Code, Division 2.5 EMS

2006.1 COUNTY EVALUATORS / PRECEPTORS REQUIREMENTS

a. Evaluators for paramedic accreditation applicants and Preceptors for paramedic students must meet the Coastal Valleys EMS Agency criteria. Minimum requirements for consideration are as follows:

1. Current Paramedic licensure in California, with at least two years full time experience working as a Paramedic.
2. At least one-year full time experience as a paramedic in the Coastal Valleys EMS Region.
3. Successful completion of a CVEMSA approved Preceptor Workshop.
4. Recommendation of the paramedic provider agency.
5. Approval by the EMS Agency Medical Director.
6. Exceptions to any of these minimum requirements will be considered on an individual basis and must be approved by the Provider Agency, and the EMS Agency.

2006.2 OTHER CONSIDERATIONS

a. The EMS Agency will approve all preceptors and evaluators. The preceptors and evaluators will receive this approval in writing.

1. The paramedic provider agency will notify the Hospital Paramedic Liaison Nurse in writing at least one week in advance of student assignments.
2. Preceptor and/or Evaluator status is subject to revocation for cause after a review by the EMS Agency and EMS Agency Medical Director,

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SPECIAL EVENTS-LIMITED PARAMEDIC ACCREDITATION

POLICY NO: **2009** PAGE **1**of **3**

EFFECTIVE DATE: 08/01/2017
REVISED DATE: 07/01/2017

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY**:** Division 2.5, California Health and Safety Code, Sections 1797.178, 1797.185(a)(2)(3), and 1797.214; Title 22, California Code of Regulations Sections 100146 and 100166.

2009.1 PURPOSE

a. To allow Coastal Valleys EMS Agency (LEMSA) approved service providers to manage extra ALS personnel needs during special events within the region.

b. To define the process by which a paramedic service provider may utilize paramedics under this policy.

c. To define the scope of practice for paramedics receiving accreditation under this policy.

d. To outline the process for service provider approval and the temporary paramedic accreditation process for special events as defined.

2009.2 DEFINITION

a. “Special Event” for the purposes of this policy is any planned and organized event where an ALS service provider utilizes its personnel and resources to provide stand-by dedicated EMS services to the participants and attendees of the event.

b. “Stand-by EMS” Services for the purposes of this policy is the utilization of personnel and resources to provide EMS services above regular staffing levels which are dedicated to the event and not expected to be available to respond to incidents unrelated to the event.

2009.3 POLICY

a. Medical Control

1. Medical Control is maintained per *Administrative Policy #1001 Medical Control.*

b. Requirements for accreditation under this policy

1. Paramedics seeking accreditation under this policy shall:

a) Be currently employed by an ALS service provider in another Local EMS Agency jurisdiction

b) Be employed by the approved LEMSA service provider during the special event.

c) Hold a current and valid California paramedic license and valid accreditation issued by a Local EMS Agency.

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d) Have completed all employer agency training requirements with current ALS service provider employer

c. Application process

1. The ALS service provider will notify the LEMSA via the approved application process, at least 10 business days prior to the event. The application shall provide the following information at a minimum:

   a) The name of the special event

   b) Dates of the special event

   c) Description of event and geographic area involved

   d) Electronic entry is the preferred method for paramedic temporary accreditation applications, if unavailable a listing of applicants with supporting documentation can be provided.

2. LEMSA First Responder fee will apply to the Special Event Limited Accreditation credential and shall be due at the time of paramedic application.

d. Approval of temporary accreditation paramedics by the LEMSA

1. The LEMSA will provide proof of temporary accreditation to the paramedic service provider naming the paramedic(s) who receive accreditation under this policy, including dates of accreditation.

2. The service provider will specify the desired effective date for accreditation under this policy. Effective dates shall not exceed thirty (30) consecutive calendar days.

e. Scope of practice under this policy

1. Paramedics accredited under this policy shall be limited to the paramedic basic scope of practice outlined in Section 100146, Title 22, CCR.

2. Paramedics accredited under this policy shall not use optional scope of practice skills or medications.

f. Orientation and deployment criteria

1. The service provider shall provide orientation to temporary accredited personnel appropriate to the needs of the work environment and deployment. Orientation should include, at a minimum, the following topics:

   a) LEMSA medical control policy

   b) Limitation to providing basic scope of practice as outlined in Section 100146, Title 22, CCR

   c) Location of hospitals

   d) Base hospital contact procedures and means of hospital contact including 12-Lead transmission

   e) MCI Plan overview

   f) Access to LEMSA Treatment Guidelines

   g) Patient Care Report requirements and utilization of the provider's e-PCR system

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h) Radio frequencies and radio procedures

i) Equipment orientation

2. Paramedics utilized under this policy shall be assigned to work with either an EMT who has completed any probationary period or a regularly accredited LEMSA paramedic.
3. A paramedic utilized under this policy shall be assigned to work at the special event and shall not be assigned to work on a unit with 911 system responsibilities.
4. The paramedic service provider shall provide a report to the EMS Agency within five (5) business days outlining the number of paramedics actually used at the event, patient care provided by the temporary paramedic, and any concerns raised related to use of this policy.

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PARAMEDIC ACCREDITATION

POLICY NO: **2012** PAGE 1 OF 3

EFFECTIVE DATE: 01-06-23
REVISED DATE: 12-06-22

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: California Health and Safety Code, Division 2.5 EMS

2012.1 LOCAL ACCREDITATION REQUIREMENTS

a. The following requirements must be met to obtain accreditation as a paramedic within the Coastal Valleys EMS Region:

1. Provide evidence of possession of a current and valid California paramedic license.
2. Provide proof of employment with a designated Paramedic service provider (Service Affiliation).
3. Complete the EMS Agency's electronic application form, which includes the statement that the individual is not precluded from accreditation for reasons defined in Section 1798.200 of the Health and Safety Code.
4. Pay the EMS Agency local accreditation application fee, which is non-refundable.
5. Provide evidence of attending the Coastal Valleys EMS ALS Update course within 90 days of application.
6. Successfully complete the Coastal Valleys EMS written protocol exam.
7. Successfully complete the pre-accreditation system orientation including:
   a) Base Hospital/medical control orientation.
   b) EMS communications/dispatch orientation.
   c) 5 ALS patient contacts, under the supervision of a CVEMSA approved evaluator meeting CVEMSA criteria.
   d) Interview with EMS Agency representative to review accreditation process

NOTE: CVEMSA approved evaluators may extend the field evaluation process an additional 5 patient contacts, for a total of 10, when deemed appropriate. Nothing in this section requires that shifts of hospital, field orientation, or preceptorship be done on consecutive days.

2012.2 LOCAL ACCREDITATION PROCESS

a. Upon satisfactory completion of items 1-4 as outlined in Section 2012 above, the EMS Agency shall issue an *Interim Accreditation Authorization* which allows the accrediting paramedic to practice under the supervision of a CVEMSA-approved evaluator for the purpose of system orientation, local protocol training and evaluation. *Interim Accreditation*

Authorizations shall be valid for at least 90 days, but may be extended at the discretion of the EMS Agency.

b. Upon proof of completion of items 5-8 as outlined in Section 2012 above, the EMS Agency shall issue a local Paramedic Accreditation card which shall be valid for a period consistent with and not to exceed the period for which their current California paramedic license is valid.
c. Applicants must complete the accreditation application and field evaluation process outlined above prior to the expiration of their *Interim Accreditation Authorization.*
d. Failure to complete the local accreditation requirements within the term of *Interim Accreditation Authorization* shall constitute an abandoned application. Individuals with abandoned applications may repeat the application process if desired.

2012.3 MAINTAINING ACCREDITATION

a. Maintaining continuous accreditation as a Paramedic shall be contingent upon:
    1. Submission of the EMS Agency's paramedic accreditation electronic renewal form for the purpose of updating information and verifying license status, completion of required training and current service affiliation within 30 days prior to the expiration of current paramedic license.
    2. Maintaining continuous employment with an approved ALS provider in the Coastal Valleys EMS region.
        a. Lapses in employment for no more than 30 days are acceptable for the purpose of this requirement.
    3. Possession of a current and valid California paramedic license at all times.
    4. Completion of the ALS policy update and optional skills review program within 24 months prior to submission of electronic renewal form.
b. Paramedics failing to maintain the requirements specified above are not authorized to provide paramedic level care under CVEMSA medical control
c. Upon receipt and review of an electronic renewal form indicating the paramedic continues to meet accreditation requirements, the EMS Agency shall issue an accreditation card with a renewal date concurrent with the paramedic's California paramedic license,

2012.4 DISCRETIONARY AUTHORITY OF EMS MEDICAL DIRECTOR

a. CVEMSA Local accreditation requirements are created for the purpose of ensuring the EMS Medical Director can establish and maintain medical control over the care delivered within the EMS system. Local accreditation is not a health care certificate or license but represents the EMS Medical Director's approval for a specific individual to practice within the system at the ALS level.
b. The requirements within this policy for training and evaluation of paramedics to obtain and maintain continuous accreditation are subject to modification at the sole discretion of the EMS Medical Director. Such modifications may be required to address identified issues in quality of

care, availability of resources or any other potentially unforeseen challenge to the delivery of care within the EMS System.

c. Temporary modifications to accreditation requirements will be communicated with EMS System partner agencies with staff affected by the modifications. The EMS Medical Director will make an effort to inform and obtain feedback from EMS system stakeholder groups prior to the modification that provides a reasonable timeframe for response. Modification without input shall require an explanation with specific examples of the need for urgency in the changes to the accreditation process.

d. Any temporary modifications to accreditation requirements will be posted on the EMS Agency website no less than 30 days prior to any increase in required training prescribed by the EMS Medical Director.

2012.5 NON-ACCREDITED PRACTICE OF ADVANCED LIFE SUPPORT

a. Any paramedic practicing without a valid local accreditation issued by CVEMSA shall be deemed as practicing outside of medical control for the purpose of professional license action.

b. Any ALS care delivered by non-accredited paramedics shall be considered as care practiced without a physician order, and ineligible for reimbursement if such legal authorization is required for medical billing or other cost recovery.

FLIGHT PARAMEDIC

POLICY NO: **2013** PAGE 1 OF 2

EFFECTIVE DATE: 01-01-21
REVISED DATE: 06-01-17

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: California Health and Safety Code, Division 2.5 EMS

2013.1 LOCAL ACCREDITATION REQUIREMENTS

a. Any individual practicing as a flight paramedic under the medical control of Coastal Valleys EMS Agency (CVEMSA) must be accredited by CVEMSA.

b. CVEMSA flight paramedics accredited per the provisions of this policy are permitted to provide Advanced Life Support (ALS) as directed by the relevant Local EMS Agency policy, procedures and guidelines while on duty with an approved air ambulance provider agency authorized by CVEMSA.

c. Flight paramedics practicing on duty with an ALS first response (non-transport), ground ambulance provider agency or ALS Air Rescue agency must comply with CVEMSA policy 2012, “Paramedic Accreditation.”

d. The following requirements must be met to obtain CVEMSA accreditation as a flight paramedic:

   1. Complete the CVEMSA electronic application form including the statement that the individual is not precluded from accreditation for reasons defined in Section 1798.200 of the Health and Safety Code.
   2. Pay the CVEMSA flight paramedic accreditation fee, which is non-refundable.
   3. Successfully complete an orientation to the response area served including:
      a) Base Hospital/medical control orientation.
      b) EMS communications/dispatch orientation.
      c) CVEMSA’s policy and procedures.

2013.2 LOCAL ACCREDITATION PROCESS

a. Upon satisfactory completion of items 1-2 as outlined in Section 2013.1(d) above, CVEMSA shall issue an interim flight paramedic authorization, which shall be valid for not more than ninety (90) days.

b. Flight Paramedics holding an Interim flight paramedic authorization may be released to independent duty upon completion of item 3 as outlined in Section 2013.1(d) above, and when deemed competent to practice independently by the air ambulance provider agency.

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c. Upon submission of proof of completion of item 3 as outlined in Section 2013.1(d) above, CVEMSA will issue a flight paramedic accreditation with a renewal date concurrent with the applicant's California paramedic license.

d. Applicants must complete the accreditation application and air ambulance provider agency response area orientation process outlined above within ninety (90) calendar days of the initial date of application. Applicants not completing the process within ninety (90) days of initial application shall be required to complete a new application, including non-refundable application fee.

e. Failure to complete the local accreditation requirements shall result in suspension or revocation of accreditation to practice as a flight paramedic.

2013.3 MAINTAINING ACCREDITATION

a. Maintaining valid accreditation as a flight paramedic shall be contingent upon maintenance of current, valid California paramedic licensure, employment with a CVEMSA-approved air ambulance provider agency and timely submission of renewal documentation including a complete CVEMSA application form thirty (30) calendar days prior to the renewal date of the accreditation.

b. Paramedics failing to maintain the requirements specified above shall be required to complete a new application, including non-refundable application fee.

c. Individuals functioning as a flight paramedic without current valid accreditation will be reported as functioning outside of medical control to the California EMS Authority and may be subject to criminal and civil penalties.

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VEHICLES and INSPECTIONS

POLICY NO: **4003** PAGE 1 OF 3

EFFECTIVE DATE: 12-01-2016
REVISED DATE: 12-01-2016

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: California Health and Safety Code, Division 2.5 EMS, CCR Title22 Div. 9 CH 12,Title 13, Div 2, CH 5, H&S Code 1797.204,1797.200 and 1798, CFR 635

4003.1 PURPOSE

a. To provide guidance for minimum ambulance design, documentation and equipment standards for ambulance transportation providers and to enable a standardized inventory within the LEMSA to promote safety, readiness and the ability to meet the requirements of a disaster and system needs. *Administrative Guideline #4004 Supplies and Medications* sets minimum acceptable inventory.

4003.2 AUTHORITY

a. Ambulances shall meet standards specified in Title 13, Chapter 2, California Vehicle Code, and each shall possess a valid emergency vehicle permit issued by the California Highway Patrol. Agencies exempt from the above standard must still comply with LEMSA requirements for equipment, medication and contractual standards. All ambulances shall be maintained in good working order. Those found to be mechanically unsafe or deficient will be removed from service.

b. All ambulances will have adequate space in the patient care compartment to accommodate more than one patient. There must be sufficient space to allow for patient care activities during transport.

4003.3 SAFETY EQUIPMENT

a. Safety equipment as required per CHP specifications will be carried on all ambulances and maintained in good working order.

Note: A child safety restraint shall be incorporated/available in each transport vehicle or other support vehicle.

4003.4 MAINTENANCE OF EMERGENCY EQUIPMENT AND SUPPLIES

a. Dressing, bandaging, instruments and other medical supplies used for care and treatment of patients will be protected so that they are sanitary when ready for use. Provisions shall be made to assure autoclaving, re-sterilization or infectious disease mitigation of emergency equipment when required. All CAL OSHA and NIOSH requirements shall be followed.

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b. Clean linen or disposable sheets and pillowcases or their equivalent shall be used in the transportation of patients and shall be changed after use and laundered unless they are disposed of. Pillows with protective coverings, additional seating and benches shall be kept clean and in good repair and disinfected after each use.

c. Adequate and clean storage for the required linens, equipment and supplies shall be provided on each ambulance. The storage space shall be so constructed to permit thorough cleaning. Adequate storage, such as covered containers or compartments with plastic liners or plastic bags, shall be provided for soiled supplies, which shall be handled in such a manner as to avoid contamination of equipment and personnel.

d. Airway adjuncts, suction catheters, resuscitator masks etc. shall be cleaned and disinfected after each use or discarded. Single patient use equipment is strongly advised.

e. Patient utensils, such as bedpans and urinals, shall be sanitized after each use, or discarded. Single patient use equipment is strongly advised.

h. When an ambulance has been utilized to transport a patient with a known or suspected communicable disease, the ambulance interior and all contact surfaces shall be cleaned and disinfected. Basic guidelines to prevent and control the spread of infectious diseases are to be routinely implemented by the EMS provider. Some resources are:

1. Occupational Safety and Health Administration (CAL-OSHA) CCR Title 8, CH7, GRP16, Art 109 ,Sec 5193 BBP
2. Centers for Disease Control and Prevention (CDC), "*Bloodborne Infectious Diseases: HIV/AIDS, Hepatitis B, Hepatitis C,"* available at http://www.cdc.gov/niosh/topics/bbp/
3. CDC, "*Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Healthcare Settings*," available at http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5417a1.htm?s_cid=rr5417a1_e
4. World Health Organization (WHO), "*Standard Precautions in Healthcare,"* available at http://www.who.int/csr/resources/publications/EPR_AM2_E7.pdf
5. Ebola: http://www.cdc.gov/vhf/ebola/heathcare-us/emergency-services/ems-systems.html

i. Required PPE shall be kept on each ambulance in an easily accessible location and in sufficient quantity that all persons assigned on a ambulance have necessary and properly fitted protection.

j. The interior of the ambulance and the equipment within the ambulance shall be sanitary, vermin free and maintained in good, clean working order at all times.

4003.5 DOCUMENTATION

a. Every permitted ambulance provider shall maintain a file (electronic or paper) for each ambulance to include registration, CHP permit (if applicable), and maintenance records.

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4003.6 SPECIALTY IDENTIFICATION

a. No ambulance shall display specialty service(s) on the unit unless that unit is staffed, licensed and equipped to provide that type of care at all times when it is in service.

4003.7 RIGHT TO INSPECT

a. The LEMSA reserves the right to inspect all ambulances within the region at any time. Inspections can also occur upon license renewal, consumer complaint or as mandated by any ordinance or contract.

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SUPPLIES AND MEDICATIONS

POLICY NO: **4004** PAGE 1 OF 3

EFFECTIVE DATE: 12-01-2016
REVISED DATE: 12-01-2016

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

Authority: Health and Safety Code, Division 2.5, Section California Code of Regulations, Title 22, Division 9, Section 100173(3). CFR Title 21 Part 1300

4004.1 MINIMUM EQUIPMENT

a. All Transport, 1st Response and LALS units will be equipped with at least the equipment described in the *Administrative Guideline # 4004 Addendum List*. Providers are expected to maintain quantities sufficient for historical daily patient contact volume.

4004.2 REMOVAL OF SUPPLIES FROM ALS UNIT

a. If a Transport, 1st Response or LALS unit is not staffed or available for response at the ALS level, the provider shall ensure all ALS/LALS equipment and medications will be secured from use or removed from the unit.

4004.3 EQUIPMENT AND SUPPLY INSPECTION

a. LEMSA personnel may inspect Transport, 1st Response and LALS units at any time for compliance with the identified minimum standards for equipment and personnel. Deficiencies may result in the unit's removal from service until the deficiencies are remedied.

b. The LEMSA will notify the Provider's designated management representative immediately of the infraction.

4004.4 DRUGS AND MEDICATIONS

a. The list of drugs, medications, solutions and supplies as listed in the addendum is the ***minimum*** number to be carried on each Transport, 1st Response and LALS unit. Requests for exemptions to this section will be considered by the LEMSA on an individual basis.

b. Use of any drug, medication, needle, catheter or specialized ALS equipment outside the scope of the ALS/LALS program or personnel certification or licensure is cause for immediate suspension and for revocation of certification/licensure as well as potential criminal and civil liability.

c. All controlled substances will be kept in a secure manner at all times. Controlled substances will be secured properly and appropriately to prevent losses by any means. The ALS provider agency is responsible for insuring that this security occurs, as well as supervising adequate record keeping as described below or required by the Authority cited.

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4004.5 CONTROLLED SUBSTANCES INVENTORY LOG

a. An inventory of controlled substances assigned to an ALS Ambulance or ALS 1st Response unit will be complete and a record maintained. Controlled substances will be accounted for, attained, stored and administered in compliance with the intent of DEA - Controlled Substance Manual Standard set forth in CFR Title 21 Part 1300 to end and requirements of providers per CCR Title 22.Div. 9, Ch.4, Article 9 §100176

b. The ALS provider agency is responsible for insuring that this security occurs, as well as supervising adequate record keeping as required by the Authority cited. The LEMSA requires all controlled substances to be kept in a secure manner at all times, properly and appropriately to prevent losses by any means.

c. The drug inventory is to be completed at the start of each shift and should include the following:

   1. Date: Date of the controlled substance inventory.
   2. Shift: Assigned personnel.
   3. LEMSA approved DEA Class II, III, IV medication by trade name and count by mg or mcg.
   4. Out: Column for initials of the person(s) checking out the medication at the start of the shift.
   5. In: Column is for initials of the person(s) checking in the medication at the end of the shift.

      Note: The out and in column are to be used when the controlled medication boxes are removed from ALS Ambulance or ALS 1st Response unit.

4004.6 CONTROLLED SUBSTANCES ADMINISTRATION LOG or OTHER TRACKING MECHANISM

a. A record of any use of controlled drugs by an ALS Ambulance or ALS 1st Response unit will be maintained.

b. The Drug Administration Log or Other Tracking Mechanism is designed to show the actual circumstances under which a drug is administered, lost or broken. This information will clarify any controlled substance inventory discrepancies and include the following:

   1. Date: Date of incident.
   2. Patient : This column can contain either the ePCR, dispatch number or patient name.
   3. LEMSA approved DEA Class II, III, IV medication by trade name and mg or mcg given.
   4. Given by: The name and accreditation number of ALS personnel administering the drug.
   5. Remarks: Indicate disposition of unused (e.g., destroyed or left with R.N. or M.D.) or indicate if drug was lost or broken.

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6. Witness counting: Witness counting and verification are required for any shift change, stocking, restocking and disposal of a controlled substance where a specific count is required. The witness mechanism is dependent on the specific system in use by the provider.
7. If theft or unusual occurrences are suspected a LEMSA Event form will be completed along with reporting per the provider internal policy for reporting discrepancies.

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A. ALL BLS AND ALS RESPONSE AND/OR TRANSPORT UNITS	Transport	ALS/BLS First Response
CVEMSA Treatment Guidelines/ **Electronic access acceptable**	1	1
AED	BLS Transport	BLS Response
Clear masks in the following sizes: Adult Child Infant Neonate	1 each	1 each
Bag valve units Adult and Pediatric	1 each	1 each
Nasopharyngeal airway (adult through child sizes)	1 each	1 each
Oropharyngeal Airways	1 each size	1 each size
Oxygen with appropriate adjuncts (portability required)	10 L/min for 20 minutes	10 L/min for 20 mins.
Suction equipment-Portable with tubing, tips rigid and flexible	1	1
Nasal cannula Adult and Pediatric	1	1
NRBM-Adult and Pediatric	1	1
Oral Glucose 15gm unit dose	1	1
Bandage scissors	1	1
Bandages		
4"x4" sterile compresses or equivalent	24	12
2",3",4" or 6" roller bandage/gauze	6	4
10"x 30" or larger dressing	2	1
5"x9" or larger dressing	2	1
Vaseline gauze or chest seal	1	1
1"-3" Tape	1	1

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	Transport	ALS/BLS First Response
Burn Sheet	1	1
Blood pressure cuffs-pediatric through thigh sizes	1	1
Emesis basin/bag	2	1
Flashlight	1	1
Traction splint or equivalent device Adult- pediatric optional	1	0
Pneumatic or rigid splints (capable of splinting all extremities)	2	1
Irrigation water or saline solution- Total fluid	2000 ml	1000 ml
SMR immobilization c-spine devices adult through pediatric with head immobilizer device	1 set	1 set
SMR alternate immobilization device-Short (vacuum, KED,board,etc..)	1	
Spine Board-Long with strapping mechanism	1	1
Sterile obstetrical kit	1	1
Cold packs	1	1
Tourniquet	2	2
Surgical masks N95 minimum	4	4
Disposable Gloves-sized for crew	1 box	1 box
START Triage tags and supplies for triage implementation	25 tag	25 tag
Stethoscope	1	1
Restraints	1	
Protective equipment per State Guideline #216- set per crew member	1	1
OPTIONAL EQUIPMENT		
Nerve agent antidote per crew member		
Hemostatic gauze per EMSA guidelines		
Metronome or metronome capable device		
Mechanical CPR Device		

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B. TRANSPORT UNIT REQUIREMENTS	Transport	
Ambulance cot or other stretcher capable device to secure transportable patient	1	
Straps to secure the patient to the stretcher or ambulance cot, and means of securing the stretcher or ambulance cot in the vehicle.	1	
Scoop with straps or Flat or Carryall	1	
Appropriate Linen for total transport capabilities	1	
Bedpan, Urinal	1	
Child restraint system integrated or stand alone	1	
Fixed oxygen system M tank or greater	1	

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	ALS Transport	ALS First Response	EMT 1st Response /Transport
C. ALS/EMT UNIT REQUIREMENTS			
Electronic documentation device	1	1	1
Two-way radio or Alternate Communication Device for alternative base hospital contact	1	1	1
Blood glucose determination device (kit)	1	1	1
SpO2 monitor- stand alone or integrated	1	1	1
Cardiac Monitor/Defibrillator equipment-12 lead including all items for Adult and Pediatric	1	1	
SGA I-GEL SIZES 1-5	1 SET	1 SET	
Endotracheal intubation tubes, sizes to meet Treatment Guideline populations- with stylets 6mm to 8.5mm	1 of each size	1 of each size	
Laryngoscope, replacement bulbs and batteries	1 set	1 set	
Curved blade #2, 3, 4	1 each	1 each	
Straight blade #1, 2, 3	1 each	1 each	
Thermometer- Oral or Temporal	1		
End Tidal Intergrated Device with numeric value capable of mainstream and/or sidestream air collection	1		
End-tidal CO2 color metric detector	1	1	
Intraosseous infusion device with Large/Small/Bariatric needles 15mm,25mm,45mm	1	1	
Continuous positive airway pressure (CPAP) device	1	1	1
□ Normal saline solution, 100 ml	2	2	
□ Normal saline solution, 1000 ml (Total 3000 ml)	3	1	
IV admin set - microdrip	1	1	
IV admin set - macrodrip	3	3	
Dial a Flow	1	1	
Saline locks and/or extension sets with flush	3	1	
IV catheter, Sizes I4, I6, I8, 20, 22	3 each	3 each	
Magill forceps Adult and Child	1	1	
Aerosol masks Adult/Pediatric	1 each	1 each	
Nebulizer with in-line adapter	1	1	
Needle Thoracostomy 14ga 3.25 in.	1	1	

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Handtevy Pediatric Emergency Standard- CVEMSA Application	1	1	
Sharps container	1	1	1
Intranasal Medication Delivery device (MAD)	1	1	1
Flexible intubation stylet or other facilitating adjunct	optional	optional	
Video Laryngoscope-optional	optional	optional	
Various syringes and needles to facilitate all administration modalities	various	various	

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D. ALS MEDICATION, MINIMUM AMOUNT	ALS Transport	ALS First Response	EMT 1st Response
Adenosine, 6 mg	3	3	
Albuterol 0.83%	6	2	
Aspirin 81 mg dose, Total 324 mg	Bottle	Bottle	Bottle
Amiodarone	300 mg	300 mg	
Atropine sulfate, 1 mg/10 ml	2	2	
Atropine 8mg multi use vial	1	1	
Atrovent 0.5mg	1	1	
Diphenhydramine (Benadryl), 50 mg/ml	2	2	
Calcium chloride, 1gm/10 ml	1	1	
Dextrose 25 gm	1	optional	
Dextrose 10% Infusion	1	1	
Epinephrine 1:1,000, 1mg/ml	5	5	EPI PEN (1)
Epinephrine 1:10,000, 1 mg/10ml	6	3	
Glucagon, 1 mg/ml	1	1	
Fentanyl	300 mcg	100 mcg	
Ketamine	30 mg	30 mg	
Ketorolac (Toradal)	30 mg	30 mg	
Naloxone Hydrochloride (Narcan) 1mg/ml - 2mg total dose or 4mg IN	2	2	1
Nitroglycerine 0.4 mg dosage preparations	1	1	
Ondansetron 4 mg IV single use vial	2	1	
Ondansetron 4 mg oral	2	1	
Midazolam Hydrochloride (Versed)	10 mg	10 mg	
Sodium bicarbonate, 50 mEq/ml	1	optional	
Tranexamic acid (TXA)	1 gram	1 gram	
Controlled Substance Log or Other Tracking Mechanism per provider policy	1	1	

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ACTIVE SHOOTER - MASS VIOLENCE INCIDENT RESPONSE

POLICY NO: **4006** PAGE 1of 9

EFFECTIVE DATE: 12-01-2016
REVISED DATE: 12-01-2016

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: California Health and Safety Code, Div 2.5,CCR Title 22 Div 9,Chpt 1.5 ec 100017 (b),(c,1 e) and 100018, CCR Title 22, Division 9, Chapter 2, 3 and 4.

REFERENCES: IAB Best Practices and Recommendations for Integrating Law Enforcement, Fire, and EMS Improving Active Shooter/Hostile Event Response September 2015; USFA FEMA Active Shooter Guide September 2013; DHC First Responder Guidance June 2015 FINAL Report; City of Petaluma Fire Department Policy 7.11; Mendocino County Sherriff Department ASMCI Model Plan; California EMSA Tactical Medicine Program

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4006.1 PURPOSE/PHILOSOPHY

a. To establish policies and procedures for the dispatch and operations of a Rescue Task Force (RTF) in active shooter or mass violence incident(s) through a standardized approach. A consistent approach to policy development and implementation throughout the LEMSA provides for efficient response, planning and integration. The primary goal being to rapidly effect rescue, save lives and enable operations mitigating risk to personnel. All involved agencies need to plan, prepare and respond in a manner that will save the maximum number of lives possible. Fire, EMS, Law Enforcement (LE), Public Safety Answering Points (PSAP) and other public safety partners should work in a coordinated effort to develop standard operating guidelines for Unified Command, Common Terminology, Communications, and Common Tactics. EMS providers must develop in house polices to identify key people, as well as set training and equipment standards.

b. **Success depends upon all participants ability to integrate. Pre-event Law Enforcement, Fire, and EMS policy development, planning, training, and exercises are essential.**

4006.2 DEFINITIONS

a. **Active Shooter**: An individual or individuals actively engaged in killing or attempting to kill people in a confined and populated area; in most cases, active shooters use firearms(s) and there is no pattern or method to their selection of victims.

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b. **Ballistic Protective Equipment**: Ballistic protective gear, including body armor, for the head and body; e.g. vests, gloves, knee pads, helmets, and shields.

c. **Casualty Collection Point (CCP)**: A location that is used for the assembly, triage (sorting), medical stabilization, and subsequent evacuation of casualties. It may be an intermediary point before formal triage.

d. **Cleared**: An area has been searched and does not pose a threat.

e. **Cold Zone**: Area where no significant danger or threat can be reasonably anticipated. The area where triage and treatment of patients would occur, additional resources would be staged, and command functions carried out.

f. **Concealment**: A structure that hides a person's exact location but can be penetrated by ballistic weapons (e.g. a sheetrock wall).

g. **Contact Team**: The first responding officers/security personnel who go directly to the ongoing threat, make contact as soon as possible, and neutralize the threat in order to minimize injuries and lives lost.

h. **Cover**: An area generally impenetrable to ballistic weapons, such as a concrete wall. Something that prevents a responder from being observed by the perpetrator AND provides direct protection from the hazard/threat.

i. **Hot Zone**: Area wherein a direct and immediate life threat exists. Depends upon current circumstances and is subjective. Area is dynamic and may change frequently depending upon the situation.

j. **Incident Command System**: A management system designed to enable effective and efficient domestic incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure.

k. **Incident Command Post**: The field location where the primary functions of Incident Command are performed.

l. **Point-of-Wound Care**: The physical location (building or otherwise) where patient care is initiated or near where the victim was injured.

m. **Rescue Task Force (RTF)**: A team or set of teams deployed to provide point of wound care to victims where there is an on-going ballistic or explosive threat. These teams treat, stabilize, and remove the injured while wearing Ballistic Protective Equipment in a rapid manner under the protection of law enforcement.

n. **Secured**: An area has been searched and is now under direct Law Enforcement control.

o. **Soft Target**: A person or thing that is relatively unprotected or vulnerable, especially to attack.

p. **Tactical Emergency Casualty Care (TECC)**: TECC guidelines are a set of best practice recommendations for casualty management during high threat civilian tactical and rescue operations. Based upon the principles of Tactical Combat Casualty Care (TCCC), TECC guidelines account for differences in the civilian environment, resource allocation, patient population, and scope of practice.

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The applications of the TECC guidelines for civilian Fire/EMS medical operations are far reaching, beyond just the traditional application in tactical and Law Enforcement operations. The medical response to almost any civilian scenario involving high risk to responders, austere environments, or atypical hazards will benefit from the guidelines, including active shooter response, CBRNE (Chemical, Biological, Radiological, Nuclear, and Explosives) and terrorism related events, mass casualty, wilderness/austere scenarios, technical rescue events, and even traditional trauma response.

q. **Unified Command**: An Incident Command System application used when more than one agency has incident jurisdiction or when incidents cross political and functional jurisdictions.

r. **Warm Zone**: Area wherein a potential threat exists, but it is not direct or immediate. Operating within this zone is permissible in order to save a life, as directed by Unified Command (e,g. Rescue Task Force performing rapid extrication of a victim under security of law enforcement). This could become a much larger area depending upon the situation. Warm Zone may be dynamic and become a Hot Zone very rapidly.

4006.3 POLICY

a. Prior to entering all active shooter-mass violence event(s) a risk analysis will be performed **on scene** with Fire, EMS and LE agencies. The analysis goal is to enable the Triage, Treatment and Extraction of victims from the warm zone while under force protection by LE.

b. CVEMSA Administrative Guidelines and Treatment Guidelines shall apply during an active shooter-mass violence event(s).The utilization of Tactical Emergency Casualty Care (TECC) principals, as indicated in this policy, may initially be necessary at scene depending on specific incident events.

1) TECC Goals:
   a) Accomplish the mission with minimal casualties.
   b) Prevent any casualty from sustaining additional injuries.
   c.) Keep response team maximally engaged in neutralizing the existing threat (e.g. active shooter, unstable building, confined space HAZMAT, etc.).
   d.) Minimize public harm.

2) Medical scope should have at its core, a focus on the **THREAT** acronym:

   Threat suppression

   Hemorrhage control

   Rapid **E**xtrication to safety

   Assessment by medical providers

   Transport to definitive care

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c. The Base Hospital/Trauma Center(s) will be notified as soon as possible (pre-alert) for any active shooter-mass violence incident, and shall be utilized for patient dispersal during any event that meets the Multiple Casualty Incidents declaration threshold. **SEE CVEMSA MCI Plan**. Trauma Triage criteria will dictate the transport destination of trauma patients. See *Treatment Guideline #7007 Point of Entry* for destination determination, trauma overflow destinations and pediatric destinations.

d. The Incident Command System (ICS) will be implemented for all active shooter-mass violence incidents. UC is imperative and will be established at the onset of dispatch and arrival of resources.

4006.4 PROCEDURES

a. **Set Up** – Law enforcement will be the lead agency and will establish a Unified Command with Fire/EMS.

b. Command and control coordination should include the following:

1) Shared common terminology and communication across Fire/EMS/LE

2) Span of control

3) Jointly develop protocols/procedures for the current response.

4) Determine/prioritize need for RTF deployment:

a) Casualty treatment

b) Casualty removal from warm to the CCP or to the cold zone.

c) Movement of supplies from cold to warm zone

c. The RTF teams should be assembled quickly. Composition should consist of a minimum of four (4) personnel: Two (2) EMS/FIRE and two (2) Law Enforcement. There should be a Law Enforcement officer for each EMS provider to deliver security. RTF EMS/FIRE personnel should be EMT certified or Paramedic licensed. EMS/FIRE personnel should perform to their respective scope of practice.

d. Prior to deploying an RTF team, threat zones must be identified and the locations identified at scene :

1) Hot Zone

2) Warm Zone

3) Cold Zone

e. **Evacuation Care** (Hot or Warm Zone)

1) Evacuation care will be started **upon approval** of the IC/UC. RTF operations and personnel may enter an area once it has been initially cleared by LE in order to provide evacuation Care.

2) Only LE or specially trained and equipped EMS personnel (i.e. Tactical Medics/EMTs) will enter the Hot Zone to provide evacuation Care.

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3) The goal of evacuation care is to provide life-saving interventions and to prevent casualties from sustaining additional injuries. Minimal trauma interventions are warranted in this phase of care. Use **THREAT** acronym procedures primarily.

4) The first RTF teams in operation will enter the area and treat as many patients as possible.

5) When an RTF is operating in the **Warm Zone**, all patients encountered by the RTF teams will be treated as they are accessed.

6) Any patient who can ambulate without assistance will be directed by the team to self-evacuate down the cleared corridor under Law Enforcement direction.

7) Any patient who is dead will be visibly marked and left in place to allow for easy identification and to avoid repeated evaluations by additional RTF teams and is to be considered as investigatory evidence.

8) Additional RTF teams that enter the area should be primarily tasked with extrication of the victims already treated by the initial team(s). However, if, additional RTF teams may be sent into areas not searched by the initial teams or to other areas with accessible victims.

9) ALL areas of victim search must be through **Warm Zones**, having already been cleared by LE.

10) All personnel on RTF teams should wear tactical PPE, NIJ approved Body Armor, identifying them as EMS/FIRE personnel if available. Ideal PPE equipment consists of:

   a) Ballistic helmet

   b) Safety Glasses/Shield

   c) Ballistic Body Armor- Type/Level IV

   d) Medical care go bags with items enough for 8 victims. (See suggested inventory below.)

f. Casualty Extraction

1) If casualties can move to safety, they should be instructed to do so.

2) If casualties are unresponsive, quickly assess for respirations. If they are not breathing, leave them and move on to the next casualty.

3) If casualties are responsive but cannot move to cover, treat as needed, then extract per a tactically feasible rescue plan.

4) Recognize that threats are dynamic and may be ongoing, requiring continuous threat assessments.

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g. Casualty Collection Point (CCP) Care (Warm Zone):

1) Limited numbers of EMS personnel (as determined by the IC/UC) should enter the Warm Zone for the purposes of patient extrication or to establish a CCP. The goal of CCP care is to stabilize and re-triage casualties to permit safe evacuation to dedicated medical treatment and transport assets.

2) LE casualties should have weapons made safe by appropriate personnel once the threat is neutralized or if their mental status is altered.

3) Assess casualties and initiate appropriate life-saving interventions based on the provider's level of training and scope of practice according to *Treatment Guideline #8015 Tourniquets and #8008 Trauma Management* (as permitted by personnel or equipment resources).

4) Prevent Hypothermia as able

5) Document Evacuation/CCP Care rendered on a Triage Tag.

6) Prepare casualties for evacuation to transport staging area:

a) Consider environmental factors for safe and expeditious evacuation.

b) Assess need for SMR. Reminder: Most penetrating trauma does not require spinal precautions.

c) Consider use of mobile equipment for transferring patients to transport staging.

4006.5 EQUIPMENT

a. It is important to have consistent equipment across all teams not only for medical care but rapid identification of medical personnel. The focus should be on early hemorrhage control and rapid extrication.

b. Consider go-bags or medical vests with the ability to treat at least eight victims with extra equipment bags to treat an additional sixteen victims.

c. Equipment to consider should include:

1) Tourniquets (adult and pediatric)
2) Pressure dressings
3) Hemostatic agents
4) Occlusive chest seals
5) Adjunct airways (Adult and Pediatric)
6) Chest decompression needles (paramedics)
7) Flashlight
8) Two-way radio with remote microphone or ear piece/microphone
9) Lightweight and single person deployable patient moving devices
10) Packaging for rapid deployment of RTF equipment by team members
11) Resupply cache packaged for rapid deployment

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4006.6 DISPATCH/PSAP

a. PSAPS using PPDS[R] should implement *Protocol 136 Active Assailant (Shooter)if installed on their system.*

b. Providers should be aware that the initial dispatch will generate the following response (at a minimum):

    1) Law Enforcement patrol units

    2) Multiple Fire/EMS units

    3) Specialty LE Response units from multiple agencies

c. The first arriving units should:

    1) Determine if they are responding into a static or ongoing situation and relay this information to dispatch. Identify if predetermined staging area is safe. If not safe, consider an area out of the line of sight of incident, in line of approach to location.

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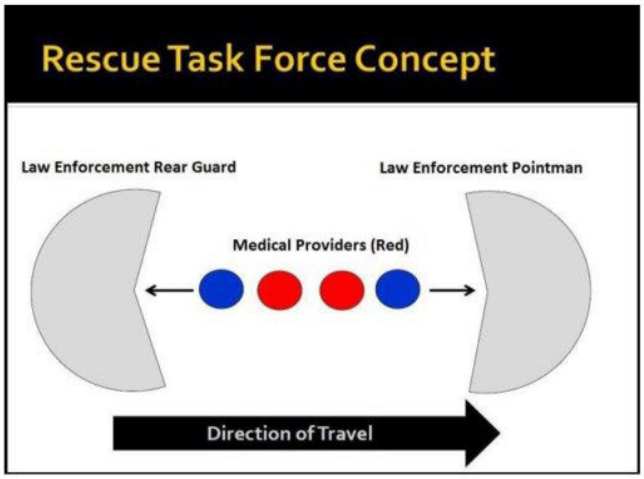

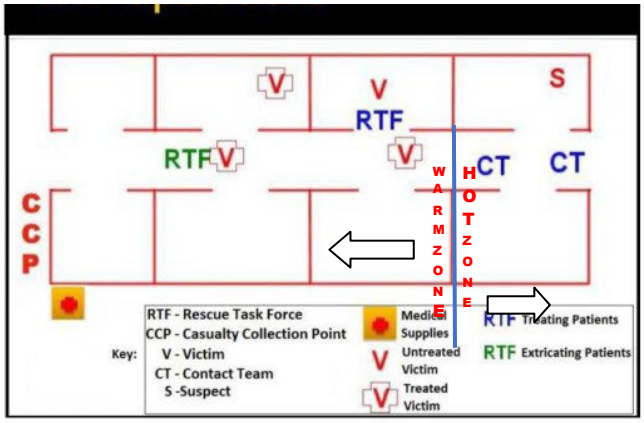

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TACTICAL MEDICAL PLANNING AND THREAT ASSESSMENT QUICK REFERENCE GUIDE

MEDICAL INTELLIGENCE (MISSION AND PATIENTS)
1. Mission Type ?
2. Number of Potential Patients?
3. Ages of Potential Patients?
4. Pre-Existing Conditions?
5. Special Populations? (Pediatric, Elderly, Language)
6. Other

MEDICAL THREAT ASSESSMENT (TEAM)
1. Weather, including Temperature (Cold, Hot) and Precipitation (Rain, Snow)? - Wind? Wind Direction? - Health Considerations?
2. Hazardous Materials? Explosive Threats? - Chemical? - Nuclear/Radiological? - Improvised Explosive Devices?
3. Biological Threats?
4. Animal Threats?
5. Plant Threats?
6. Regional Specific Threats?
7. Personal Protective Equipment Needed (Ballistic Vest, Helmet, Mask)? - As locally determined

MEDICAL PLANNING AND RESOURCES
1. Communication - Tactical Frequency _____ - Base Hospital _____
2. Location of Key Areas - Staging Area _____ - Casualty Collection Point(s) _____ - Triage Area/Treatment Area _____
3. Hospital - Closest Hospital _____ - Trauma Center/Burn Center _____
4. EMS Transport - Ground Ambulance_____Standby Location? - Air Ambulance_____Landing Zone, Lat/Long?
5. Support Services - Poison Control System 1-800-222-1222 - Veterinary Services? Animal Control? - Mental Health/Chaplain? - Social Services/CPS? - Public Works?

TEAM HEALTH CONSIDERATIONS
1. Completed Team Medical Records? - Access to Records?
2. Exposure Protection
3. Hydration
4. Food/Nutrition
5. Extended Operations, Inc. Sleep/Fatigue
6. Need for Rehabilitation Station/First Aid Station - Medical Equipment - OTC Meds
7. Other

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BASIC TACTICAL CASUALTY CARE (TCC)
CALIFORNIA QUICK REFERENCE GUIDE

HOT ZONE / DIRECT THREAT CARE (DTC) / CARE UNDER FIRE

1. Mitigate any threat and move to a safer position.
2. Direct the casualty to *stay engaged* in operation, if appropriate.
3. Direct the casualty to *move to a safer position* and apply self-aid, if appropriate.
4. Casualty Extraction. Move casualty from unsafe area, to include using manual drags or carries, or use a soft litter or SKEDCO as needed.
5. STOP *LIFE-THREATENING* EXTERNAL HEMORRHAGE, using appropriate PPE, if tactically feasible:
   - Apply effective tourniquet for hemorrhage that is anatomically appropriate to tourniquet application.
6. Consider quickly placing casualty in position to protect airway, Recovery Position, if unable to move patient immediately and tactically feasible.

WARM ZONE / INDIRECT THREAT CARE (ITC) / TACTICAL FIELD CARE

1. Law Enforcement casualties should have weapons made safe once the threat is neutralized or if mental status is altered.
2. AIRWAY MANAGEMENT:
   a. Unconscious patient without airway obstruction:
      - Chin lift or jaw thrust maneuver.
      - Nasopharyngeal airway, if approved by LEMSA as an optional skill
      - Place patient in Recovery position.
   b. Patient with airway obstruction or impending airway obstruction:
      - Chin lift or jaw thrust maneuver.
      - Nasopharyngeal Airway, if approved by LEMSA as an optional skill
      - Allow patient to assume position that best protects the airway, including sitting up.
      - Place unconscious patient in Recovery Position.
3. BREATHING:
   a. All open and/or sucking chest wounds should be treated by applying an Vented Chest Seal or non-vented occlusive seal to cover the defect and securing it in place. Monitor for development of a tension pneumothorax.
4. BLEEDING:
   a. Assess for unrecognized hemorrhage and control all sources of bleeding. If not already done, use a tourniquet, and appropriate pressure dressing.
   b. For compressible hemorrhage not amenable to tourniquet use, apply a California EMS-approved hemostatic dressing with a pressure bandage.
   c. Reassess all tourniquets that were applied during previous phases of care. Consider exposing the injury and determining if a tourniquet is needed. If a tourniquet is not needed, use other techniques to control bleeding and remove TQ.
5. ASSESS FOR HEMORRHAGICSHOCK
   a. Elevate Lower Extremities if patient in shock.
6. PREVENTION OF HYPOTHERMIA:
   a. Minimize patient's exposure to the elements. Keep protective gear on if feasible.
   b. Replace wet clothing with dry if possible. Place onto an insulated surface ASAP.
   c. Cover the casualty with self-heating Blanket or rescue blanket to torso, Place hypothermia prevention cap on the patient's head. Use dry blankets, poncho liners, sleeping bags, or anything that will retain heat and keep the patient dry.
7. PENETRATING EYE TRAUMA:
   If a penetrating eye injury is noted or suspected: a) perform a rapid field test of visual acuity; b) cover the eye with a rigid eye shield (NOT a pressure patch).
8. REASSESS CASUALTY AND TREAT OTHER CONDITIONS AS NECESSARY:
   a. Complete Secondary Survey checking for additional injuries or conditions. Inspect and dress known wounds that were previously deferred.
   b. Consider Splinting known/suspected fracture or Spinal Immobilization, if indicated.
   c. Use Nerve Agent Auto-Injector (ie Duo-Dote) for Nerve Agent Intoxication, if approved by LEMSA as an optional skill.
   d. Use EpiPen for Anaphylactic Reaction, if approved by LEMSA as an optional skill.
9. BURNS:
   a. Aggressively monitor airway and respiratory status for casualties with smoke inhalation or facial burns, including oxygen or cyanide antidote treatment when significant symptoms are present.
   b. Estimate TBSA and cover burn area with dry, sterile dressings.
10. MONITORING:
    Apply monitoring devices or diagnostic equipment if available. Obtain vital signs.
11. PREPARE CASUALTY FOR MOVEMENT:
    - Move packaged patient to site where evacuation is anticipated.
    - Monitor airway, breathing, bleeding, and reevaluate the patient for shock.
12. COMMUNICATE WITH THE PATIENT IF POSSIBLE:
    - Encourage, reassure, and explain care.
13. CARDIOPULMONARY RESUSCITATION (CPR) AND AED:
    Resuscitation in the tactical environment for victims of blast or penetrating trauma who have no pulse or respirations should only be treated when resources and conditions allow.
14. DOCUMENTATION: LEMSA Option
    Document clinical assessments, treatments rendered, and changes in the patient's status. Forward this information with the patient to the next level of care.

California EMS Authority (2015 Revision)

BLUE—Authorized Basic Skills for Public Safety First Aid Providers and EMTs
RED—Local Optional Skill which may be added by the Local EMS Agency Medical Director

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COASTAL VALLEYS EMS AGENCY

EMS AIRCRAFT

POLICY NO: **4007** PAGE 1 OF 6

EFFECTIVE DATE: 1/1/2021
REVISED DATE: 10/26/2020

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: California Health and Safety Code, Section 1797 et sec and California Code of Regulations, Title 22, Division 9, Chapter 8 "Prehospital EMS Aircraft Regulations".

4007.01 DEFINITIONS

Air Ambulance: Any aircraft specifically constructed, modified, or equipped, an used for the primary purpose of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has a minimum of two (2) attendants licensed in Advanced Life Support (ALS). One of the attendants must be a registered nurse. All air ambulance aircraft must maintain CAMTS certification.
Rescue Aircraft: An aircraft which does not have a medical flight crew that meets minimum requirements established in regulations for classification as an air ambulance. Also, an aircraft that does not primarily function as prehospital emergency patient transport but which may be utilized, in compliance with local EMS policy, for prehospital emergency patient transport, when use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft include ALS rescue aircraft, Basic Life Support (BLS) rescue aircraft and auxiliary rescue aircraft.
EMS Aircraft: Any aircraft utilized for the purpose of prehospital emergency patient response and transport. EMS aircraft includes air ambulances and all categories of rescue aircraft.
Air Medical Resource Management: A management system which makes optimum use of all resources, including but not limited to equipment, procedures, and personnel to promote safety and enhance the efficiency of flight operations.
Authorizing Agency: Local EMS agency which approves utilization of specific prehospital EMS aircraft within its jurisdiction.
Classifying Agency: Entity which categorizes the prehospital EMS aircraft into the groups identified in California Code of Regulations Section 100300 (c)(3). This shall be the local EMS agency in the jurisdiction of origin except for aircraft operated by the California Highway Patrol (CHP), the California Department of Forestry (Cal Fire) or the California National Guard which shall be classified by the EMS Authority.
Emergency Landing Zone: the term used to designate an "emergency landing site" of an EMS aircraft by a public safety official.
ED: Emergency Dispatch
Flight Paramedic: California-licensed paramedic accredited by Coastal Valleys EMS Agency as an approved paramedic to transport patients with an RN and operate to include flight paramedic optional scope. All terms not specifically defined in this section are provided in the California Code of Regulations, Division 9, Chapter 8: Prehospital EMS Aircraft Regulations."

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4007.02 AUTHORIZATION OF EMS AIRCRAFT

a. All EMS aircraft providing prehospital patient transport within the jurisdiction of CVEMSA must be authorized by the CVEMSA. Authorization will be provided by written agreements between the CVEMSA and EMS Aircraft provider.

b. Notwithstanding the requirement for a written agreement set forth above, aircraft operated by California Highway Patrol, California Department of Forestry and California National Guard may be authorized to operate as an EMS aircraft by a designated dispatch center.

c. A request to out of area EMS aircraft providers by a designated dispatch center shall constitute authorization to respond to that emergency only and does not provide ongoing authorization for operation within the LEMSA jurisdiction.

4007.03 COMPLIANCE WITH APPLICABLE LAWS, REGULATIONS, ORDINANCES, POLICIES & PROCEDURES

a. All EMS aircraft shall adhere to all federal, state and local statues, ordinances, policies and procedures related to EMS aircraft operations, including the qualifications of flight crews, aircraft maintenance and equipment standards (CA Health and Safety Code 1797.18 and Title 22, Division 9: Prehospital Emergency Medical Services §100300 - §100306).

4007.04 MEDICAL STAFFING REQUIREMENTS

a. In accordance with state and local requirements- EMS aircraft shall be staffed at all times with medical personnel accredited by the appropriate CVEMSA Policy as follows:
   1. Air Ambulance – Minimum of two (2) attendants licensed in advanced life support, e.g., accredited flight paramedic, registered nurse, and physician.
   2. ALS Rescue – Minimum of one (1) attendant licensed in advanced life support, e.g., paramedic.
   3. BLS Rescue – Minimum of one (1) attendant certified as an EMT.

4007.05 MEDICAL CONTROL

a. Medical control for patients cared for and transported by EMS Aircraft from the scene shall be under the direction of the CVEMSA Medical Director.

b. EMS aircraft medical crew members are subject to LEMSA Administrative Guidelines.

c. The LEMSA Medical Director may provide medical direction in coordination with the EMS aircraft provider agency Medical Director through provider's LEMSA approved treatment guidelines and operational protocols for Inter-Facility Transfers.

4007.06 AUTHORIZED EMS AIRCRAFT DISPATCH CENTERS

a. EMS aircraft may respond to a prehospital scene emergency only upon the request and direction of the authorized EMS aircraft dispatch centers:
   1. Sonoma County – LEMSA Authorized Dispatch Center

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2. Mendocino County – LEMSA Authorized Dispatch Center

4007.07 DISPATCH OF EMS AIRCRAFT

a. Authorized dispatch centers will simultaneously dispatch the appropriate EMS air ambulance along with the ground ambulance. In addition, rescue aircraft will also be dispatched when scene information indicates the need for rescue capabilities. Dispatch of EMS aircraft will occur for all scene locations greater than 30 minutes ground transport time to the closest receiving facility, in accordance with emergency dispatch determinate codes as defined by Medical Direction. All air resources responding to an incident must be dispatched by the authorized dispatch center.

1. EMS aircraft shall remain en-route to an incident until an on-scene evaluation is conducted by highest level of medical personnel at scene and determines appropriate transport.
2. An air resource cannot cancel another air resource unless there is a safety concern.
3. All air resources, air ambulance and air rescue, entering and exiting Mendocino or Sonoma Counties shall notify the LEMSA -Authorized Dispatch Center for that County. Advisement shall include their intent and area of the county that they will be available to respond from.

4007.08 REQUESTING EMS AIRCRAFT BY RESPONDING UNITS

a. Emergency personnel that have knowledge of the scene or additional information beyond that provided by the dispatch center may request an EMS aircraft be dispatched. After assessing the scene the emergency personnel may cancel or ask for a continued response by the EMS aircraft. .

b. The patient(s) meets CVEMSA prehospital trauma triage criteria and /or on-scene personnel determine the use of the prehospital EMS Aircraft will provide a significant reduction in transport time to a receiving facility capable of providing definitive care

4007.09 DETERMINING TYPE OF AIRCRAFT RESPONSE

Authorized dispatch centers will request from an authorized air resource dispatch center to dispatch the closest most appropriate available air ambulance resource to the scene.

a. In the event the primary aircraft is not available, the authorized air dispatch center shall send the next closest air ambulance**.**

b. In the event that an ALS air rescue has a time savings of greater than 10 minutes that air rescue should be dispatched in addition to the air ambulance.

1. The primary care paramedic at scene upon assessment (ground) will make the determination as to which aircraft to cancel based on the medical care needed and destination requirements of the patient.

c. A rescue aircraft should be dispatched to any rescue incident.

Dispatch centers shall advise EMS aircraft and field personnel when multiple aircraft are responding

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4007.10 SCENE SAFETY & COORDINATION

a. The responsibility for scene management and safety shall be under the control of the Incident Commander (the appropriate public safety agency having primary investigative authority; Health & Safety Code § 1798.6)

b. Management of the scene shall be conducted in a manner that minimizes the risks to the patient and other persons while recognizing the importance of ensuring appropriate medical care and transportation.

c. The Incident Commander shall consult with on-scene emergency medical personnel in making decisions regarding the use of or landing of an EMS aircraft. (HSC § 1798.6).

d. The Incident Commander (or designee) shall have the authority for allowing an EMS aircraft to land. Notwithstanding this authority, the pilot of any EMS aircraft has the final discretion regarding the decision to respond to any incident if in his/her judgment such flight imposes undue risk or danger.

e. If the EMS aircraft pilot questions safety, they shall have the final authority in the decision to continue or cancel the response. Air medical crew resource management and/or the pilot in command may deviate from LEMSA destination policy based on safety concerns.

4007.11 DESTINATION OF SCENE PATIENTS TRANSPORTED BY EMS AIRCRAFT

a. The patient should be transported to the closest appropriate hospital per CVEMSA Point of Entry Guidelines with an Emergency Department that has an approved helipad or emergency landing site. Emergency Landing Sites (ELS) or heliport stops are acceptable landing locations when required by patient or weather conditions. If a patient is requesting to be transported outside of the CVEMSA region and the flight team believes there would be benefit, the base hospital should be contacted for a consultation.

4007.12 CANCELLATION OF EMS AIRCRAFT

a. After a complete patient assessment, qualified on-scene personnel may cancel the aircraft if they determine that ground transport is more appropriate, through Incident Command.

4007.13 COMMUNICATIONS

a. EMS aircraft shall have the capability of communicating with:

1. The approved dispatch centers
2. EMS ground units and first responders
3. Designated base hospitals
4. Receiving hospitals
5. Other aircraft on air to air frequency 123.025mhz
6. Other appropriate facilities and/or agencies as may be necessary

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4007.14 TRANSPORTATION OF EMERGENCY PERSONNEL

a. When appropriate and necessary, EMS aircraft may be used to transport first responders, EMS personnel, or equipment/supplies to the scene of an emergency or other location.

4007.15 UNUSUAL OCCURRENCE REQUEST DOCUMENTATION

a. When an EMS aircraft is requested for situations not meeting accepted criteria, the designated dispatch center receiving the request shall report the occurrence to the CVEMSA via CVEMSA EMS Event Reporting policy within 72 hours of the incident.

4007.16 CQI

a. All EMS aircraft scene calls will be reviewed by CVEMSA to evaluate appropriate utilization, deviation from protocol, dispatch trends and to assess EMS system management.

b. The CVEMSA may select a special review committee that will systematically review each EMS aircraft flight for appropriate utilization and adherence to policy standards.

Consistent with Chapter 12 of Title 22 of the California Code of Regulation, EMS aircraft service providers are to develop and participate in a CQI program in cooperation with the LEMSA as outlined in CVEMSA Administrative Policy 6002.

SPECIAL CIRCUMSTANCES

4007.17 ON-SITE LANDING ZONE

a. Field personnel may use on-site hospital helipads as landing zones for aircraft rendezvous when patient's condition requires transport to a specialty care center.

b. The hospital with the helipad has no Emergency Medical Treatment and Active Labor Act (EMTALA) obligations to the patient as long as:

1. The hospital is not the receiving facility.
2. Neither the ground or air crew requests assistance, with patient care, from hospital staff. *Hospital staff do not need to make contact with crew or patient.*

c. The incident commander (IC) or designee shall notify the hospital of the intended use of their helipad for transporting a patient to another receiving facility.

4007.18 LANDING SITE FOR INTER-FACILITY TRANSFER FLIGHTS

a. Off-site landing determination for inter-facility transfers applies to Santa Rosa Memorial Hospital only. This determination is required pursuant to impacts and mitigation measures established in the Environmental Impact Report (EIR) for the Level II Trauma Center Designation at the hospital. In consultation with the sending physician, EMS Aircraft will use the following criteria to determine the appropriate on-site vs. off-site landing location for inter-facility transfer patients being transported by helicopter:

1. Is the patient intubated and /or requiring ventilatory assistance?

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2. Does the patient have an unstable cervical spine fracture?

b. Does the patient require any of the following emergent interventions:

1. Active titration of cardiovascular or tocolytic agents
2. Active treatment of cardiac related pain
3. Active fluid resuscitation
4. Emergent diagnostic and/or surgical interventions

c. If the answer is “yes” to any of the above questions, the helicopter should land at Santa Rosa Memorial Hospital. If the answer is “no” to all of the above questions, the helicopter should land at an appropriate off-site landing location.

d. The medical flight crew should discuss the decision regarding use of on-site vs. off-site landing as per the above criteria with the transferring physician prior to initiating transport. The medical flight crew may include the receiving physician at the destination hospital in that discussion.

e. The helicopter flight crew shall contact the appropriate ground ambulance communications center to request a ground unit whenever an off-site landing location is utilized. Such contact will be initiated in a timely manner to ensure the availability and response of the ground unit to meet the helicopter at the off-site location.

f. The transfer of care, if occurring, will be conducted in accordance with EMS policy and procedures. If at any time during transport of patient’s condition deteriorates such that it poses a threat to life or limb, the flight crew may cancel the off-site landing and transport to the on-site location.

g. In the event that a flight does not result in an off-site landing as specified above, an EMS Event Report documenting the circumstances, along with an electronic PCR shall be submitted by the flight crew to the LEMSA within 72 hours of the incident.

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TURNOVER OF PATIENT CARE

EFFECTIVE DATE: 05/12/2024
REVISED DATE: 04/12/2024

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798 & 1798.6. California Code of Regulations, Title 22, Division 9, Section 100169 100175

4008.1 POLICY and INTENT

The purpose of this policy is to define the process for the transfer of care between prehospital care providers.

4008.2 DEFINITIONS

a. **BLS**: EMT level of care
b. **ALS:** Paramedic level of care
c. **First Response:** Non-ambulance EMS response
d. **Transport**: EMS ambulance
e. **IC**: Incident Commander

4008.3 TRANSFER OF RESPONSIBILITY - PATIENT TURNOVERS

a. Patients under the care of a First Responder or transport provider may be transferred to another provider or transport unit, if the level of care is appropriate for the patient's condition.
b. Providers transferring care will provide the transport care provider with a complete report on the patient's condition, treatment provided and properly document the transfer of responsibility and care per *Administrative Guideline #6001 ePCR Completion*
c. Transition of patient care may be affected by scene hazards such as SWAT operations, heavy rescue, crash-fire-rescue, confined space rescue or hazardous materials incidents. In such hazardous situations, the Incident Commander (IC) shall determine when the patient can be safely accessed by transport care providers.
d. The care provider with patient health care authority shall comply with all IC decisions regarding scene safety. The care provider with patient health care authority shall keep IC informed of resource needs and medical decisions.
e. ALS First Response or ALS transport personnel may transfer care of patients to BLS transport units if an assessment on scene has been completed, the patient is deemed stable, and does not meet the following BLS Exclusion Criteria:

BLS Exclusion Criteria:

1. Airway emergencies
2. Respiratory distress that has received any ALS intervention
3. Unresolved hypotension for any reason
4. Cardiac-related working primary impression
5. Suspected stroke, regardless of time of onset
6. Acute change in mental status
7. Severe **acute** pain where complaints of pain and physical exam are consistent
8. Anaphylaxis. This is defined as systemic symptoms characterized by respiratory findings and shock, usually within 30 minutes of exposure. This does not include localized swelling and itching at site of exposure.
9. Obstetric complaint with reported gestational age of 20 weeks or later
10. Hypoglycemia when the patient cannot safely take oral glucose during transport
11. Paramedic Discretion: Any condition where the complaint, or extent of a known problem is unclear. Examples include multiple trauma, severe abdominal pain in a patient with co-morbid conditions of age and complex medical history, etc.
12. Meets Specialty Care destination/activation/alert criteria

f. The process to ensure patient transport ***safety*** will include:

1. Patients must be stable with medical complaints that can be cared for at the BLS level. Before transferring care to the BLS transport unit, the examining paramedic will reasonably determine that there are no anticipated changes in the patients' present condition.
2. ALS assessment tools may be utilized (such as EKG monitoring and blood glucose determination) in order to fully assess the patient and determine eligibility for turnover to BLS. Saline locks are permissible.
3. All administration of ALS medications requires the patient to remain under the care of ALS personnel with the **exception of Ondansetron-PO.**
4. Except during a declared MCI or when no other ALS transport alternative exists, patients meeting trauma criteria will be considered ALS patients and treated accordingly.
5. The EMT who will be in attendance is comfortable with the patients' condition and fully accepts responsibility for the patient and ongoing care.

4008.4 TRANSFER BETWEEN SPECIALTY UNITS AND CIRCUMSTANCES

a. Flight nurses may turn patients over to paramedics. These patients must not have or require any medications or therapies that are outside the paramedic scope of practice, and the transporting paramedic must agree to accept responsibility for the patient.

b. These same procedures should be utilized for turnovers from, or to, specialized transport

vehicles or other modality as long as the delay caused by the turnover is offset by a safer or more rapid transport overall.

c. These procedures will also apply when providers caring for patients in a standby capacity at a special event or mass gathering and require another unit to transport from the event location.

4008.5 MEASURABLE INDICATORS

a. A patient status change resulting in the BLS transport unit upgrading to an emergent transport or requesting emergent ALS assistance or intercept will be a sentinel event requiring investigation. All sentinel events will be reviewed by the provider Medical Director.

b. Medical decisions or actions of the care provider, at the time of occurrence, that seem to be non-compliant with LEMSA policies and procedures should be brought to the attention of the IC, when present. The IC **may** intervene by advising the involved medical care provider of such concerns. If concerns persist after consultation and communication with the care provider, the Base Hospital should be contacted. The Base Hospital Physician has final authority over patient care decisions. The IC will submit a written incident report detailing the concerns via the LEMSA Event Reporting system per *Administrative Guideline #6003 EMS Event Reporting*.

c. Any significant problem which poses a potential or actual threat to patient care or public health and safety that requires immediate attention should be brought to the attention of the IC, or Incident Safety Officer, if one is appointed. Care providers should follow up by preparing an incident report which provides a factual summary of the incident, actions, results and incident outcome. Incident reports shall be submitted through the organization, agency or department chain of command, with referral to the LEMSA.

PROCEDURES FOR CVEMSA PARAMEDICS OUTSIDE OF THE REGION

POLICY NO: 4009 PAGE 1 OF 3

EFFECTIVE DATE: 08/01/2017
REVISED DATE: 07/01/2017

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: California Code of Regulations Title 22, Division 9, Section Chapter 2,3,4. Health and Safety Code, Sections 1797.170(b),1797.204, and 1797.220, CA Mutual Agreements and Guidelines and EMSA whitepaper 2011

4009.1 PURPOSE

a. To provide guidelines for Coastal Valleys EMS Agency (LEMSA) paramedics when providing care during authorized transports, auto aid, mutual aid and disaster responses outside of the LEMSA area. This includes responses for officially requested Fireline Paramedic Programs and Ambulance Strike Teams, along with State/Federal Agencies need requests or contract fulfillment requests.

b. With the exception of on-view incidents, this policy does not authorize ALS operation within another LEMSA Area without a mutual-aid request from that area and approval from CVEMSA or CVEMSA-Approved EMS Communications Centers.

4009.2 POLICY

a. This policy is intended to permit the provision of ALS level care during emergency operations/situations and inter-facility transportation. It is not intended to replace existing emergency medical services or circumvent the established response of emergency medical services in locations outside of the LEMSA.

b. A paramedic who is on-duty with an approved ALS provider is authorized to practice paramedic level skills in compliance with all LEMSA prehospital care policies during the treatment or transportation of patients from within the LEMSA area to destinations outside of the LEMSA area. A paramedic who is on-duty with an approved LEMSA ALS provider on authorized mutual aid, Fireline Paramedic assignment or auto aid deployment may perform paramedic level skills during emergency operations outside the LEMSA in compliance with LEMSA policies and treatment guidelines.

c. A paramedic who is on duty with an approved LEMSA ALS provider is authorized to provide paramedic level care in compliance with all LEMSA policies and treatment guidelines if presented with a patient contact while outside the LEMSA area (on-view) until patient care can be handed over to the local EMS ALS Ambulance provider.

d. Provider Agency EQIP will be completed as indicated in *Administrative Policy #6002 Quality Improvement Program.*

e. The paramedic must have access to the Advanced Life Support equipment as required by *Administrative Policy #4004 Supplies and Medications*, except as defined in the following sections.

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4009.3 FIRELINE PARAMEDICS (FEMP):

a. ALS Provider Agencies shall develop and submit to the LEMSA, policies and procedures for the deployment of FEMP resources. At minimum these policies will include:

   1. Narcotics shall be stored and handled in accordance with *Administrative Policy #4004 Supplies and Medications* and in compliance with any additional ALS Provider Agency procedure developed for FEMP operations.
   2. Procedures for Continuous Quality Improvement and Clinical Quality Assurance of the care delivered by paramedics deployed in the FEMP role.
   3. Documentation practices to comply with *Administrative Policy #6001 ePCR Completion*. As electronic documentation of patient care may be impossible, FEMPs may utilize the CVEMSA "Field Notes" form; with later entry in to the electronic format.

b. ALS Provider Agencies must obtain approval from CVEMSA prior to deploying personnel under this policy.

c. Designation by an ALS Provider Agency as a FEMP must include verification the paramedic has completed standard FIRESCOPE training and meets requirements mandated for that position.

d. Paramedics operating during emergency operations as a Fireline Paramedic (FEMP) shall be subject to the provisions of California OES/FIRESCOPE Position Manual ICS 223-11, and shall comply with ICS 223-11 as applicable to their assignment.

e. The FEMP shall present their credentials (paramedic license and department identification) to the Medical Unit Leader at the incident.

f. The complement of required equipment, medication and supplies may be varied for special assignments or circumstances (i.e. ICS 223-11 FEMP) by the CVEMSA Medical Director. **Reference 4009.5 for the FEMP minimum equipment inventory.**

g. All ALS equipment and supplies are to remain under the direct control of a paramedic at all times. If a paramedic is on an extended assignment, is relieved of duty, and another paramedic does not assume control of the ALS equipment and supplies, all such equipment and supplies must be secured in such a manner as to prevent access by non-paramedic personnel.

h. Paramedics shall follow the directions of the Incident Commander or other designated ICS official, as appropriate.

4009.4 FEMP CONTROLLED SUBSTANCE INVENTORY

a. ALS Provider Agencies shall carry a minimum controlled substance inventory to meet the expected need, secured in the vehicle to act as a resupply cache. In circumstances requiring the paramedic to deploy to the fire line on foot, the following controlled substance inventory shall be allowable in the FEMP backpack:

   1. Midazolam: up to 20 mg
   2. Fentanyl: up to 600 mcg ***or*** 60 mg Morphine Sulfate as a substitute medication per *Treatment Guideline #9007 Alternate Medications*.
   3. FEMP paramedic backpack must be in constant possession of assigned paramedic with controlled substances secured per DEA and CVEMSA locking requirements.

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4009.5 FEMP INVENTORY

FEMP Inventory Sheet (rev 9/16)	1	Macro drip IV tubing	2
Compact AED/SAD	1	16 gauge IV catheter, over the needle	2
AED/SAD patches	2	18 gauge IV catheter, over the needle	2
Pleural decompression kit	1	20 gauge IV catheter, over the needle	2
Laryngoscope handle	1	Syringes, 10 mL	2
Intubation stylet, adult	1	1 mL	2
Water-soluble lubricant	1	Needles, 18 ga.	4
Magill forceps, adult	1	25 ga.	2
Endotracheal tubes, size 6.0, 7.5	1 each	Bag/valve mask (Adult)	1
Laryngoscope blades, Mac/Miller #4	1 each	Oropharyngeal airways	Adult Sizes
Size 3,4 and 5 King airway	1 each	Cervical collar, adjustable	1
ET tube holder	1	4" x 4" sterile compresses	6
Pulse oximeter	Optional	3"-5" rolled bandages (Kling/Kerlix)	2
End-tidal CO2 detectors	1	40" triangular bandages	2
If FEMP will carry O2:		10" x 30" Multi-trauma dressing	4
Aerosol masks, adult	1	Moldable splint	1
Nebulizer sets	1	Ace bandage or equivalent	2
Albuterol 0.083%, 3 cc unit dose,	4	Eye wash	1 bottle
Atrovent, 0.5mg in 3cc saline unit dose	2	Petroleum dressing/chest seal	2
If FEMP will not carry O2:		1” cloth tape	2
Albuterol MDI 90 mcg./puff	1	Burn sheets, sterile	2
Amiodarone 150 mg	3	Cold pack	3
Atropine Sulfate, 1 mg	2	Splinter kit	1
Aspirin, chewable 81 mg	1 bottle	Portable blood pressure cuff, adult	1
Benadryl, 50 mg/cc	4	Flashlight	1
Dextrose 50%, 25 Gm/50 cc	1	Manual suction device	1
Dextrose 10%, 250 cc	2	Bandage shears	1
Epinephrine 1:1000, 1 mg/1 cc	4	Masks, disposable with eye shield	1
Epinephrine 1:10,000, 1 mg/10 cc	2	Gloves, disposable non-latex	2 pair
Glucagon, 1mg/ml,	1	Pad, writing with pen and pencil	1
Glucose paste, oral	1	Digital thermometer	1
Midazolam 10mg	2	Space blanket	2
Morphine Sulfate (**as substitute med only)**	60 mg	Stethoscope	1
Fentanyl	600 mcg	Patient care reports- field notes	6
Naloxone Hydrochloride 1mg/cc	2	RAS-AMA form	3
Nitroglycerine, 0.4 mg/SL tablets, bottle or spray, 0.4 mg per dose	1	Triage tags/tape	6
Glucometer with lancets and strips	1 Kit	Controlled substance log	1
IV start tourniquet	2	Compact sharps container	1
1” adhesive tape	1	Locked narcotics storage system	1
Disposable razor	1	Antiseptic hand wipes	10
IV site dressing	2	Biohazard bag	2
Alcohol preps	6	12 lead ECG recommended	
NS IV solution total volume carried	1000 mL		

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EMT TRANSPORT OF EMERGENT PATIENTS

POLICY NO: **4010** PAGE 1 OF 2

EFFECTIVE DATE: 05/12/2024
REVISED DATE: NEW

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798 & 1798.6. California Code of Regulations, Title 22, Division 9, Section 100170

4010.1 POLICY AND INTENT

The purpose of this policy is to provide direction for EMTs making transport decisions for emergent patients in their care. While in general patients meeting criteria for ALS transport should be turned over to ALS personnel, in certain circumstances, the rapid BLS transport of an emergent patient is preferable to waiting for ALS response or intercept.

4010.2 BLS IMMEDIATE TRANSPORT

EMTs with emergent patients in their care must determine the ETA of ALS unit to their location. In cases where the time to the arrival of an ALS unit to the scene is longer than the combination of patient extrication and transport time to an appropriate ED, the BLS unit should transport the patient without delay. If EMT personnel determine immediate transport is appropriate, any ALS response to the scene should not be canceled until the BLS ambulance is enroute to the closest hospital.

4010.3 ALS INTERCEPT

In some circumstances, EMTs should rendezvous with an ALS ambulance or first responders to access ALS care.

Rendezvous Procedure:

1. EMTs shall contact the dispatch center as soon as possible to request an ALS rendezvous if an ALS ambulance is not responding to the incident., The request for ALS intercept should be made as early as possible.
2. The BLS transporting unit shall not wait at the scene for a rendezvous.
3. Once a rendezvous location has been identified and if the BLS transporting unit arrives to that location prior to the ALS ambulance, the BLS transporting unit shall not wait at the initial rendezvous site if there is extended wait time for the ALS ambulance arrival. If the ALS rendezvous unit has not arrived at the rendezvous site, the BLS transporting unit should proceed to the next best rendezvous location or to the closest hospital without delay.
4. The EMS dispatch center will monitor and support communication for the rendezvous; however, EMS units may also communicate directly to provide a report on patient condition and/or additional rendezvous information if appropriate.
5. When the rendezvous occurs, paramedic personnel shall join the patient in the back of the BLS ambulance transporting the patient. Good pre-rendezvous communications are

essential to allow the paramedics to prepare the proper equipment for transfer into the transporting unit.

PUBLIC SAFETY DEFIBRILLATION

POLICY NO: **4011** PAGE 1 OF 1

EFFECTIVE DATE: 08/01/2017
REVISED DATE: 07/01/2017

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: California Health and Safety Code, Division 2.5 EMS, CCR Title 22. Division 9 Chapter 1.5

4011.1 PURPOSE

a. To develop minimum standards for Public Safety AED Service Providers and Personnel as authorized in California Code of Regulations (CCR) Title 22 Div. 9 Ch.1.5 § 100021.

4011.2 DEFINITIONS

a. A Public Safety AED Service Provider is an agency or organization that is responsible for, and is approved to operate AEDs.

4011.3 REQUESTS FOR AUTHORIZATION AND PROGRAM AUTHORIZATION

a. Public safety AED service providers shall be approved by the LEMSA, or in the case of state or federal agencies, the California EMS Authority, prior to beginning service.

b. Any Public Safety AED Service Provider wishing to utilize AEDs within the LEMSA area will be approved if they meet the following requirements in conformity with CCR Title 22 § 100021:

   1. Submission of CVEMSA Public Safety AED Service Provider Authorization form.
   2. Provide an orientation to the AED for authorized personnel.
   3. Ensure maintenance of AED equipment.
   4. Ensure initial training and continued competency of AED-authorized personnel.
   5. Maintain a list of all Public Safety AED Service Provider authorized personnel and provide upon request to the LEMSA.

c. Public Safety AED Service Provider approval may be revoked or suspended for failure to maintain the requirements. (CCR Title 22 § 100021)

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AMBULANCE PATIENT OFFLOAD TIME
EMERGENCY DEPARTMENT TRANSFER OF CARE STANDARDS

POLICY NO: **4012** PAGE 1 OF 3

EFFECTIVE DATE: 08/01/2017
REVISED DATE: 07/01/2017

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: California Health and Safety Code, Division 2.5 EMS, CCR Title 22. Division 9 Chapter 1.5, Health and Safety Code 1797.120, 1797.225

4012.1 PURPOSE

a. To provide guidelines and standards for the transfer of care of patients arriving via the 911 system to Coastal Valleys EMS Agency (LEMSA) approved receiving facilities. The establishment and review of the standards are essential to public safety, EMS system oversight and for implementing standardized methodologies for Ambulance Patient Offload Time data collection for reporting to the LEMSA and to the California EMSA.

4012.2 POLICY

a. Receiving facilities designated by the LEMSA shall be prepared to receive patients transported by 911 ambulance providers and accept these patients upon arrival. The ambulance patient offload time performance standard is set at twenty (20) minutes or less 90% of the time.

4012.3 DEFINITIONS

a. **Ambulance arrival at the Emergency Department (ED)** - the time the ambulance arrives at the location outside the hospital ED where the patient will be unloaded from the ambulance.

b. **Ambulance Patient Offload Time** - the time interval between the arrival of an ambulance patient at an ED and the time the patient is transferred to the ED gurney, bed, chair or other acceptable location and the emergency department assumes the responsibility for care of the patient [1,2,] (Reference- NEMSIS eTimes.11 and eTime.12)

c. **Ambulance Patient Offload Delay** – the ambulance patient offload time for a patient exceeds a period of time designated by the LEMSA.[3] For purposes of this policy and for LEMSA system oversight review, all transfer of care timestamps over 20 minutes and up to 60 minutes will be considered an offload delay.

d. **Ambulance Patient Offload Delay Sentinel Event** – the occurrence of a patient remaining on the ambulance gurney and/or the emergency department has not assumed responsibility for patient care beyond the LEMSA maximum delay time-over 60 minutes.

c. **Emergency Department (ED) Medical Personnel** – an ED physician, mid-level practitioner (e.g. Physician Assistant, Nurse Practitioner) or Registered Nurse (RN).

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4012.4 911 TRANSPORT PROVIDER RESPONSIBILITIES

a. Transportation units will notify ED staff of their estimated time of arrival as soon as practical, once patient destination has been established.

b. EMS caregivers shall provide continuity in their treatments upon arrival at the hospital

c. During periods of unusual levels of demand, EMS personnel ***may*** provide the stable patient with information on hospital delays to assist the patient in their choice of destination. Transportation providers should consider the patient's historical location of medical care when considering advising a patient of offload delays.

d. Transportation units will promptly notify ED, LEMSA contracted dispatch centers and any provider agency supervisory staff of ambulance patient offload issues past the twenty minute (20 mins) standard. If able EMS supervisory staff will assist with the resolution of the availability issues and follow up with the LEMSA and hospital.

e. Notification of the need to release ambulance resources will be communicated by EMS personnel using the following chain of command:

   1. ED charge nurse and physician in charge
   2. Hospital House Nursing Supervisor

f. The EMS Duty Officer should be notified of all "Sentinel Events."

4012.5 RECEIVING FACILITY RESPONSIBILITIES

a. The hospital responsibility for the care of a patient begins when the patient or ambulance arrives on hospital grounds and requires an initial assessment and triage of the patient without delay.[4]

b. ED staff will work with ambulance personnel to ensure optimal patient transfer of care and resolve any instances of delay past the time standard.

c. During periods of unusual level of demand, hospitals shall activate internal protocols for ED saturation.

d. Predictable daily and seasonal high utilization periods are considered normal EMS System operations that should be included in hospital planning and are not considered unusual level of demand episodes.

e. Hospital staff will work with the LEMSA to ensure internal policies and procedures are in place to prioritize patients arriving by 911 transport providers.

4012.6 LEMSA RESPONSIBILITIES

a. Provide hospitals and ED leadership with reliable patient transfer of care performance reports.

b. Post publically EMS to ED patient transfer of care reports including "Sentinel Events" on the LEMSA website.

c. All "Sentinel Events" will be referred to the ED supervisor for the appropriate review and action. Review by the LEMSA CQI process per *Administrative Guideline #6002 Quality Improvement Program* will occur.

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4012.7 METRICS

a. **Clock start**: Time stamp when the 911 transport provider stops outside the receiving facility ED. Data collection can be made by:

   1. Transport provider CAD systems, with two-way radio voice communication or MDC;
   2. Automated systems with AVL/GPS capability;
   3. ePCR or other commercial data collection system (e.g. FirstWatch, ImageTrend)

b. **Clock stop**: Statute defines the process for patient care transfer from LEMSA Medical Control with two criteria:

   1. When the patient is transferred to the emergency department gurney, bed, chair or other acceptable location **and**
   2. The emergency department has assumed the responsibility for care of the patient.

c. **Ambulance patient offload time:** Will be defined as an event, recorded as a clock timestamp to be inserted on all ePCR platforms, occurring when:

   1. The patient is off of the ambulance gurney and the verbal patient report is given by transporting EMS personnel and acknowledged by ED medical personnel [2]

   Note: Completion of the ePCR and/or removal of equipment is not required for transfer of care to occur.

d. **Sentinel Events**: In addition to offload delays in excess of LEMSA standard as defined in 4012.3 (d), reportable Sentinel Events include:

   1. Occurrence of Ambulance Patient Offload Delay with the patient decompensating or worsening in condition
   2. Occurrence of Ambulance Patient Offload Delay with associated delayed 911 system ambulance response(s) within the LEMSA.
   3. Continued facility or system performance below established fractile (e.g. 90%) for compliance to the LEMSA's APOT standard

[1] Health and Safety Code Division 2.5, Chapter 3, Article 1, Section 1797.120 (b).
[2] Verbal report must include a structured and complete report with the following information: Chief complaint; initial vital signs; pertinent history and exam findings; laboratory tests (e.g., glucose) and copy of EKG; interventions and treatment provided in the field; current vital signs and status.
[3] Health and Safety Code Division 2.5, Chapter 4, Article 1, Section 1797.225(c)(1) and (2).
[4] Emergency Medical Treatment and Labor Act (EMTALA)

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COASTAL VALLEYS EMS AGENCY

LEAVE BEHIND NARCAN AUTHORIZATION

POLICY NO: **4013**

EFFECTIVE DATE: 05-01-2023
REVISED DATE: NEW POLICY

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: California Health and Safety Code, Division 2.5 §1797.220, §1798.

4013.1 PURPOSE

a. To authorize EMS prehospital personnel to distribute Naloxone and provide training material to patients with suspected opioid misuse, or family and/or friends of these patients. The opioid crisis has had a profound impact on communities across the United States. This policy is part of a broader harm reduction strategy that attempts to mitigate the impact of the crisis by increasing the availability of Naloxone to the public.

4013.2 POLICY

a. This policy will authorize prehospital EMS personnel to distribute Naloxone and approved training materials to patients with suspected opiate misuse, or to the friends and/or family of these patients.

b. Indications:

1. Suspected opioid misuse or self-reported dependence

4013.3 PROCESS

a. The Leave Behind Narcan Program is an optional initiative – EMS and fire agencies are not mandated to participate. EMS and fire agencies that choose to participate in the program are required to ensure CQI oversight and comply with the following program specifications within their agency Leave Behind Narcan Program guidelines.

1. Provide all appropriate patient care in accordance with CVEMSA treatment guidelines.
2. Once determined that a patient will refuse transport for a suspected overdose, AMA shall be completed in accordance with CVEMSA policy 8003 – Patient Refusal of Treatment or Transport.
3. Provide Naloxone and approved training materials to patient directly or a friend and/or family member at scene. Approved training material can be printed or provided through

an electronic format through this link: https://cabridge.org/resource/naloxone-what-you-need-to-know/

4. If unable to resuscitate or patient meets Determination of Death policy due to suspected overdose, friends and/or family can be offered Naloxone if they appear to be at risk for opioid misuse. Example, if they were using drugs with the patient, identify a self-dependence or drug paraphernalia is found on scene.
5. If the patient is treated with Naloxone for a suspected overdose and transported to the hospital, but the patient's friends and/or family at scene express concern that they may need Naloxone because of identified self-dependence or financial limitations to access a prescription, Naloxone may be left on scene. Efforts should be made to ensure patients, friends and/or family understand resources that are available related to overdose prevention. Agencies within Coastal Valleys shall provide local area resources to staff.
6. The maximum dose to be left on scene is one package of Naloxone. One package contains two, 4 mg Intra-nasal doses.
7. Provide documentation of any Naloxone distribution through the EMS data system.
    a) EMS and fire agencies who wish to participate in the Leave Behind Narcan program shall notify the EMS Agency.
    b) Once the EMS Agency receives notification, reportable Leave Behind Narcan data fields will be uploaded to the agency's patient care report.
    c) Field providers who Leave Behind Narcan are required to complete the applicable data fields when completing the patient care report. If Leave Behind Narcan is left on scene with a family member or friend and not the patient, the field provider does not need to create a new patient care report as it is applicable to the emergency scene of the initial 911 response.

4013.4 SPECIAL CONSIDERATIONS

a. Leave Behind Narcan may be provided when a patient refuses transport after a naloxone field reversal, a suspected opioid-related overdose, or if friends and/or family at scene identify a potential need due to self-identified dependence. It is not to be used as an alternative to transporting a patient to the hospital.

b. The Leave Behind Narcan Program is an important component in improving outreach to a vulnerable patient population by increasing opportunities for access to care and treatment and recovery from opioid addiction. Agencies who participate in this program shall provide field personnel access to information about local support and recovery services to better inform our patient care population and the public.

STAT (Emergency) AMBULANCE TRANSFER

POLICY NO: **4014**
EFFECTIVE DATE: 04-11-2024
REVISED DATE: 04-11-2024

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: California Health and Safety Code, Division 2.5 EMS

4014.1 PURPOSE

a. In order to facilitate the emergency transport of critical patients between acute care facilities within the Region, the LEMSA has instituted the Stat Ambulance Transfer procedure. The LEMSA defines "Stat" as requiring an immediate response by an ambulance for unstable patients requiring urgent/emergent transportation. In contrast to routine patient transfers, Stat Ambulance Transfer requests will be directed into the 911 priority dispatch system and result in the dispatch of an appropriate ambulance.

4014.2 PROCEDURE

a. A request from an Acute Care Facility for a ***Stat Ambulance Transfer*** to the appropriate 911 EMS dispatch center (REDCOM or HFCC) should only be used for acute, unstable patients in need of immediate intervention by a facility offering a higher level of care. The patient categories that this procedure is meant to help are those who need acute medical and/or surgical intervention within 30 minutes or less, examples are:
   1. Patients who need immediate surgical/ trauma services intervention.
   2. Patients who need immediate cardiac intervention.

b. When placing a call to **REDCOM or HFCC** to request a Stat Ambulance Transfer response, you will be asked the following questions by the REDCOM dispatcher:
   1. Are you requesting a Stat Ambulance Transfer?
   2. Is this an emergency cardiac, surgical or trauma patient?
   3. Does the patient need to be transported within 30 minutes or less?
   4. Have you completed all the necessary transfer agreements (between sending and receiving facilities)?
   5. Where is the patient (floor/unit and room number) now and is the patient ready to be transported?
   6. Are the patient's records, forms, x-rays, medications and/or equipment with the patient now?
   7. Is a hospital staff person going to accompany this patient?

c. Once the above questions are answered appropriately, an Advanced Life Support ambulance will be dispatched to your facility. It is essential that the patient be ready and waiting for immediate transport.

Note: A Stat ALS ambulance cannot replace the higher level of care provided by a Critical Care Transport (CCT) ambulance. If the critical patient requires a higher level of care than a paramedic can provide, a CCT unit should be requested. Requests for CCT transports must be made through the appropriate dispatch/referral center for the CCT provider agency.) Use of a Stat Ambulance Transfer for patients that need a higher level of care during transport will require the sending facility to provide the appropriate staff to accompany the patient during the transfer.

d. This procedure draws from the 911 system ambulance resources in the local EMS system. Requesting a Stat Ambulance Transfer will not result in a fire department response to your facility.

EMS PROVIDER DATA REQUIREMENTS

POLICY NO: **6000** PAGE 1 OF 3

REVISED DATE: JANUARY 1, 2016

APPROVED: Bryan Cleaver, EMS Administrator
Dr. Mark Luoto, EMS Medical Director

AUTHORITY: California Health and Safety Code, Division 2.5 EMS, HS 1797.1,1797.102,1797.204, 1797.103, 1797.174; Title 22 Div 9 Ch 4 Article 8 Sec 10017,100169,100170,100171; CA EMS System Core Quality Measures (EMSA #166); AB1129-2015

6000.00 PURPOSE

a. To define the use of standardized records and data sets or fields to be used by all Emergency Medical Service providers for documentation of prehospital care. This policy defines the minimum documentation sets and defines the structure for computer aided dispatch and patient care records maintained by prehospital care providers and submitted to the LEMSA as outlined in State regulations.

6000.01 POLICY

a. PCR- Requires an emergency medical care provider (EMS) to, when collecting and submitting data to the Coastal Valleys EMS Agency (LEMSA), use a system that exports data in a format that is compatible with the California Emergency Medical Services Information System (CEMSIS) and the National Emergency Medical Services Information System (NEMSIS) standards and includes those data elements required by the LEMSA. The LEMSA will not mandate that a provider use a specified system to collect and share data with the LEMSA. Providers must use a system that can be integrated with the LEMSA's system, as specified. Providers shall ensure compatibility with the LEMSA's system.

b. CAD- Dispatch Providers (or their Contractor) shall submit computer aided dispatch data to the LEMSA, in an electronic format acceptable to the LEMSA, a near real-time basis is optimal, in very limited cases time is NOT TO EXCEED 5 MINUTES. Computer aided dispatch data shall include records for all emergency and nonemergency ambulance or medical aid requests received at the provider's dispatch center.

c. CAD- Each computer dispatch record submitted to the LEMSA shall contain the following fields, as a minimum:

1. Call Date.
2. Incident Number.
3. Scene County.
4. Call Type (e.g. scene, interfacility transfer).
5. Emergency Medical Dispatch (EMD) Patient determinate.
6. Code of Response.
7. Updated Code of Response.
8. Code of Transport.
9. Updated Code of Transport.

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10. Time Public Service Answering Point (PSAP)
11. Provider LEMSA.
12. Vehicle/Unit ID Number.
13. Time Call Entered.
14. Time Dispatched.
15. Time En Route.
16. Time Arrived Scene.
17. Time Departed Scene.
18. Time Arrived at Hospital
19. Time Available
20. Time Canceled, if applicable
21. Call disposition
22. GIS Map Page information

d. ePCR- EMS Providers shall create patient care records in an electronic format acceptable to the LEMSA. EMS providers not utilizing the LEMSA selected ePCR system shall establish a process with the LEMSA ePCR vendor to allow for EMS data submission.

e. Data shall be submitted to the LEMSA data system on a schedule agreed to by the provider and the LEMSA.

f. Patient care record data shall include records for all EMS incidents and patient contacts. Refer to *Administrative Policy 6001 Completion of Patient Care Records* for minimum requirements.

6000.02 PROVISION OF ACCESS AND PROGRAM

a. The LEMSA will provide access to the approved Electronic Patient Care Report system and software to EMS system participants required to enter, edit, or analyze data**.**

6000.03 TECHNICAL PROBLEMS/RECOVERY PROCEDURES

a. Device Failure - In the event of a device failure, contact your agency's support person. Document all pertinent information on paper and enter the ePCR in an offline mode-Imagetrend users can use Bridge mode. Electronic documentation device failure is NOT an exception for providing the required PCR documentation. Device failure will be resolved within 48 hours.

b. Connectivity Failure – If there is connectivity failure, document all patient information on your device and save. Post your call to the server as soon as connectivity returns.

c. System Failure – In the event of system failure document all patient information on your device and save. Post/Sync to the server as soon as the system is rebooted.

d. The LEMSA shall be notified of downtime or transmission difficulties lasting more than 24 hours.

e. Any system upgrades or system maintenance must be reviewed and approved in writing by the LEMSA prior to implementation. Any planned issue that could cause a delay in data transmission will be notified to the LEMSA at least 24 hours in advance.

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6000.04 GENERAL INSTRUCTIONS AND CONDITIONS

a. The ePCR is a part of the patient's permanent medical record and is used for, but not limited to, the following purposes:

   1) Transfer of information to other healthcare providers
   2) Medical legal documentation
   3) Billing for services
   4) Development of aggregate data reports for Continuous Quality Improvement (CQI) including specific quality indicators and identification of educational needs
   5) LEMSA case investigation

b. The EMS Medical Director is the final authority for determination of all aggregate data reports that are to be maintained confidential or distributed.

c. Willful omission, misuse, tampering or falsification of documentation of patient care records is cause for formal investigative action under section 1978.200 of the California Health and Safety Code.

6000.05 PRIVACY

a. Maintaining confidentiality is an essential part of all health care, including prehospital care. The confidentiality of personal health information (PHI) is covered by numerous State and Federal Statutes, Policies, Rules and Regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), California Civil Code Section 56.36;Division 109; Section 130200 and California Health and Safety Code Sections 1280.1,1280.15 and 1280.3. All EMS Providers are responsible to enact policies which ensure patient privacy by restricting access and implementing electronic protections. Any ePCR shall be made available to the LEMSA upon request.

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COMPLETION OF PATIENT CARE RECORDS

POLICY NO: **6001** PAGE 1of 4

REVISED DATE: 8/1/2016

APPROVED: Bryan Cleaver
EMS Administrator

Dr. Mark Luoto
EMS Medical Director

AUTHORITY**:** California Health and Safety Code, Division 2.5, Sections 1797.202, 1797.204, 1797.220, 1798 and 1798.220. California Code of Regulations, Title 22, Chapter 2, 3 and 4.

6001.00 PURPOSE

a. The purpose of the following policies and procedures is to define all requirements regarding the Patient Care Report (ePCR) completion, reporting, and submission within the Coastal Valleys Emergency Medical Services (CVEMSA) Region. The electronic ePCR data elements, data system, forms, documents, reports must meet the requirements of CVEMSA Policy 6000- EMS Provider Data Requirements.

6001.01 DEFINITIONS

a. Incident: An incident is any response involving EMS personnel to any event in which there is an actual victim or the potential for a victim, regardless of whether or not the responding unit was cancelled en route. This includes all emergency responses, nonemergency responses, walk-in contacts, responses that are cancelled before scene arrival, any pre-arranged ambulance standby and any ambulance transfers originating in region.

b. Patient: any person encountered by prehospital personnel who demonstrates any known or suspected illness or injury OR is involved in an event with significant mechanism that could cause illness or injury OR who requests care or evaluation.

c. Patient Contact: A patient contact is defined as any contact between an EMT or Paramedic and a patient, including contacts which fall into the Determination of Death Policy. All patient contacts require completion of an ePCR.

6001.02 POLICY

a. ePCRs shall be completed and submitted electronically by all Advanced Life Support and/or ambulance transport services providing service within CVEMSA EMS Area .

b. EMS personnel shall complete ePCRs on all EMS incidents or patient contact responses.

c. All available and relevant information shall be accurately documented on the ePCR.

d. Intentional failure to complete an ePCR when required, or fraudulent or false documentation on an ePCR, may result in formal investigative action under the California Health and Safety Code, 1798.200.

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e. Patient care documentation management is to be compliant with HIPAA and medical record retention requirements.

f. The Local EMS Agency (LEMSA) may request specific documentation elements related to CQI, field study or trials and other emergency management data collection requirements.

6001.03 ePCR AVAILABILITY

a. A completed ePCR, available to the receiving facility, is a high priority for each patient prior to clearing the receiving hospital. When unable due to system demands or technical hindrance a completed patient ePCR shall be made available within 2 hours of providing patient care. (Exception: EOA Contract Compliance standards)

b. A partially completed or preliminary ePCR, marked as such, shall be left with the patient if a complete ePCR cannot be completed prior to clearing the receiving facility.

c. When possible, non-transporting agencies that have turned over care to transporting personnel will send a partially completed or preliminary ePCR (or acceptable paper form), marked as such, with the patient. When circumstances prevent the completion of the PCR prior to turnover of care, non-transport personnel will complete the PCR as soon as circumstances allow.

d. Any completed or partially completed paper PCR provided to a transport ambulance by another responder shall be delivered to the receiving facility for incorporation into the patient's medical record or incorporated as an attachment to the transport ambulance ePCR.

e. All INCIDENT (non-patient) ePCRs must be fully completed and submitted within 24 hours

6001.04 ePCR PROCEDURES

a. Personnel providing patient care are responsible for accurately documenting all available and relevant patient information on the ePCR or approved paper alternative. Provider agencies may set documentation standards which are more specific than required by regulation and/or LEMSA policy.

b. Care given prior to arrival, by bystanders or first responder personnel, shall be documented on an ePCR.

c. Use of usual and customary abbreviations is permitted in the narrative section of the record or as defined in automated ePCR pre-designated pick lists.

d. The PCR shall contain the following Basic Data Elements, in a format defined by the LEMSA:

1. Initial Response Information
   a) Incident Number
   b) Agency Case Number
   c) EMS unit number
   d) Date and estimated time of incident
   e) Time of receipt of call (PSAP)
   f) Time of dispatch to the scene
   g) Time responding
   h) Time of arrival at the scene
   i) Incident location (Address, City, State, County and ZIP Code)

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2. Patient Information
   a) Name
   b) Age or date of birth
   c) Gender
   d) Weight, if necessary for treatment
   e) Address
   f) Chief complaint
   g) Patient history
   h) Vital signs
   i) Appropriate physical assessment
   j) Emergency care rendered and patient's response to such treatment
   k) LEMSA defined/ required electronic data element fields
   l) Patient disposition
   m) Time of departure from scene (if transported)
   n) Time of arrival at receiving facility (if transported)
   o) Name of receiving facility (if transported)
   p) Name and unique identifier number(s) of EMS personnel on the call
   q) Signature of EMS personnel on the call

e. The ePCR shall be completed and distributed in accordance with this policy.

f. A completed ePCR shall not be altered or changed except by the individual who completed the ePCR. Exceptions are permitted to add or change billing information, or add a name or other pertinent demographics unknown at the time of the call.

g. If a paper interim PCR is used, or a change is made on a hard copy of an automated ePCR, documentation errors shall be lined through (e.g. ~~Like this~~), and the correction shall have the patient attendant's initials beside it.

h. Any changes made to an ePCR shall have documentation of those changes retained in the computer database.

i. In situations where the patient or their legal representative declines medical care or transport when care is recommended and felt to be necessary by the prehospital personnel attending that patient, documentation should include all available basic data elements. *Refer to Treatment Guideline 7005 Patient Refusal of Treatment or Transport*.

6001.05 CORE MEASURES DATA ELEMENTS

a. The California Emergency Medical Services Authority (EMSA) has developed outcome based Core Measures. Data elements for these core measures shall be addressed in any provider agency documentation standards. (REFERENCE EMSA Document #166)

   1. Trauma - Times, Destination decisions
   2. Acute Coronary Syndrome (ACS) - ASA, 12-lead destination decisions
   3. Cardiac Arrest - AED use, bystander involvement
   4. Stroke- use stroke screening, destination decisions, times, FSBG use
   5. Respiratory - CPAP use, Beta2 use
   6. Pediatric - Bronchodilator use and Trauma Center Diversion
   7. Pain - Measured
   8. Endotracheal Intubation - Success and ETCO2

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9. Response and Transport - Times

6001.06 HOSPITAL RESPONSIBILITIES

a. Hospitals should implement mechanisms to assure that prehospital documentation arriving electronically or with the patient is readily available to ED staff and is incorporated into the hospital medical record system.

6001.07 NON-TRANSPORT BLS PROVIDERS

a. Non-transport BLS Personnel have an obligation to document care provided to patients as part of the medical response to emergency calls. Such provider agencies are encouraged to migrate as soon as practical to an ePCR system meeting State of California EMS Authority guidelines for data submission. Until migration is achieved, BLS non-transport providers may comply with this policy by utilizing an acceptable paper alternative first-response PCR for each patient contact.
b. Non-transport BLS Level EMS Provider Agencies will implement the procedures to be compliant with this policy as soon as practical with an implementation deadline of January 1, 2017.

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CONTINUOUS QUALITY IMPROVEMENT PROGRAM

POLICY NO: **6002** PAGE 1 OF 4

REVISED DATE: JANUARY 1, 2016

APPROVED: Bryan Cleaver
Regional EMS Administrator

Dr. Mark Luoto
Regional EMS Medical Direct

AUTHORITY: Health and Safety Code, Division 2.5, Section 1797.220; California Code of Regulations, Title 22, Division 9, Chapter 12

6002.00 PURPOSE

a. To identify primary responsibilities of all participants in the Coastal Valleys EMS Agency (LEMSA) Quality Improvement Program (EQIP) and to ensure optimal quality of care for all patients who access the EMS system. By the continuous study and improvement of a process, system or by an organization's participation, the EQIP will promote, enhance and ensure the quality of prehospital emergency medical care and the system.

b. This will be done by:

   1) Establishing an advisory committee to evaluate, monitor and improve, on a continual basis, the quality of patient care given by all EMS personnel and the effectiveness of local policies and treatment protocols.

   2) Providing a mechanism whereby EMS personnel or other interested parties can have quality improvement issues and questions related to out of hospital care addressed.

   3) Evaluating and improving system performance by constant and consistent data review.

6002.01 DEFINITIONS

a. EMS Quality Improvement Plan: An integrated, multidisciplinary program that focuses on system improvement. Methods of evaluation are composed of structure, process and outcome measurements.

b. Quality Assurance (QA): Looks backwards at either individual events or the system and evaluates compliance against a standard.

6002.02 EMS SYSTEM EQIP

a. The LEMSA will establish and facilitate a system-wide EQIP to monitor, review, evaluate and improve the delivery of prehospital care services. The program will involve all permitted system participants providing any level or type of prehospital care and will include, but not be limited to the following activities:

   1) Prospective: designated to prevent prospective problems.
   2) Concurrent: designated to identify problems or potential problems during patient care.

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3) Retrospective: designed to identify potential or known problems and prevent their recurrence.
4) Reporting/Feedback: all EQIP activities will be reported to the LEMSA.

b. The LEMSA shall collect and analyze data from the EMS System Providers to evaluate quality of prehospital care in the Coastal Valleys EMS System. Development of EQIP indicators will be consistent with Title 22 Division 9 chapter 12 and modeled after the State of California EMS Authority (EMSA) publication #164 EMS-QIP Model Guidelines. Collection and data requirement will be consistent with *Administrative Policy 6000 EMS Provider Data Requirements.*

c. The oversight for the EQIP will be the responsibility of the EMS Medical Director with advice from stakeholders participating on the Prehospital Quality Improvement Committee.

d. Appropriate QI indicators shall be requested of providers and participants, reviewed at the provider level on a monthly basis and a report of findings shall be made to the LEMSA at agreed upon intervals. Aggregate data for the EMS System will be maintained by the LEMSA.

e. The LEMSA shall provide an annual report of quality improvement activities to the California EMS Authority. This information may be incorporated as part of the Coastal Valleys Emergency Medical Services Agency Annual Report.

f. All proceedings, documents and discussions of the Pre-hospital Quality Improvement System are confidential pursuant to section 1157.7 of the Evidence Code of the State of California.

6002.03 LEMSA RESPONSIBILITIES FOR EQIP

a. Prospective

1) Comply with all pertinent Federal, State and County rules, regulations, laws and codes.
2) Certify, accredit or authorize first responders, EMT and Paramedics to practice.
3) Coordinate prehospital quality improvement committees.
4) Develop and assist EQIP program participants in the development of performance standards and indicators.
5) Implement basic and advanced life support systems.
6) Approve and monitor prehospital training programs.
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 improvement requirements.
8) Facilitate system wide compliance and implementation of required quality improvement plans.

b. Concurrent

1) Serve as a resource for EQIP program participants.
2) Conduct analysis of data received from system participants
3) Conduct site visits to monitor and evaluate system components.
4) Participate in direct medical oversight activities.

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5) Communicate EQIP activities and findings to system participants.

c. Retrospective

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) Monitor and evaluate the unusual occurrence review process.

4) Take appropriate action with first responder, BLS providers, ALS providers, receiving hospitals, base hospitals and medical dispatch centers that do not meet established thresholds for service quality.

d. Reporting/Feedback

1) Evaluate submitted reports from system participants and make changes in system design as necessary.

2) Provide feedback to system participants when applicable or when requested on Quality Improvement issues.

3) Design prehospital research and efficacy studies regarding prehospital care including but not limited to medication administration, treatment and interventions, equipment, prehospital personnel skill performance, and patient care outcomes.

4) Update policies and procedures to reflect best practices in prehospital care based upon reliable, current research based evidence.

5) Recognize and reinforce exemplary performance by prehospital care providers.

6002. 04 EMS SYSTEM PROVIDER QUALITY ASSURANCE PROGRAMS

a. The EMS Provider Quality Assurance Program (EQAP) shall be in accordance with the CEMSA Emergency Medical Services System Quality Improvement Program Model Guidelines (Rev. 3/04), incorporated herein by reference, and shall be approved by the LEMSA, which at a minimum addresses:

1) Prospective

a) Participate on EMS advisory committees

b) Evaluation

A. Develop criteria for evaluation of personnel to include, but not limited to:

i. Patient record report form (or ePCR).

ii. Field/Workplace observation.

iii. Routine call/dispatch audit/review.

iv. Problem-oriented cases as identified by the EQAP process.

v. Action plans for individual provider and provider agency deficiencies.

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2) Concurrent Activities
   a) Field observation: Establish a procedure for evaluation of field/workplace providers utilizing performance standards through direct observation.
   b) Review specific audit topics established through the CQI Committee.
   c) Comply with reporting and other CQI requirements, as specified by the LEMSA
   d) Participate in prehospital research and efficacy studies requested by the LEMSA
3) Retrospective Analysis
   a) Develop a process for retrospective analysis of field care, utilizing available documentation and data sources, to include, but not limited to:
      A. High-risk.
      B. High-volume.
      C. Problem-oriented calls as identified by the EQAP process and those calls requested to be reviewed by the LEMSA
4) Reporting / Feedback
   a) Develop a process for identifying trends in the quality of field or responsible agency care.
   b) Provide reports as specified by the LEMSA
   c) Design, offer and participate in educational offerings based on problem identification and trend analysis.
   d) Make changes in internal policies and procedures based on trend analysis.
   e) Establish procedure for informing all field/agency personnel of system changes.

b. All permitted providers shall participate in the activities of the LEMSA via provider quality assurance programs.

6002.05 QUALITY IMPROVEMENT (CQI) COMMITTEE AND COMPLIANCE

a. CQI Committee -Scheduled meetings will be held Quarterly. This committee is comprised of EMS staff, EMS Medical Director, EMS representatives from all provider agencies and the Base Hospital. The committee is chaired by the EMS Quality Improvement Coordinator or designee.

b. Purpose:
   1) The committee coordinates and monitors the quality of prehospital care and overall prehospital quality improvement activates of the LEMSA.
   2) Provide a forum to develop a consistent approach to gathering and analyzing data, and other quality improvement activities.
   3) Provide guidance and support to EQIP and EQAP activities.
   4) Identifies EQIP and EQAP educational needs.
   5) Facilitates/provides education.

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c. Quality Improvement Standards Compliance

1) The process(s) contained herein will be followed to ensure active participation of all system participants in the EQIP program.

2) When a provider agency continues to fail to meet participation requirements as outlined in this policy, the LEMSA may revoke provider status. At this point, the provider agency will be required to comply with LEMSA requests for committee participation and re-apply to regain provider status.

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EMS EVENT REPORTING

POLICY NO: **6003** PAGE 1 OF 3

REVISED DATE: JANUARY 1, 2016

APPROVED: Bryan Cleaver, EMS Administrator; Dr. Mark Luoto, EMS Medical Director

AUTHORITY: California Health and Safety Code; California Code of Regulations, Title 22 and California Health and Safety Code section 1798.200.

6003.00 PURPOSE

a. To establish a clear system of patient safety and EMS response related reporting for the purposes of review, data analysis, and EMS system performance.

b. To define reporting requirements for events which have the potential to cause community concern or represent a threat to public health and safety.

c. To define the reporting and monitoring responsibilities of all EMS system participants.

6003.01 POLICY

a. EMS events shall be appropriately reported, reviewed and tracked to monitor, maintain and improve safety. Exemplary care may also be identified, tracked and acknowledged through this process. Reporting is encouraged from any individual who encounters or recognizes a situation in which a safety related or exemplary event occurred while a patient was in the care of a prehospital provider..

6003.02 DEFINITIONS OF EMS EVENTS

a. Any event that has resulted in or has the potential to lead to an adverse patient outcome. These events may be related to systems, operations, devices, equipment, medications or any aspect of patient care.

b. Events that represent a threat to public health and safety as cited in Health and Safety Code 1798.200

6003.03 REVIEW PROCESS

a. Involved agencies will review all reports generated and implement follow-up actions on all reported EMS events.

b. The on-duty officer, supervisor or provider designated personnel shall verbally notify the LEMSA promptly of events that may cause public concern or immediately affects public health or safety.

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c. Involved agencies should review, and if appropriate, report EMS events to the LEMSA using the Coastal Valleys EMS Agency Electronic Reporting Form.

d. Interagency review process

1. To allow for prompt review and follow-up, communication of events should occur between the involved agencies. Each agency is responsible for its own internal review and follow-up. EMS Agency staff is available to assist all participants in seeking solutions to patient safety events that affect the EMS system.

di. EMS events that require review by the LEMSA include:

1. Any threat to public safety as defined by the Health and Safety Code 1798.200
2. Medication related: incorrect drug choice, dosage, or route
3. Equipment related (endangering patient or crew): equipment problems, adverse events or failures related to patient care or EMS response
4. Treatment or Procedure difficulties, unexpected events, adverse events inconsistent with expectations.
5. Care delivered outside the EMT or Paramedic scope of practice.
6. Verbal or physical event identified which resulted or had the potential for harm, insult, in neglect or abuse the patient.

6003.04 RESPONSIBILITIES

a. Prehospital personnel:

1. Shall assure patient safety by immediately notifying the hospital staff at the receiving/base hospital (if involved), when an event impacts or has a potential to impact the patient.
2. Immediately report event of concern to a provider on-duty officer or supervisor using the appropriate internal reporting structure.
3. Complete the LEMSA EMS Event Form when mandated.

b. Provider Agency:

1. Will have a process of fact-finding, follow-up and tracking of EMS events.
2. All reported events regardless of significance should be reviewed and tracked as part of the provider's quality improvement program.
3. Assure patient safety first.
4. Evaluate the event and notify the LEMSA promptly with issues involving public safety.
5. Provide the LEMSA with additional written or verbal reports if requested.
6. Take action to remediate the situation.

c. Base Hospital

1. Should notify the Paramedic Liaison Nurse (PLN) of any identified EMS events.
2. The PLN will:

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a) Assure patient safety, evaluate the event, complete an LEMSA EMS Event Form when mandated and forward to the involved agency(s) for review.

b) Notify the LEMSA if event meets prompt notification criteria.

c) Take action to remediate the situation if and when able.

d. Receiving Hospitals:

1. Will report any identified EMS events to the involved agency supervisor(s) or use the LEMSA EMS Event Reporting Form.

e. EMS Agency:

1. The Agency will acknowledge all EMS event reports received and ensure or facilitate the appropriate resolution of each event.

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