

3340 Glenwood Street, Eureka, CA 95501 (707) 445-2081 (800) 282-0088 FAX (707) 445-0443

MEMORANDUM:

DATE: July 30, 2010

TO: Joint Powers Governing Board Members
County Health Officers
Lake County Administrative Officer
Prehospital Care Medical Directors
Prehospital Care Nurse Coordinators
Fire Chiefs' Associations/EMS Liaisons
EMCC Chairpersons

FROM: Linn Tyhurst, Administrative Assistant

RE: E-Informational Mailing

1. For Your Information:
 - a. Quarter 4 Progress Report Special Project Contract #EMS -9070
2. Policy Change # 89
3. Draft Policies:
 - a. Emergency Medical Technician Incident Investigation, Determination of Action, Notification and Administrative Hearings Process

Please send any comments on the draft policy to Louis Bruhnke (Louis@northcoastems.com) by Friday, September 17.



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CHANGE NOTICE

CHANGE #89

JULY 2010

TO: ALL PREHOSPITAL CARE POLICY MANUAL HOLDERS

| INSTRUCTIONS | POLICY # | POLICY DESCRIPTION | # OF PAGES |
|--------------|----------|---|------------|
| Replace | 2201 | Administration- Provider Application for Emergency Medical Dispatch Center Provider (EMD) | 2 |
| Replace | 2201.1 | Administration- Provider Emergency Medical Dispatch Center Provider Designation (EMD) | 5 |
| Add | 2215 | Administration – Specialty Center Designation STEMI Receiving Center Designation Criteria | 4 |
| Replace | 5304 | Scope of Practice/Procedure Atropine Sulfate Protocol | 2 |
| Replace | 5305 | Scope of Practice/Procedure Calcium Chloride 10% Solution | 1 |
| Replace | 5307 | Scope of Practice/Procedure-EMT-II Epinephrine (Adrenalin) | 3 |
| Replace | 5308 | Scope of Practice/Procedure- EMT-II Furosemide (Lasix) | 1 |
| Replace | 5309 | Scope of Practice/Procedure- EMT-11 Lidocaine (Xylocaine) | 2 |
| Replace | 5310 | Scope of Practice/Procedure-EMT-II Morphine Sulfate Protocol | 2 |
| Replace | 5311 | Scope of Practice/Procedure- EMT-II Naloxone (Narcan) Protocol | 1 |
| Replace | 5312 | Scope of Practice/Procedure- EMT-II Nitroglycerine (NTG) Protocol | 1 |
| Replace | 5328 | Scope of Practice/Protocol- EMT-II Fibrinolytic Checklist Procedure | 2 |
| Replace | 5332 | Scope of Practice/Protocol- EMT-II Benzodiazepines | 2 |

| | | | |
|---------|-------|---|---|
| Replace | 5418 | Scope of Practice/Protocol- Paramedic Valsalva Maneuver | 1 |
| Replace | 5421 | Medical Control EMT-P Standing Orders/Radio Failure/Direct Voice Contact | 4 |
| Replace | 5427 | Scope of Practice/Procedure- Paramedic Adenosine | 2 |
| Replace | 5434 | Scope of Practice/Procedure- Paramedic Carotid Sinus Massage | 2 |
| Replace | 5438 | Scope of Practice/Procedure- Paramedic Zofran (Ondansetron) | 1 |
| Replace | 6511 | Treatment Guidelines- ALS Personnel Cardiac Emergencies- Suspected Acute MI / Acute Coronary Syndrome | 3 |
| Add | 6511a | Treatment Guidelines- ALS Personnel 12 Lead Electrocardiography | 2 |
| Add | 6553 | Medical Control Endotracheal Tube Introducer (ETTI) | 2 |
| Add | 6554 | Approval of New ALS Interventions | 1 |
| Replace | | Table of Contents | 8 |

Subject: Administration - Provider
**Application for Emergency Medical Dispatch Center Provider
Designation**

Associated Policies: 2201.1


- I. Authority and Reference (incorporated herein by references)
 - A. Division 2.5 of Health and Safety Code
 - B. North Coast EMS Policies and Procedures
 - C. California EMS Authority's EMS Systems Standards and Guidelines
 - D. California EMS Authority Emergency Medical Services Dispatch Program Guidelines


- II. Purpose
To establish a standardized procedure for dispatch agencies to apply for designation as an Emergency Medical Dispatch (EMD) Provider.

- III. Procedure for agency application for designation.
 - A. Agency applying for EMD Provider designation shall provide North Coast EMS with the following documentation:
 1. Letter of interest indicating commitment to implement and maintain the North Coast EMS EMD Program 24 hours per day 365 days per year and pay the initial and ongoing fee to North Coast EMS when implemented.
 2. Agency EMD policies and procedures.
 3. Agency Continuous Quality Improvement (CQI) Plan and related policies required in Policy 2201.1.
 4. Copies of certification records of employees who are currently EMD users. Only Priority Dispatch certified dispatchers affiliated with a North Coast EMS designated EMD Provider are authorized to use the Priority Dispatch System.
 5. Two (2) copies of the signed contract.
 - B. North Coast EMS shall review documentation submitted per III(A) above and upon approval and when implemented, request payment of the initial fee and upon receipt, of payment, issue a letter of designation.
 1. Designation shall be valid for four (4) years from the date of the letter.
 2. To re-apply for designation the agency should provide North Coast EMS with the documentation described in III(A) above and a report outlining findings of their CQI program.
 3. Re-applications must be provided no less than ninety (90) days prior to designation expiration.

Subject: Administration - Provider
**Application for Emergency Medical Dispatch Center Provider
Accreditation**

- IV. North Coast EMS will invoice designated EMD Providers annually the EMD fee when approved by the Joint Powers Governing Board. Failure to pay the fee within the prescribed period will result in immediate probation, suspension or withdrawal of EMD designation.
- V. North Coast EMS reserves the right to request verification of continuous compliance with EMD standards and may conduct a site survey with or without notice.
- VI. North Coast EMS reserves the right to probate, suspend or withdraw EMD Provider designation for verified non-compliance with EMD standards.

Approved: 

Approved as to Form: 

Subject: Administration - Provider
Emergency Medical Dispatch Center Provider Designation

Associated Policies: 2201

- I. Authority and Reference (incorporated herein by references)
 - A. Division 2.5 of Health and Safety Code
 - B. North Coast EMS Policies and Procedures
 - C. California EMS Authority's EMS Systems Standards and Guidelines
 - D. California EMS Authority Emergency Medical Services Dispatch Program Guidelines

- II. Purpose
To establish standardized criteria for the designation of Emergency Medical Dispatch (EMD) Provider agencies.

- III. Level of Emergency Medical Dispatching: Full Time Provider – a designated EMD Provider shall provide EMD coverage 24 hours, 365 days per year. Sufficient numbers of affiliated dispatchers must currently be Priority Dispatch certified and immediately available to provide continuous EMD service to 9-1-1 callers. Centers receiving full time designation by North Coast EMS can advertise their accomplishment.

- IV. Types of Designation – EMD Provider designation applies only to local agencies who have been approved after completing the application process described in Policy #2201.

- V. Continuous Quality Improvement (CQI) Program Policy
 - A. Designated EMD Providers shall develop and submit an EMD CQI Policy or Plan for approval by North Coast EMS that establishes, implements and maintains a continuous quality improvement (CQI) program that evaluates ongoing EMD performance.
 - B. The EMD CQI Plan shall address structural, resource, and/or protocol deficiencies as well as measure compliance to Priority Dispatch EMD Protocol standards through ongoing random case review for each emergency medical dispatcher.
 - C. The CQI Plan shall ensure that:
 - a. Monitoring of the quality of medical instruction is given to callers including ongoing random case review for each emergency medical dispatcher and observing telephone care rendered by emergency medical dispatchers for compliance with Priority Dispatch EMD standards.
 - b. Random or incident specific case reviews are conducted to identify calls/practices that demonstrate excellence in dispatch performance and/or

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Emergency Medical Dispatch Center Provider Accreditation

identify practices that do not conform to current Priority Medical EMD practices or procedures so that appropriate training can be initiated that help ensure compliance. .

c. EMD reports and /or other records of patient care are reviewed by a currently trained EMD user to compare performance against medical standards of practice.

d. A process exists to recommend training, policies and procedures for continuous quality improvement.

e. Strategic planning and the development of broader policy and position statements are performed.

f. Continuous Dispatch Education needs are identified.

g. The critical components of the EMD case review process listed in Section E below are followed.

h. The EMD Provider is solely responsible for it's own risk management and use of the EMD Priority Dispatch System.

D. The CQI Plan shall contain at least the following components:

a. Confidentiality commitment for medical and personnel records.

b. Operational polices and procedures (see Section VI).

c. Verification of current training and certification using the Priority Dispatch EMD program of all EMD dispatchers with re-certification every two years. The EMD Provider shall notify North Coast EMS of all additions or deletions to the list of EMD certified dispatcher within thriyt (30) days of the change.

d. Agency liaison appointed as contact to North Coast EMS.

e. Case Review procedure whereby the agency manager or designee periodically reviews a designated percentage of all EMD cases

f. System for forwarding to North Coast EMS background on cases that require medical review, cases involving complaint and cases where current EMD practices and procedures were not followed or used.

g. Quality Improvement system for reporting and investigating events or circumstances to North Coast EMS. Reports may be related to equipment, process, or non-compliance with current EMD practices and procedures and may be initiated by employee/peer reports, allied agencies, identified during case review process, or by public complaint.

h. Remediation program for problem investigation and resolution compatible with North Coast EMS policy #2104 and addendum.

E. EMD case review is the basis for all aspects of continuous quality improvement to maintain a high level of service and to provide a means for

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continuously checking the system. Consistency and accuracy are essential elements of EMD case review.

a. Critical components of the EMD case review process:

- 1) Each CQI program shall have a case reviewer(s) who is:
 - a) A currently licensed or certified physician, registered nurse, physician assistant, EMT-P, EMT-II, or EMT-I, who has at least two years of practical experience within the last five years in pre-hospital emergency medical services with a basic knowledge of emergency medical dispatch, and who has received specialized training in the case review process, or
 - b) An emergency medical dispatcher with at least two years of practical experience within the last five years, and who has received specialized training in the case review process.
- 2) The case reviewer shall measure individual emergency medical dispatcher performance in an objective, consistent manner, adhering to a standardized scoring procedure.
- 3) The regular and timely review of a pre-determined number of EMD calls shall be utilized to ensure that the emergency medical dispatcher is following protocols when providing medical instructions.
- 4) Routine and timely feedback shall be provided to the EMD to allow for improvement in their performance.
- 5) The case reviewer shall provide a compliance-to-protocol report at least annually to the North Coast EMS Medical Director to ensure that the EMD Provider Agency is complying with Priority Dispatch minimum protocol compliance standards, and North Coast EMS policies and procedures.

VI. Policies and Procedures

A. The EMD Provider Agency shall establish policies and procedures through its continuous quality improvement program, consistent with the Priority Dispatch scope of practice that includes, but is not limited to:

- 1) Ensuring the EMD call answering point maintains direct access to the calling party,
 - 2) Providing systematized caller interview questions,
 - 3) Providing systematized post-dispatch and pre-arrival instructions,
 - 4) Establishing protocols that determine vehicle response code and configuration based on the North Coast EMS approved Response
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Determinants Matrix.

- 5) Utilizing the Priority Dispatch call classification coding system, for quality assurance and statistical analysis,
- 6) Establishing a written description of the communications system configuration for the service area including telephone and radio service resources, and
- 7) Establishing a record-keeping system, including report forms or a computer data management system to permit evaluation of patient care records to ensure emergency medical dispatcher compliance with the Priority Dispatch, timeliness of interview questions and dispatch, and with North Coast EMS EMD policies.

VII. North Coast EMS Medical Direction and Oversight

1. North Coast EMS shall provide one copy of the Priority Dispatch EMD Protocol Card System to all designated EMD Providers.
2. The Regional Medical Director shall provide medical oversight for all medical aspects of the EMD program.
3. The Regional Medical Director shall be responsible for approval of the Priority Dispatch Program and:
 - a. Approval of medical aspects of the emergency medical dispatcher orientation and performance evaluations,
 - b. Evaluation of the medical care, post-dispatch, pre-arrival instructions, cases and other documentation submitted by EMD Providers, Approval of the Response Determinants Matrix and specific pre-arrival cards that require local approval. The Medical Director reserves the right to approve only those local protocols that are congruent with the established EMS system.
 - d. Review of EMD Providers CQI Plan, policies and procedures.
 - e. Participation in the local EMS system CQI process.

VIII. Records Management

1. Course Completion Records:
 - a. The EMD Provider shall maintain a copy of the basic EMD training program course completion record in the individual emergency medical dispatcher's training file.
 - b. The EMD Provider shall maintain a record of "in-house" EMD CDE topics, methodologies, date, time, location, and the number of CDE hours completed for each session of CDE in the individual emergency
-

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medical dispatcher's training file.

c. The EMD Provider shall maintain a copy of EMD CDE program course completion records from Priority Dispatch in the individual emergency medical dispatcher's training file.

d. The EMD Provider shall submit a list of all affiliated and currently certified EMD dispatchers to North Coast EMS and report additions or deletions within 30 days of any change.

2. CQI Case Review Records:

a. Each EMD Provider shall retain compliance-to-protocol reports and dispatch records as required by law.

Approved: 

Approved as to Form: 

Subject: Administration - Provider
Emergency Medical Dispatch Center Provider Designation

Associated Policies: 2201

Subject: Administration – Specialty Center Designation
STEMI Receiving Center Designation Criteria

I. Authority and Reference (incorporated herein by references)

- A. Division 2.5 of Health and Safety Code
- B. California code of Regulations, Title 22
- C. North Coast EMS Policies and Procedures

II. Purpose

To establish requirements for designation and re-designation of a North Coast EMS STEMI Receiving Center (SRC) for self-transported patients, or patients being transported via the 9-1-1 system according the North Coast EMS policy, with ST-elevation myocardial infarction (STEMI) or other cardiac conditions, who may benefit from rapid assessment, percutaneous intervention (PCI) or other cardiac procedures requiring utilization of a cardiologist and Cath Lab.

III. Definitions: (to be added if needed)

IV. Application and Designation Process

To apply for designation as a North Coast EMS STEMI Receiving Center (SRC), a hospital located within the North Coast EMS region shall:

- A. Submit to North Coast EMS a letter of interest verifying the commitment by hospital administration, cardiology, Cath Lab and Emergency Department representatives to proceed with designation and pay associated fees including site visit. Associated fees will be determined by the North Coast EMS Joint Powers Governing Board.
- B. Submit to North Coast EMS verification that all of the designation criteria are met.

V. SRC Designation Criteria

- A. Current California licensure as an acute care facility providing Basic or Comprehensive Emergency Medical Services.
- B. Current national accreditation (to be specified)
- C. Written agreement between North Coast EMS and SRC.
- D. Verification that Hospital meets STEMI Receiving Center Designation Criteria.
The criteria includes:

1. Hospital Services

- a. Special permit for cardiac catheterization laboratory.
- b. Submission of prior door-to –balloon time data, PCI volume per operator, total PCI volumes including walk-ins and transports. The following nationally recommended numeric volumes are intended as guidelines for QI purposes only: A minimum of 36 primary (emergency) procedures per year and 200 total (emergency plus elective) procedures per year is expected by hospital, and each interventional cardiologist should perform a minimum of 11 primary

(emergency) and 75 total (emergency plus elective) procedures per year.

- c.** Intra aortic balloon pump capability.
- d.** Special permit for cardiovascular surgical services.
- e.** Continuous availability of PCI resources 24/7.
- f.** Back up plan for when Cardiac Cath Lab (CCL) is not available
- g.** Policy for activation of interventionalist and CCL crew with response times to CCL
- h.** Communication systems for notification of incoming STEMI 24/7.
- i.** Participation in data collection and evaluation as required by North Coast EMS.

2. Hospital-Personnel

- a.** STEMI Receiving Center Medical Director/CCL Medical Director (need to add qualifications but most likely head cardiologist of the Cath Lab)
- b.** STEMI Receiving Center Program Coordinator
- c.** Cardiac CCL Manager/Coordinator.
- d.** Intra Aortic Balloon Pump Technician(s) or Nurse.
- e.** Appropriate CCL nursing and ancillary support.
- f.** ED Physician & Nurses – who shall in-house and immediately available
- g.** Physician Consults – who shall be on-call and promptly available (within 30 minutes) to the CCL:
 - 1)** Cardiology Interventionalist.
 - 2)** CV surgeon.
- h.** Cardiac Cath Lab Crew – who shall be on-call and promptly available (within 30 minutes)

3. Clinical Capabilities

- a.** Utilization of ACC/AHA/SCAI guidelines for activity levels of facilities and practitioners for both primary PCI and total PCI events are optimal benchmarks.
- b.** Performance (timelines) and out comes will be assessed initially in the survey process, and will be monitored on an ongoing basis.

E. SRC Internal Hospital Policies/Plans

- a.** Base Hospital STEMI medical control and quality improvement plan
- b.** ED STEMI patient management plan
- c.** Cardiac interventionalist activation plan.
- d.** CCL team activation plan
- e.** STEMI contingency plans for personnel and equipment.
- f.** Coronary angiography policy.
- g.** PCI and use of fibrinolytic policy.

- h. Interfaculty transfer STEMI policies/procedures.
- i. Fibrinolytic therapy protocol to be used in unforeseen circumstances when PCI of STEMI not available.
- j. Re-routing of STEMI patients ONLY during times of internal disaster. A written notification describing the event must be submitted to North Coast EMS within 24hours.
- k. Universal and immediate acceptance of STEMI patients from STEMI Referral Facilities (SRFs) and non-designated hospitals that do not have PCI capabilities.
- l. Patient tracking and treatment (acutely and at discharge) with ACC/AHA guideline-based Class I therapies.
- m. Internal hospital multi-disciplinary team meetings to evaluate outcomes and CQI data. Operational, policy and system issues should be reviewed, problems identified and solutions implemented.

F. Performance Improvement Program/QCI/Internal Plan

- a. SRC shall develop an ongoing CQI program which monitors all aspects of treatment and management of STEMI/cardiac patients and identify areas that need improvement. The program must, at a minimum, monitor the following parameters:
 - i. Death rate (with in 30 days, related to procedure regardless of the mechanism).
 - ii. Emergency CABG rate (result of procedure complication or failure).
 - iii. Vascular Complications (access site, transfusion, or operative intervention required).
 - iv. CVA rate (peri-procedure).
 - v. Sentinel event, system and organization issue review and resolve processes.
 - vi. Tracking door to dilation times.
 - vii. Other additions such as: use of a single standardized STEMI care pathway, arrival of interventionists and CCL team within 30 minutes, volume/experience characteristics, etc.
 - b. Meetings to be held with NCEMS and the Humboldt Cardiac Coordinating Committee on a quarterly basis initially, meeting frequency to be reviewed following the first year.
 - c. **Participants in the QIP Meetings, should have the following:**
 - i. North Coast EMS Medical Director and/or Executive Director, EMS Coordinator and/or Cardiac Nurse Contractor
 - ii. Designated STEMI or QIP representative(s) from hospital
 - iii. Designated cardiologist from SRC
 - iv. Other members of the HCCC.
- 4. Participate in Prehospital STEMI related activities.**

G. Data Collection, submission, and analysis

- a. Participate in NCDR (national cardiac registry)
- b. ED Door-to-ECG Time (goal = less than 10 minutes)
- c. Proportion of ED STEMI patients receiving PCI or fibrinolytic therapy
- d. ED Door-to cath lab time (for non-transfer patients) or Door-to-disposition time (for transferred patients): goal less than 90 minutes).
- e. ED Door-to-needle time (goal: less the 30 minutes)
- f. ED portion of ineligible patients
- g. Hospital transfer time
- h. Etc from the State STEMI Plan?

H. Designation

- i. SRC designation shall be awarded to a hospital following satisfactory review of written documentation and initial site visit, by a team TBA, and a MOU between the hospital and North Coast EMS.
- ii. SRC designation shall be for a period of 2 years initially, then every four years after that, contingent on satisfactory reviews.
- iii. Designation may be probated, suspended or revoked for cause

I. Basis for Probation, Suspension or Revocation of Designation

- a. Inability to meet and maintain STEMI designation criteria.
- b. Failure to provide required data.
- c. Failure to participate in the STEMI CQI process
- d. Other criteria as defined in the North Coast EMS Cardiac Subsystem Plan and North Coast EMS Policy # 6549.

Approved: 

Approved as to Form: 

Subject: Scope of Practice/Procedure
Atropine Sulfate Protocol

Associated Policies:

- I. Class
 - A. Parasympathetic blocker (anticholinergic). Blocks vagal effects.

- II. Indications
 - A. Symptomatic bradycardia
 - B. Second or third degree atrioventricular (AV) block
 - C. Pulseless bradycardias.
 - D. Asystole.
 - E. Symptomatic organophosphate poisoning.

- III. Therapeutic Effects
 - A. Blocks parasympathetic action on the heart.
 - B. Enhances conduction through the AV junction.
 - C. Accelerates heart rate thereby improving cardiac output.
 - D. Suppresses hypercholinergic effects of organophosphate poisoning.


- IV. Contraindications
 - A. Absolute:
 - 1. Tachycardia.
 - 2. Hypersensitivity.
 - B. Relative:
 - 1. Narrow-angle glaucoma.
 - 2. Wide complex Third Degree AV block.


- V. Adverse Effects
 - A. Blurred vision.
 - B. Dryness of the mouth.
 - C. Flushing of the skin.
 - D. Urinary retention.
 - E. Headache.
 - F. Tachycardia.
 - G. Palpitations.

- VI. Administration and Dosage
 - A. Bradycardia with pulses:

Subject: Scope of Practice/Procedure
Atropine Sulfate Protocol

1. Adult: 0.5 mg IV (minimum single dose 0.5 mg) every 5 minutes to a maximum of 0.04 mg/kg.
 2. Pediatric: 0.02 mg/kg (minimum single dose 0.1 mg and a maximum single dose 0.5 mg), which may be repeated every 5 minutes as needed to a maximum total dose of 1 mg in a child and 2.0 mg in an adolescent.
- B. Pulseless bradycardias:
1. Adult: 1.0 mg IV repeat every 3-5 minutes up to maximum total dose of 0.04 mg/kg. Double the dose to 2 mg for ET.
 2. Pediatric: 0.02 mg/kg IV or IO minimum single dose 0.1 mg. 0.04 mg/kg ET administration and dilute to total volume of 3-5 ml with normal saline.
- C. Asystole:
1. Adult: 1.0 mg. IV (2-2.5 mg ET) repeat every 3-5 minutes up to maximum total dose of 0.04 mg/kg.
 2. Pediatric: 0.02 mg/kg IV or IO, minimum single dose 0.1 mg. 0.04 mg/kg ET and dilute to total volume of 3-5 mg with normal saline.
- D. Organophosphate:
1. Adult: 2 mg IV or IM every 5 to 15 minutes as needed.
 2. Pediatric: 0.05 mg/kg, IV, IO or IM every 15 minutes as needed.
- VII. Special Information
- A. Doses smaller than 0.5 mg in an adult can cause paradoxical bradycardia.
 - B. Doses smaller than 0.1 mg in a child or infant can cause paradoxical bradycardia.
 - C. Rule out hypoglycemia before treating for organophosphate poisoning.
 - D. Need for atropine should be weighed against exacerbation of possible ischemic heart disease or AMI. Use with caution in the presence of chest pain.
 - E. Can cause ventricular fibrillation in the presence of hypoxia or acidosis.

Approved: 

Approved as to Form: 

B. Potent local irritant at injection site.

Subject: Scope of Practice/Procedure – EMT-II
Epinephrine (Adrenalin)

Associated Policies:

- I. Class
 - A. Naturally occurring catecholamine with alpha and beta adrenergic effects.

- II. Indications
 - A. Anaphylactic shock.
 - B. Acute asthma.
 - C. Cardiac arrest.
 - D. Bradycardia refractory to atropine.
 - E. Treatment of shock with profound hypotension from any cause unresponsive to fluid resuscitation.
 - F. Severe croup.
 - G. Life threatening epiglottitis.

- III. Therapeutic Effects
 - A. Bronchodilator.
 - B. Maintains blood pressure.
 - C. Stimulates spontaneous contractions of myocardium.
 - D. Increases myocardial tone.

- IV. Contraindications
 - A. Absolute:
 - 1. None.
 - B. Relative:
 - 1. Use with cautions in persons over 40 years of age or known ischemic heart disease.

- V. Adverse Effects
 - A. Tachycardia.
 - B. Palpitations.
 - C. Tremors.

- VI. Administration and Dosage
 - A. Anaphylactic shock:
 - 1. Adult:
 - a. Epinephrine 1:1,000 0.3 mg-0.5 mg IMo, may repeat every 15 minutes as necessary.

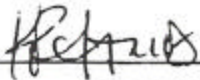
Subject: Scope of Practice/Procedure – EMT-II
Epinephrine (Adrenalin)


- b. Epinephrine 1:10,000 slow IV (15-60 seconds) in 0.1 mg increments to maximum of 0.5 mg titrated to relieve signs of shock.
 - 2. Pediatric:
 - a. Epinephrine 1:1,000 0.01 mg/kg (maximum dose 0.5 mg)IM.
 - b. Epinephrine 1:10,000 slow IV (15-60 seconds) in 0.05 mg (0.5cc) increments to maximum of 0.01 mg/kg.
- B. Asthma:
 - 1. Adult:
 - a. Epinephrine 1:1,000 0.01 mg/kg SQ (maximum single dose 0.5 mg). May repeat in 20 minutes.
 - 2. Pediatric:
 - a. Epinephrine 1:1,000 0.01 mg/kg SQ (maximum single dose 0.5 mg). May repeat in 20 minutes.
- C. Cardiac Arrest:
 - 1. Adults:
 - a. Epinephrine 1:10,000 1 mg IV IO or 2-2.5 mg ET every 3 to 5 minutes. If no response consider:
 - 2. Pediatric:
 - a. Epinephrine 1:10,000 0.01 mg/kg, IV or IO.
 - b. Epinephrine 1:1,000 0.1 mg/kg ET diluted with normal saline to total volume of 3-5 ml.
 - c. Subsequent doses Epinephrine 1:1,000 0.1-0.2 mg/kg IV, IO, or ET every 3 to 5 minutes.
- D. Severe Bradycardia and Hypotensive Shock State:
 - 1. Adult:
 - a. Dilute 1 mg epinephrine in 500 ml D₅W or NS (or 0.5 mg in 250 ml) = 2 mcg/ml. Initial infusion rate = 1 mcg/minute, titrated to the desired effect (average infusion dose range = 2-10 mcg/min).

| Drip Set Used | Drops per Minute to Deliver Desired Dose per Minute | | | | | | | | | |
|----------------------|---|------|------|------|------|------|------|------|------|-------|
| | 1mcg | 2mcg | 3mcg | 4mcg | 5mcg | 6mcg | 7mcg | 8mcg | 9mcg | 10mcg |
| 10gtts/ml set | 5 | 10 | 15 | 20 | 25 | 30 | 35 | 40 | 45 | 50 |
| 15gtts/ml set | 7.5 | 15 | 23 | 30 | 38 | 45 | 53 | 60 | 68 | 75 |
| 20gtts/ml set | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 100 |
| 60gtts/ml set | 30 | 60 | 90 | 120 | 150 | 180 | 210 | 240 | 270 | 300 |

Subject: Scope of Practice/Procedure – EMT-II
Epinephrine (Adrenalin)

2. Pediatric:
 - a. Dilute Epinephrine 1:1,000 0.6 mg/kg in enough NS to create a 100 ml solution. 1 ml/hr (60 gtt tubing) delivers 0.1 mcg/kg/min. Initiate infusion at 20 ml/hr until tachycardia ensues. Then reduce infusion to the desired rate. Average dose range = 0.1-1 mcg/kg/minute, or
 - b. Use the Pediatric Resuscitation tape, refer to each weight for specific doses, ml's to remove and add to make 100 ml solution, and delivery rate. Each weight will provide a different concentration of the infusion solution and rate of delivery.
 - E. Severe Croup or Epiglottitis:
 1. Adult and pediatric:
 - a. Nebulize 5cc Epinephrine 1:1,000 via SVN without dilution. Do not repeat within 60 minutes
- VII. Special Information
- A. Incompatible with bicarbonate and furosemide solutions. Flush IV lines between injections.
 - B. Endotracheal administration is no longer the preferred route of administration and should be avoided.

Approved: 

Approved as to Form: 

Subject: Scope of Practice/Procedure – EMT-II
Lidocaine (Xylocaine)

Associated Policies:

- I. Class
 - A. Ventricular antidysrhythmic.

- II. Indications
 - A. Unstable and persistent premature ventricular contractions not responsive to oxygenation and improved perfusion.
 - B. Ventricular tachycardia with or without a pulse.
 - C. Recurrent ventricular fibrillation.

- III. Therapeutic Effects
 - A. Suppresses ventricular ectopic activity by decreasing the excitability of the heart muscle and its conduction system.


- IV. Contraindications
 - A. Absolute:
 - 1. Bradycardia.
 - 2. Asystole.
 - 3. Idioventricular rhythms.
 - 4. Hypersensitivity.
 - 5. 2nd or 3rd degree heart block.
 - B. Relative:
 - 1. Renal dysfunction.
 - 2. CHF.
 - 3. Patients over 70 years old. (Consider lower doses and/or very slow IV for these patients.)


- V. Adverse Effects
 - A. Slurred speech.
 - B. Altered level of consciousness.
 - C. Toxic levels can cause seizures.
 - D. Muscle twitching.

- VI. Administration and Dosage
 - A. Adult:
 - 1. Symptomatic PVC's with a pulse: 1.0-1.5 mg/kg IVP/ IO followed by additional 0.5-0.75 mg/kg boluses every 5-10

Subject: Scope of Practice/Procedure – EMT-II
Lidocaine (Xylocaine)

- minutes, to a total of 3 mg/kg. If lidocaine is successful, initiate IV/IO infusion at 2-4 mg/minute.
2. Ventricular fibrillation or Pulseless ventricular tachycardia: 1.0-1.5 mg/kg IV/IO. (ET dose: 2 to 2.5 times normal dose.) Repeat every 3-5 minutes as needed. Total maximum dose 3 mg/kg. If Lidocaine is successful, initiate IV/IO infusion at 2-4 mg/minute.
- B. Pediatric:
1. 1 mg/kg IV, IO, or ET (ET administration dilute with NS to volume of 3-5 ml).
 2. Infusion rate: Dose of 20-50 mcg/kg/min.
 - a. To mix: add 300 mg (15 ml of 2% Lidocaine 20 ml/cc) to 250 ml NS or D₅W. (1 micro drop/kg/minute of this solution = 20 mcg/kg/minute), or
 - b. Use the Pediatric Resuscitation tape, refer to each weight for specific doses, ml's to remove and add to make desired solution, and delivery rate. Each weight will provide a different concentration of the delivery solution and rate of delivery.
- C. Special Considerations:
1. ET is no longer a preferred method of administration. If IV access cannot be obtained, IO access should be considered in all age groups.
 2. Routine use of Lidocaine in the presence of chest pain should be avoided. Focus should be on increasing oxygenation and treating possible underlying causes.
 3. In the presence of cardiac arrest, focus should be on high quality chest compressions without interruptions.

Approved: 

Approved as to Form: 

Subject: Scope of Practice/Procedure – EMT-II
Morphine Sulfate Protocol

Associated Policies: 5322, 5422

- I. Class
 - A. Opiate (narcotic). Natural opium alkaloid.

- II. Indications
 - A. Ischemic chest pain.
 - B. Acute pulmonary edema.
 - C. Burns without hypotension.
 - D. Isolated extremity trauma.
 - E. Abdominal pain in the absence of hypotension.

- III. Therapeutic Effects
 - A. Promotes analgesia, decreases pain perception and anxiety.
 - B. Increase venous capacitance and reduces systemic vascular resistance.
 - C. Decreases myocardial oxygen demand.

- IV. Contraindications
 - A. Absolute:
 - 1. Hypersensitivity.
 - 2. Hypovolemia.
 - 3. Head injury.
 - 4. Abdominal pain.with hypotension.

 - B. Relative:
 - 1. Hypotension.
 - 2. Compromised respirations, except pulmonary edema.

- V. Adverse Effects
 - A. Respiratory depression.
 - B. Decreased level of consciousness.
 - C. Transient hypotension.
 - D. Bradycardia or tachycardia.
 - E. Nausea and vomiting.

- VI. Administration and Dosage
 - A. Adult: 2 to 5 mg slow IV over 1 to 5 minutes. May repeat every 5-10 minutes until desired effect is achieved. Intramuscular (IM) 5 to 15 mg.

Subject: Scope of Practice/Procedure – EMT-II
Morphine Sulfate Protocol

Associated Policies: 5322, 5422

-
- B. Pediatric: 0.05 to 0.1 mg/kg slow IV (Maximum 2 mg single dose) over 3 to 5 minutes. May repeat every 5-10 minutes at 1/2 dose until desired effect is achieved. IM 0.1 mg/kg every 3-4 hours.
 - C. Infant under 6 months (est. 8 kg): 0.05 mg/kg slow IV over 3 to 5 minutes. May repeat every 5 to 10 minutes at 1/2 dose until desired effect is achieved.

VII. Special Information

- A. Place all patients receiving MS on cardiac monitor and pulse oximetry if available.
- B. Patients receiving Morphine should always receive supplemental oxygen.
- C. Excessive narcosis can be reversed with IV Naloxone.
- D. Use caution and consider smaller increments of dosing in the Acute Inferior MI patient. Monitor closely for hypotension and be prepared for fluid resuscitation.

Approved: 

Approved as to Form: 

Subject: Scope of Practice/Procedure – EMT-II
Naloxone (Narcan) Protocol

Associated Policies:

- I. Class
 - A. Narcotic antagonist.

- II. Indications
 - A. Narcotic overdose.
 - B. Altered level of consciousness or unconsciousness of unknown etiology.

- III. Therapeutic Effect
 - A. Reverses action of narcotic drugs.

- IV. Contraindications
 - A. Absolute:
 - 1. None.
 - B. Relative:
 - 1. Use caution in depressed neonate with suspected narcotic exposure.
May precipitate seizures.

- V. Adverse Effects
 - A. May cause acute withdrawal symptoms.
 - B. Tachycardia.
 - C. Hypertension.
 - D. Dysrhythmias.
 - E. Nausea and vomiting.

- VI. Administration and Dosage
 - A. Adult: 0.4-2.0 mg IV, IM, ET, IO or IN , may repeat as needed. ET doses 2-2.5 times normal dose.
 - B. Pediatric: 0.2 mg/kg to a maximum dose of 2.0 mg, IV, IM, IO or ET.
 - C. Neonate: 0.1 mg/kg IV, IM, IO, or ET.

- VII. Special Information

Approved: 

Approved as to Form: 

Subject: Scope of Practice/Procedure – EMT-II
 Naloxone (Narcan) Protocol

Associated Policies:

- A. Duration of the action of Naloxone is shorter than the duration of narcotics, repeated doses may be necessary.

Approved: _____

Date: _____

Approved as to Form: _____

Date: _____

Subject: Scope of Practice/Procedure – EMT-II
Nitroglycerine (NTG) Protocol

Associated Policies:

- I. Class
 - A. Nitrate.

- II. Indications
 - A. Unstable Angina Pectoris.
 - B. Chest pain of suspected cardiac origin.
 - C. Hypertensive emergency.
 - D. Acute CHF/Pulmonary edema.

- III. Therapeutic Effects
 - A. Peripheral vasodilatation and decreased pre-load.
 - B. Decreases myocardial workload and oxygen demand.

- IV. Contraindications
 - A. Absolute:
 - 1. Hypersensitivity.
 - 2. Patients less than 12 years old.
 - 3. Cerebral hemorrhage.
 - 4. Head injury.
 - B. Relative:
 - 1. Blood pressure less than 100 systolic.
 - 2. Avoid use in the presence of the Acute Inferior MI. Consider Mophine for pain control.

- V. Adverse Effects
 - A. Transient hypotension and dizziness.
 - B. Temporary pulsating headache.
 - C. Facial flushing and burning under the tongue.
 - D. Weakness and nausea.

- VI. Administration and Dosage
 - A. Sublingual Only: 0.4 mg (1/150 gr.) tablets, or metered-dose spray; repeat every 3-5 minutes if discomfort is unrelieved and systolic blood pressure remains greater than 100.

Subject: Scope of Practice/Procedure – EMT-II
Nitroglycerine (NTG) Protocol

Associated Policies:

VII. Special Information

- A. Age increases hypotensive response.
- B. Patient should be supine or semi-fowlers position during administration.

Approved: _____

Approved as to Form: _____

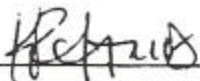
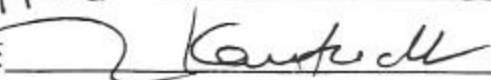
Subject: Scope of Practice/Procedure – EMT-II
Fibrinolytic Checklist Procedure

Associated Policies: , 6511

- I. Authority and Reference (incorporated herein by references)
 - A. Division 2.5 of Health and Safety Code
 - B. California Code of Regulations, Title 22
 - C. North Coast EMS Policies and Procedures

- II. Purpose
 - A. This Policy is intended to serve as a guidance document.
 - B. A rapid evaluation of a patient with suspected acute stroke or acute myocardial infarction that may benefit from fibrinolytics.
 - C. To determine the presence of comorbid conditions for which fibrinolytic therapy are contraindicated.

- III. Procedure
 - A. Follow the checklist for patient's chief complaint to assess the need for fibrinolytics or contraindication for its use.
 - B. If contraindications exist for the Acute MI or STEMI patient, consider transport to the PCI facility regardless of extended transport times.
 - C. Prehospital personnel should notify their base hospital as soon as possible of the suspected AMI patient's age, gender, and clinical findings, including cardiac rhythm (or 12-lead electrocardiogram (EKG) if available) and pertinent medical history.
 - D. Any contraindication for fibrinolytics should also be relayed to the base hospital (and in turn to the receiving hospital, if different)
 - E. Ability of prehospital personnel to complete the checklist will depend on patient condition but every attempt should be made to complete the checklist on all STEMI/ACUTE MI patients.
 - F. Checklist is not to be completed on scene.
 - G. Fibrinolytic Checklist
Attached

Approved: 
Approved as to Form: 

FIBRINOLYTIC CHECKLIST FOR STEMI

STEP 1:

Has patient experienced chest discomfort for greater than 15 minutes and less than 12 hours?

YES

NO

Does ECG show STEMI or new or presumably new LBBB?

YES

NO



Step 2

Are there contraindications to fibrinolysis?

If any of the following is checked YES, fibrinolysis MAY be contraindicated.

- Systolic BP>180mm Hg or diastolic BP>110mmHG ___ Yes ___ No
- Right vs left arm systolic BP difference >15 mm HG ___ Yes ___ No
- History of structural central nervous system disease ___ Yes ___ No
- Stroke > 3 hours or < 3 months ___ Yes ___ No
- Significant closed head/facial trauma within the previous 3 months ___ Yes ___ No
- Recent (within 6 weeks) major trauma, surgery (including laser eye surgery), GI/GU bleed ___ Yes ___ No
- Bleeding or clotting problem on blood thinners ___ Yes ___ No
- CPR > 10 minutes ___ Yes ___ No
- Pregnant female ___ Yes ___ No
- Serious systemic disease (eg, advanced cancer, severe liver or kidney disease) ___ Yes ___ No

Step 3

Is patient at high risk?

If ANY of the following is Checked YES, consider transfer to PCI facility.

- Heart rate >100/min AND systolic BP<100 mm Hg ___ Yes ___ No
- Pulmonary edema ___ Yes ___ No
- Signs of shock ___ Yes ___ No
- Contraindications to fibrinolytic therapy. ___ Yes ___ No

Subject: Scope of Practice/Procedure- EMT-II
Benzodiazepines

- I. Indications
 - A. Sustained and/or recurrent grand mal seizures.
 - B. Before cardioversion or transcutaneous pacing in conscious patients.

- II. Therapeutic Effects
 - A. Decreased cerebral irritability
 - B. Relaxes skeletal muscles
 - C. Sedation

- III. Contraindications
 - A. Absolute:
 - 1. Suspected or known allergy to Benzodiazepines.
 - B. Relative:
 - 1. Shock
 - 2. Pregnancy
 - 3. Trauma to rectum (for rectal administration).
 - 4. Congenital or surgical anomaly of the rectum (for rectal administration)

- IV. Adverse Effects
 - A. Respiratory depression or arrest may be caused or worsened by Benzodiazepines.
 - B. Drowsiness, vertigo, ataxia, transient hypotension
 - C. Rectal injury may occur due to forceful entry of the syringe
 - D. Inadequate absorption, following rectal administration

- V. Administration of Diazepam
 - A. Adult:
 - 1. 2.5-20 mg IV push in 2.5 mg increments titrated to effect. May give up to 40mg in status epilepticus. 5-10 mg IM.
 - B. Pediatric:
 - 1. 0.1-0.3 mg/kg slow IV push or 0.5 mg/kg (maximum dose 20mg) rectally.

Subject: Scope of Practice/Procedure- EMT-II
Benzodiazepines

VI. Administration of Midazolam (Paramedic Scope Only)

A. Adult:

1. IV: 1-2.5 mg slow IV (over 2-3 min);
may be repeated if necessary in small increments (total maximum dose to 0.1 mg/kg not to exceed 10 mg)
2. IM: 5 mg (0.07 mg/kg) IM
3. IN: 5 mg – 10 mg maximum 1 cc volume each nostril if agency approved.

B. Pediatric:

1. IV .05 mg/kg not to exceed 5 mg per dose or 10 mg total.
2. IM 0.1 mg/kg. Further doses up to .4 mg/kg. No single dose to exceed 5 mg or 10 mg total.
3. IN: 0.1mg/kg with maximum volume of 1cc each nostril with agency approved.

VII. Special Information

- A. Never give without resuscitation equipment available
- B. Push as close to the hub as possible. Benzodiazepines may precipitate if mixed with other drugs or IV solutions.
- C. Effects of Benzodiazepines potentiated with alcohol and other sedatives.
- D. Painful upon IM administration, unpredictable absorption.
- E. Do not inject a single IM dose of more than 2 cc. Any dose greater than 2 cc should be administered in multiple injections.

Approved: _____

Approved as to Form: _____

Subject: Scope of Practice/Procedure – Paramedic
Valsalva Maneuver

Associated Policies:

- I. Indications
 - A. Supraventricular tachycardias with signs of decreased cardiac output (hypotension and decreased level of consciousness).
- II. Therapeutic Effects
 - A. Vagal stimulation causes slowing of the sinus node and decreased AV conduction.
- III. Contraindications
 - A. None.
- IV. Equipment
 - A. Heart Monitor/Defibrillator.
 - B. Patent IV.
- V. Procedure
 - A. Administration of oxygen.
 - B. Place the patient on the heart monitor.
 - C. Start an IV TKO.
 - D. Obtain 12 Lead for diagnostic purposes if available and patient is stable.
 - E. Run a continuous rhythm strip throughout the procedure.
 - F. Ask the patient to take a deep breath and bear down against a closed glottis, much like straining for a bowel movement.
 - G. Observe monitor for changes.
 - H. Reassess vital signs.
 - I. May repeat as needed.
- VI. Special Information
 - A. Do not perform during carotid sinus massage.

Approved: 

Approved as to Form: 

Subject: Medical Control
EMT-P Standing Orders/Radio Failure/Direct Voice Contact

Associated Policies: 2402, 2404

- I. Authority and Reference (incorporated herein by references)
 - A. Division 25 of Health and Safety Code
 - B. California Code of Regulations, Title 22, Section 100144
 - C. North Coast EMS Policies and Procedures

- II. Purpose

To define which procedures Paramedic personnel may perform prior to attempting voice contact with the base hospital, which procedures may be performed upon radio failure, and which procedures may only be performed under direct verbal orders of the base hospital.

- III. Responsibilities
 - A. Standing Orders
 - 1. The paramedic may initiate emergency treatment prior to attempting voice contact with the base hospital physician or MICN when (s)he reasonably determines that such therapy is indicated.
 - 2. The paramedic continues to be required to contact the base hospital at the earliest practical opportunity within the continuum of patient assessment and treatment. The base hospital report must include patient assessment information, any treatment that has been initiated, and ETA. Hospital notification should be given a high priority for any acute patient, to allow hospital personnel adequate time to mobilize resources.
 - 3. Use of standing orders will be documented on the Prehospital Care Report (PCR). See NCEMS policy # 2404.
 - B. Radio Failure
 - 1. When a paramedic attempts direct voice contact with the base hospital physician or MICN, but cannot establish or maintain that contact, and reasonably determines that a delay in treatment may significantly increase patient morbidity or mortality, the paramedic may initiate any of the procedures listed in this policy under section IV, B “Radio Failure,” until such direct communication may be established and maintained or until the patient is brought to a general acute care hospital.
 - 2. Immediately upon ability to make voice contact, the paramedic who initiated procedures under Radio Failure guidelines shall make a verbal report to the base hospital physician or MICN.
 - 3. The use of Radio Failure procedures will be documented in the Patient Care Report (PCR). The PCR shall be evaluated and forwarded to NCEMS in accordance with policy.

Subject: Medical Control
EMT-P Standing Orders/Radio Failure/Direct Voice Contact

C. Direct Voice Contact

1. Under no circumstances should a paramedic initiate any of the procedures listed under section IV. C of this policy without receiving direct voice orders to do so from the base hospital physician or MICN. Failure to obtain direct voice orders will result in the initiation of a Case Review.

IV. Procedure

A. Standing Orders

The following procedures may be performed prior to attempting voice contact with the base hospital.

Administer the following medications:

- a. Adenosine for symptomatic narrow complex tachycardia >150 bpm in adults
- b. Albuterol Sulfate via SVN for bronchospasm or acute bronchial asthma.
- c. Aspirin, PO, for chest pain suspect of AMI.
- d. Atropine Sulfate, IV, ET, IO, for cardiac arrest, symptomatic bradycardia, or third degree block.
- d. Dextrose 25% and 50% for ALOC or status epilepticus from suspected hypoglycemia.
- e. Diphenhydramine Hydrochloride for anaphylaxis or EPR.
- f. Diazepam IV or rectally for status epilepticus.
- g. Dopamine for cardiac shock after fluid administration
- h. Epinephrine IV, IO, ET, IM for cardiac arrest, anaphylaxis, or acute asthma.
- i. Furosemide (when used for pulmonary edema for patients with signs and symptoms of congestive heart failure) after the administration of nitrates.
- j. Glucagon IM for ALOC with proven hypoglycemia without IV access.
- k. Lidocaine Hydrochloride IV, IO or ET for V-tach, V-fib, wide complex PSVT, or symptomatic ventricular ectopy.
- j. Morphine Sulfate for burns without hypotension, obvious isolated extremity trauma, acute pulmonary edema, ischemic chest pain and nontraumatic abdominal pain with stable vital signs.
- k. Naloxone Hydrochloride IV, ET, IM, IO or IN for ALOC suspect of narcotic OD.
- l. Neosynephrine topical prior to nasal intubation.

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Subject: Medical Control
EMT-P Standing Orders/Radio Failure/Direct Voice Contact

- m. Nitroglycerin sublingual for chest pain or acute pulmonary edema with BP > 100 systolic.
- n. Versed IV, IO or IN for Status Seizures
- 2. Perform the following procedures:
 - a. Control airway by insertion of OPA, NPA, PTL, EOA, EGTA, ETAD, needle cricothyrotomy, ET or NT intubation, and use of suction devices and Magill Forceps.
 - b. Administer Oxygen by use of nasal cannula, mask, BVM, and jet insufflation devices.
 - c. Defibrillate V-fib or pulseless V-tach.
 - d. Cardiovert an unconscious patient with pulses in V-tach.
 - e. Provide instruction for Valsalva maneuver for SVT.
 - f. Establish peripheral vascular access with IV cap, saline locks, or other cannulae and administer NS, LR or D₅W.
 - g. Obtain venous sample or capillary bed sample for diagnostic tests.
 - h. Obtain intraosseous access and perform intraosseous infusion in the pediatric patient.
 - i. Perform adult IO access when working for an approved provider.
 - j. Perform needle thoracostomy for obvious tension pneumothorax.
 - k. Apply suction extraction device in cases of envenomation.
 - l. Place nasogastric or orogastric tubes for gastric decompression in the cardiac arrest setting.
 - m. Utilize pulse oxymetry or end-tidal CO₂ monitors.
 - n. Perform transcutaneous pacing when accredited for pacing and working for an approved pacing provider. See Policy 4803.
 - o. Apply CPAP device when working for an approved provider.
 - p. Administer Narcan or Versed via IN when working for an approved provider.
 - q. Perform 12 Lead monitoring when working for an approved provider.
- B. Radio Failure
The following procedures may be performed in the event that the paramedic is not able to establish or maintain direct voice contact with the base hospital.

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Subject: Medical Control
EMT-P Standing Orders/Radio Failure/Direct Voice Contact

1. All procedures listed under IV.A. Standing Orders.
 2. Administer the following medications.
 - a. Activated charcoal for poisonings.
 - b. Atropine for organophosphate poisoning.
 - c. Calcium Chloride for cardiac arrest in renal patients.
 - d. Benzodiazepines for pre-cardioversion sedation.
 - e. Glucagon as inotropic agent in Beta Blocker overdose.
 - f. Magnesium Sulfate in Torsades de Pointes, V-tach or V-fib refractory to Lidocaine.
 - g. Oxytocin.
 - h. Procainamide for V-Fib and wide complex tachycardias refractory to other ACLS measures.
 - i. Sodium Bicarbonate for cardiac arrest with down time of > 10 minutes, known hyperkalemia, tricyclic antidepressant overdose, or known ASA overdose.
 - j. Administer nebulized Epinephrine 1:1,000 for presumptive epiglottitis or severe croup for patients in severe distress.
 3. Perform the following procedures:
 - a. Monitor or administer medications through a pre-existing central or peripheral line.
 - b. Monitor Potassium Chloride solutions with < 40 meq/ml.
 - c. Insert nasogastric or orogastric tubes for gastric lavage in the poisoning patient.
 - d. Cardiovert severely symptomatic, unstable V-tach, PSVT, A-fib, or A-flutter in the conscious patient.
- C. Direct Voice Orders
- The following procedures should only be performed following direct voice orders from the base hospital physician or MICN.
1. Administer the following medications:
 - a. Morphine sulfate in trauma (except in burns without hypotension and obvious isolated extremity trauma).
 - b. Magnesium Sulfate for eclampsia, severe pre-eclampsia, and pre-term labor.
 2. Perform the following procedures:
 - a. Carotid sinus massage
 - b. Monitor thoracostomy tubes
 3. Initiation of any other procedures or medication dosages which deviate from approved NCEMS policy.

Approved: 

Approved as to Form: 

Subject: Scope of Practice/Procedure – Paramedic
Adenosine

Associated Policies:

- I. Class
 - A. Endogenous nucleotide.

- II. Indications
 - A. Supraventricular Tachycardias.

- III. Therapeutic Effect
 - A. Adenosine slows conduction time through the A-V node, can interrupt the re-entry pathways through the A-V node and can restore normal sinus rhythm in patients with paroxysmal supraventricular tachycardia (PSVT), including PSVT associated with Wolfe-Parkinson-White (WPW) Syndrome.


- IV. Contraindications
 - A. Absolute:
 - 1. Second or third degree heart block.
 - 2. Sick sinus syndrome (except in patients with a functioning artificial pacemaker).
 - 3. Hypersensitivity.


- V. Adverse Effects
 - A. Transient dysrhythmias.
 - B. Facial flushing.
 - C. Shortness of breath/dyspnea.
 - D. Chest pressure.
 - E. Hypotension.
 - F. Lightheadedness.
 - G. Nausea/vomiting.
 - H. May produce bronchoconstriction in patients with history of asthma or pulmonary disease.

- VI. Administration and Dosage
 - A. Adult:
 - 1. Initial dose of 6 mg bolus, administered as a rapid (1-2 seconds) IVP, followed by a saline flush. If no response or conversion not sustained, repeat with 12 mg rapid IVP. Repeat with 12 mg dose in 1-2 minutes if desired response is not obtained.

Subject: Scope of Practice/Procedure – Paramedic
Adenosine

- B. Pediatric:
1. Initial dose of 0.1mg/kg followed by saline flush. If no response or conversion not sustained, may repeat 0.2 mg/kg (maximum 12 mg single dose). Repeat 0.2 mg/kg in 1-2 minutes if desired response is not obtained.
- VII. Special Instructions
- A. Adenosine is not effective in converting atrial flutter, atrial fibrillation, and ventricular tachycardia.
 - B. Dipyridamole (Persantine) and Carbamazepine (Tegretal) potentiate the effects of Adenosine. Smaller doses may be effective.
 - C. Methylxanthines (theophylline, caffeine, etc.) antagonize the effect of Adenosine. Larger doses may be required.
 - D. Severely symptomatic/unstable PSVT patients should be electrically cardioverted.
 - E. Adenosine must be given as a rapid (1-2 seconds) IVP followed by a rapid saline flush.

Approved: 

Approved as to Form: 

Subject: Scope of Practice/Procedure – Paramedic
Carotid Sinus Massage

Associated Policies:

- I. Therapeutic Effect
 - A. Carotid sinus massage is used to convert paroxysmal supraventricular tachycardia into sinus rhythm by stimulation of the baroreceptors in the carotid bodies. This results in an increase in vagal tone and a decrease in heart rate.

- II. Indications
 - A. Paroxysmal supraventricular tachycardia.

- III. Contraindications
 - A. Relative:
 1. Older patients and those known to have arteriosclerosis.

- IV. Adverse Effects
 - A. Dysrhythmias.
 - B. PVC's.
 - C. Ventricular tachycardia or fibrillation.
 - D. Syncope.
 - E. Seizure.
 - F. Stroke.
 - G. Bradycardias.
 - H. Nausea or vomiting.

- V. Procedure
 - A. Initiate IV, oxygen, and ECG monitoring.
 - B. Obtain 12 Lead for diagnostic purposes if available.. Confirm rhythm.
 - C. Position patient supine, while slightly hyperextending the head.
 - D. Gently palpate each carotid pulse separately. Auscultate each side for the presence of carotid bruits. If the pulse is diminished, or if carotid bruits are present, do not attempt carotid sinus massage.
 - E. Tilt the patient's head to the left side and place your index and middle fingers over the artery below the angle of the jaw and as high up on the neck as possible.
 - F. Firmly massage the artery by pressing it against the vertebral body and rubbing.
 - G. Monitor the ECG and obtain a continuous readout. Terminate massage at the first sign of slowing or heart block.
 - H. Maintain pressure no longer than 15-20 seconds.

Subject: Scope of Practice/Procedure - Paramedic
Zofran (Ondansetron)

Associated Polices:

- I. Class
A selective antagonist of a specific type of serotonin receptor located in the CNS at the area postrema (chemoreceptor trigger zone) and in the peripheral nervous system on nerve terminals of the vagus nerve. The drug's blocking action may occur at both sites.
- II. Indications:
 - A. Prevention of nausea and vomiting.
- III. Contraindications and Precautions:
 - A. Known hypersensitivity to the medication.
- IV. Administration and Dosage::
 - A. Adult: 4mg IV slowly over 2 to 5 minutes/IM/IO. May repeat once in 30 minutes.
4mg PO orally dissolvable tablets.
 - B. Pediatrics: Greater than 4 years of age. 4mg IV slowly over 2 to 5 minutes/IM/IO. May repeat once in 30 minutes. 4mg PO orally dissolvable tablets.
- V. Side Effects and Special Notes:
 - A. Use cautiously in patients with liver failure.

Approved: 

Approved as to Form: 

Subject: Medical Control
Endotracheal Tube Introducer (ETTI)

Associated Policies: DRAFT New Intervention Policy

I. Policy

- A. Only North Coast EMS approved ALS ETTI provider agencies may carry and employ the ETTI.
- B. ALS providers desiring to stock and employ the ETTI must do so according to North Coast EMS DRAFT policy “New ALS Interventions.”
- C. All paramedics must complete **at least 1 hour** of training on the use of ETTI according to the training process outlined in North Coast EMS DRAFT policy “New ALS Interventions.”

II. Indications

- A. Generally prior to proceeding to needle cricothyrotomy.
- B. Patient with Grade II through IV laryngeal views (Cormak-Lehane grade);
- C. Patients with airway edema regardless of laryngeal view;

III. Contraindications

- A. Do not use on Endotracheal tubes smaller than 6.0.

IV. Procedure

- A. Perform laryngoscopy as per oral tracheal intubation procedure, and obtain the best possible laryngeal view.
- B. Holding the ETTI in your right hand with the angled tip pointing upward, gently advance the ETTI anteriorly (under the epiglottis) to the glottic opening (cords).
 - a. For Grade II views, direct through the cords.
 - b. For all other situations, direct the ETTI to the area where you believe the cords should be, and feel for washboard sensation as the tip ratchets on the tracheal rings.
- C. Gently advance the ETTI until resistance is encountered at the carina.
- D. NOTE: Because the ETTI can potentially cause pharyngeal/tracheal perforation, never force it. If no resistance is encountered and the entire length of the ETTI is inserted, the device is in the esophagus.
- E. The ETTI is correctly placed when you see the device going through the cords, when you feel the ratcheting of the tip on the trachea, and/or when you meet resistance while advancing the device (ETTI is at the carina).
- F. Once positioned, withdraw the ETTI until the 37 cm black line mark is aligned with the lip and advance an endotracheal tube over the ETTI into the trachea. This indicates that the tip is well beyond the cords and the proximal end has enough length to slide the endotracheal tube over it.
- G. If resistance is encountered – caused by the endotracheal tube catching on the aryepiglottic folds or aryepiglottic folds – withdraw the endotracheal tube slightly, rotate 90

Subject: Medical Control
Endotracheal Tube Introducer (ETTI)

Associated Policies: DRAFT New Intervention Policy

degrees and reattempt. If this is unsuccessful, attempt with a smaller tube. Monitor pulse oximetry and attempt time during procedure.

- H. Once the Endotracheal tube is in position, while holding the tube, remove the ETTI through the endotracheal tube.

- I. Confirm tube placement and secure tube according to North Coast EMS Policy 5318 (ET Tube).

- J. Document use of ETTI and confirmation methods used on the patient care record.

Subject: Medical Control
Endotracheal Tube Introducer (ETTI)

Associated Policies: DRAFT New Intervention Policy

Approved: Heppner

Approved as to Form: Kantrell

7-2010

SUBJECT: Approval of New ALS Interventions

- I. Authority and Reference (incorporated herein by references)
 - A. Division 2.5 of Health and Safety Code
 - B. California code of Regulations, Title 22
 - C. North Coast EMS Policies and Procedures

- II. Purpose
 - A. To establish a procedural framework for the approval of new ALS medications, procedures or devices.

- III. Policy
 - A. This policy is intended to provide a standardized procedure for speeding the process by which North Coast EMS provider agencies desiring to employ a newly North-Coast-EMS approved ALS interventions may do so.
 - B. This policy may only be employed for approval in the use of new ALS interventions for which North Coast EMS policy is in force.
 - C. This policy shall be employed by reference as specified in the North Coast EMS policy corresponding to the new medication, procedure or device in question. Providers may only be approved to employ new medications, procedures or devices that have been previously approved by the North Coast EMS Medical Director. This policy is not intended to be employed for new medications, procedures or medications that have not been previously approved by the North Coast EMS Medical Director.
 - D. Only North Coast EMS approved ALS provider agencies may carry and/or employ the medication, procedure or device in question.
 - E. Prior to receiving North Coast EMS approval, for the medication, procedure or device, the ALS provider must document that all that ALS provider agency's paramedic personnel have received adequate training in the use of the medication, procedure or device. Provider documentation should include information regarding the medication, procedure or device to be employed. All provider documentation, including training materials, must be endorsed by the Prehospital Care Medical Director of the Base Hospital (or Modified Base Hospital) to which that provider has been assigned. The North Coast EMS Medical Director **or** the (Modified) Base Hospital Prehospital Care Medical Director may rescind this approval at any time.
 - F. ALS Provider agencies must agree to ensure that newly accredited paramedics will not employ the medication, procedure or device in question prior to having been adequately trained in the use of the medication, procedure or device per this policy. ALS provider agencies must agree to ensure that new paramedics receive adequate training in the intervention in question within 30 days of their employment
 - G. All paramedics must complete **a minimum time** of training on the use of the medication, procedure or device as noted in the North Coast EMS policy corresponding to that medication, procedure or device.

Approved: 

Approved as to Form: 

NORTH COAST EMS

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SUBJECT: Emergency Medical Technician Incident Investigation, Determination of Action, Notification and Administrative Hearings Process

- I. Authority and Reference (incorporated herein by references)
 - A. Division 2.5 of Health and Safety Code
 - B. California code of Regulations, Title 22
 - C. North Coast EMS Policies and Procedures

- II. Purpose
 - A. To establish a policy and procedure governing reportable situations and the evaluation and determination regarding whether or not disciplinary cause exists.

- III. Definitions

Certificate - means a valid Emergency Medical Technician (EMT) certificate issued pursuant to Division 2.5 of the California Health and Safety Code.

Certifying entity - as used in this policy, means the Medical Director of the North Coast EMS Agency.

Certification Action - means those actions that may be taken by the North Coast EMS Medical Director that include denial, suspension, revocation of a certificate, or placing a certificate holder on probation.

Certificate Holder - for the purpose of this policy, shall mean the holder of a certificate, as that term is described above.

CCR - means the California Code of Regulations, Title 22, Division 9.

Discipline - means either a disciplinary plan adopted by a relevant employer pursuant to Section 100206.2 of the CCR or certification action taken by a Medical Director pursuant to Section 100204 of the CCR, or both a disciplinary plan and certification action.

Disciplinary Cause - means an act that is substantially related to the qualifications, functions, and duties of an EMT and is evidence of a threat to the public health and safety, per Health and Safety Code Section 1798.200.

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Disciplinary Plan - means a written plan of action that can be taken by a relevant employer as a consequence of any action listed in Section 1798.200 (c). The Disciplinary Plan shall be submitted to the NORTH COAST EMS Medical Director and may include recommended certification action consistent with the Recommended Guidelines for Disciplinary Orders and Conditions of Probation for EMTs (MDOs).

Functioning outside of medical control - means any provision of prehospital emergency medical care which is not authorized by, or is in conflict with, any policies, procedures, or protocols established by the Merced County EMS agency, or any treatment instructions issued by the base hospital providing immediate medical direction.

Model Disciplinary Orders (MDO) - means the Recommended Guidelines for Disciplinary Orders and Conditions of Probation (EMSA document #134) which were developed to provide consistent and equitable discipline in cases dealing with disciplinary cause.

Prehospital emergency medical personnel - means those persons who have been certified/authorized/accredited as qualified to provide prehospital emergency medical care pursuant to Division 2.5, HSC.

Relevant employer(s) - means those ambulance services permitted by the Department of the California Highway Patrol or a public safety agency that the certificate holder works for or was working for at the time of the incident under review, as an EMT either as a paid employee or a volunteer.

Valid, Validate or Validated – for the purpose of this policy means to determine by preliminary investigation, within reasonable certainty, that a violation of Health and Safety Code §1798.200 may have occurred and that said violation may be reason for disciplinary cause.

IV. Policy

- A. Any information received from any source, including discovery through medical audit or routine follow-up on complaints, which purports a violation of, or deviation from, state or local EMS laws, regulations, policies, procedures or protocols will be evaluated pursuant to this policy and consistent with the CCR, Title 22, Division 9, Chapter 6.

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V. Procedure

A Responsibilities of Relevant Employer

1. Under the provisions of the CCR and this policy, relevant employers:
 - a) May conduct investigations to determine disciplinary cause.
 - b) Shall notify the North Coast EMS Medical Director within three (3) working days after an allegation has been validated as potential for disciplinary cause.
 - c) Upon determination of disciplinary cause, the relevant employer may develop and implement a disciplinary plan, in accordance with the Model Disciplinary Orders (MDOs).
 - 1) The relevant employer shall submit that disciplinary plan to the North Coast EMS along with the relevant findings of the investigation related to disciplinary cause, within three (3) working days of adoption of the disciplinary plan.
 - 2) The employer's disciplinary plan may include a recommendation that the Medical Director consider taking action against the holder's certificate to include denial of certification, suspension of certification, revocation of certification, or placing a certificate on probation.
 - d) Shall notify the Medical Director within three (3) working days of the occurrence of any of following:
 - 1) The employee is terminated or suspended for a disciplinary cause,
 - 2) The employee resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause, or
 - 3) The employee is removed from employment-related duties for a disciplinary cause after the completion of the employer's investigation.

B Jurisdiction of the North Coast EMS Medical Director

1. The Medical Director shall cause to have conducted investigations to validate allegations for disciplinary cause when the EMT is not an employee of a relevant employer or the relevant employer does not conduct an investigation. Upon determination of disciplinary cause, the Medical Director may take certification action as necessary against a certificate holder.
2. The Medical Director may, upon determination of disciplinary cause and according to the provisions of this policy, take certification action

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3. against an EMT to deny, suspend, or revoke, or place a certificate holder on probation, upon the findings by the Medical Director of the occurrence of any of the actions listed in Health and Safety Code, Section 1798.200 (c) and for which any of the following conditions are true:
 - a) The relevant employer, after conducting an investigation, failed to impose discipline for the conduct under investigation, or the Medical Director makes a determination that discipline imposed by the relevant employer was not in accordance with the MDOs and the conduct of the certificate holder constitutes grounds for certification action.
 - b) The Medical Director determines, following an investigation conducted in accordance with this policy, that the conduct requires certification action.
3. The Medical Director, after consultation with the relevant employer or without consultation when no relevant employer exists, may temporarily suspend, prior to a hearing, a certificate holder upon a determination of the following:
 - a) The EMT has engaged in acts or omissions that constitute grounds for revocation of the certificate; and
 - b) Permitting the EMT to continue to engage in certified activity without restriction poses an imminent threat to the public health and safety.
4. If the Medical Director takes any certification action the Medical Director shall notify the State EMS Authority of the findings of the investigation and the certification action taken by entering said information into the state registry.

C Evaluation of Information

1. A relevant employer who receives an allegation of conduct listed in Section 1798.200 (c) of the Health and Safety Code against a certificate holder and once the that relevant employer has validated the allegation, shall notify the North Coast EMS Medical Director, within three (3) working days, of the certificate holder's name, certification number, and the allegation(s).
2. When North Coast EMS receives a complaint against a certificate holder, North Coast EMS shall forward the original complaint and any supporting documentation to the relevant employer for investigation, if there is a relevant employer, within three (3) working days of receipt of the information. If there is no relevant employer or the relevant employer does not wish to investigate the complaint, the Medical Director shall evaluate the information received from a credible source, including but not limited to, information obtained from an application,

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medical audit, or public complaint, alleging or indicating the possibility of a threat to the public health and safety by the action of an applicant for, or holder of, a certificate issued by North Coast EMS or pursuant to Division 2.5, H&SC.

3. The relevant employer or Medical Director shall conduct an investigation of the allegations in accordance with the provisions of this policy, if warranted.

D Investigations Involving Firefighters

1. The rights and protections described in Chapter 9.6 of the Government Code shall only apply to a firefighter during events and circumstances involving the performance of his or her official duties.
2. All investigations involving certificate holders who are employed by a public safety agency as a firefighter shall be conducted in accordance with Chapter 9.6 of the Government Code, Section 3250 et. seq.

E Due Process

1. The certification action process shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

F Determination of Action

1. Upon determining the disciplinary or certification action to be taken, the relevant employer or Medical Director shall complete and place in the personnel file or any other file used for any personnel purposes by the relevant employer or North Coast EMS, a statement certifying the decision made and the date the decision was made. The decision must contain findings of fact and a determination of issues, together with the disciplinary plan and the date the disciplinary plan shall take effect.
2. In the case of a temporary suspension order pursuant to Section 100209 (c) of the CCR, it shall take effect upon the date the notice required by Section 100213 of the CCR is mailed to the certificate holder.
3. For all other certification actions, the effective date shall be thirty days from the date the notice is mailed to the applicant for, or holder of, a certificate unless another time is specified or an appeal is made.

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G Temporary Suspension Order

1. The North Coast EMS Medical Director may temporarily suspend a certificate prior to hearing if there is a valid complaint that the certificate holder has engaged in acts or omissions that constitute grounds for denial or revocation according to Section 100216(c) of the CCR and, if in the opinion of the Medical Director, permitting the certificate holder to continue to engage in certified activity would pose an imminent threat to the public health and safety.
2. Prior to, or concurrent with, initiation of a temporary suspension order of a certificate pending hearing, the Medical Director shall consult with the relevant employer of the certificate holder.
3. The notice of temporary suspension pending hearing shall be served by registered mail or by personal service to the certificate holder immediately, but no longer than three (3) working days from making the decision to issue the temporary suspension. The notice shall include the allegations that allowing the certificate holder to continue to engage in certified activities would pose an imminent threat to the public health and safety.
4. Within three (3) working days of the initiation of the temporary suspension by North Coast EMS, North Coast EMS and the relevant employer shall jointly investigate the allegation in order for the North Coast EMS Medical Director to make a determination of the continuation of the temporary suspension.
 - a) All investigatory information, not otherwise protected by the law, held by North Coast EMS and the relevant employer shall be shared between the parties via facsimile transmission or overnight mail relative to the decision to temporarily suspend.
 - b) North Coast EMS shall serve within fifteen (15) calendar days an accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code (Administrative Procedures Act).
 - c) If the certificate holder files a Notice of Defense, the administrative hearing shall be held within thirty (30) calendar days of North Coast EMS's receipt of the Notice of Defense.
 - d) The temporary suspension order shall be deemed vacated if the North Coast EMS fails to serve an accusation within fifteen (15) calendar days or fails to make a final determination on the merits within fifteen (15) calendar days after the Administrative Law Judge (ALJ) renders a proposed decision.

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H Final Determination of Certification Action by the Medical Director

1. Upon determination of certification action following an investigation, and appeal of certification action pursuant to Section 100211.1 of the CCR, if the respondent so chooses, the Medical Director may take the following final actions on an EMT certificate:
 - a) Place the certificate holder on probation
 - b) Suspension
 - c) Denial
 - d) Revocation

I Placement of a Certificate Holder on Probation

1. The North Coast EMS Medical Director may place a certificate holder on probation any time an infraction or performance deficiency occurs which indicates a need to monitor the certificate holder's conduct in the EMS system, in order to protect the public health and safety. The term of the probation and any conditions shall be in accordance with the MDOs. North Coast EMS may revoke the EMT certificate if the certificate holder fails to successfully complete the terms of probation.

J Suspension of a Certificate

1. The Medical Director may suspend an individual's EMT certificate for a specified period of time for disciplinary cause in order to protect the public health and safety.
2. The term of the suspension and any conditions for reinstatement shall be in accordance with the MDOs.
3. Upon the expiration of the term of suspension, the individual's certificate shall be reinstated only when all conditions for reinstatement have been met. The Medical Director shall continue the suspension until all conditions for reinstatement have been met.
4. If the suspension period will run past the expiration date of the certificate, the EMT shall meet the recertification requirements for certificate renewal prior to the expiration date of the certificate.

K Denial or Revocation of a Certificate

1. The Medical Director may deny or revoke any EMT certificate for disciplinary cause that has been investigated and verified by application of this policy.
2. The North Coast EMS Medical Director shall deny or revoke an EMT certificate if any of the following apply to the applicant:

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- a) Has committed any sexually related offense specified under Section 290 of the Penal Code.
 - b) Has been convicted of murder, attempted murder, or murder for hire.
 - c) Has been convicted of two (2) or more felonies.
 - d) Is on parole or probation for any felony.
 - e) Has been convicted and released from incarceration for said offense during the preceding fifteen (15) years for the crime of manslaughter or involuntary manslaughter.
 - f) Has been convicted and released from incarceration for said offense during the preceding ten (10) years for any offense punishable as a felony.
 - g) Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to the use, sale, possession, or transportation of narcotics or addictive or dangerous drugs.
 - h) Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to force, threat, violence, or intimidation.
 - i) Has been convicted within the preceding five (5) years of any theft related misdemeanor.
3. The Medical Director may deny or revoke an EMT certificate if any of the following apply to the applicant:
- a) Has committed any act involving fraud or intentional dishonesty for personal gain within the preceding seven (7) years.
 - b) Is required to register pursuant to Section 11590 of the Health and Safety Code.
4. Subsection 3. (a) and (b) shall not apply to convictions that have been pardoned by the Governor, and shall only apply to convictions where the applicant/certificate holder was prosecuted as an adult. Equivalent convictions from other states shall apply to the type of offenses listed in (a) and (b). As used in this Section, “felony” or “offense punishable as a felony” refers to an offense for which the law prescribes imprisonment in the state prison as either an alternative or the sole penalty, regardless of the sentence the particular defendant received.
5. This Section shall not apply to those EMT’s who obtain their California certificate prior to July 1, 2010; unless:
- a) The certificate holder is convicted of any misdemeanor or felony after July 1, 2010.
 - b) The certificate holder committed any sexually related offense specified under Section 290 of the Penal Code.

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- c) The certificate holder failed to disclose to the certifying entity any prior convictions when completing his/her application for initial EMT certification or certification renewal.
6. Nothing in this Section shall negate an individual's right to appeal a denial of an EMT certificate pursuant to this policy.
7. Certification action by the North Coast EMS Medical Director shall be valid statewide and honored by all certifying entities for a period of at least twelve (12) months from the effective date of the certification action. An EMT whose application was denied or an EMT whose certification was revoked by the North Coast EMS Medical Director shall not be eligible for EMT application by any other certifying entity for a period of at least twelve (12) months from the effective date of the certification action. An EMT whose certification is placed on probation must complete their probationary requirements with the EMS Agency that imposed the probation.

L Notification of Final Decision of Certification Action

1. For the final decision of certification action, the North Coast EMS Medical Director shall notify the applicant/certificate holder and his/her relevant employer(s) of the certification action within ten (10) working days after making the final determination.
2. The notification of final decision shall be served by registered mail or personal service and shall include the following information:
 - a) The specific allegations or evidence which resulted in the certification action;
 - b) The certification action(s) to be taken, and the effective date(s) of the certification action(s), including the duration of the action(s);
 - c) Which certificate(s) the certification action applies to in cases of holders of multiple certificates;
 - d) A statement that the certificate holder must report the certification action within ten (10) working days to any other LEMSA and relevant employer in whose jurisdiction s/he uses the certificate.