NORTH COAST EMERGENCY MEDICAL SERVICES
3340 Glenwood Street, Eureka, CA 95501 (707) 445-2081 (800) 282-0088 FAX (707) 445-0443

MEMORANDUM:

DATE: **March 24, 2014**

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
Interested Others

FROM: **Rhiannon Potts, Administrative Assistant**

RE: **E-Informational Mailing**

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1. For Your Information:

a. Change Notice # 102

(*Please email all Draft comments by April 21, 2014 to Louis Bruhnke* **Louis@northcoastems.com**)

Draft- Policy #2302 Cancellation and Transfer of Patient Care Policy
Draft- Policy #2304 AEMT/BLS- Determination of Death
Draft- Policy #2305 ALS Determination of Death
Draft- Policy #2306 Physician Involvement with EMT's and Paramedics
Draft- Policy #5310 Morphine Sulfate Protocol
Draft- Policy #5318 Adult and Pediatric Endotracheal Intubation Protocol
Draft- Policy #5439 Fentanyl
Draft- Policy #6030 Oxygen Administration Protocol
Draft- Policy #6037 Spinal Motion Restriction
Draft- Policy #6555 Pain Management Policy (Adult and Pediatric)
Replace- Policy #5102 EMT-I Scope of Practice
Replace- Policy #6038 Hemostatic Dressing Use
Replace- Table of Contents
Remove- Policy #2203.1 ETAD Authorized Service Provider
** The last informational mailing directed removing Policy 2203 instead of 2203.1*
Remove- Policy # 2213 Scope of Prac/Trans Cardiac Pacing
Remove- Policy #6543
Remove- Policy #6547 Pralidoxime (2-PAM) and Mark I Kit Provider Authorization
Note - Policy #2208 Inter-Facility Transfer Procedure is under internal review

b. MCI Channel Test 3/13/2014

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CHANGE NOTICE CHANGE #101

DATE: 03/24/2014

TO: ALL PREHOSPITAL CARE POLICY MANUAL HOLDERS

INSTRUCTIONS	POLICY #	POLICY DESCRIPTION	# OF PAGES
DRAFT	2302	Cancellation and Transfer of Patient Care Policy	3
DRAFT	2304	AEMT/BLS- Determination of Death	2
DRAFT	2305	ALS-Determination of Death	3
DRAFT	2306	Physician Involvement with EMT's and Paramedics	2
DRAFT	5310	Morphine Sulfate Protocol	2
DRAFT	5318	Adult and Pediatric Intubation Protocol	4
DRAFT	5439	Fentanyl	2
DRAFT	6030	Oxygen Administration Protocol	3
DRAFT	6037	Spinal Motion Restriction	3
DRAFT	6555	Pain Management Protocol	2
REPLACE	5102	EMT- I Scope of Practice	2
REPLACE	6038	Hemostatic Dressing Use	2
REPLACE		Table of Contents	7
REMOVE	2203.1	ETAD Authorized Service Provider	
REMOVE	6543	Trauma Triage Criteria	
REMOVE	6547	Pralidoxime (2-PAM) and Mark I Kit Provider Authorization	
NOTE	2208	Inter-Facility Transfer Procedure is under internal review	

Subject: Administration – Patient Care
Cancellation and Transfer of Patient Care Policy

Associated Policies:

I. Authority and Reference (incorporated herein by references)
- A. Division 2.5 of Health and Safety Code
- B. California Code of Regulations, Title 22, Division 9
- C. North Coast EMS Policies and Procedures

II. Purpose

To establish procedural guidelines for basic life support (BLS) personnel to discontinue response of advanced life support (ALS) or Advanced Emergency Medical Technician (AEMT) and provide BLS transport, and guidelines for AEMT personnel to discontinue an ALS response and provide AEMT transport. This policy is also intended to establish a procedure for prehospital care personnel to relinquish care and custody of a patient to a lower certificate holder.

III. Guidelines For Cancellation of ALS or AEMT Response by BLS Personnel

A. In general, BLS personnel at the scene of a medical emergency should not transport if ALS or AEMT personnel are responding. Ordinarily, BLS personnel should wait for ALS or AEMT personnel to arrive at the scene. The following exceptions may be applied:

1. the patient is suffering from an injury or illness which clearly requires rapid transport in order to reduce the risk of increased morbidity or mortality caused by delayed transport; or,
2. the patient clearly has only a minor injury or illness which has no apparent indication for ALS or AEMT care.

B. If, in the opinion of BLS personnel, the patient meets one of the above exceptions for cancellation of ALS or AEMT with BLS transport, then the BLS provider shall contact the base hospital by radio or telephone with a complete report of the patient's condition. The base hospital physician or MICN shall determine if cancellation of ALS or AEMT with BLS transport is appropriate.

C. ALS or AEMT may be cancelled with base hospital permission for BLS transport. Transporting BLS units shall attempt to rendezvous with an ALS or AEMT unit between the scene and receiving hospital if so ordered by the base hospital.

D. In the event of radio failure and/or inability to telephone the base hospital, the BLS unit may transport a patient if the patient clearly meets one of the exception criteria in paragraph A of this section. In the event that the patient has any apparent indication for ALS or AEMT, then the transporting BLS unit shall not cancel an ALS or AEMT response; rather,

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Subject: Administration – Patient Care
Cancellation and Transfer of Patient Care Policy

the BLS unit shall attempt to rendezvous with an ALS or AEMT unit between the scene and receiving hospital.

IV. Guidelines For Cancellation of ALS Response by AEMT Personnel

A. AEMT personnel at the scene of a medical emergency should not transport a patient if ALS personnel are responding, and the patient has indication(s) for prehospital ALS treatment exceeding AEMT scope of practice. The following exceptions may be applied:

1. the patient is suffering from an injury or illness which clearly requires rapid transport in order to reduce the risk of increased morbidity and mortality caused by delayed transport; or,
2. the patient has an injury or illness which does not require EMT-P treatment (therapy within EMT-P scope of practice that exceeds AEMT scope of practice) for the relief of unnecessary suffering, and/or decreased risk of morbidity and mortality.

B. If, in the opinion of AEMT personnel, the patient meets one of the above exceptions for cancellation of ALS with AEMT transport, then the AEMT provider shall contact the base hospital by radio or telephone with a complete report of the patient's condition. The base hospital physician or MICN shall determine if cancellation of ALS with AEMT transport is appropriate.

C. ALS may be cancelled with base hospital permission for AEMT transport. Transporting AEMT units shall attempt to rendezvous with an ALS unit between the scene and receiving hospital if so ordered by the base hospital.

D. In the event of radio failure and/or inability to telephone the base hospital, the AEMT unit may transport a patient if the patient clearly meets one of the exception criteria in paragraph A of this section. In the event that the patient has any apparent indication for ALS, then the transporting AEMT unit shall not cancel an ALS response; rather, the AEMT unit shall attempt to rendezvous with an ALS unit between the scene and receiving hospital.

V. Relinquishing Patient Care to a Lower Certificate Holder

A. The following prehospital care certificate holders may relinquish custody and care of a patient to a lower certificate holder when the patient's condition clearly does not require the scope of practice of higher certificate holder; that is, the scope of practice of the lower certificate holder can address the needs of the patient: EMT-P to AEMTI or EMT-I; AEMT to EMT-I.

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B. If a prehospital provider seeks to relinquish care to a lower certificate holder, he/she shall contact the base hospital with a complete report of the

patient's condition, and specify to whom the patient will be transferred (AEMT to EMT-I; EMT-P to AEMT, etc.). The base hospital may grant or deny permission for the same.

C. In the event of radio failure and/or inability to telephone the base hospital, the higher certificate holder shall maintain care and custody of the patient.

VI. Documentation and Base Hospital Review

A. Implementation of this policy by prehospital care personnel shall be documented on the Prehospital Care Report (PCR).

B.

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Deleted: When applicable, a Radio Failure Report shall also be completed and submitted with a copy of the ARR in accordance with North Coast EMS Policy and Procedure.

Deleted: The base hospital should review and discuss implementation of this policy during regular chart review, and shall report any problem or pattern of irregularity in compliance with this policy to the North Coast EMS Medical Director.

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Subject: Administration – Patient Care
AEMT/BLS – Determination of Death

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 regional policy and procedure for basic life support (BLS) and AEMT personnel to determine and document death in the prehospital setting. For the purpose of this policy, "BLS personnel" is defined as a rescuer who is currently certified as a Emergency Medical Technician-I within the North Coast EMS region. AEMT is defined as an Advanced Emergency Medical Technician currently certified within the North Coast EMS region.

III. Policy

A. Do Not Resuscitate (DNR) Requests:

CPR should not be initiated on a pulseless, non-breathing patient when a valid Do Not Resuscitate (DNR) Request,No Code or No CPR Order meeting Policy #2307 requirements is presented.

B. Obvious Death:

CPR does not need to be initiated if a pulseless, non-breathing patient has one or more of the following conditions:

1. Decapitation.
2. Decomposition.
3. Incineration of the torso and/or head.
4. Visible exposure, destruction, and/or separation of vital internal organs (brain, spinal cord, liver, heart, or lungs).
5. Rigor or livor mortis (without contributing environmental factors - see special considerations).
6. Severe injuries obviously incompatible with life.
7. Submersion greater than or equal to twenty-four (24) hours.

C. Possible Death:

If any doubt exists regarding the patient's conformance with the criteria above for obvious death, then CPR shall be initiated (unless impossible) and maintained until transfer of patient care to ALS personnel, or patient delivery at a receiving hospital.

D. North Coast Paramedics's may discontinue CPR upon voice orders from a base hospital physician. EMT-I's/AEMT transferring care to ALS personnel are authorized to follow a Paramedics instructions to discontinue resuscitation.

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Subject: Administration – Patient Care
BLS – Determination of Death

E. At no time shall BLS/AEMT personnel discontinue CPR unless one or more of the following criteria are met:
   1. The rescuer is physically exhausted and unable to continue.
   2. Spontaneous circulation and respiration is restored.
   3. CPR is being transferred to other persons qualified to perform CPR.
   4. A California-licensed physician at the scene assumes total responsibility for the patient by ordering BLS personnel to discontinue CPR.
   5. A valid Do Not Resuscitate (DNR) Request, No Code, or No CPR Order meeting Policy #2307 requirements is provided.

IV. Procedure
   A. In any event where death is determined by BLS/AEMT personnel notify the appropriate agency with primary investigative authority (coroner, law enforcement) and all pertinent facts and findings should be documented as soon as possible. Refer to your County Coroner's policy regarding disposition of the deceased.
   B. If death appears to be from other than natural causes, the body and scene should be disturbed as little as possible to protect potential crime scene evidence.
   C. BLS Personnel who do not begin resuscitation of a pulseless and apneic patient shall document the prehospital event on a First Responder Report or Prehospital Care Report (PCR) to be retained by that provider agency for a period of not less than 4 years.

V. Special Information
   A. Division 2.5 of the California Health and Safety Code, Section 1798.6(a), states that the authority for patient care management in an emergency shall be vested in that licensed or certified health care professional, which may include any paramedic or other prehospital emergency personnel, at the scene of the emergency who is most medically qualified specific to the provision of rendering medical care.
   B. Hypothermia can mask the positive neurological reflexes which indicate life, so it is imperative to be certain no contributing environmental factors exist, such as cold water submersion or cold exposure. If there exists any possibility that either of these could be a factor, resuscitation should be started immediately.

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Subject: Administration- Patient Care
ALS- Determination of Death

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 regional policy and procedure for advanced life support (ALS) personnel to determine and document death in the prehospital setting. For the purpose of this policy, "ALS personnel" is defined as a rescuer that is a currently licensed as a EMT-P within the North Coast EMS Region. Additionally, this policy shall outline procedures to be followed whenever CPR is withheld or discontinued in the prehospital setting (also, refer to Policy #2307).

III. Policy

A. Do Not Resuscitate (DNR) Requests:
CPR should not be initiated on a pulseless, non-breathing patient when a valid Do Not Resuscitate (DNR) Request, No Code or No CPR Order meeting Policy #2307 requirements is presented.

B. Obvious Death:
CPR does not need to be initiated if a pulseless, non-breathing patient has one or more of the following conditions:
1. Decapitation
2. Decomposition
3. Incineration of the torso and/or head
4. Visible exposure, destruction, and/or separation of vital internal organs (brain, spinal cord, liver, heart or lungs).
5. Rigor or livor mortis (without contributing environmental factors- see special information)
6. Major trauma resulting in full arrest with a known down time of greater than twenty (20) minutes with no CPR initiated.
7. Severe injuries obviously incompatible with life.
8. Submersion greater than or equal to twenty-four (24) hours.
9. Blunt trauma in asystole or PEA<40bmp.

C. Discontinuation of CPR
Resuscitation attempts may be discontinued under the following circumstances:
1. Upon presentation of a valid Do Not Resuscitate (DNR) Request, No Code or No CPR Order meeting Policy #2307 requirements.
2. When the EMT is exhausted and cannot continue resuscitative efforts.

3. When the base hospital physician directs the discontinuation of resuscitative efforts based on the information available to him/her. Some suggested guidelines are:
    a. Documented apnea and pulselessness > ten (10) minutes without CPR.
    b. No response to ACLS > thirty (30) minutes.
    c. No ventricular activity after ten (10) minutes of ACLS.

IV. Procedure

A. ALS personnel need not initiate CPR when death has been determined using the criteria outlined above.

B. A cardiac monitor may be used by ALS personnel to assist in their determination of death without being committed to initiation of other ALS procedures.

C. Discontinuation of CPR:
    1. Identify all mortal injuries or confirm that a valid Do Not Resuscitate (DNR) Request, No Code or No CPR Order meeting Policy #2307 requirements is provided.
    2. Record EKG rhythm strip and confirm asystole.
    3. Contact base hospital, relay all facts/findings and request permission to discontinue CPR.

D. When CPR is not initiated, or has been discontinued after treatment of asystole, by BLS, AEMT, or ALS personnel:
    1. Notify base hospital physician or MICN of findings via radio or telephone
    2. Notify County Coroner or appropriate investigative authorities if this has not already been done.
    3. Complete North Coast EMS Prehospital Care Report (PCR) with all surrounding facts, findings, and time death was determined.

V. Special Information

A. Division 2.5 of the California Health and Safety Code, Section 1798.6(a), states that the authority for patient care management in an emergency shall be vested in that licensed or certified health care professional, which may include any paramedic or other prehospital emergency personnel, at the scene of the emergency who is most medically qualified specific to the provision of rendering medical care.

B. Hypothermia can mask the positive neurological reflexes which indicate life, so it is imperative to be certain no contributing environmental factors exist, such as cold water submersion or cold exposure, especially in children. If there exists any

possibility that either of these could be a factor, resuscitation should be started immediately.

C. Resuscitative efforts may be extended despite apparent death, at the discretion of the base hospital physician, to facilitate organ donation.

Subject: Administration – Patient Care
Physician Involvement with EMT's and Paramedics

Associated Policies:

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
- D. California Medical Association
- E. State Emergency Medical Services Authority

II. Purpose
To establish alternatives for physician involvment with EMTs and Paramedics.

III. Procedure
- A. Physicians
  After identifying yourself by name as a physician licensed in the State of California, and if requested, showing proof of identity, you may choose to do one of the following:
  1. Offer your assistance with another pair of eyes, hands, or suggestions, but let the life support team remain under base hospital control; or,
  2. request to talk to the base hospital physician and directly offer your medical advice and assistance; or,
  3. take total responsibility for the care given by the life support team and physically accompany the patient until the patient arrives at a base hospital and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedure. When possible, remain in contact with the base hospital physician.
- B. EMT's and Paramedics
  1. Treat all physicians on-scene politely and with respect.
  2. May request that the physician identify himself as a physician licensed in the State of California, and may request proof of identity.
  3. If possible, contact base hospital physician.
  4. Drugs and equipment may be made available for the physician's use if the MD complies with the requirements as listed above under Section A.

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Subject: Administration – Patient Care
Physician Involvement with EMT's and Paramedics

5. Medical control of ALS/AEMT personnel remains with the base hospital.
6. If complications arise, consider initiation of an incident report.

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Subject: Scope of Practice/Procedure
Morphine Sulfate Protocol

Associated Policies:

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

II. Indications
A. Ischemic chest pain without improvement from nitrites.
C. Burns.
D. Trauma patients with adequate vital signs.
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.
4. Hypotension by evidence of systolic blood pressure of less than 90. Stablize blood pressure prior to administration. .
5. Acute Pulmonary Edema from all causes.

B. Relative:
1. Compromised respirations.
2. Women in labor - REQUIRES BASE CONTACT

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 (max single dose should not exceed 0.1mg/kg) slow IV. Repeat every 5 minutes until desired effect is achieved to maximum of 20mg. Monitor respiratory effort and blood pressure closely. Intramuscular (IM) 5 to 15 mg single dose, MAY NOT BE REPEATED.

Subject: Scope of Practice/Procedure
Morphine Sulfate Protocol

Associated Policies:

For Adult patients ONLY.- If significant pain persists after Morphine Sulfate administration IV/IO, consider Midazolam 1mg. Following Midazolam administration, additional dosing of Morphine will be reduced to 2 mg increments only. May repeat Midazolam once in 10 minutes if needed**. ANY ADDITIONAL DOSING OF MIDAZOLAM REQUIRES BASE CONTACT.**

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 once prior to BASE CONTACT. Contact base hospital for IM dosing of Infants under 6 months of age.

VII. Special Information

A. Place all patients receiving MS on cardiac monitor and pulse oximetry.
B. Patients receiving Morphine Sulfate may require supplemental oxygen.
C. Administer Oxygen per Oxygen Administration Policy #6030.
D. Excessive narcosis can be reversed with Naloxone.
E. Use caution and consider smaller increments of dosing in the Acute Inferior MI patient. Monitor closely for hypotension and be prepared for fluid resuscitation.
F. Consider premedicating patients with Zofran prior to administration of Morphine Sulfate to prevent nausea or vomiting, if no contraindications exist.

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Subject: Scope of Practice/Procedure – EMT-II
Adult and Pediatric Endotracheal Intubation Protocol

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I. Indications
   A. Respiratory insufficiency.

II. Therapeutic Effects
   A. Isolates the trachea and permits complete control of the airway.
   B. Prevents gastric distension.
   C. Provides direct route for suctioning of respiratory passages.
   D. Permits administration of medications via endotracheal tube.
      1. Medications that can be administered:
         a. Epinephrine.
         b. Atropine.
         c. Narcan.
         d. Lidocaine.

III. Contraindications
   A. Absolute:
      1. None.
   B. Relative:
      1. Severe pharyngeal or esophageal burns: thermal or caustic.
      2. Possible epiglottis.
      3. Pediatric ET with short transport times of 10 minutes or less.

IV. Equipment
   A. Adult and pediatric laryngoscopes.
   B. Adult and pediatric endotracheal tubes (2.5-9.0mm).
   C. Tape or other device for securing tube.
   D. Inserting stylets.
   E. 10 ml syringe.
   F. Bag-Valve-Mask.
   G. Adult and pediatric Magill forceps.
   H. Suction device.
   I. Stethoscope.
   J. CO2 Detector Device-Adult and Pediatric

V. Adverse Effects
   A. Hypoxia.
   B. Esophageal or right main stem bronchus-intubation.
   C. Aspiration during the procedure.
   D. Vagal stimulation with severe bradychardia and hypotension.
   E. Laryngospasm.
   F. Vocal cord damage.

G. Displacement of a cervical fracture and paralysis.
H. Complete obstruction of airway in epiglottis.

VI. Procedure
A. Insertion:
1. Ensure that the equipment is working and that suction is available.
2. Select appropriate size ET tube:
a. Adult: Average adult sizes of 7.0, 7.5 and 8.0 cuffed tubes.
b. Pediatric and infant sizes can be determined using:
1) Resuscitation tape should be used but ET tubes can be sized using the child's small fingernail.
2) Cuffed tubes for children greater than 1 year of age can be used by personnel have been specially trained in their use.
3) Uncuffed tubes are still acceptable for routine use in all ages of pediatrics.
3. Insert stylet and bend ET tube into a "Lazy J". The distal end of the stylet should be recessed from the tip of the tube.
4. Position patient:
a. Medical patient: Sniffing position. Facilitate this position for a child or infant by placing towel roll under shoulders.
b. Trauma patient: Neutral position with inline axial stabilization.
5. Preoxygenate the patient.
6. Grasp laryngoscope in the left hand and ET tube in the right.
7. Exert traction upward along the axis of the laryngoscope handle until glottic opening is exposed. Do not use top teeth as a fulcrum.
8. Insert ET tube into the trachea.
9. Inflate cuff in adult patient with 10cc air.
10. Remove syringe and stylet, maintaining tube position.
11. Ventilate patient and watch for chest rise, auscultate lung fields and epigastic area.
12. Place CO_2 Detector:
a. Use the correct size device. (Do not use Adult CO_2 detector on a patient less than 15kg).
b. Place on ET tube and ventilate patient.
c. Observe CO_2 detector for appropriate color change.
13. When Capnography is available,
a. Attach sensor endotracheal tube.
b. Note CO2 level and waveform changes.

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c. Capnography should remain in place and monitored through out transport.

14. Note tube position and secure tube in place with tape or ET tube hold device.
15. Reassess ventilations, watch for chest rise and auscultate lung fields

VII. When considering need for Extubation:

1. No chest rise with ventilation.
2. Absent breath sounds.
3. Presence of epigastric ventilation sounds.
4. Purple color on CO_2 detector with exhaustion for patient with a pulse.
5. ETCO2 less than 20 in a patient with a pulse, or less than 10 in a pulseless patient.
6. Only consider extubation on the patient who have return of spontaneous respirations, when they have regained consciousness, AND who are coughing, gagging AND struggling against the ET tube.
7. Critical airway patients (IE severe facial burns, severe facial injuries or any respiratory failure patient) that are ALREADY intubated with confirmed tube placement and who are "bucking" the tube or struggling against assisted ventilations, consider "light" sedation with
   a. Versed 1mg IV every 5 minutes or as needed to maintain control of the patient. DO NOT medicate to completely eliminate patient's own respiratory effort.
   b. Consider pain management in the critically injured patient with obvious painful injuries as their agitation may be due to pain.
   c. Consider Morphine OR Fentynl per protocol.
   d. Always monitor pulse Ox and ECG monitor or ETCO2 when available.

VII. If patient requires extubation.:

1. Ensure patient is awake and alert and able to protect their own airway. Patient should be explained the procedure when possible.
2. Turn patient on side or sit them upright and suction oropharynx.
3. If cuff was used, deflate cuff completely.
4. Removing the tube should occur while the patient is exhaling.

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5. Gently but quickly remove the tube to avoid the gag reflex.
6. Patient may have a cough or sore throat.

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Subject: Scope of Practice/Procedure - Paramedic
FENTANYL (SUBLIMAZE)

Associated Policies:

I. Class:
A. Potent synthetic opioid analgesic.

II. Indications:
A. Moderate to severe pain associated with medical or traumatic conditions.
B. Premedication for cardioversion or transcutaneous pacing.

III. Therapeutic effects:
A. CNS depressant
B. Binds to various opiate receptors for producing analgesia and sedation.
C. Decreases sensitivity to pain

IV. Contraindications:
A Absolute:
1. Hypersensitivity
B.Relative:
1. Use with caution in hypertension
2. Use with caution in patients with increased ICP
3. Use with caution in elderly patients

V. Administration:
IV, IO, IN(Intranasal) - Onset: Within 2~3 minutes, Duration: 30 minutes

A. Dosage:
1. Adult:
IV/IO route: 1-2 mcg/kg, SLOW IV/IO bolus.
Dose may be repeated after 10 minutes and titrated to clinical effect to a maximum cumulative dose 200mcg
Additional dosing requires BASE CONTACT
IN route:
1-2 mcg/kg IN single dose. Repeat dosing only via IV route, and 10 minutes after initial IN dose up to a maximum cumulative dose of 200mcg
Additional dosing requires BASE CONTACT
Consider initial lower dose of 0.5-1 mcg/kg in elderly

B. Pediatric: (1-12 years):
IV/IO route: 1 mcg/kg SLOW IV/IO bolus.
Dose may be repeated after 10 minutes and titrated to clinical effect to a maximum cumulative dose of 3 mcg/kg

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Subject: Scope of Practice/Procedure - Paramedic
FENTANYL (SUBLIMAZE)

Associated Policies:

IN route:

1 mcg/kg IN single dose. Repeat dosing only via IV route, and 10 minutes after initial IN dose up to a maximum cumulative dose of 3 mcg/kg

VI. Side effects:

A. Respiratory depression, including apnea. May occur suddenly and more commonly in children and elderly.
B. Hypotension especially when used with other sedatives such as alcohol or benzodiazepines.
C. Bradycardia
D. Nausea/Vomiting
E. Drowsiness
F. Can increase intracranial pressure
G. Chest wall rigidity (Wooden Chest Syndrome) has been reported with rapid administration.
H. Pediatric patients may develop apnea without manifesting significant mental status changes

VII. Special Information:

A. Naloxone (Narcan) (NCEMS Policy #5311)can be used to reverse the effects of Fentanyl including the Wooden Chest Syndrome.

Approved:_____Date:_____

Approved as to Form:_____

Subject: Treatment Guidelines – BLS
Oxygen Administration Protocol

Associated Policies:

I. Purpose:

1. The purpose of this policy is to ensure that high quality care is delivered to patients with regard to the administration of oxygen and the appropriate monitoring of patients receiving oxygen.
2. The administration of supplemental oxygen is an essential element of appropriate management for a wide range of clinical conditions. However, oxygen should be regarded as the drug that it is and not administered unless the patient's condition warrants its use.
3. Failure to administer oxygen appropriately can result in serious harm to some patients.

II. Definitions:

1. High vs. Low Concentration
   a. Low Concentration (21% to 50%)
   b. High Concentration (50% to 100%)
2. High or Low flow -
   a. Low flow adds oxygen to patients' inspiratory flow.
   b. High flow provides all inspiratory flow. (40-60liters per minute)

III. Equipment:

1. Low Flow devices:
   a. Nasal Cannulas
   b. Simple Face Masks
   c. Non Rebreather Masks
2. High Flow devices:
   a. CPAP Mask Device
   b. Bag Valve Mask Device
   c. Mechanical Ventilators (*not in BLS scope*)

IV. Indications:

1. The lowest flow of supplemental oxygen should be given to patients to maintain normal oxygen saturations.
2. Noninvasive monitoring of blood oxygen saturation can be useful to decide on the need for oxygen administration and how much should be administered.
3. It is appropriate to administer high concentrated oxygen to patients during the initial assessment to avoid any unnecessary delay for those patients who are truly hypoxic.
4. Once the initial assessment has been completed, oxygen administration than can be titrated to the patient's needs.

Subject: Treatment Guidelines – BLS
Oxygen Administration Protocol

5. Patients who should always receive high concentrations of oxygen include those patients with evidence of hypoxia, (IE agitation or cyanosis), altered mental status, poor tissue perfusion or Carbon Monoxide exposure.
6. Severe trauma patients, GI bleeds or potential hypovolemic patients should receive high concentrations of oxygen.
7. In addition, any patient with actual or potential airway compromise or respiratory compromise should receive high concentrations of oxygen.
8. Critically ill or injured patients should be given low flow/ high concentrated oxygen via a non-rebreather mask without delay and reevaluated frequently to determine if supplemental oxygen is being delivered in the appropriate amounts.
9. Patient who should not receive high concentrated oxygen:
   a. Patients who have oxygen saturations of greater than 94% without signs or symptoms of hypoxia or impending airway compromise.
   b. Chest pain or stroke patients without respiratory distress and adequate vital signs.
   c. Patients without hypoxia or hemodynamically compromised.
   d. Patient with history of COPD without signs of respiratory failure.
10. Any patient may benefit from low concentration/low flow administration of oxygen but the clinician needs to weigh the risks and benefits of doing so.

V. Procedure

1. Assemble supplies and equipment:
2. Obtain baseline Pulse Oximetry level when available.
3. Ensure oxygen is available in quantity needed
4. Determine patient's oxygen need and provide oxygen via appropriate device.
5. Connect device to oxygen source, and adjust liter flow to desired rate. Be sure oxygen is flowing before patient application.
6. Apply delivery device to patient.
7. Recheck patient frequently for signs of improvement or deterioration.
8. Evaluate Pulse oximetry reading frequently.
9. Titrate oxygen delivery to maintain Pulse Oximetry of 94%.

VI..Dosage

1. Mild Distress: - No signs of hypoxia or hemodynamic compromise. Patients with Pulse Oximetry of 94% to 100%.
   a. Low flow/low concentration - 2 to 6 liters via Nasal Cannula or blow by.

2. Medium Distress: - Signs of hemodynamic compromise and a normal mentation with adequate respiratory rate and effort. During initial evaluation of potentially critical patients. (e.g. --multi system trauma patients, altered level of consciousness or complicated chest pain or stroke patients.)
   Patients with Pulse Oximetry of 90% to 94%
   a. Low flow/Medium to High Concentration Simple face mask or Non Rebreather Mask-

3. Severe Distress: - Unresponsive with or without adequate respiratory effort and/or rate. Respiratory and/or cardiac arrest. Partial airway obstruction or impending airway compromise. Critically ill, hemodynamically unstable patients who are altered from possible hypoxic causes. Severe congestive heart failure patients or COPD patients that would benefit from positive pressure.
   a. Low Flow/High Concentration - Non-rebreather mask - 12 to 15 liters per minute, if respiratory effort is adequate.
   b. High Flow/High Concentration - CPAP mask device - 10 to 20 liters per minute for respiratory distress secondary to CHF or COPD in the conscious patient.
   c. High Flow/ High Concentration - Assist Ventilations with BVM with 15 to 25 liters, when respiratory effort or rate is inadequate at appropriate ventilatory rate:
      Adults and children: 10 to 12 times a minute.
      Infants < one (1) year: 20 times a minute.

VII. Precautions:
1. Monitor respiratory effort and rate closely if patient has a history of COPD. In isolated cases, respiratory depression may occur during administration of high concentrated oxygen to COPD patients.
2. Evaluate all patients frequently and determine the need to titrate oxygen administration either more aggressively or the need to reduce the administration rate.
3. When pulse Oximetry is available, leave in place to allow for serial levels to be monitored.

Subject: Treatment Guidelines - BLS
Spinal Motion Restriction Policy

Associated Policies:

I..INTRODUCTION

A. The purpose of SMR is to protect patients from movement that could worsen an unstable spinal fracture, which is rare (<1% in major trauma victims).
B. Multiple studies have shown that mechanism of injury is generally a poor predictor of injury, and that many patients are immobilized inappropriately.
C. Traditional full spinal immobilization, the current standard for almost all patients, may cause airway compromise, skin breakdown, and pain in virtually everyone, which inevitably leads to unnecessary X-rays.
D. Most significant spinal injuries will present with spine pain, vertebral tenderness to palpation, and sometimes with neurologic symptoms and/or deficits. Alert and oriented patients with true spinal injuries will self-splint. These injuries are best recognized with a careful history and physical exam.
E. SMR should reduce, not increase, patient discomfort. SMR/immobilization that increases pain should be avoided.
F. SMR should be accomplished using the most appropriate tool for each specific circumstance. This may include vacuum splints, stiff or soft cervical collars, short boards or KEDS, padded long boards, straps, commercial head stabilizer, soft materials such as pillows and pull sheets.
G. Penetrating trauma patients without spinal pain or neurologic deficits do not need SMR.
H. No patient should be placed in SMR without being thoroughly assessed for its need.

II. SPINAL INJURY ASSESSMENT

A. Determine if there is a potential for unstable spinal injury.
    1. Assess for High-Risk Factors - If any high-risk factors are present, strongly consider SMR.
        - Age >65
        - Meets NCEMS Trauma Triage Criteria (Policy # 7000)
        - Axial load to the head (IE Diving Injury)
        - Numbness or tingling in extremities
B. Assess for patient reliability.
    1. Is patient cooperative, sober and alert without:
        - Significant distracting injuries
        - Language barrier
C. Perform a spinal exam
    1. Palpate vertebral column thoroughly for tenderness
D. Perform a motor/sensory exam:
        - Assess wrist and finger extension (both hands)

Approved: _____ Date: _____

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Subject: Treatment Guidelines - BLS
Spinal Motion Restriction Policy

Associated Policies:

- Assess planterflexion (both feet)
- Assess dorsilflexion (both feet)
- Check gross sensation in all extremities.
- Check for abnormal sensations to extremities.

E. Are all exam findings normal?
Omit Spinal Motion Restriction

F. Any abnormal exam or finding? - Possible Spine Injury
Apply Spinal Motion Restriction.

III. PROCEDURE:

A. Perform the spinal injury assessment prior to application of SMR.
B. Methods/tools to achieve SMR that are allowable: (less invasive to more invasive) Lateral, semi-fowler's or fowler's position with cervical collar only, soft collars, pillows, vacuum splint or mattress, children's car seats, KED, backboards with adequate padding, head immobilizers or straps.
C. Provide manual stabilization restricting gross motion. Alert and cooperative patients may be allowed to self-limit motion if appropriate with or without cervical collar.
D. Apply cervical collar as needed or as appropriate to limit patient movement.
E. When needed, extricate patient limiting flexion, extension, rotation and distraction of spine.
F. Keeping with the goals of restricting gross movement of spine and preventing increased pain and discomfort, self extrication by patient is allowable.
G. Pull sheets, other flexible devices, scoops and scoop-like devices can be employed if necessary.
H. Hard backboards should only have limited utilization for extrication and for securing certain patient groups.
I. Apply adequate padding or vacuum mattress to prevent tissue ischemia and increase comfort.
J. Place patient in position best suited to protect airway and allow adequate breathing.
K. Ensure patient is secured to the transport gurney with proper seatbelts.
L. Securing the head with head bed and tape can be considered for patient comfort but never without the torso being secured.
M. Regularly reassess motor/sensory function (including wrist/finger extension, plantar/dorsal flexion of the feet and sharp/dull sensation exam if possible).

IV. SPECIAL PATIENT POPULATION CONSIDERATIONS

A. Use SMR with caution with patients presenting with dyspnea. Consideration must be made for elevation of the upper body once patient is secured.

Approved: _____ Date: _____

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Subject: Treatment Guidelines - BLS
Spinal Motion Restriction Policy

Associated Policies:

B. Bariatric patients can suffocate when placed flat on their backs. Use devices that would allow a more upright position.

C. Pediatric Patients and Car Seats

1. Infants restrained in a rear-facing car seat may be immobilized and extricated in the car seat. The child may remain in the car seat if the immobilization is secure and his/her condition allows (no signs of respiratory distress or shock). Pediatric patients in car seats that do not support their entire bodies need to be placed in SMR using other means

D. Combative patients: Avoid methods that provoke increased spinal movement and/or combativeness.

E. In the event of a patient being placed in SMR/full immobilization prior to the BLS/ALS transporting unit arrival to the scene, the transporting provider has the discretion to remove or modify SMR if the patient meets the requirements outlined in the spinal injury assessment.

F. CMS/PMS should be re-assessed prior to and after complete removal of spinal precautions. It must be considered that rapid transport to appropriate definitive care is of the utmost importance. This must be taken into account in the management of SMR and major trauma patients.

Approved: _____ Date: _____

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Subject: Treatment Guidelines - ALS Personnel
Pain Management Policy (Adult and Pediatric)

Associated Policies:

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

II. Purpose

To provide guidelines for the management of pain, both traumatic and medical in nature, to adult and pediatric prehospital patients.

III. Indications:

- A. Severe pain in the presence of adequate vital signs (blood pressure >90).
- B. When extrication, movement or transportation is required which will cause considerable pain to the patient AND there are no known contraindications to administering any analgesia.

IV. Contraindications:
- A. Absolute:
  1. Any known or suspected drug allergies to narcotics.
- B. Relative:
  2. Active Labor - Requires BASE CONTACT

V. Procedure:
- A. Determine origin of the pain (examples: isolated extremity trauma, chronic medical condition, burns, abdominal pain, multi-system trauma).
- B. Identify those patients with the complaint of pain or have obvious signs of discomfort.
- C. Determine initial pain score on a scale of 1 to 10 and document this finding in the Prehospital care report.
- **D. May use either Morphine Sulfate or Fentanyl per agency and NCEMS policies, NEVER BOTH unless directed to so by Base Hospital via Direct Verbal Order.**
- E. Determine baseline blood pressure, pulse rate and Pulse Oximetry.
- F. Monitor vital signs closely (i.e. respiratory rate/effort, LOC, O_2 saturation).
- G. Leave Pulse Oximetry in place for serial saturations.

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Date: _____

Subject: Treatment Guidelines - ALS Personnel
Pain Management Policy (Adult and Pediatric)

Associated Policies:

H. Determine need for oxygen per Oxygen Administration Policy # 6030.
I. Establish IV or IO access per policy.
J. Determine need for IV fluids. Do not administer fluid boluses without indications.
K. Administer Morphine Sulfate (Policy # 5310) IV/IO. Consider one IM injection if IV is delayed or unavailable.

OR

L. Administer Fentanyl (Policy # 5439) IV/IO. Consider one IN administration if IV is delayed or unavailable.
M. If significant pain persists after Morphine Sulfate in doses greater than 10mg IV/IO consider a single dose of Midazolam 1 mg IV/IO. Subsequent dosing of Morphine Sulfate should be reduced to 2mg increments.
N. DO NOT administer Fentanyl and Midazolam in the same patient without a DIRECT ORDER from the BASE HOSPITAL.
O. Zofran may be prophylactically co-administered to prevent nausea / vomiting with narcotics. Strongly consider Zofran use for patients who are immobilized.
P. Repeat pain scale and all vital signs following administration of all medications.
Q. Contact Base Hospital physician for additional fentanyl administration requests when needed.
R. Monitor patient and vital signs carefully and ensure a patent airway.

VI. Special Considerations:

A. Always have Narcan readily available to reverse any respiratory depression that may occur or chest rigidity caused from Fentanyl.
B. Consider half (½) the dose in patients $\geq$ 65 years with all routes.
C. Use caution in the suspected drug or alcohol intoxication.

VIII. Documentation and Patient Care Reporting

A. Document initial and post treatment pain score, expressed in a measurable form.
B. All interventions used for pain management including all BLS and ALS procedures.
C. Initial and post vital signs.
D. When physician consult was required.

Approved: _____

Approved as to Form: _____

Date: _____

Subject: Scope of Practice/Procedure – BLS Personnel
EMT-I Scope of Practice

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 define the regional Emergency Medical Technician-I (EMT-I) scope of practice.

III. Procedure

A. During training, while at the scene of an emergency, during transport of the sick or injured, or during interfacility transfer, a supervised EMT-I student or certified EMT-I is authorized to do any of the following:

1. Evaluate the ill and injured.
2. Render basic life support, rescue and emergency medical care to patients.
3. Obtain diagnostic signs to include but not be limited to the assessment of temperature, blood pressure, pulse and respiration rates, pulse oximetry, level of consciousness, and pupil status.
4. Perform cardiopulmonary resuscitation, including the use of mechanical adjuncts to basic cardiopulmonary resuscitation.
5. Administer oxygen.
6. Use the following adjunctive airway and breathing aids:
   a. oropharyngeal airway;
   b. nasopharyngeal airway;
   c. suction devices;
   d. basic oxygen delivery devices for supplemental oxygen therapy including but not limited to, humidifiers, partial rebreathers, and venturi masks, and
   e. Manual and mechanical ventilating devices designed for prehospital use including Continuous Positive Airway Pressure (CPAP) mask devices.
7. Use various types of stretchers and body immobilization devices.
8. Provide initial prehospital emergency care of trauma including but not limited to

   a. Bleeding control through the application of tourniquets

   b. Use of hemostatic dressings from a list approved by the State Authority.

   c. Spinal immobilization

   d. Seated spinal immobilization.

Subject: Scope of Practice/Procedure – BLS Personnel
EMT-I Scope of Practice

e. Extremity splinting.
f. Traction splinting..

9. Administer:
   a. Oral glucose or sugar solutions.
   b. Aspirin
10. Extricate entrapped persons.
11. Perform field triage.
12. Transport patients.
13. Mechanical patient restraint.
14. Set up for ALS procedures, under the direction of an Advanced EMT or Paramedic.
15. Perform automated external defibrillation when authorized by an EMT AED service provider.
16. Assist patients with the administration of physician prescribed devices, including but not limited to, patient operated medication pumps, sublingual nitroglycerin, and self-administered emergency medications, including epinephrine devices.
17. Monitor intravenous lines delivering glucose solutions or isotonic balanced salt solutions including Ringer's lactate for volume replacement.
18. Monitor, maintain, and adjust if necessary in order to maintain, a pre-set rate of flow and turn off the flow of intravenous fluid.
19. Transfer a patient, who is deemed appropriate for transfer by the transferring physician, and who has nasogastric (NG) tubes, gastrostomy tubes, heparin locks, foley catheters, tracheostomy tubes and/or indwelling vascular access lines, excluding arterial lines.

B. The scope of practice of an EMT-I shall not exceed those activities authorized in this policy.

Approved: _____ Date: _____

Approved as to Form: _____ Date: _____

Subject: Scope of Practice/Procedure – BLS
Hemostatic Dressing Use

Associated Policies:

I. Purpose

After tourniquet placement and to aid in severe arterial bleeding, or to control severe bleeding where tourniquets are not indicated (trunk, head, neck, etc) use of a hemostatic agent is indicated.

II. Indications.

Severe uncontrolled external bleeding is not controllable with the use of a tourniquet or other means.

Nosebleeds that are not controlled by direct pressure.

III. Contraindications

A. Absolute:

1. None when used per protocol and manufactures recommendations.

IV. Equipment

A. Approved list of Hemostatic Dressings

1. Quick Clot(r), Z-Medica(r)
2. Quick Clot(r), Combat Gauze(r)
3. LEQuick Clot(r), EMS Rolled Gauze, 4x4 Dressing,TraumaPad(r)
4. Celox(r)
5. Celox(r) Gauze, Z-Fold Hemostatic Gauze
6. Celox(r) Rapid, Hemostatic Z-Fold Gauze

V. Procedure

A. Assure that the patient's airway is open and that breathing is adequate.
B. Identify location of severe bleeding.
C. For all bleeding wounds, attempt to control bleeding by first applying pressure directly on the wound with sterile dressings.
D. For severe bleeding to extremities, do not delay tourniquet application.
E. When bleeding is severe and continues after above procedures, Apply a hemostatic gauze dressing over the entire wound and directly to the bleeding site simultaneously applying direct pressure for at least three minutes of continuous pressure.
F. In case of severe nose bleeding, gauze will need to be folded and inserted into the bleeding nare. Insert the gauze as far up the nare as tolerated. Continue to apply external pressure until bleeding stops.
G. For larger wound, ensure that the hemostatic dressing is placed directly over the bleeding source. More than one dressing may be required to cover the wound. .
H. Wounds may need to be slightly opened to ensure that the hemostatic dressing is applied to all the surfaces of the wound.

Subject: Scope of Practice/Procedure – BLS
Hemostatic Dressing Use

Associated Policies:

I. Wrap and tie bandage to maintain pressure.
J. If severe bleeding persists from the trunk, neck, head or other location, a second layer of hemostatic gauze dressings could be used to ensure that the entire wound has been covered.
K. Additional bulky dressing should be applied over the dressing and held tightly in place.
L. Protect patient from heat loss.
M. Apply oxygen per Oxygen administration Protocol.
N. Reassess patient and wounds frequently for recurrence of bleeding.
O. Ensure that the use of hemostatic dressing is communicated to transporting ambulance and/or receiving hospital.
P. Communicate with transporting ambulance and/or Base hospital.

Approved: _____

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Date 03/01/2014

NORTH COAST EMS

POLICIES AND PROCEDURES

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MCI CHANNEL TEST

03/13/2014

- The Tuesday before the Second Wednesday of each month (Thursday after second Wednesday for PM test)
- Contact City Ambulance 10 minutes prior to drill
- At 1000 switch MED-NET ENHANCED on the Moducom to tone "EMERGENCY" (2100 for PM test)
- Stack and send page over Med Net
- Announce "Fortuna with the monthly MCI channel test, standby by for check-back". Wait 15 to 30 seconds and do check:

ROLL CALL: IMPORTANT! Pause 3-5 seconds each time after pressing transmit before speaking into microphone.

Phelps Hospital	X	GRA1	X
Redwood Memorial		FRA 1	O /C
St. Josephs Hospital	X	FRA 2	O/C
Mad River Hospital	X	CTA1	Scratchy
Eureka Medcom	X	CTA2	O/C
		CTA3	X
		Arcata 1	X
		Arcata 2	X

- After the test, announce "The test is complete and the MCI channel will be deactivated in 1 minute".
- Reset Med-Net channel to Enhanced repeater tone
- This should stack "emergency off", send this over Med Net enhanced
- **E-MAIL TO HUUECC ->MCI TEST**
- **NR=No Response U/S=Unstaffed O/C = On Call**