Scene Management and Authority

EMS ADMINISTRATION 101

PURPOSE

I. To define roles and responsibilities regarding scene management and authority at the scene of a medical emergency.

POLICY

I. AT THE SCENE OF A MEDICAL EMERGENCY

A. Authority for patient health care management shall be vested in the pre-hospital response personnel holding the highest level of medical certification or license.

1. If multiple advanced life support (ALS) personnel are on scene, the first arriving ALS provider will coordinate the medical response as the patient team leader.

    a. In Napa City limits, the City of Napa Fire Department is recognized as the primary ALS emergency first responder.

        i. The transfer of patient care between providers on scene shall not occur more than once.

    b. All providers, regardless of certification/licensure level or organizational affiliation are encouraged to participate in the coordination of patient care.

        i. In the event of disagreements between providers about the appropriate patient treatment plan, personnel are encouraged to discuss treatment and consult with the Base Hospital Physician.

2. The patient team leader, consistent with EMS policy, should release associated responders (first responders, ambulances, or helicopters) from the incident if their assistance will not be required.

B. Notwithstanding the above, authority for the management of the scene shall be vested in the appropriate public safety agency having primary investigative authority.

C. The scene of an emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition and priority shall be placed upon the interests of those persons exposed to the more serious and immediate risks to life and health. Public safety officials shall consult emergency medical services personnel or other authoritative health care professionals at the scene in the determination of relevant risks.

D. Medical management at the scene of a medical emergency includes:

1. Medical evaluation.
2. Medical aspects of extrication and all movement of the patient(s).
3. Medical care.
4. Patient destination.
5. Transport code.

POLICY

E. Responsibility for emergency medical management is based on the following order as personnel arrive on the scene:

1. First responder (Public Safety First Aid).
2. First responder Basic Life Support (BLS).
3. Transport unit BLS.
4. First responder Advanced Life Support (ALS).
5. Transport unit ALS.

F. Whenever a pre-hospital care provider transfers patient care responsibility to another pre-hospital care provider, he/she is responsible for noting that such action took place on their electronic patient care record (ePCR). The responsible pre-hospital care provider is required to document patient findings and treatments according to Napa County Emergency Medical Service (EMS) policy.

G. All providers, regardless of certification or licensure level, may only perform those skills that are in their scope of practice.

II. EMS RESPONSE TO HAZARDOUS MATERIALS INCIDENTS

A. EMS personnel should remain in the cold zone and ensure that patient has been decontaminated prior to transport.

B. EMS personnel should notify the receiving facility as early as possible and consult with the base hospital regarding treatment for specific types of exposure.

III. CRIME SCENE MANAGEMENT

A. EMS personnel need to remain aware of potential evidence and take appropriate steps to limit disruption of potential evidence (e.g., weapons, bloodstains, skid marks, etc.).

IV. ON-VIEWING MEDICAL EMERGENCIES

A. When EMS personnel come upon the scene of a medical emergency without being dispatched to that emergency, the crew of that unit shall immediately notify the EMS dispatch of the location and nature of that emergency.

1. If no prehospital care responders are on scene and the on-viewing unit is not enroute to another medical emergency or not transporting a patient, the crew of that unit shall stop and render aid until a 9-1-1 ambulance has arrived and taken over patient care.
2. When enroute to another medical emergency or transporting a patient, notify dispatch and continue current assignment unless redirected by dispatch.

Reporting Suspected Assault or Abuse

EMS ADMINISTRATION 102

PURPOSE

I. To provide guidance for reporting suspected assault or abuse that is not related to a child or an elderly or dependent adult.

POLICY

I. PRINCIPLES:

A. EMS personnel are required to report to local law enforcement any patient who is suffering a wound or physical injury inflicted as a result of assaultive or abusive conduct, or by means of a firearm.

B. Reporting requirements apply not simply to a domestic violence situation but to all injuries caused by abusive or assaultive conduct as defined by law.

II. REPORTING PROCEDURES:

A. Immediate verbal notification should be made to the local law enforcement agency with jurisdiction at the scene of the incident.

1. The verbal report must contain:

a. The name of the injured person, if known;

b. The injured person's whereabouts;

c. The character and extent of the person's injuries;

d. The identity of the person who allegedly inflicted the injury.

B. A written report is required to be submitted within two working days.

1. EMS personnel should use the Cal OES 2-920 form to complete the reporting requirement. Submitting directly to the local law enforcement agency with jurisdiction at the scene of the incident.

2. There is no exemption to this requirement if law enforcement is at the incident.

Use of Restraints

EMS ADMINISTRATION 103

PURPOSE

I. To provide guidelines on the use of restraints in the field or during transport for patients who are violent or potentially violent or who may harm themself or others.

POLICY

I. PRINCIPLES:

A. The Safety of the patient, community and responding personnel is of paramount concern when following this policy.

B. Authority for scene management shall be vested in law enforcement.

C. Restraints are to be used only when necessary in situations where the patient is potentially violent and is exhibiting behavior that is dangerous to themself or others.

D. Pre-hospital personnel must consider that aggressive or violent behavior may be a symptom of medical conditions such as head trauma, alcohol, drug-related problems, metabolic disorders, stress and psychiatric disorders.

E. The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway nor compromise neurological or vascular status.

F. For patient safety reasons, restraints applied by law enforcement require the officer to remain available to remove or adjust the restraints. This policy is not intended to negate the need for law enforcement personnel to use appropriate restraint equipment that is approved by their respective agency to establish scene management control.

II. PROCEDURE:

A. The following procedure should guide pre-hospital personnel in the application of restraints and the monitoring of a restrained patient:

1. Restraint equipment applied by pre-hospital personnel must be either padded leather restraints or soft restraints (i.e. Posey, Velcro or seatbelt type). Both methods must allow for quick release.
2. The application of any of the following forms of restraint shall not be used by Emergency Medical Services (EMS) pre-hospital care personnel:
    a. Hard plastic ties or any restraint device requiring a key to remove.
    b. "Sandwiching patients between backboards, scoop-stretchers or flat, as a restraint.
    c. Restraining a patient's hands and feet behind the patient (i.e. "hog-tying").
    d. Methods or other materials applied in a manner that could cause respiratory, vascular or neurological compromise.
3. Restraint equipment applied by law enforcement (handcuffs, plastic ties, or "hobble" restraints) must provide sufficient slack in the restraint device to allow the patient to straighten the abdomen and chest and to take full breaths.

POLICY

4. Restraint devices applied by law enforcement require the officer's continued presence to ensure patient and scene management safety. The officer should, if at all possible, accompany the patient in the ambulance or follow by driving in tandem with the ambulance on a predetermined route. A method to alert the officer of any problems that may develop during transport should be discussed prior to leaving the scene.
5. Patients shall not be transported in a prone position. Pre-hospital personnel must ensure that the patient's position does not compromise the patient's respiratory/circulatory systems or does not preclude any necessary medical intervention to protect the patient's airway should vomiting occur.
6. Restrained extremities should be evaluated for pulse quality, capillary refill, color, nerve and motor function every fifteen (15) minutes. It is recognized that the evaluation of nerve and motor status requires patient cooperation and thus may be difficult or impossible to monitor.
7. Restrained patients shall be transported to the most accessible emergency department facility within the guidelines of Napa County EMS Agency **Administrative Policy 501, Patient Destination**.

III. DOCUMENTATION

A. Documentation on the patient care report shall include:

1. The reasons the restraint were needed.
2. Which agency applied the restraints (i.e., EMS/Law Enforcement).
3. Information and data regarding the monitoring of circulation to the restraint extremities.
4. Information and data regarding the monitoring of respiratory status while restrained.

Search for Donor Information

EMS ADMINISTRATION 104

PURPOSE

I. To establish guidelines for EMS field personnel to meet legislative requirements that they search for organ donor information on adult patients for whom death appears imminent.

POLICY

I. PROCEDURE:

A. When EMS field personnel encounter an unconscious adult patient for whom it appears death is imminent (that is, death prior to the arrival of the patient at a receiving facility), they shall attempt a “reasonable search” of the patient’s belongings to determine if the individual carries information indicating the patient’s status as an organ donor.

1. This search must be done in the presence of a witness, preferably a public safety officer.
2. No search is to be made by EMS personnel after the patient has obviously expired.

B. Treatment and transport of the patient remains the highest priority for field personnel. This search shall not interfere with patient care or transport.

C. Field personnel shall notify the receiving hospital personnel if organ donor information is discovered.

D. Any organ donor document that is discovered should be transported to the receiving hospital with the patient unless it is requested by the investigating law enforcement officer.

E. In the event that no transport is made, any document should remain with the patient.

EMS Aircraft

EMS ADMINISTRATION 105

PURPOSE

I. To define guidance for the utilization of EMS aircraft by EMS personnel.

POLICY

I. AIRCRAFT AUTHORIZATION:

A. All EMS aircraft providing prehospital patient transport within the Napa County shall be authorized by the Napa County EMS Agency. Authorization will be confirmed by written agreements between the Napa County EMS Agency and the EMS aircraft provider.

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

C. A request to other EMS aircraft providers by a designated dispatch center to respond to an emergency shall constitute temporary authorization to respond to that emergency.

II. AIRCRAFT DISPATCH

A. The Napa County Emergency Command Center (ECC) is the designated helicopter dispatch center for Napa County. Any request for EMS Helicopter services in Napa County shall be coordinated through the Napa County Emergency Command Center.

B. The Napa County ECC will automatically dispatch an air ambulance and/or ALS rescue aircraft when the incident or patient meets autolaunch criteria established by the Napa County EMS Agency or when requested by EMS personnel.

C. The simultaneous dispatch of an EMS helicopter and a ground ambulance shall occur when the following criteria are met:

1. The patient's condition meets an autolaunch EMD determinant code; and
2. The patient is located within an autolaunch response zone.

III. CANCELLATION

A. After a complete patient assessment, qualified on-scene personnel shall cancel the aircraft if they determine that ground transport is appropriate.

IV. SPECIAL CONSIDERATIONS

A. ALS Rescue Aircraft

1. In the event that an ALS Rescue aircraft is available, and has the fastest response time by ≥ 20 minutes to the scene, the ALS Rescue may also be dispatched in addition to the air ambulance. It is the responsibility of the IC (or designee) to cancel the resource that is not needed.
2. The ECC shall advise EMS aircraft and field personnel when multiple aircraft are responding.
3. An ALS Rescue aircraft shall be dispatched, when available, to any rescue incident where air rescue services are needed.

POLICY

B. Scene Safety

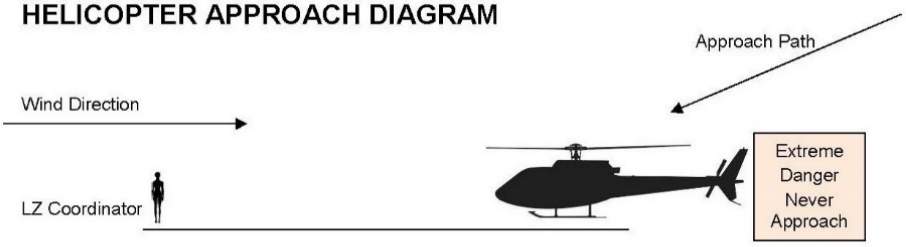
1. The responsibility for scene management and safety shall be under the control of the Incident Commander (IC).
2. The IC shall be responsible for coordinating the scene activities including establishing a safe and appropriate landing site.
3. The IC shall consult with on-scene emergency medical personnel in making decisions regarding the utilization, or landing of, an EMS aircraft.
4. In the absence of on-scene public safety or EMS personnel, the decision to land at any incident shall be at the discretion of the aircraft pilot.

C. Transportation of Emergency Personnel

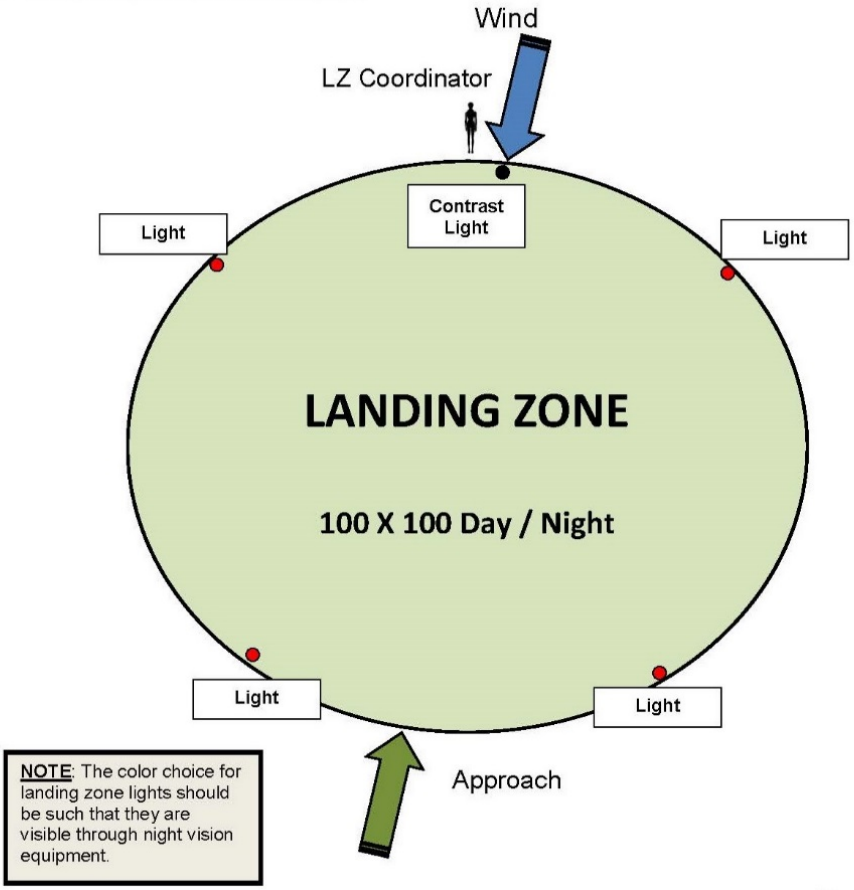
1. When appropriate and necessary, EMS aircraft may be used to transport emergency personnel or equipment/supplies to the scene of an emergency.

AIRCRAFT SAFETY

HELICOPTER APPROACH DIAGRAM



NIGHT TIME LIGHTING DIAGRAM



Turnover of Patient Care

EMS ADMINISTRATION 106

PURPOSE

I. To provide guidance for the transfer of care from non-transport providers to transport providers in the prehospital setting.

POLICY

I. TRANSFER OF RESPONSIBILITY:

A. Patient turnover occurs between a first responder provider and transport provider or two transport provider agencies.

B. The first responder or non-transporting provider shall provide the transport personnel with a complete report on the patient's condition and properly document the transfer of responsibility on an electronic patient care report (ePCR).

C. ALS First Response or ALS transport units may transfer care of BLS patients to BLS transport units within the following guidelines:

1. Patients must be stable with medical complaints that can be cared for at the BLS level and the examining paramedic will reasonably determine that there are not anticipated changes in the patient's present condition.
2. Patient is able to maintain their airway without assistance or adjuncts.
3. The patient must be hemodynamically stable. Vital signs should be steady and commensurate with the patients' condition.
4. Patient must be of their normal mental status and not impaired due to alcohol/drugs.
5. The patient does not have a mechanism of injury that would warrant a trauma alert or activation.
6. The patient has no cardiac, respiratory, or neurological complaints that may warrant ALS intervention.
7. The EMT who will be in attendance is comfortable with the patient's condition.

D. No patient will be turned over to BLS level care once ALS interventions have been initiated.

E. ALS assessment tools may be utilized (e.g., 12-lead ECG) in order to fully assess the patient and determine eligibility for turnover to BLS.

Public Safety Defibrillation Program

EMS ADMINISTRATION 107

PURPOSE

I. A.The purpose of this policy is to outline the minimum standards for Public Safety and EMT Service Providers and Personnel for the use of Public Safety AEDs in the Napa County EMS System.

POLICY

I. PROGRAM AUTHORIZATION

A. Any Public Safety Service Provider wishing to utilize AEDs within the County of Napa must be authorized by the Napa County EMS Agency.

B. To be approved by the Napa County EMS Agency , each Public Safety provider must agree to do the following:

1. Submit a completed application.
2. Designate a Program Liaison.
3. Utilize only AEDs that store a computerized recording of rhythms, times, and interventions.
4. Ensure proper maintenance of all AED equipment – maintenance to include monthly equipment inspection completed and documented.
5. Ensure initial training and continued competence of AED authorized personnel.
6. Designate a QI Coordinator responsible for implementing and maintaining the quality improvement activities required in this policy.
7. Authorize personnel to use an AED and maintain a list of all authorized personnel and provide the list to the EMS Agency annually or upon request.

C. An approved AED service provider and its authorized personnel shall be recognized statewide.

D. Public Safety AED service provider approval may be revoked or suspended for failure to maintain the requirements of this policy and/or applicable state regulations.

II. TRAINING REQUIREMENTS

A. The Public Safety AED Service Provider must utilize an initial training course that meets the training standards outlined in Title 22, Division 9, Chapter 1.5 of the California Code of Regulations.

B. Provide orientation of AED authorized personnel to the specific AED used by the service provider.

C. To ensure that all AED authorized personnel are proficient in the use of an AED they shall demonstrate defibrillation skills, at a minimum, every other year.

III. QUALITY IMPROVEMENT

A. Each Public Safety AED service provider shall designate a Program Liaison/Quality Improvement (QI) Coordinator. This individual shall be responsible for ensuring that all authorized AED personnel meet the training requirements of this policy.

B. The Program Liaison/QI Coordinator is also responsible for ensuring the quality and continuous improvement of their agencies Public Safety AED program.

POLICY

1. Each AED use shall be audited.
2. Any audit that identifies improper care or AED use shall be reported to the Napa County EMS Agency within one week of the AED use.
3. Copies of the report for each call involving an AED shall be maintained for a minimum of four years and shall be made available to the Napa County EMS Agency upon request.

C. The goal of the on-going continuous quality improvement efforts will be to strive for an affirmative answer to each of the following questions regarding AED usage.

1. Did personnel quickly recognize sudden cardiac arrest and the need for a response?
2. Did the personnel quickly and effectively set up the necessary equipment?
3. Was adequate BLS maintained?
4. Was defibrillation, when recommended, performed as rapidly as possible?
5. Was the AED operated safely, correctly, and following the Napa County EMS Agency standing orders?
6. Did the AED operate properly, e.g. recommend shock when appropriate?

IV. REPORTING REQUIREMENT

A. Each Public Safety AED service provider shall report the following information on the **Napa County EMS Event Reporting Form** within twenty-four (24) hours of an incident where a Public Safety AED has been used:

1. The date/time of the incident
2. The incident number
3. Was the sudden cardiac arrest witnessed or not witnessed
4. Was CPR given, if so by whom
5. Was a shock recommended/given. If yes, how many shocks

Suspected Elder and Dependent Adult Abuse Reporting Guidelines

EMS ADMINISTRATION 108

PURPOSE

I. To define suspected elder and dependent adult abuse and the required reporting procedures for prehospital care personnel.

POLICY

I. PRINCIPLES:

A. EMTs and Paramedics, as health care practitioners, are mandated reporters and have a legal obligation to report known or suspected elder or dependent adult abuse under the following circumstances:

1. When the reporter has observed an incident that reasonably appears to be physical abuse; or
2. When the reporter has observed a physical injury where the nature of the injury, its location on the body, or the repetition of the injury, clearly indicates that physical abuse has occurred; or
3. When the reporter is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse.

B. The law mandates all prehospital reporters to report known or suspected instances of other types of abuse of an elder or of a dependent adult, including neglect, mental abuse, financial abuse, isolation and abandonment.

C. Reporting is the responsibility of the mandated reporter. No supervisor or administrator may prohibit the filing of a required report.

II. REPORTING PROCEDURE:

A. Reports of abuse shall be verbally submitted within two hours, or as soon as possible, by telephone.

1. When reporting abuse that allegedly occurred in a long-term care facility or Adult Day Health Care Center, contact either the local law enforcement agency or the Long-term Care Ombudsman Program: 707-255-4236
2. When the abuse is alleged to have occurred anywhere else, contact either the local law enforcement agency or Adult Protective Services at: 707-253-4398 (during business hours) or 888-619-6913 (after hours).

B. EMS personnel shall complete the State of California – Health and Human Services Agency SOC-341 form and submit per the instructions on the form.

NAPA COUNTY EMS AGENCY

Suspected Child Abuse Reporting Guidelines

EMS ADMINISTRATION 109

PURPOSE

I. A.To define suspected child abuse and the required reporting procedures for prehospital care personnel.

POLICY

I. PRINCIPLES:

A. The purpose of reporting suspected child abuse/neglect is to protect the child, prevent further abuse of the child and other children in the home, and begin treatment of the entire family. The infliction of injury, rather than the degree of that injury, is the determinant for intervention by the Child Protective Services and law enforcement.

B. Under current law, all healthcare professionals are mandated to report suspected child abuse/neglect that they have knowledge of or observe in their professional capacity. Any person who fails to report as required may be punished by six months in jail and/or a $1,000 fine.

C. It is the job of law enforcement, CPS and the Courts to determine whether or not child abuse/neglect has, in fact, occurred. It is not necessary for the mandated reporter to determine child abuse, but only to suspect that it may have occurred.

D. When a mandated reporter has knowledge of or has observed child abuse or neglect, that individual is required to report to the local law enforcement and/or to the CPS immediately or as soon as practically possible by telephone and shall complete the suspected child abuse report form within thirty-six (36) hours.

E. When two or more mandatory reporters, jointly have knowledge of a known, or suspected, instance of abuse, a single report may be made.

F. Those persons legally required to report suspected child abuse have immunity from criminal or civil liability for reporting as required.

II. REPORTING PROCEDURES:

A. EMS personnel shall complete a Department of Justice (DOJ) Suspected Child Abuse Report for SS 8572 for all suspected cases of child abuse/neglect.

B. The purpose of the DOJ Suspected Child Abuse Report form SS 8572 is to make appropriate agencies aware of possible abuse/neglect. In Napa County, it is recommended that a prompt verbal report be made to both CPS and local law enforcement. However, if the child is in imminent danger, local law enforcement should be notified immediately.

C. This should be done as soon as possible. It is recommended that the Child Abuse Report form be completed prior to making verbal notification. EMS personnel should be aware of their local law enforcement reporting procedures and telephone numbers for notification.

D. To make a verbal report to CPS, call the 24-hour Child Abuse Hotline:

1. 707-253-4261
2. 800-464-4216

POLICY	
	E. The suspected child abuse/neglect report is to be completed according to the instructions on the back of the form. The completed form shall be sent to local law enforcement and CPS within thirty-six (36) hours: Napa County CPS P O Box 815 Napa, CA 94559

Fireline Paramedic

EMS ADMINISTRATION 110

PURPOSE

I. To establish procedures for Fireline Paramedics responding outside of Napa County, when requested, through the statewide Fire and Rescue Mutual Aid System, to respond to and provide advanced life support (ALS) care on the fireline of large-scale incidents.

POLICY

I. PROCEDURE

Under the authority of State regulations, a paramedic may render ALS care during emergency operations as long as the following conditions are met:

A. The paramedic is currently licensed by the State of California and is accredited by a Local EMS Agency within California.

B. The paramedic is currently employed and on-duty with an approved ALS provider and possesses the requisite wildland fireline skills and equipment.

C. The paramedic does not exceed the scope of practice or medical control policies from their county of origin.

D. The Fireline Paramedic from the Napa County EMS Agency jurisdiction shall follow all the Napa County EMS Agency polices and treatment guidelines in the provision of ALS care on the fireline and will not administer any medication or perform any procedures listed as “Base Hospital Orders ” without such approval from a Base Hospital Physician at The Queen of the Valley Medical Center.

E. The Fireline Paramedic from the Napa County EMS Agency jurisdiction shall respond with a minimum of ALS/BLS inventory as outlined in the FIRESCOPE–FEMP ICS 223-11 document. Inventory shall include all medications and equipment in order to provide all necessary care allowed by Napa County EMS Administrative Policies and Field Treatment Guidelines.

F. Controlled substances will be obtained, secured and inventoried in accordance with the Napa County EMS Agency **Administrative Policy 401, Equipment and Supply Standard**.

G. Documentation of patient care will be completed first on paper, for host agency reporting, then entered into an ePCR as indicated in the Napa County EMS Agency **Administrative Policy 601, ePCR Completion**.

ADDITIONAL REQUIREMENTS

A. Fire service provider agencies are responsible for establishing non-medical qualifications in order to serve as a Fireline Paramedic.

B. Albuterol HFA can substitute Aerosolized Beta 2 Specific Bronchodilator listed in FEMA ICS 223-11 when treating patients with shortness of breath. Administer 2-6 puffs q 10 minutes PRN respiratory distress max 12 puffs in one hour. If not responding to initial treatment, seek higher level of care.

NAPA COUNTY EMS AGENCY

Physician Interaction with EMS

EMS ADMINISTRATION 111

PURPOSE

I. To provide guidance to EMS personnel for dealing with a person that identifies themselves as a physician at the scene of an incident and wishes to be involved in patient care.

POLICY

I. POLICY:

A. Physicians interacting with EMS at the scene of an emergency may be unfamiliar with the prehospital scope of practice and local EMS protocols.

B. If the physician wants to involve themselves beyond that of a layperson, Base Hospital contact should be made and maintained for the duration of the call.

C. Any bystander that identifies themselves as a physician (MD or DO) must show proof of active license unless any of the following are present:

1. Call is to a healthcare facility and it is reasonably apparent to EMS personnel that bystander is a physician, i.e. uniform, name tag, etc. or physician is known to EMS personnel.

D. Physician should be given the EMSA/CMA "Note to Physicians on Involvement with EMS Personnel" card, which provides a written explanation of how they can interact with EMS personnel.

II. PROCEDURE:

A. Once physician identity is established, and card is given to and acknowledged by the physician bystander, offer them one of the three alternatives for physician involvement (as per EMSA/CMA card).

1. **Option 1:** Offer your assistance with another pair of eyes, hands or suggestions but let EMS personnel remain under base hospital control.
2. **Option 2:** Request to talk to the base station physician and directly offer your medical advice and assistance.
3. **Option 3:** Take total responsibility for the care given by EMS personnel and physically accompany the patient until the patient arrives at a hospital (if safety allows) and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedures. (Whenever possible, remain in contact with the base station physician).

EMSA/CMA CARD

California Medical Association

NOTE TO PHYSICIANS ON INVOLVEMENT WITH EMS PERSONNEL

EMS Personnel operate under standard policies and procedures developed by the Local EMS Agency and approved by their Medical Director under the Authority of Division 2.5 of the California Health and Safety Code. The drugs they carry and the procedures they can do are restricted by law and local policy.

If you want to assist, this can only be done through one of the alternatives listed on the back of this card. These alternatives have been endorsed by CMA, State EMS Authority, and CCLHO.

Assistance rendered in the endorsed fashion, without compensation, is covered by the protection of the "Good Samaritan Code"(see Business and Professional Code, Sections 2144, 2395-2298 and Health and Safety Code 1799.104).**(over)**

ENDORSED ALTERNATIVES FOR PHYSICIAN INVOLVEMENT

After identifying yourself by name as a physician licensed in the State of California, and if requested, showing proof of identity, you may choose one of the following:

1. Offer your assistance with another pair of eyes, hands, or suggestions, but let EMS personnel remain under base hospital control; or,
2. Request to talk to the base station physician and directly offer your medical advice and assistance; or,
3. Take total responsibility for the care given by EMS personnel and physically accompany the patient until the patient arrives at a hospital (if safety allows) and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedures. (Whenever possible, remain in contact with the base station physician)

(REV. 7/88) 88 49638 Provided by the EMS Authority

Trauma Triage

EMS ADMINISTRATION 112

PURPOSE

I. Provide guidance to EMS personnel regarding trauma triage decisions.

POLICY

I. TRAUMA TRIAGE DECISION SCHEME

A. Physiologic Criteria:

1. GCS ≤ 13 with mechanism attributed to trauma
2. Adult: Systolic BP < 90 mm Hg
3. Pediatric: Systolic BP < 80 mm Hg – Age 7-15
   Systolic BP < 70 mm Hg – Age <7
4. Respiratory compromise (assisted ventilations, obstruction, advanced airway)

B. Anatomic Injury Factors:

1. Open or depressed skull fracture.
2. Penetrating injury to head, neck, torso, abdomen, pelvis, groin, or extremities proximal to elbow or knee.
3. Evidence of two or more proximal long-bone fractures (femur, humerus).
4. Pelvic fracture.
5. Traumatic amputation proximal to wrist or ankle.
6. Flail chest.
7. Traumatic paralysis.
8. Major burns (2^{nd} and/or 3^{rd} degree burns ≥ 15% BSA) associated with trauma.
9. Traumatic pulseless extremity.
10. EMS Provider discretion.

C. Mechanism of Injury

1. Ejection from a vehicle, (e.g., auto, jet-ski, motorcycle) ≥ 20 mph.
2. Auto vs. pedestrian or bicycle with greater than 5mph impact.
3. MVC, with any of the following:
   a. ≥ 40 mph head-on or side-impact, or;
   b. Rollover, or;
   c. Death of occupant in same vehicle.
   d. Extrication time ≥ 20 minutes.
4. Fall ≥ 10 feet.

POLICY

5. Significant blunt trauma with any of the following:
    a. Age < 5 or ≥ 70.
    b. Pregnancy.
    c. Bleeding disorder or anticoagulants.
    d. Inability to communicate, (e.g., language, psychological and/or substance impairment).
6. EMS personnel discretion.

II. SPECIAL CONSIDERATIONS

A. Patients with the following conditions should be considered for transport to an out-of-county specialty center per the Napa County EMS Agency **Administrative Policy 501, Patient Destination**.

1. Pediatric patients (patients < 15 years old) who meet the trauma triage criteria shall be transported directly to the most appropriate pediatric trauma receiving center.
2. Major / Critical Burns are encouraged to be transported directly to the most appropriate Burn Center.
3. Base hospital contact is required in these instances and EMS aircraft should be considered.

Treatment and Transport of Minors

EMS ADMINISTRATION 113

PURPOSE

I. Provide guidance to EMS personnel regarding treatment and/or transport of a patient under the age of eighteen.

POLICY

I. MINORS REQUIRING TRANSPORT

A. In the absence of a parent or legal representative, minors with an emergency condition shall be treated and transported to the health care facility most appropriate to their needs.

B. Hospital or EMS personnel shall make every effort to inform a parent or legal representative of where their child has been transported.

C. If EMS personnel believe a parent or other legal representative of a minor is making a decision that appears to endangering the health and welfare of the minor by refusing indicated immediate care or transport, law enforcement authorities should be involved.

II. MINORS NOT REQUIRING TRANSPORT

A. A minor child who is evaluated by EMS personnel and determined not to be injured, to have sustained only minor injuries, or to have illnesses or injuries not requiring immediate treatment or transportation, may be released to:

1. Parent or legal guardian
2. Designated care giver who has been given authorization by parent or legal guardian to make medical decisions for the minor.
3. Law enforcement

III. MINORS WHO MAY CONSENT

A. A legally married minor;

B. A minor on active duty with the U.S. military;

C. A minor seeking prevention or treatment of pregnancy or treatment related to sexual assault;

D. An emancipated minor (must provide proof).

Patient Refusal Against Medical Advice & Release At Scene

EMS ADMINISTRATION 114

PURPOSE

I. Provide guidance for EMS personnel to follow that allows patients to refuse treatment and/or transport against medical advice or be released at scene.

DEFINITIONS

I. PATIENT: A patient is defined as any individual identified by EMS personnel:

A. Who has requested medical assistance; or

B. For whom medical assistance has been requested by another person; or

C. Observed to be experiencing an apparent medical emergency.

D. If any uncertainty of the request for medical aid or emergency medical condition exists, the EMS personnel will consider the individual a patient.

II. AGAINST MEDICAL ADVICE (AMA): After evaluation and recommendation from Advanced Life Support EMS personnel for treatment and transport, the patient who has decision-making capacity or the legal representative, declines treatment and/or transport.

III. RELEASE AT SCENE (RAS): A patient who, after an assessment by EMS personnel, does not desire transport to an emergency department and does not meet protocol criteria for an emergency medical condition for treatment and/or transportation to an emergency department.

POLICY

I. PATIENT REFUSAL AGAINST MEDICAL ADVICE: ALS PERSONNEL ONLY

A. Principles:

1. A competent adult or a competent emancipated minor has the right to determine the course of their own medical care and shall be allowed to make decisions affecting their medical care, including refusal of care.
2. An adult or emancipated minor may refuse medical evaluation, treatment, and/or ambulance / medical transportation, provided that they are competent and have been advised of the risks and consequences.
3. Refusal of evaluation, treatment and/or transportation should not be considered for patients who do not have the capacity to make competent decisions regarding their own care. A patient's competence may be significantly impaired by mental illness, drug or alcohol intoxication, physical or mental impairment, abnormal physiologic states or distracting circumstances. Incidents where patients have attempted suicide, verbalized suicidal intent or when other factors lead EMS personnel to suspect suicidal intent, should have law enforcement involvement
4. Minors (unless emancipated), cannot legally consent or refuse evaluation or treatment. Provider must secure consent / refusal for parents or legal guardian(s). Minors must be left in the custody of a parent, legal guardian, conservator or law enforcement.
5. Consent to leave a minor on-scene can be obtained from a parent, legal guardian or conservator via telephone. Ensure complete documentation (including but not limited to): name of parent / legal guardian or conservator, relationship to patient, date, and time.

POLICY

B. Procedure:

1. When a competent adult or emancipated minor refuses indicated emergency treatment or transportation, EMS personnel shall:
    a. Advise the patient of the risks and consequences which may result from refusal of treatment or transport.
    b. Have the patient or his / her legal representative, as appropriate, sign the AMA release. The patient should be advised to arrange for medical care immediately, if appropriate or if he / she develops adverse symptoms at a later time. If the patient requests additional medical advice, the base hospital should be involved.
    c. Document the patient's refusal and the paramedics warning, using direct quotes if possible on then PCR.
    d. If the patient refuses to sign the AMA form, this fact should be documented on the form.
    e. If EMS personnel determine that a patient with an emergency condition is not competent to refuse evaluation, treatment and/or transport, (and they still refuse) the following alternatives exist:
        i. Ensure appropriate law enforcement agency is on scene.
        ii. Initiate consultation with the base hospital physician.
        iii. If EMS personnel determine it is necessary to transport the patient against his / her will, and the patient resists or the EMS personnel believe the patient will resist, assistance from law enforcement should be requested in transporting the patient.

II. RELEASE AT SCENE (RAS): BLS OR ALS PERSONNEL

A. Principles

1. The individual at no time requests EMS transport and after EMS evaluation, the attending provider agrees that no further treatment and/or transport is necessary.
2. An exhaustive and all-inclusive list of RAS conditions is not possible.
    a. Examples:
        i. A bystander calls 911 because an individual "appears dead" on the park bench. EMS arrives and determines after evaluation that the individual was sleeping and is competent.
        ii. A bystander calls 911 to report a possible traffic collision with injuries. EMS arrives and determines after evaluation that all parties involved do not have a medical problem that either the individual or provider believes to require treatment and/or transport by the EMS system.
3. Consent to leave a minor on-scene can be obtained from a parent, legal guardian or conservator via telephone. Ensure complete documentation (including but not limited to): name of parent / legal guardian or conservator, relationship to patient, date, time, etc.

POLICY

B. Eligibility for RAS:

1. All of the following must be present

i. Patient does not have a complaint of illness or injury that warrants further treatment and/or transport by the EMS system.

ii. Patient does not have obvious evidence of illness of injury that warrants further treatment and/or transport by the EMS system.

iii. Patient has not experienced an event or circumstance that could reasonably suggest or lead to illness or injury that warrants further treatment and/or transport by the EMS system.

iv. Patient does not have a medical problem at this time that either the individual or the provider believes to require further treatment and/or transport by the EMS system.

C. Procedure:

1. Honor the request.
2. Complete a PCR detailing circumstances of refusal of service if a complaint is determined.
3. Complete RAS release for each individual released at scene.

III. BASE HOSPITAL CONSULTATION:

A. A refusal of care may be against the advice of the EMS responders and/or the base hospital physician (AMA); however, a competent adult has the legal right to refuse care. For patients with acute conditions, every effort should be made to convince the patient to be transported.

1. Be persuasive – get help from:
   a. Family members, friends, etc.
   b. The base physician.
   c. Consider calling law enforcement especially if the patient is a child.
2. Paramedics should contact the Base Physician:
   a. The patient requests transport to a facility that is not the destination recommended by EMS personnel.
   b. Whenever the refusal of care and/or transport poses a significant threat to the patient's wellbeing.
   c. Additional examples of situations where base physician contact should be made include but are not limited to:
      i. Markedly abnormal vital sign.
      ii. Uncontrolled hemorrhage.
      iii. Suspected ischemic chest pain.
      iv. Suspected new onset Acute Stroke.
      v. Any patient meeting critical trauma criteria.
      vi. Any time ALS medical treatment has begun and then the patient refuses transport.

Determination of Death

EMS ADMINISTRATION 115

PURPOSE

I. Provide guidance on when EMS personnel can terminate or withdraw resuscitative efforts.

POLICY

I. TERMINATING OR WITHDRAWING RESUSCITATIVE EFFORTS

A. CPR will not be initiated under the following circumstances:

1. Obvious Death:
    a. Decapitation.
    b. Incineration.
    c. Destruction or separation of major organs (brain, heart, liver).
    d. Blunt traumatic arrests in asystole or pulseless electrical activity at a rate < 40.
    e. Penetrating trauma arrests when the time from onset of arrest to arrival at the trauma center is > 10 minutes.
2. Declared Mass Casualty Incidents
    a. Pulseless, apneic or agonal patient where triage principles and available resources preclude initiation of resuscitation.

B. CPR may be withheld or terminated under the following circumstances:

1. A pulseless, apneic patient who has multiple signs of prolonged lifelessness
    a. Rigor Mortis: Determination of rigor mortis should include immobility of the jaw and/or upper extremities.
    b. Lividity: visible pooling of blood in dependent extremities or dependent areas of the body.
    c. Pupils: fixed and dilated (this sign, by itself is not evidence of death).
    d. Body temperature: loss of body warmth in a warm environment (this sign by itself is not evidence of death).

C. Do Not Resuscitate (DNR) Order / Physician Order for Life-Sustaining Treatment (POLST)

1. EMS personnel will at times encounter patients who clearly should not receive resuscitation yet who do not have all of the necessary documentation for withholding resuscitation. In such situations, the paramedic shall make base hospital contact and communicate pertinent patient medical information. The base hospital will issue appropriate orders, which may include the limitation or termination of resuscitation.
2. If EMS personnel are unsure about the appropriate level of intervention the base hospital physician shall be consulted.
3. In addition to serving as a traditional Do Not Resuscitate (DNR), the POLST form provides guidance to the paramedics and base hospital physicians in making decisions appropriate for those patients in such situations.

POLICY

4. If the patient is in cardiac arrest and a valid POLST form is present and indicates in Section (a) no resuscitation is desired, no resuscitation shall be performed and determination of death in the prehospital setting applies.
5. If the patient is not in cardiac arrest and has a valid POLST form, EMS personnel may provide limited or comfort measures as described in section (B) of the form.
6. The patient shall be transported to the hospital if comfort measures are started by EMS personnel, unless an alternate care plan is approved by the base hospital physician.
7. It is vital for the continuity of appropriate care the POLST form accompany the patient to the receiving facility.
8. Upon presentation of a valid POLST form, DNR Medallion, DNR Order or Durable Power of Attorney for Health Care (DPAHC) that specifies DNR or similar status:
    a. Do not initiate CPR.
    b. Terminate CPR if already in progress.
    c. If there is any doubt whether to start or withhold CPR, first responders should start CPR and await the arrival of an ALS provider.
    d. Notify appropriate law enforcement agency and/or coroner. A completed Patient Care Report must be left at the scene or faxed within 3 hours to the coroner.
    e. Ensure scene security until released by law enforcement representative.
    f. Base contact is NOT necessary.

D. Resuscitation may be withheld at family request if there is unanimous agreement between all family members on scene. In such a case the EMT or paramedic may choose to consult with base physician, however the consultation is optional. If there is any doubt or dissention among family or rescuers as to the appropriateness of the decision to withhold resuscitation, resuscitative efforts should continue as per applicable guidelines(s).

II. TERMINATION OF ADVANCED LIFE SUPPORT RESUSCITATION

A. Resuscitation may be terminated under the following circumstances:
    1. Any case in which information becomes available that would have prevented initiation of resuscitation had that information been available before resuscitation was initiated.

B. Termination of resuscitation during transport:
    1. If the patient is already enroute to the hospital, such a decision results in the immediate termination of Code 3 transport.
    2. Transport shall continue to the closest receiving facility.
    3. All disposable ALS devices shall remain in place unless otherwise directed by law enforcement.

POLICY

C. Termination of resuscitation prior to transport:

1. If resuscitation is discontinued prior to transport, the coroner shall be notified.
2. In general, the patient should not be moved or searched. The area shall be secured until the arrival of the coroner and/or the appropriate law enforcement representative.
3. Some post-resuscitative situations pose a challenge to responders due to the location of the patient (e.g. public area with children). In the absence of suspicious or obvious signs of criminal involvement, EMS personnel *may* choose to move the pronounced patient to a more private and/or discrete location. Movement of a pronounced patient should only occur when it is necessary to minimize bystander exposure.
4. Movement of a pronounced patient may also occur if EMS personnel experience extreme, unusual or dangerous social or scene situations.
5. EMS personnel shall notify the Napa County Coroner or applicable law enforcement having jurisdiction and must remain on scene (retaining custody of the pronounced patient) until law enforcement personnel arrive (e.g. move pronounced patient to on-scene ambulance). All disposable ALS devices shall remain in place unless otherwise requested by law enforcement.

III. ARRESTS IN A PUBLIC FORUM

A. With the exception of a crime scene, victims of cardiac arrest in a public area may be moved to a more private working space as practical without delaying or hindering resuscitative efforts.

Naloxone Administration by Law Enforcement

EMS ADMINISTRATION 116

PURPOSE

I. To establish minimum standards for law enforcement first responders seeking naloxone administration designation from the Napa County EMS Agency.

II. To describe criteria for law enforcement officer administration of naloxone in cases of suspected acute opioid overdose.

III. To provide medical direction and naloxone administration parameters for (approved optional scope) for law enforcement officers in Napa County.

IV. Current certification in Basic Life Support (AHA or American Red Cross equivalent) is required of any deputy or officer approved for administration of naloxone.

POLICY

I. GENERAL PROVISIONS

A. Before a law enforcement agency shall be considered for approval for the administration of Naloxone by Napa County EMS Agency, the following items shall be submitted for review in conjunction with the Naloxone Administration by Law Enforcement (NALE) application:

1. Name, address and phone number of agency.
2. A letter of intent to utilize naloxone, expressing willingness to abide by all Napa County EMS Agency policies, procedures and requirements.
3. A description of the training related to the administration of naloxone by law enforcement first responders.
4. Name and procedure of training officer/coordinator or other designated individual, responsible for:
    a. Training as outlined in California Code of Regulations, Title 22, Division 9, Chapter 1.5 First Aid and CPR Standards and Training for Public Safety Personnel, including the optional skill administration of Naloxone.
    b. Proper and efficient deployment of naloxone.
    c. Replacement of naloxone after use.
    d. Record of documented use, restocking, damaged and unusable or expired naloxone.
    e. Reporting the use of naloxone administration to Napa County EMS Agency using the **Napa County EMS Event Reporting Form**.

B. Provide documentation of medical control for initial and ongoing procurement and accountability of naloxone.

C. A description of the agencies quality improvement (QI) monitoring and oversight processes related to the administration of naloxone. At a minimum, the monitoring and review of the administration of naloxone, shall focus on the following:

1. Documentation of naloxone use per law enforcement policy.
2. Reporting the use of naloxone to Napa County EMS Agency.
3. Compliance with Napa County EMS Agency policies and treatment protocols.
4. Identification of potential provider or system issues related to the use of naloxone by law .enforcement personnel.

POLICY

D. Name of the Agency's Liaison to Napa County EMS Agency. All questions and correspondence shall be directed to this person.

II. TRAINING

A. Training shall be provided as outlined in California Code of Regulations, Title 22, Division 9, chapter 1.5. First Aid and CPR Standards and Training for Public Safety Personnel, including the optional skills administration of naloxone for suspected narcotic overdose.

B. The Training Officer/Coordinator/Agency Liaison or other designated individual, shall be responsible for the following:

1. Ensuring the nasal naloxone is current and not expired.
2. Proper and efficient deployment of nasal naloxone for use.
3. Replacement of any nasal naloxone that is damaged, unusable, expired or deployed.
4. Ensuring all personnel that will be using nasal naloxone has received appropriate training.
5. Replacing the nasal naloxone and ensuring that there is an adequate supply available for use.
6. Keep record of all documented use, restocking, damaged, and unusable or expired naloxone.

III. ADDITIONAL POLICY REQUIREMENTS

A. Notify Napa County EMS Agency of any changes related to the organizations training program within thirty (30) calendar days.

B. Notify Napa County EMS Agency within twenty-four (24) hours any incident involving a potential policy/protocol violation resulting in potential patient harm from the use of naloxone.

C. Once the organization has satisfactorily completed the above requirements the organization shall enter into a written agreement with Napa County EMS Agency for the use of naloxone by law enforcement first responders.