NAPA COUNTY EMS AGENCY

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General Patient Care

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Use of Restraints

ADMINISTRATIVE POLICY 7001

7001.1 PURPOSE

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 self or others.

7001.2 PRINCIPLES

A. The safety of the patient, community and responding personnel is of paramount concern when following this policy. Restraints are to be used only when necessary in situations where the patient is potentially violent and is exhibiting behavior that is dangerous to him / herself or others. Prehospital personnel must consider that aggressive or violent behavior may be a symptom of conditions such as: head trauma; alcohol; drug-related problems; metabolic disorders; stress and psychiatric disorders. Base hospital contact shall made during complex or unusual situations.

B. The responsibility for patient health care management rests with the highest medical authority on scene. Therefore, medical intervention and patient destination shall be determined by prehospital personnel. Overall authority for scene management shall be vested in the appropriate public safety agency having primary investigative authority.

C. Restraints applied by law enforcement require the officer to remain available to remove or adjust the restraints for patient safety. 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.

   1. 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.

D. It is recognized that in certain unusual situations, law enforcement officers may determine that safety cannot be maintained without ongoing application of physical restraints (i.e. abusive, uncooperative and/or violent patients). In these circumstances, every effort will be made to provide appropriate care without endangering prehospital care personnel.

   1. The initial restraint of a violent or combative patient should be performed by law enforcement personnel. The transfer of restraints (e.g. from hand cuffs to 4-point restraints) may be performed later once deemed safe.

E. Documentation as described in section 7001.4 below shall be performed to completely characterize the reasons for any necessary deviations from standard patient care. Collaborative efforts between law enforcement, EMS personnel and the base hospital will be made to provide the greatest degree of safe patient care allowed by these circumstances.

   1. Any situations which require deviation(s) from policy / protocol shall require base hospital contact.

7001.3 PROCEDURES

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

   1. Restraint equipment applied by prehospital 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 applied by EMS prehospital 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. When EMS personnel assume patient care from law enforcement, ensure the restraint equipment applied by law enforcement (handcuffs, plastic ties or “hobble” restraints) provides sufficient slack (in the restraint device) to allow the patient to straighten the abdomen and chest and to take full tidal volume breaths.

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.
   a. If deemed safe and appropriate, restraints applied by law enforcement should be transitioned to soft / leather restraints (e.g. from hand cuffs to 4-point restraints).

5. Patients shall not be transported in a prone position. Prehospital personnel shall ensure that the patient’s position does not compromise the patient’s respiratory or circulatory systems and does not preclude any necessary medical intervention to protect the patient’s airway should vomiting occur.
   a. It is crucial to collaborate with law enforcement personnel to minimize the risk of positional asphyxiation.

6. Restrained extremities will 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 basic emergency department facility within the Patient Destination / Point of Entry Guideline # 7007.

8. Refer to the Treatment Guideline Restraint “Checklist”.

7001.4 DOCUMENTATION

A. Documentation on the Patient Care Report (PCR) shall include:
   1. The reasons the restraints 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.
   5. Reasons for any necessary deviations from standard patient care.
   6. Any situations which require deviation(s) from policy / protocol shall require base hospital contact.

NAPA COUNTY EMS AGENCY

Physician Interaction with EMS

ADMINISTRATIVE POLICY 7002

7002.1 PURPOSE

To provide the steps needed to be followed when a bystander identifies themselves as a physician at the scene of an incident and wishes to be involved in patient care above and beyond that of a layperson bystander.

7002.2 POLICY

EMS personnel work under the medical control of the base hospital physician. If a physician arrives on scene and offers help, it should be assumed they are unfamiliar with the prehospital scope of practice and local EMS protocols. For this reason, the base hospital should be involved for the duration of the call if a physician wants to involve themselves beyond that of a layperson bystander. In such a case, respectfully hand them the EMSA approved, "Note to Physicians on Involvement with EMS Personnel" which provides a written explanation of the position of NCEMSA.

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 health care facility and it is reasonably apparent to EMS personnel that bystander is a physician, i.e. uniform, name tag, etc.
2. Physician is known to EMS personnel.
3. When in doubt ask for identification or establish base contact.

7002.3 PROCEDURE

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 CMA card).

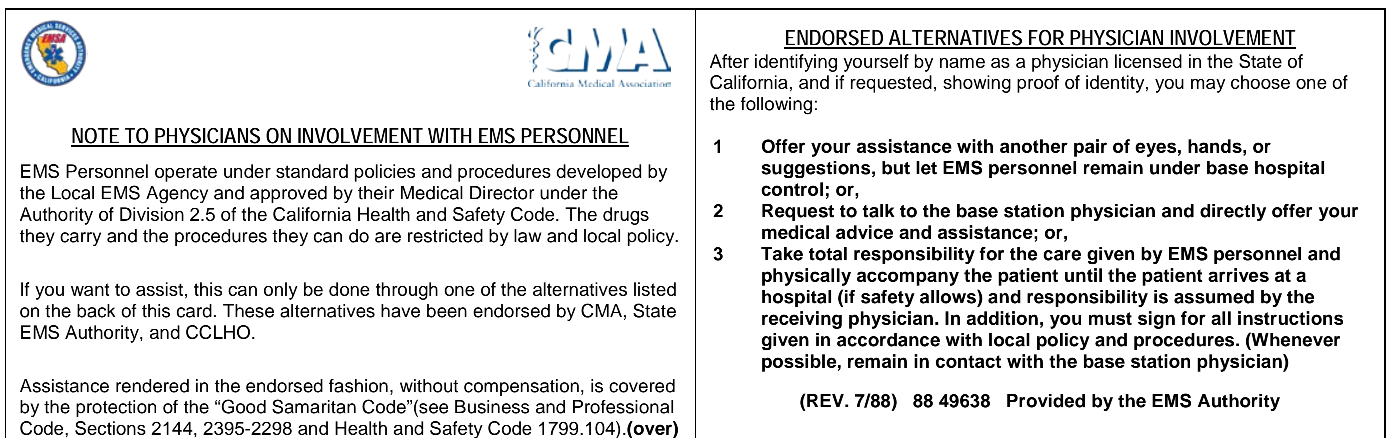
Option 1: Offer your assistance with another pair of eyes, hands or suggestions but let EMS personnel remain under base hospital control.

Option 2: Request to talk to the base station physician and directly offer your medical advice and assistance.

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).

7002.4 NOTE TO PHYSICIANS ON INVOLVEMENT WITH EMS PERSONNEL

EMS personnel must have a copy of this card readily available to hand to physicians.



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

NAPA COUNTY EMS AGENCY

Trauma Triage Decision Scheme

ADMINISTRATIVE POLICY 7003

7003.1 PURPOSE

Varying field circumstances make rigid application of any set of rules impractical. These criteria should serve as guidelines. Clinical circumstances may dictate that transport be undertaken immediately with trauma base contact made enroute.

7003.2 PATIENT TRANSPORTATION

If the patient meets any of the below criteria (excluding pediatric and major burns) transport to closest most appropriate trauma center. The physician at the base hospital may direct the patient to an out-of-county trauma center if that facility is the closest most appropriate receiving hospital.

7003.3 SPECIAL PATIENT TRANSPORTATION

A. Patients with the following considerations should be considered for transport to an out-of-county specialty center:

1. **Pediatric patients** (patients $\leq$ 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** (refer to ALS / BLS Burns Guideline # 9602) are encouraged to be transported directly to UC Davis Medical Center.

NOTE: Base hospital contact is required in these instances. EMS Aircraft should be considered

Trauma Triage Decision Scheme

Physiologic Criteria:

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

Anatomic Injury Factors:

- Open or depressed skull fracture
- Penetrating injury to head, neck, torso, abdomen, pelvis, groin, or extremities proximal to elbow or knee
- Evidence of two (2) or more proximal long-bone fractures (femur, humerus)
- Pelvic fracture
- Traumatic amputation proximal to wrist or ankle
- Flail chest
- Traumatic paralysis
- Major burns (2nd and/or 3rd degree burns ≥ 15% BSA) in association with trauma
- Traumatic pulseless extremity
- EMS provider discretion

Mechanism of Injury / Special Considerations:

- Ejection from a vehicle, (e.g., auto, jet-ski, motorcycle) ≥ 20 mph
- Auto vs. pedestrian or bicycle with greater than 5 mph impact
- MVC:
  - ≥ 40 mph head-on or side-impact
  - Rollover
  - Death of occupant in same vehicle
  - Extrication time ≥ 20 minutes
- Fall ≥ 10 feet
- Significant blunt trauma with any of the following:
  - Age < 5 or ≥ 70
  - Pregnancy
  - Bleeding disorder or anticoagulants
  - Inability to communicate, (e.g., language, psychological and/or substance impairment).
- EMS provider discretion

Treatment / Transport of Minors

ADMINISTRATIVE POLICY 7004

7004.1 PURPOSE

To describe the guidelines for treatment and/or transport of a patient under the age of eighteen (18).

7004.2 DEFINITIONS

Minor: A person less than eighteen (18) years of age who is not emancipated.

Emancipated Minor: A person less than eighteen (18) years of age whom:

A. Is married or previously married.
B. Is on active duty in the military.
C. Is an emancipated minor (decreed by court, identification card by DMV).

Legal Representative: A person who is granted custody or conservatorship of another person by a court of law.

Emergency: Condition or situation in which an individual has a need for immediate medical attention or where the potential for need is perceived by EMS personnel or a public safety agency.

7004.3 DEFINITIONS OF CONSENT

A. Voluntary Consent: Treatment or transport of a minor child shall be with the verbal or written consent of the parents or legal representative. If the minor is legally able to consent, then treatment or transport shall be with the verbal or written consent of the minor.
B. Implied Consent: In the absence of a parent or legal representative, emergency treatment and/or transport of a minor may be initiated without consent.

7004.4 PROCEDURE

A. Minors requiring transport:
   1. 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 the needs of the patients.
   2. Hospital or provider agency personnel shall make every effort to inform a parent or legal representative of where their child has been transported.
   3. If prehospital care personnel believe a parent or other legal representative of a minor is making a decision that appears to be endangering the health and welfare of the minor by refusing indicated immediate care or transport, law enforcement authorities should be involved.
B. Minors not requiring transport:
   1. 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:
      a. Parent or legal representative.
      b. A responsible adult at the scene.
      c. Designated care giver.
      d. Law enforcement.
   2. EMS personnel shall document on the PCR to whom the patient was released.

Patient Refusal of Treatment / Transport & RAS

ADMINISTRATIVE POLICY 7005

7005.1 PURPOSE

Release at Scene (RAS)

To provide procedures for BLS and ALS personnel to follow when both a competent person and the provider feels that no further EMS system treatment/transport is needed and the individual exhibits and/or complains of no illness or injury (as defined in section 7005.4).

Against Medical Advice (AMA)

To provide procedures for ALS personnel to follow when patients refuse medical treatment or ambulance transportation or when a parent(s) or legal guardian refuses medical treatment or ambulance transport for a minor.

7005.2 DEFINITIONS

5150: Refers to section “5150” of the California Welfare and Institutions Code (specifically, the Lanterman–Petris–Short Act or "LPS") which allows a qualified officer or clinician to involuntarily confine a person deemed to have a mental disorder that makes them a danger to self and/or others and/or is gravely disabled.

Adult: For purposes of this policy, a person at least eighteen (18) years of age or an emancipated minor.

Against Medical Advice (AMA) “refusal of treatment / transport”: The circumstance in which an individual who is determined to have a medical problem which requires the treatment and/or transport capabilities of the EMS system and who has been advised of his / her condition along with the known and unknown risks and/or possible complications of refusing medical care and nevertheless, declines treatment or transport.

Competent: The patient is alert and oriented and has the capacity to understand the circumstances surrounding his / her illness or impairment and the risks associated with refusing treatment or transport. Abnormal vital signs, deranged mentation, confusion and irrational behaviors may be signs of incompetence.

Emancipated Minor: A person less than eighteen (18) years of age who:

A. Is an emancipated minor (decreed by court, identification card issued by DMV).
B. Is on active duty in the military.

Emergency: Condition or situation in which an individual has a need for immediate medical attention or where the potential for need is perceived by EMS personnel or a public safety agency.

Implied Consent: The principal under which individuals who are unconscious or incompetent would consent to life or limb-saving treatment and/or transport.

Minor: A person less than eighteen (18) years of age who is not emancipated.

Release at Scene (RAS): The circumstance in which an individual who, after an appropriate evaluation by ALS or BLS personnel, does not have a medical problem that either individual or provider believes to require further treatment and/or transport by the EMS system and meets criteria listed in 7005.4.

RELEASE AT SCENE (RAS)

(BLS / ALS Personnel)

7005.3 PRINCIPLES

A. 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.

B. An exhaustive and all-inclusive list of RAS conditions is not possible.

1. Examples:
    a. 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.
    b. 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.

C. 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.

7005.4 CRITERIA FOR RAS

A. All of the following must be present

B. The individual:

1. Does **not** have a complaint of illness or injury that warrants further treatment and/or transport by the EMS system.
    a. Provider discretion should be used with hospice patients or in other similar circumstances.
2. Does **not** have obvious evidence of illness of injury that warrants further treatment and/or transport by the EMS system.
3. 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.
4. Does **not** have a medical problem at this time that either individual or provider believes to require further treatment and/or transport by the EMS system.

7005.5 PROCEDURE FOR RAS

A. Honor the request.

B. Complete a PCR detailing circumstances of refusal service if a complaint is determined.

C. Complete the "RAS section" of the RAS / AMA (7005 Form-1) for each RAS individual.

D. In an event where multiple individuals are released at scene, the circumstances of the entire incident should be documented (not for each individual – refer to 7005 – Log 1).

AGAINST MEDICAL ADVICE (AMA)
PATIENT REFUSAL OF TREATMENT / TRANSPORT
(ALS Personnel)

7005.6 PRINCIPLES

A. A competent adult or a competent emancipated minor has the right to determine the course of his / her own medical care and shall be allowed to make decisions affecting his / her medical care, including the refusal of care.

B. An adult or emancipated minor may refuse medical evaluation, treatment, and/or ambulance / medical transportation, provided that he / she is competent and has been advised of the risk and consequences. Providers should consider the principle of implied consent for incompetent individuals with life threatening illness or injury.

C. 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. Patients, who have attempted suicide, verbalized suicidal intent or when other factors lead EMS personnel to suspect suicidal intent, should not be regarded as competent.

D. Minors (unless emancipated), can't 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.

E. 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.

7005.7 PROCEDURE

A. When a competent adult or emancipated minor refuses indicated emergency treatment or transportation, EMS personnel shall:

1. Advise the patient of the risks and consequences which may result from refusal of treatment or transport.
2. Have the patient or his / her legal representative, as appropriate, sign the release (AMA) section of the RAS / AMA form. The signature shall be witnessed, preferably by a family member. 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.
3. Document the patient's refusal and the paramedics warning, using direct quotes if possible on the PCR.
4. If the patient refuses to sign the RAS / AMA form, this fact should be documented on the form.
5. 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:
   a. Ensure appropriate law enforcement agency is on scene.
   b. Initiate consultation with the base hospital physician.

B. 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.

NOTE: At no time are field personnel to put themselves in danger by attempting to treat and/or transport a patient who refuses. At all times, good judgment should be used and appropriate assistance obtained. However, use all possible available means to transport a seriously ill or injured patient who refuses.

7005.8 BASE CONTACT

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, (see below) 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 recommended destination by EMS personnel.

     b. Whenever the refusal of care and/or transport poses a significant threat to the patient's well-being.

     c. Additional examples of situations where base physician contact should be made include but are not limited to:

        1. Markedly abnormal vital sign.

        2. Uncontrolled hemorrhage.

        3. Suspected ischemic chest pain.

        4. Suspected new onset Acute Stroke.

        5. Any patient meeting critical trauma criteria.

        6. Any time ALS medical treatment is begun and then the patient refuses transport.

7005.9 PSYCHIATRIC HOLDS (5150)

Patients exhibiting signs of being a danger to themselves or others or are gravely disabled, cannot be released at scene. EMS personnel should notify the proper authorities to request a 5150 determination and remain with the patient until authorities have made such a determination. A 5150 should not be used to transport a competent, seriously ill or injured patient who refuses treatment and/or transport.

7005.10 DOCUMENTATION

A. A patient care report and RAS / AMA form must be competed for each incident of patient refusal of emergency medical evaluation, care and/or transportation. EMS personnel shall ensure that documentation includes a patient history and assessment, details of the exam / evaluation that was performed, a description of the patient that clearly indicates his / her decision making capacity, why the patient is refusing care, a statement that the patient understands the risks and consequences of refusing medical attention and any alternatives presented to the patient.

B. Each provider agency shall retain the appropriate RAS / AMA form and attach it to the specific patient care report once completed.

NAPA COUNTY EMS AGENCY

RAS/AMA FORM

ADMINISTRATIVE POLICY 7005

Date: _______________ Unit #: ___________ Incidental/Dispatch #: _______________________

BLS/ALS Personnel

☐ *Person/Patient Refused to Sign*

Section I - Release at Scene (RAS)

Neither I nor the attending EMT(s) and/or paramedic(s) believe that I (or my child) have an illness or injury requiring EMS system transport. I agree that I *do not* need further EMS assessment, treatment and *do not* require EMS system transportation at this time. I understand that if I change my mind or if my condition changes and I wish further treatment/transportation by the EMS system; I can call 911 and they will respond.

Person/Patient Name (print): _______________________ Person/Patient Signature: __________________

Phone Number: ________________________________ E-mail Address: __________________________

Person/Patient Guardian Signature: _________________ Relationship: ____________________________

Witness Name: _________________________________ Witness Signature: ________________________

EMT/Paramedic Name: ___________________________ EMT/Paramedic Signature:_________________

ALS Personnel Only

Section II - Against Medical Advice (AMA) - Refusal of Evaluation/Treatment/Transportation

I, ______________________________________ acknowledge that on _____________________________

Patient Name (print) Date

__________________________________ / __________________________ / ___________________________

Paramedic License Service Provider Agency

Explained my condition to me and advised me of some of the potential risks and/or complications which could or would arise from refusal of medical care. I have also been advised that other unknown risks and/or complications are possible up to and including the loss of life or limb. Being aware that there are known and unknown potential risks and/or complications, it is still my desire to refuse the advised medical care.

☐ All Care Refused

☐ Specific Care Refused: ____

☐ *Person/Patient Refused to Sign*

I do hereby release EMS personnel from all liability resulting from any adverse medical condition(s) caused by my refusal of the recommended medical care.

Patient Name (print): ____________________________ Patient Signature: _________________________

Patient/Guardian Signature: _______________________ Relationship: ____________________________

Witness Name: _________________________________ Witness Signature: ________________________

Paramedic Name: _______________________________ Paramedic Signature:_______________________

Comments: ____

____

NAPA COUNTY EMS AGENCY

Servicios Médicos de Emergencia del Condado de Napa

RAS/AMA FORM

Rehúso a una Evaluación/Tratamiento/Transporte Formulario

Date: _______________ Unit #: ___________ Incident/Dispatch #: ______________________

El Personal de Apoyo Vital Básico / Apoyo Vital Avanzado (BLS/ALS Personnel)

Sección I – Si es dado de alta en el lugar del Incidente

☐ *Person/Patient Refused to Sign*

Ni yo (ni mi hijo, según corresponda) ni el asistente de EMT(s) y/o paramédico(s) creen que tengo una enfermedad o lesión (herida) que requieran EMS tratamiento médico y transporte. Estoy de acuerdo que no es necesario una nueva EMS evaluación, tratamiento o transporte en este momento. Yo entiendo que si cambio de opinión o si mi condición empeora y me gustaría más tratamiento/transporte por el sistema de Servicios Médicos de Emergencia (SME) puedo llamar al 911 y ellos responderán.

Nombre del Persona/Paciente: ____________________ (Person/Patient Name) Firma del Persona/Paciente: ____________________ (Person/Patient Signature)

Número de Teléfono del Paciente: ________________ (Patient Phone Number) Correo Electrónico del Paciente: ________________ (E-mail Address)

Firma del Persona/Padre Guardián: ____________________ (Person/Parent Guardian Signature) Parentesco: ____________________ (Relationship)

Nombre del Testigo: ____________________ (Witness Name) Firma del Testigo: ____________________ (Witness Signature)

Nombre del Paramédico/EMT: ____________________ (Paramedic Name) Firma del Paramédico: ____________________ (Paramedic Signature)

El Personal de Apoyo Vital Avanzado Solamente (ALS Personnel Only)

Sección II– Contra el Consejo Médico (CCM)- Rehúso a una Evaluación/Tratamiento/Transporte

Yo, ______________________________ reconozco que el ______________________________
Nombre Del Paciente (Patient Name) Fecha (Date)

______________________ / ______________________ / ______________________
Paramédico (Paramedico) Licencia (License) Agencia de Servicios de Proveedores (Service Provider Agency)

Se me explicó mi condición y se me aconsejo sobre algunos de los riesgos posibles y/o complicaciones que podrían surgir por no aceptar el cuidado médico que se me ofrece. También se me aviso de otros riesgos y/o complicaciones que en este momento son desconocidos como pudiera ser la perdida de una de mis extremidades y posiblemente hasta la vida. Estoy consciente de que hay riesgos y/o complicaciones conocidas y desconocidas, aun rehusó el consejo médico que se me sugiere.

☐ *Person/Patient Refused to Sign*

- ☐ Rehusó Todo el Cuidado Médico (All Care Refused)
- ☐ Rehusó el Cuidado Especifico (Specific Care Refused): ______________________________

Yo mantendré libre de toda responsabilidad al personal de Servicios Médicos de Emergencia (SME) por cualquier condición(es) médica que resulte a causa de no haber seguido las recomendaciones de recibir cuidado médico sugerido.

Nombre del Paciente: ____________________ (Patient Name) Firma del Paciente: ____________________ (Patient Signature)

Firma del Padre/Guardián: ____________________ (Parent/Guardian Signature) Parentesco: ____________________ (Relationship)

Nombre del Testigo: ____________________ (Witness Name) Firma del Testigo: ____________________ (Witness Signature)

Nombre del Paramédico/EMT: ____________________ (Paramedic Name) Firma del Paramédico: ____________________ (Paramedic Signature)

Commentaries (comments): ____

____

SPANISH

NAPA COUNTY EMS AGENCY

Servicios Médicos de Emergencia del Condado de Napa

RAS FORM

Rehúso a una Evaluación/Tratamiento/Transporte Formulario

Date: _______________ Unit #: ___________ Incident/Dispatch #: ______________________

BLS/ALS Personnel

☐ *Person/Patient Refused to Sign*

Section I - Release at Scene (RAS)

Neither I nor the attending EMT(s) and/or paramedic(s) believe that I (or my child) have an illness or injury requiring EMS system transport. I agree that I *do not* need further EMS assessment, treatment and *do not* require EMS system transportation at this time. I understand that if I change my mind or if my condition changes and I wish further treatment / transportation by the EMS system; I can call 911 and they will respond.

Person/Patient Name (print): ______________________ Person/Patient Signature: ________________________

Person/Patient Phone Number: ___________________ E-mail Address: _______________________________

Person/Patient Guardian Signature: ________________ Relationship: __________________________________

Witness Name: _________________________________ Witness Signature: _____________________________

EMT/Paramedic Name: __________________________ EMT/Paramedic Signature:_______________________

E

El Personal de Apoyo Vital Básico / Apoyo Vital Avanzado (BLS/ALS Personnel)

☐ *Person/Patient Refused to Sign*

Sección I – Si es dado de alta en el lugar del Incidente

Ni yo (ni mi hijo, según corresponda) ni el asistente de EMT(s) y/o paramédico(s) creen que tengo una enfermedad o lesión (herida) que requieran SME tratamiento médico y transporte. Estoy de acuerdo que no es necesario una nueva SME evaluación, tratamiento o transporte en este momento. Yo entiendo que si cambio de opinión o si mi condición empeora y me gustaría más tratamiento/transporte por el sistema de Servicios Médicos de Emergencia (SME) puedo llamar al 911 y ellos responderán.

Nombre del Paciente: ____________________________ Firma del Paciente: _____________________________
Patient Name Patient Signature

Número de Teléfono del Paciente: _________________ Correo Electrónico del Paciente:____________________
Patient Phone Number E-mail Address

Firma del Padre/Guardián: _______________________ Parentesco: ___________________________________
Parent/Guardian Signature Relationship

Nombre del Testigo: ____________________________ Firma del Testigo: ______________________________
Witness Name Witness Signature

Nombre del EMT/Paramédico:______________________ Firma del EMT/Paramédico:______________________
EMT/ Paramedic Name EMT/Paramedic Signature

S

Comments/Commentarios: ____

____

____

____

____

RAS ONLY (ENGLISH ~ SPANISH)

Determination of Death

ADMINISTRATIVE POLICY 7006

7006.1 PURPOSE

To identify criteria where prehospital providers can terminate or withdrawal resuscitative efforts.

7006.2 PROCEDURE

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. Pulseless, apneic patient with injury not compatible with life (e.g. blunt traumatic arrest) who is in asystole or IVR.
   e. Penetrating trauma patients who are pulseless and apneic, when the time from “on-set of cardiac arrest to arrival at the trauma center” will be greater than ten ($\geq$ 10) minutes.
2. **Declared MCI's**
   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: Muscular stiffness following death, progressing from the upper to lower body, first detectable in the short muscles. Determination of rigor mortis should include immobility of the jaw muscles 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).
2. **Do Not Resuscitate Order / POLST**
   a. EMS personnel will at times encounter patients who clearly should not receive appropriate resuscitation yet who do not have all of the necessary documentation for withholding resuscitation. In such situations the paramedic shall make base station contact and communicate pertinent patient medical information. The base station will issue appropriate orders which may include the limitation or termination of resuscitation.
   b. If EMS personnel are unsure about the appropriate level of intervention the base hospital physician shall be consulted.
   c. 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.
   d. 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.
   e. 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.

f. 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.

g. It is vital for the continuity of appropriate care the POLST form accompany the patient to the receiving facility.

h. 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:

1. Do not initiate CPR.
2. Terminate CPR if already in progress.
3. If there is any doubt whether to start or withhold CPR, first responders should start CPR and await the arrival of an ALS provider.
4. Notify appropriate law enforcement agency and/or coroner. A completed Patient Care Report must be left at the scene or faxed within three (3) hours to the coroner.
5. Ensure scene security until released by law enforcement representative.
6. Base contact is NOT necessary.
7. 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).

C. **Consideration**: Strong family insistence on resuscitation may lead to base contact in cases where it otherwise may not be indicated.

7006.3 DEATH WITH DIGNITY

A. A terminally ill and competent patient may elect to obtain medications to expedite their death so that it may occur at a time and place of their choosing. They must satisfy extensive and stringent requirements as required by California law to obtain an Aid-In-Dying Drug and complete a "Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner."

B. The following guidelines are provided for EMS personnel when responding to a patient who has self-administered an aid-in-dying drug.

1. Provide supportive measures according to patients' wishes whenever possible.
2. Withhold resuscitative measures if patient has taken a medication intending to expedite their death.
3. The patient may withdraw or rescind their request for an aid-in-dying drug at any time, regardless of the patient's mental state.
4. Family members may be at the scene of a patient who has self-administered an aid-in-dying drug. If conflict arises as to resuscitation efforts, inform the family that only supportive measures will be provided according to the patient's wishes.
5. EMS field personnel are encouraged to consult with their base hospital whenever necessary.
6. All circumstances surrounding the incident must be documented on the EMS patient care report. If EMS field personnel are unable to obtain a copy of the End of Life Options Act Final Attestation form, the following shall be documented on the patient care report:

a. Presence of the End Of Life Option Act Attestation.

b. Date of order.

c. Name of physician who signed the form.

7. If a patient dies at home and the patient is not under the care of Hospice, law enforcement must be notified. In all cases, The Napa County Coroner must be notified.

7006.4 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.
2. Refer to Cardiocerebral Resuscitation Guideline # 7014 if applicable.

B. Termination of resuscitation during transport: (In general, cardiac arrest patients should not be transported).

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.

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.

7006.4 DOCUMENTATION

A. A completed PCR must be left with the body or faxed within three (3) hours to the coroner.

B. If ALS interventions were initiated prior to the determination of death, ECG strips showing date, time, patient name, paramedic ID#, and asystole / IVR in two (2) contiguous leads must be included with the PCR.

7006.5 PROCEDURE FOR AN ARREST IN A PUBLIC FORUM (County Fairgrounds, etc.)

A. 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.

B. Exceptions include:

1. Suspected crime scene.
2. Decapitation.
3. Incineration.

C. Should determination of death be made during transport, an immediate termination of Code 3 transport shall occur. The patient will then be transported to the appropriate facility, either a hospital, or an authorized on-site medical facility. All other determination of death procedures shall apply.

D. In the event the patient expires on scene, refer to section 7006.4 (above)

Patient Destination / Point of Entry

ADMINISTRATIVE POLICY 7007

7007.1 PURPOSE AND DEFINITION

A. Patients shall be transported to the nearest appropriate California licensed emergency receiving facility which is equipped, staffed, and prepared to receive emergency cases and administer emergency medical care appropriate to the needs of the patient as set forth herein.

NOTE: This does not preclude the transport of a patient to other facilities during the course of non-emergency inter-facility transfers (IFTs) or scheduled non-emergency transports at the request or direction of the patient's private physician.

B. Transport time: The interval of time between the time vehicle / aircraft leaves the scene with a patient until the time of arrival at the receiving facility.

7007.2 APPROVED RECEIVING FACILITIES

A. Approved receiving facilities within Napa County include:

Facility Name	Status	Location
Queen of the Valley Medical Center (QVMC)	Basic	Napa
St Helena Hospital (SHH)	Stand by	St Helena

B. Refer to "Facilities" section of the policy manual for more information on receiving hospitals.

7007.3 DESTINATION DETERMINATION – GENERAL CONSIDERATIONS

A. The destination for patients shall be based upon the clinical capabilities of the receiving hospital and the patient's condition. Although the criteria listed below are the primary factors for determining the appropriate destination for patients, when the patient's condition is unstable or life threatening, the patient should be transported to the closest appropriate hospital (based on its clinical capabilities).

B. The following factors may also be considered in determining patient destination:

1. Patient request.
2. Family request.
3. Patient's physician request or preference.

7007.4 DESTINATION FOR MAJOR TRAUMA PATIENTS

A. Major trauma patients (e.g. those patients meeting trauma triage criteria) shall be transported as follows:

1. Less than (<) sixty (60) minutes transport time to a trauma center - patients shall be transported to the closest appropriate trauma center.

2. Greater than (>) sixty (60) minutes transport time from a trauma center - patients may be transported either to the closest hospital with an emergency department (ED) or directly to the closest appropriate trauma center upon base hospital physician direction.

NOTE: Special consideration for safety and timeliness of transport should be exercised when utilizing an EMS aircraft within other urban density areas located within Napa County EMS system.

B. Notwithstanding the above, patients with the following conditions shall be transported to the closest appropriate emergency department:

1. Pulseless, non-breathing following trauma.

2. Unstable or unmanageable airway.
3. Overall transport time to trauma center greater than (>) sixty (60) minutes may be waived upon direct order of base hospital physician.
4. Base hospital physician order.

7007.5 APPROVED TRAUMA CENTERS

A. The following factors shall be considered in determining the appropriate local trauma center for patient transports:

B. **QVMC** - Napa (Level III Trauma Center) - capable of receiving all trauma with 24/7 neurosurgical capabilities (Helipad On-Site).

C. Other trauma centers within the Bay Area / Northern California region that may be used when appropriate (with base hospital direction) include:

1. **Santa Rosa Memorial Hospital** (SRMH) Santa Rosa (Level II Trauma Center) - capable of receiving all types of trauma patients (Helipad On-Site).
2. **North Bay Medical Center** (NBMC) Fairfield (Level III Trauma Center) - capable of receiving all types of trauma patients (Helipad On-Site).
3. **Kaiser Vacaville** (KVV) Vacaville (Level II Trauma Center) - capable of receiving all types of trauma patients (Helipad On-Site).
4. **John Muir Medical Center** (JMMC) - Walnut Creek (Level II) - capable of receiving all types of trauma patients (Helipad On-Site).
5. **Marin General Hospital** (MGH) - Larkspur (Level III) - capable of receiving all trauma with 24/7 neurosurgical capabilities (No On-Site Helipad).
6. **San Francisco General** (SFG) - San Francisco (Level I) - capable of receiving all types of trauma patients (No On-Site Helipad).
7. **UC Davis** (UCD) - Sacramento (Level I B adult & pediatric) - capable of receiving all types of trauma patients (Helipad On-Site).
8. **Eden Hospital** (Eden) - Castro Valley (Level II) - capable of receiving all types of trauma patients (Helipad On-Site).
9. **Highland Medical Center** (Highland) - Oakland (Level II) - capable of receiving all types of trauma patients (No On-Site Helipad).
10. **Enloe Hospital** (Enloe) - Chico (Level II) - capable of receiving all types of trauma patients (Helipad On-Site).

7007.6 DESTINATION FOR PEDIATRIC TRAUMA PATIENTS

A. Pediatric patients (less than [<] fifteen [15] years of age) with major trauma may be transported by EMS helicopter to an approved pediatric trauma center - Oakland Children's Hospital (CHO) or UCD with the following exceptions:

1. Greater than (>) sixty (60) minutes transport time to CHO / UCD unless otherwise authorized by base hospital.

NOTE: Special consideration for safety and timeliness of transport should be exercised when utilizing an EMS aircraft within other urban density areas located within Napa County EMS system.

B. Notwithstanding the above, pediatric patients with the following conditions shall be transported to the closest appropriate emergency department:

1. Pulseless, non-breathing following trauma.
2. Unstable or unmanageable airway.

3. Rapidly deteriorating vital signs.
4. Overall transport time to pediatric trauma center greater than (>) sixty (60) minutes may be waived upon direct order of base hospital physician.
5. Base hospital physician order.

7007.7 DESTINATION FOR BURN PATIENTS

A. Consider direct transport to UCD Medical Center for major / critical burns (See Treatment Guideline # 8009 / 9602 Adult and Pediatric ALS / BLS Burns).

B. Base hospital contact is required in these instances.

C. EMS Aircraft should be considered

Suspected Elder & Dependent Adult Reporting

ADMINISTRATIVE POLICY 7009

7009.1 PURPOSE

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

7009.2 POLICY

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.
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.
3. When an elder or a dependent adult tells the reporter that he or she has experienced behavior constituting physical abuse.

B. The law encourages mandated reporters to voluntarily 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. Reports made under this law are confidential. The identity of all persons making reports of elder or dependent adult abuse is also confidential. This information will be shared only between the investigating and licensing agencies, with the district attorney in a criminal prosecution resulting from the report, by court order, or when the reporter waives the right to remain anonymous.

D. When two (2) or more persons who are required to report are present and jointly have knowledge of a known or suspected instance of abuse of an elder or dependent adult, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by the selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall hereafter make the report.

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

F. Mandated reporters who report suspected cases of elder or dependent adult abuse in good faith, have absolute immunity, both civilly and criminally, for making a report of physical abuse of an elder or dependent adult. This includes taking of photographs of the victim and surroundings to submit with the report.

G. Failure to make a mandatory report of suspected physical abuse of an elder or dependent adult is a misdemeanor.

7009.3 REPORTING PROCEDURES

A. Reports of physical abuse are to be made immediately, or as soon as possible, by telephone:

Adult Protective Services at (707) 253-4398 or (888) 619-6913

B. If you need help in resolving problems or have questions regarding Skilled Nursing Facilities or Assisted Living Facilities, contact:

Napa Long Term Care **Ombudsman** Program at (707) 255-4236 or (800) 231-4024

7009.4 VERBAL REPORT

A. Reports are to include the following information:

1. The name, address, telephone number and occupation of the person making the report.
2. The name, address, and age of the elder or dependent adult.
3. Date, time, and place of the incident.
4. Other details, including the reporter's observations and beliefs concerning the incident.
5. Any statement relating to the incident made by the victim.
6. The name(s) of any individual(s) believed to have knowledge of the incident.
7. The name(s) of the individual(s) believed to be responsible for the incident and their connection to the victim.

7009.5 WRITTEN REPORT

The report of suspected dependent adult / elder abuse must be completed and submitted to the agency initially contacted within two (2) working days of the verbal report.

7009.6 VOLUNTARY REPORTS

Reports of mental or financial abuse, neglect, isolation or abandonment of an elder or dependent adult by that person's caretaker may be made by verbal or written report.

7009.7 REPORT INSTRUCTIONS

A. The following instructions are to be followed when completing a report:
   1. Complete a form for each incident and each victim of suspected elder or dependent adult physical abuse.
   2. Fill out the form as completely and clearly as possible using lay terminology.
   3. If any item of information is unknown, write 'unknown' beside the item.

B. Section A - Reporting Party:
   1. The person initiating the report must complete this section. It must include the reporting person's name, place of employment, and employment phone number.
   2. For legal purposes, the date of the written report must be completed.
   3. The signature of the reporting party is required in this section.

C. Section B - Report Made To:
   1. Record the name of the person and agency to whom a verbal report was first made. This person will be receiving the written reports.
   2. When the report was made to more than one (1) agency, the contact person(s) for the additional agencies should be listed in the comment section.
   3. The date and time of the verbal report must be recorded to provide legal proof of the verbal report.

D. Section C - Victim:
   1. Enter as much information as possible.
   2. If the birth date is unknown, enter the approximate age.

E. Section D - Incident Information:
   1. Record the date, time, and place of incident.
   2. Check the appropriate box indicating how the person filing the report became aware of the incident.
   3. If the incident occurred in an out of home care setting, check the appropriate box.
   4. When more than one (1) type of abuse is suspected, check all that apply.

F. Section E - Comments:

   1. Write objectively.
   2. Quote statements made by the victim or guardian.
   3. Document the incident as it was told by each person (use extra paper if necessary).
   4. Indicate circumstances that may have contributed to the abusive / neglectful situation (i.e. handicapped, bedridden, lack of resources).

7009.8 DISTRIBUTION INSTRUCTION

A. Send the original report to the elder protective agency previously contacted by phone.

B. Send a copy of the report to:

   900 Napa County APS
   Combs St., Suite 257
   Napa, CA 94559

   The reporting party should retain one (1) copy of the original report.

Suspected Child Abuse Reporting

ADMINISTRATIVE POLICY 7010

7010.1 PURPOSE

To provide guidelines for the identification of suspected child abuse / neglect and the procedure for reporting such suspicions by prehospital personnel.

7010.2 DEFINITIONS

Agencies authorized to accept mandated reports: Police Department, Sheriff's Department, and Child Protective Services (CPS). School district police and security departments are not included.

Child: Any person under the age of eighteen (18).

Mandated reporter: Any healthcare practitioner, childcare custodian, or employee of a child protective agency. This includes EMTs and paramedics.

Neglect: The negligent failure of a parent or caretaker to provide adequate food, clothing, shelter, medical / dental care, or supervision.

Physical abuse: A physical injury, including death, to a child that appears to have been inflicted by other than accidental means.

Sexual abuse: Sexual assault on or the exploitation of a minor. Sexual assault includes: Rape, rape in concert (aiding or abetting or acting in concert with any person in the commission of a rape), incest, sodomy, oral copulation, penetration of genital or anal opening by a foreign object, and child molestation. It also includes lewd or lascivious conduct with a child under the age of fourteen (14) years, which may apply to any lewd touching if done with the intention of arousing or gratifying the sexual desire of either the person involved or the child. Sexual exploitation includes conduct or activities related to pornography depicting minors and promoting prostitution by minors.

7010.3 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 CPS and law enforcement.

B. California Penal Code, Sections 11166 and 11168, requires that mandated reporters promptly report all suspected non-accidental injuries, sexual abuse, or neglect of children to local law enforcement and/or to CPS.

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. Children under the age of four (4), especially less than six (6) months, are at highest risk.

D. 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. They are required to sign a statement acknowledging their understanding of this requirement. Any person who fails to report as required may be punished by six (6) months in jail and/or a $1,000 fine.

E. 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 CPS immediately or as soon as practically possible by telephone and shall complete the suspected child abuse report form within thirty-six (36) hours.

F. When two (2) or more mandated reporters are present at scene and jointly have knowledge of a known or suspected instance of child abuse / neglect, the telephone report can be made by a selected member and a single written report may be made and signed by the selected member of the reporting

team. Any member who has knowledge that the designated reporter failed to uphold their agreement, shall thereafter make the report. If the paramedics are not selected as the designated reporter, they shall document the name and agency of the appointed team member on the patient care Report to indicate that the reporting obligation has been met.

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

7010.4 POLICY REPORTING PROCEDURES

A. The primary purpose of the Department of Justice (DOJ) suspected child abuse report form SS 8572 is to make all agencies aware of possible abuse / neglect. This will lead to a thorough investigation and protection of the child. In order to facilitate this process 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.

B. To make a verbal report to CPS, call the 24-hour child abuse hotline for Napa (707) 253-4261 or 1 (800) 464-4216.

C. This should be done as soon as possible. It is recommended that the child abuse report form be completed prior to making the verbal notification. Prehospital care providers should be aware of their local law enforcement reporting procedures and telephone numbers for notification.

D. The suspected child abuse 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 to:

    Napa County CPS
    P O Box 815
    Napa, CA 94559

E. The following should be documented on the EMS patient care report:

    1. The name of the CPS social worker and/or name, department and badge number of the law enforcement officer.
    2. Time of notification.
    3. Disposition of child if not transported.

7010.5 REPORTING INSTRUCTIONS

A. Complete DOJ Suspected Child Abuse Report form, SS 8572, for all suspected cases of child abuse / neglect reported. The report shall be filled out as completely and clearly as possible using lay terminology.

    1. Section A - Case Identification:
        a. To be completed by investigating agency authorized to receive the report.
    2. Section B - Reporting Party:
        a. To be completed by the person who initiated the report. Include name, title, address, phone number (include area code), date of report and signature.
    3. Section C - Report Sent To:
        a. Check the appropriate box that identifies the agency designated to receive the report.
        b. Enter the name and address of the agency to which the report is being sent.
        c. Enter the name and phone number of the official at the designated agency and the date and time that contact occurred.
            1. The date and time are extremely important as they provide legal proof of verbal report.
    4. Section D - Involved Parties:

a. Victim: Enter the name, address, physical data, present location and phone number where victim is located (attach additional sheets if multiple victims). If the birth date is not known, enter the approximate age.

b. Siblings: Enter the name and physical data of siblings living in the same household as the victim. It is important to indicate when there are other children in the home even if no definitive information is available.

c. Parents: Enter the names, physical data, addresses and phone numbers of father / stepfather and mother / stepmother. If information is unavailable, document "information not available."

5. Section E - Incident Information:

   a. Enter the date, time and place where the incident occurred or was observed and check the appropriate boxes.

   b. Check the type of abuse (there may be more than one (1) type of abuse).

   c. Write objectively; carefully describe all injuries and evidence of sexual assault, if applicable.

   d. When obtaining information from the individual who is witness to the alleged abuse / neglect, attempt to use direct quotes when describing the incident.

   e. If the parent, guardian or person accompanying the child changes his / her description of the occurrence, document both versions (use extra paper if needed).

   f. If known, document prior incidents involving the victim.

   g. When documenting neglect situations, stress the endangerment of the child. Endangerment is a key factor in the timely investigation of these cases.

   h. Indicate circumstances that may contribute to an abusive / neglectful situation (e.g. handicapped child or parent, substance abuse, spousal abuse, lack of resources, etc.).

7010.6 DISTRIBUTION

Retain the yellow copy of the Suspected Child Abuse Report form SS8572 for your records and submit the top three (3) copies (white, blue and green) to the applicable child protective agency.

NAPA COUNTY EMS AGENCY

Unexpected Infant / Child Death

ADMINISTRATIVE POLICY 7011

7011.1 PURPOSE

To establish routine procedures to assist EMS personnel with calls involving the death of children in the prehospital setting. The goals of these procedures include: minimizing the stress placed on parents and other family members, providing avenues for support to parents and families, and preventing scene contamination and disruption.

7011.2 PROCEDURE

A. Determine whether to perform further resuscitation measures:
   1. If patient does not exhibit lividity or rigor and there is no authorized DNR present, proceed with CPR and follow applicable resuscitation treatment policies.
   2. If patient exhibits lividity and rigor, do not resuscitate or transport. If in the EMS personnel's judgment, transport will be beneficial due to scene conditions, transport may be initiated.

B. Provide supportive measures for parents and siblings:
   1. Do not express your assumptions or judgments regarding the cause of death.
   2. Explain the resuscitation process, transport decision and further actions to be taken by hospital personnel or the medical examiner.
   3. Use the child's first name.
   4. Allow parent(s) to see the child and say goodbye.
   5. Maintain a supportive, professional attitude no matter how the parent(s) react.
   6. Whenever possible, be responsive to parental requests.
   7. Be sensitive to ethnic and religious needs or response and make allowances for them.
   8. Assist family with contacting grief support, if available.

C. Obtain a patient history. Use a non-judgmental approach. Ask open ended questions as follows:
   1. When was your child well? What has changed or occurred since then?
   2. Has the child been sick?
   3. Who found the child? Where?
   4. Has the child been moved?
   5. What time was the child last seen breathing?
   6. Was the child taking any medications?
   7. What was done after the child was discovered?
   8. When did the child eat last?

7011.3 DOCUMENTATION

Thoroughly document all findings obtained during history gathering, patient assessment, and scene examination.

NAPA COUNTY EMS AGENCY

Apparent Life Threatening Event (ALTE)

ADMINISTRATIVE POLICY 7012

7012.1 PURPOSE

To increase awareness of the risks of apparent life threatening events (ALTE) and to encourage the transport of patients who have suffered symptoms of an ALTE.

7012.2 DEFINITION

An ALTE: Is an episode that frightens a child's caretaker and includes two (2) or more of the following:

A. Apnea.

B. Color change (cyanosis or pallor).

C. Marked change in muscle tone (limpness).

D. Choking or gagging.

These events usually occur in infants less than twelve (12) months old, but ALTE should be suspected in any child less than two (2) years of age who displays these symptoms.

Most patients will appear stable and may have a normal physical exam by the time field personnel arrive. Despite their appearance, the majority of these patients will be later diagnosed with conditions that may require further medical care.

7012.3 TREATMENT

A. Assume the history given is accurate.

B. Obtain a description of the severity, nature, and duration of the event.

C. Obtain a complete medical history. Check for:

1. Any known chronic illnesses.
2. Evidence of seizure activity.
3. Current or recent infections.
4. History of gastro-esophageal reflux (spitting, vomiting).
5. Inappropriate mixture of formula.
6. History or evidence of recent trauma.
7. Medications (current and recent including over the counter drugs).
8. Associated events (eating, crying, etc.).

D. Complete a comprehensive physical exam. Include evaluation of the child's appearance, skin color, and interaction with the environment and parents. Check for any evidence of trauma.

E. Treat any identifiable injuries / illnesses.

F. Transport.

G. If the parent or guardian refuses medical care and/or transportation, make base contact with the base hospital physician prior to completing an AMA form and leaving the scene.

Stun Gun / Foreign Body Removal

ADMINISTRATIVE POLICY 7013

7013.1 PURPOSE

To provide guidelines for treatment and disposition of patients who have sustained a stun gun/TASER exposure.

7013.2 PRINCIPLES

A. Field personnel have no training and experience in the removal of foreign bodies.

B. Many patients who have been barbed and/or received an electrical shock from a stun gun/TASER, or similar electroshock devices may have ingested unknown substances or may have been exposed to drugs or toxins.

C. Deaths have been associated with stun gun / TASER use.

7013.3 PROCEDURE

A. EMS personnel are not authorized to remove the barbed electrodes from individuals in police custody, regardless of how superficial the barbs are in the body.

B. When EMS personnel are requested to evaluate individuals who have been barbed and/or received an electrical shock from a stun gun / TASER, they will perform a field evaluation **and** will transport to the closest appropriate medical facility for additional evaluation.

NAPA COUNTY EMS AGENCY

Cardiac Arrest and CCR Reporting

ADMINISTRATIVE POLICY 7015

7015.1 PURPOSE

To disseminate accurate information and instructions that will promote the highest success at gathering cardiac arrest data.

7015.2 PRINCIPLES

To facilitate the gathering, reporting and quality improvement activities of all cardiac arrest resuscitations. This policy applies to all cardiac arrest cases managed by ALS providers in Napa County.

7015.3 POLICY

All Life-Pak (LP15 & LP12s) monitor / defibrillators shall be changed from Lead 2 view / mode on the screen to PADS mode by pressing the “LEAD” button once after applying the defibrillation electrodes to the patient. The monitor shall remain in “PADS” mode if CCR is ongoing.

7015.4 PROCEDURES

A. In all cardiac arrest cases that are attended by ALS providers, paramedics shall:
   1. On arrival, transfer pads from the BLS defibrillator to the LP15/LP12 by unplugging them from the AED and plugging them back into the ALS Monitor (if applicable).
   2. Power ON the LP15/LP12 and change from Lead 2 (the default view) to PADS mode by pressing the “LEAD” button once.
   3. The LP15/LP12 shall remain in “PADS” mode as long as CCR is ongoing.
   4. If return of spontaneous circulation (ROSC) is achieved, attach the 12-Lead and move the LP15/LP12 out of “PADS” mode and into “LEAD 2” by pressing the LEAD button once more.
   5. Place the LP15/LP12 back in the “PADS” mode if the patient loses ROSC and CCR is restarted.
   6. Enter the patients name in the LP15/LP12 record.
   7. Transmit the completed case to the site: “CODE STAT” as soon as patient care has been transferred or ended and before you have turned the monitor off.

NOTE: No cardiac arrest CCR data is collected if the LP15/LP12 is out of the “PADS” mode.

7105.5 CCR REPORTING PROCEDURE

A. The on-duty crew will notify the AMR operations supervisor (S3) to advise a report was sent to “Code Stat”.

B. S3 will then annotate the data and will email a CCR report as soon as possible, with the goal being within 3-4 hours to the following persons:
   1. The on-scene personnel, specifically all ALS personnel.
   2. The shift’s captain / supervisor or the applicable station.
   3. Clinical care coordinators / EMS Specialist from each respective agency.

C. Providers will utilize CCR data in teaching and quality assurance for BLS and ALS personnel.

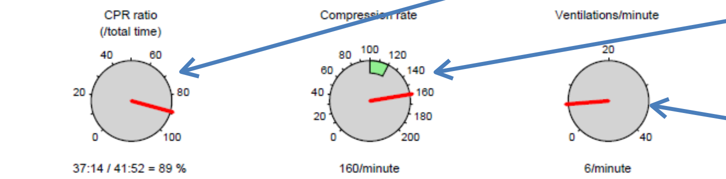
D. Napa County EMS Agency shall track aggregate data only.

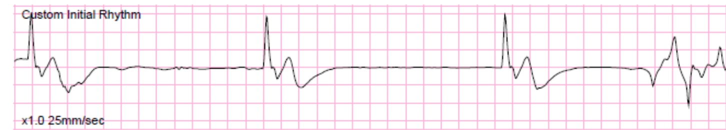
CPR report

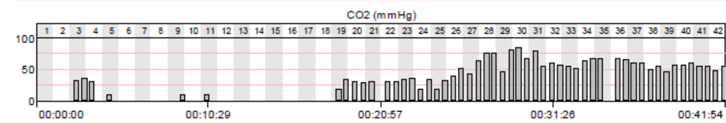
Device Type:	Duration:
Power On:	Incident ID:
CPR Annotations Edited:	Statistical Parameters:
Device Configuration:	

PHYSIO CONTROL

*Times have been adjusted by the system







Summary

Compression count	= 5691	Longest compression pause	= 0:18
Pauses over 10 sec	= 11		

Ventilation	AED-prompted CPR period	Shock
Chest compression	AED Analysis	ROSC (user annotated)

CPR QUIK-VIEW

	CPR ratio, %	Compr. rate	Vent. /min
0:00	90	162	--
1:00	83	167	6
2:00	74	167	6

Interval Statistics

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Compression Ratio Chest Compressions were performed 89% of the time

Compression Rate When compressions were performed, they were performed at an average rate of 160/minute

Ventilations Performed at a rate of 6/min average

Initial Rhythm When Monitor Placed

ETCO2 Trend by Minute

Summary of Reported Items

Key of Symbols

Each Compression Noted by a Vertical Red Line

Each Respiration Noted by a Blue Triangle

Eaih Shock Noted with a lightning bolt and then summarized at the bottom with preand post pause times

Goals

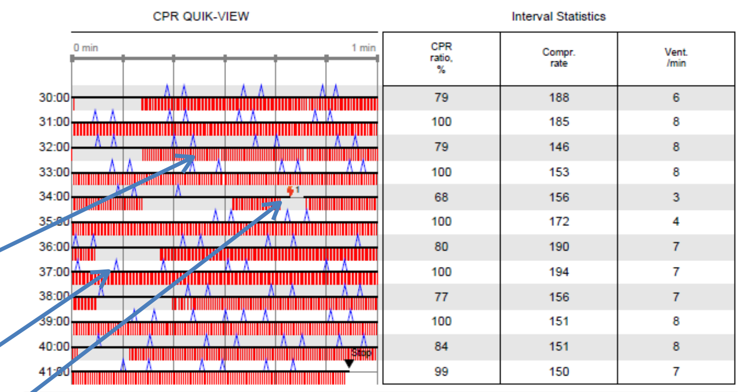
- Compression Ratio >80%
- Compression Rate 100-110
- ETCO2 Monitoring in Place
- Minimal Pauses in CPR
- CPR Performed Closely Around Shocks

CPR report

Device Type:	Duration:
Power On:	Incident ID:
CPR Annotations Edited:	Statistical Parameters:
Device Configuration:	

PHYSIO CONTROL

*Times have been adjusted by the system


CPR QUIK-VIEW

Interval Statistics

	CPR ratio, %	Compr. rate	Vent. /min
30:00	79	188	6
31:00	100	185	8
32:00	79	146	8
33:00	100	153	8
34:00	68	156	3
35:00	100	172	4
36:00	80	190	7
37:00	100	194	7
38:00	77	156	7
39:00	100	151	8
40:00	84	151	8
41:00	99	150	7

Shock	Time	Energy	Pre-shock CPR pause	Post-shock CPR pause
1	34:43	200J	0:02	0:03

1/29/2014 3:52:10 PM Organization Name Page 3 of 3

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Key Points For Obtaining Good Data

- Ensure LP-15 is in "Paddles" Mode
- LP-15 Should be showing ECG Strip and CO2 waveforms
- Make sure you transmit to "CodeSTAT" site when complete!

NAPA COUNTY EMS AGENCY

Monitoring Thoracostomy Tubes

ADMINISTRATIVE POLICY 7016

7016.1 PURPOSE

To monitor thoracostomy tubes previously established.

7016.2 EQUIPMENT

A. Firm plastic thoracostomy tube.

B. Negative pressure drainage receptacle attached to the thoracostomy tube to form a closed drainage system.

C. Rubber-tipped clamp.

7016.3 PRECAUTIONS

A. Keep drainage receptacle below level of chest to prevent drained fluid from re-entering pleural space.

B. Keep drainage tubing in view.

C. Do not permit dependent loops of kinks to form, as this will increase pleural pressure, formation of clots or interference with the flow of drainage.

D. Keep dressing at insertion site secure to prevent air entering the pleural space.

E. Maintain aseptic technique.

F. Do not disconnect drainage system or puncture tubing.

G. Tape all connections securely to prevent violation of sterility and loss of negative drainage pressure.

H. Avoid pulling on thoracostomy tube to prevent accidental dislodging of the tube.

7016.4 COMPLICATIONS

Complications require immediate intervention. Contact the base hospital to report the problem, the intervention taken and to request further assistance.

7016.5 TUBE DISLODGEMENT OR WITHDRAWAL

A. If accidental withdrawal of tube occurs, place occlusive dressing over insertion site.

B. If the tube becomes dislodged or a malfunction with air leak occurs in the system, clamp the tube close to the chest wall and observe for signs and symptoms of tension pneumothorax.

7016.6 DRAINED FLUID RE-ENTERS PLEURAL SPACE

If drained fluid re-enters the pleural space, place receptacle below level of chest to facilitate gravity drainage.

7016.7 HEMORRHAGE THROUGH TUBE

If hemorrhage occurs through chest tube, observe for signs and symptoms of shock and refer to Cardiogenic Shock Guideline # 9109.

7016.8 RECEPTACLE FILLS IN TRANSIT

A. If drainage receptacle fills in transit:

   1. Keep in position.
   2. Do not remove or elevate.

Naloxone Administration by Law Enforcement (NALE)

EMS ADMINISTRATION 7017

7017.1 PURPOSE

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

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

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

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

7017.2 AUTHORITY

A. California Health and Safety Code, Div. 2.5, 1797.182, 1797.183

B. California Code of Regulations, Title 22, Div. 9, § 100017

7017.3 DEFINITIONS

A. <u>Opioid overdose</u>: Opioid (narcotic) overdose is the result of an individual's intentional/accidental exposure to narcotic pharmacological substance(s), e.g. heroin, morphine, oxycodone, hydrocodone, fentanyl, methadone, opium, Dilaudid, and Demerol.

B. <u>Naloxone (Narcan)</u>: Naloxone is an antagonist <u>ONLY</u> to opioid narcotics and is not effective with other medications. It will <u>NOT</u> reverse non-opioid drug exposures, e.g. benzodiazepines, sedative hypnotics, alcohol or other class of drugs.

7017.4 POLICY

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:

A. Name, address and phone number of agency.

B. A letter of intent to utilize naloxone, expressing willingness to abide by all Napa County EMS Agency policies, procedures and requirements.

C. A description of the training related to the administration of naloxone by law enforcement first responders.

D. Name and procedure of training officer/coordinator or other designated individual, responsible for:

1. 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.
2. Proper and efficient deployment of naloxone.
3. Replacement of naloxone after use.
4. Record of documented use, restocking, damaged and unusable or expired naloxone.
5. Reporting the use of naloxone administration to Napa County EMS Agency using the standard reporting form.

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

F. 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.

G. Name of the Agencies Liaison to Napa County EMS Agency. All questions and correspondence shall be directed to this person.

7017.5 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.

7017.6 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.

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.

NAPA COUNTY EMS AGENCY

Naloxone Administration by Law Enforcement (NALE)

APPLICATION

Law Enforcement Agency Name: ____________________

Law Enforcement Agency Address: ____________________

Agency Liaison Name: ____________________

Agency Liaison Phone: ____________________ Agency Liaison Email: ____________________

Please submit the following for approval by the Napa County EMS Agency:	ENCLOSED	APPROVED OFFICE USE ONLY
1. Letter of Intent	☐	☐
2. Name(s) and qualifications of training Officer(s)/Coordinator(s)	☐	☐
3. Statement that officers are POST trained or trained in accordance to the Public Safety First Aid/CPR/AED course outlined in Title 22, Division 9, Chapter 1.5.	☐	☐
4. Documentation of medical control for ongoing procurement of naloxone.	☐	☐
5. Description of the naloxone training that includes:	☐	☐
a. Course Outline	☐	☐
b. Presentation materials, e.g. PowerPoint, Prezi, Keynote, etc.	☐	☐
c. Written test	☐	☐
d. Sample record for documenting use, restocking, and waste of medication	☐	☐
e. Description of agency's continuous quality improvement plan, and process related to inventory control	☐	☐
f. Statement of commitment to retrain every two years	☐	☐

Forward the completed application to:

Napa County EMS Agency
2751 Napa Valley Corporate Drive, Bldg. B
Napa, CA 94558
Office: (707) 253 – 4341 / Fax: (707) 299 – 4126
Email: ems@countyofnapa.org

FOR OFFICE USE ONLY

Date Application Received: ____________________ Approved: ☐ Denied: ☐

Reviewed by (Name): ____________________ Signature: ____________________