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**Department of Public Health
Emergency Medical Services Agency**

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Director of Public Health

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Policy #: 130.00
Effective Date: 07/1993
Revision Date: 10/2006
Review Date: 10/2008

This policy supersedes any other existing policy on this subject.

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Subject: POLICY DEVELOPMENT PROCESS

Authority: California Health and Safety Code, Division 2.5, Section 1797.220

Purpose: To establish a mechanism for the development of EMS policies, procedures and guidelines, hereinafter referred to as policies.

Policy: The development of EMS policies shall be conducted as described in the following sections.

1. When a problem or issue is brought to the attention of the EMS Agency, the Agency shall address the issue in the following manner:
 - A. Determine if the issue is an isolated event that is addressed by the Reportable Situations and Unusual Occurrences Policy or the Continuous Quality Improvement process, and effect resolution of the issue through the appropriate mechanism.
 - B. Determine if the issue has demonstrated a pattern of recurrence, suggesting the need for the development of a policy to address said issue.
2. If the above steps reveal the need for policy development, the EMS Agency staff shall initiate the policy development, utilizing the following procedures:
 - A. Policy development shall be consistent with the lines of authority as defined in the California Health and Safety Code, Division 2.5, and the California Code of Regulations, Title 22, Division 9.
 - B. Policy language shall not be in conflict with existing statute or regulations, whether local, state, or federal.
3. EMS Agency Staff shall prepare a draft policy, and submit said draft to the EMS Policy and Procedure Sub-Committee for their thirty (30) day review.
4. At the conclusion of the thirty (30) day review period, the EMS Policy and Procedure Sub-Committee shall convene to review and amend said policy, as needed. The draft policy shall then be submitted to the Public Health and Agency Medical Director for their review and approval.

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ON-FILE

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5. If substantive change is made to the draft policy as a result of gaining approval of the Directors, the EMS agency shall post the revised draft policy on the Agency Web Site for a fifteen (15) day review, and email notification of said posting to the EMS Policy and Procedure Sub-Committee. If formal objection is submitted to the EMS Agency within this fifteen (15) day period, the EMS Agency shall submit the policy to the Emergency Medical Care Committee (EMCC) membership at their next scheduled meeting for discussion and recommendation. The EMS Agency shall incorporate appropriate changes, based on the EMCC recommendations, into the final policy and implement. The EMS Agency shall retain final authority on policy content.
6. If no substantive change is made to the policy as a result of gaining Director approval, the EMS Agency shall post a copy of the approved policy in the EMS Agency on-line policy manual at least thirty days prior to the implementation date.
7. In the event that the EMS Medical Director or the Director of Public Health feel that an imminent threat to the public health and safety exists, the EMS Agency may immediately implement an emergency policy. The duration of said emergency policy shall not exceed 180 days, pending submission of said policy through the development process as outlined in this policy.



DEPARTMENT OF PUBLIC HEALTH
Emergency Medical Services Agency

POLICY NO. 131.00

EFFECTIVE DATE: 7/1/93

REVISION DATE: 03/2006

REVIEW DATE: 03/2008

EMS

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Subject: POLICY REVISION PROCESS

Authority: California Health and Safety Code, Division 2.5, Section 1797.220

Purpose: To establish a mechanism for the revision of EMS policies, procedures and guidelines, hereinafter referred to as policies.

Policy: Policies, procedures and guidelines of the EMS Agency should be reviewed bi-annually by the EMS Agency.

1. Policy revision shall be consistent with the lines of authority as defined in the California Health and Safety Code, Division 2.5, and California Code of Regulations, Title 22, Division 9, and shall not be in conflict with existing policy or regulations, whether local, state, or federal.
2. All newly developed policies shall be reviewed within 180 days following implementation for possible revision.
3. If no revision of policies due for review is deemed necessary, the EMS Agency shall notify the Policy and Procedure Sub-committee of same. The Sub-committee members shall have 15 days to review the policy and submit suggested revisions.
4. If no substantive revisions are recommended by the Policy and Procedure Committee, the EMS Agency shall forward the policy for approval to the EMS Medical Director and the Director of Public Health. Once approved, the policy shall be posted in the EMS Agency on-line policy manual and shall indicate an implementation date and revised review date.
5. If substantive revisions are recommended by the Policy and Procedure Committee, the policy shall be re-developed as outlined in Sections 4-7 of the Policy Development Process, EMS Policy No. 130.00.
6. In the event that the EMS Medical Director or the Director of Public Health feels that an imminent threat to the public health and safety exists, the EMS Agency may immediately revise existing policy. The emergency revisions shall not exceed 180 days, pending submission of said policy through the Policy Revision Process described herein.

APPROVED:

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**Department of Public Health
Emergency Medical Services Agency**

Policy #: 201.00
Effective Date: 07/1993
Revision Date: 09/2006
Review Date: 09/2008

This policy supersedes any other existing policy on this subject.

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Subject: EMERGENCY MEDICAL DISPATCHER AUTHORIZATION

Authority: California Health and Safety Code, Division 2.5, Sections 1797.210, 1797.220.

Definitions: "**Agency**" - means the Merced County Health Department, as the designated Emergency Medical Services Agency for Merced County.

"Emergency Medical Dispatcher" or "EMD" - Any individual employed by an agency, public or private, which provides emergency medical dispatch service and who has successfully completed an Agency approved EMD course of instruction that is consistent with the standards adopted by the California State EMS Authority for EMDs, Level II Priority Dispatching.

"Level II Priority Dispatching" - The process by which an EMD determines, through the use of key medical questions, whether a call is a life threatening, or non-life threatening emergency. The EMD, using established guidelines, determines the appropriate priority of the response, and remains on-line with the calling party to provide pre-arrival instructions. Level II Priority Dispatch does not include "call screening", and in all cases a response is dispatched.

Purpose: To establish the qualifying standards for authorization as an Emergency Medical Dispatcher within the Merced County EMS System.

Policy: Individuals who possess a current EMD Member Certification issued by the National Academies of Emergency Dispatch (NAED) or an equivalent certification, as determined by the Agency, and successfully fulfill EMD requirements as established herein are eligible for authorization.

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Procedure:

1. **AUTHORIZATION**

- A. The candidate shall be issued an authorization card upon payment of the established authorization fee and completion of an application to include:
 - 1) Copy of current NAED EMD Member Certification.
 - 2) Copy of current CPR/AED certification, utilizing the standards as established by the American Heart Association or the American Red Cross at the Health Provider or equivalent level.
 - 3) Copy of Driver's License or other acceptable photo identification.
 - 4) Signed affidavit denying preclusion from certification for reasons as defined in the Health and Safety Code, Section 1798.200 of the Health & Safety Code.
 - 5) Proof of employment by an agency, public or private, which provides emergency medical dispatch service.
 - 6) Background criminal record clearance to the Agency. This one time criminal record clearance shall be completed prior to issuing or renewing authorization. Applicants shall be responsible for any costs associated with completing the criminal record clearance.
- B. Upon successful completion of the authorization process, a Merced County EMD Authorization card shall be issued reflecting the remainder of the EMD Member Certification period.

2. **REAUTHORIZATION**

A Merced County authorized EMD in good standing shall be eligible for reauthorization upon payment of the established authorization fee and completion of an application to include:

- A. Items described in subsections (A)(1), (2), (4), (5), (6 – if not already completed) of Section 1.
- B. Individuals shall not function as an EMD without current authorization issued by the Agency.



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 215.00
Effective Date: 09/1993
Revision Date: 05/2008
Review Date: 08/2010

This policy supersedes any other existing policy on this subject.

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Subject: PUBLIC SAFETY AED SERVICE PROVIDER

Authority: California Code of Regulations, Title 22, §100020 and 100021

Purpose: To establish the procedure for approval and designation of Public Safety/EMT AED Service Providers.

Definitions: **Agency** - Shall mean the Merced County EMS Agency, a program area within the Department of Public Health Administration, duly appointed by the Board of Supervisors.

AED or Automated External Defibrillator – means an external defibrillator capable of cardiac rhythm analysis which will charge and deliver a shock either automatically or by user interaction, after electronically detecting and assessing ventricular fibrillation or rapid ventricular tachycardia.

Public Safety AED Service Provider – Means an agency, or organization that employs individuals as defined in the California Code of Regulations, Title 22 §100006, which is responsible for, and is approved to operate, an AED.

Policy: This policy shall define the methodology that shall be used for Public Safety agencies to be approved as AED Service Providers.

1. Training for the AED shall meet the standards as established by Title 22, Division 9, §100020.

Procedure: A Public Safety Agency may apply for approval as an AED Service Provider upon completion of an Application for Service Provider Approval.

1. The Eligible AED Service Providers shall ensure compliance with Title 22, Division 9, §100020 and §100021 and shall submit all required documentation with the application.
2. The Agency will notify the applicant requesting approval within seven (7) business days of receiving request that:

- A. The application was received;

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- B. It contains or does not contain the information required; and specifies what information, if any, is missing.
- 3. Provider approval or disapproval will be made in writing by the Agency within thirty (30) days of receipt of application.
- 4. The effective date of Provider approval shall be the date the approval notification was mailed.
- 5. Provider approval shall be for four (4) years following the effective date and may be renewed every four (4) years subject to the procedure for provider approval within this policy and Title 22.



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 217.00
Effective Date: 04/2005
Revision Date: 10/2008
Review Date: 10/2010

This policy supersedes any other existing policy on this subject.

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Subject: LAYPERSON AED PROGRAMS

Authority: California Health and Safety Code, Division 2.5, California Code of Regulations, Title 22, Chapter 1.8

Purpose: To establish a policy for the implementation of Layperson AED Programs.

Definitions: **Agency** - Shall mean the Merced County EMS Agency, a program area within the Department of Public Health Administration, duly appointed by the Board of Supervisors.

AED or Automated External Defibrillator – means an external defibrillator capable of cardiac rhythm analysis which will charge and deliver a shock either automatically or by user interaction, after electronically detecting and assessing ventricular fibrillation or rapid ventricular tachycardia.

AED Service Provider – means any agency, business, organization or individual who purchases an AED for use in a medical emergency involving an unconscious person who has no signs of circulation. This definition does not apply to individuals who have been prescribed an AED by a physician for use on a specifically identified individual.

Authorized Individual - means any person, not otherwise licensed or certified to use the automated external defibrillator, who has met the training standards of this chapter, and who has been issued a prescription for use of an automated external defibrillator on a patient not specifically identified at the time the physician's prescription is given.

Policy: Individuals or organizations that desire to implement a Layperson AED Program shall be in compliance with California Code of Regulations (CCR), Division 9, Chapter 1.8 and this policy.

1. An AED Service Provider shall ensure their internal AED programs include all of the following:

A. Development of an Internal Emergency Response System which complies with the regulations contained in the CCR, Div. 9, Section 100035.

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- B. Notification of the Agency of the existence, location and type of AED at the time it is acquired.
 - C. That all applicable Agency policies and procedures are followed.
 - D. That expected AED users complete a training course in CPR and AED use that complies with requirements of the CCR, Div. 9, Section 100038 and the standards of the American Heart Association or the American Red Cross.
 - E. That the defibrillator is maintained and regularly tested according to the operation and maintenance guidelines set forth by the manufacturer, and according to any applicable rules and regulations set forth by the governmental authority under the federal Food and Drug Administration and any other applicable state and federal authority.
 - F. That the defibrillator is checked for readiness after each use and at least once every 30 days if the AED has not been used in the previous 30 days. Records of these periodic checks shall be maintained.
 - G. That a mechanism exists to ensure that any person, either an employee or agent of the AED service provider, or member of the general public who renders emergency care or treatment on a person in cardiac arrest by using the service provider's AED activates the emergency medical services system as soon as possible, and reports any use of the AED to the Agency.
 - H. That there is involvement of a California licensed physician and surgeon in developing an Internal Emergency Response System and to ensure compliance with these regulations and requirements for training, notification and maintenance.
 - I. That a mechanism exists that will assure the continued competency of the authorized individuals in the AED Service Provider's employ to include periodic training and skills proficiency demonstrations.
2. The AED Service Provider shall ensure the availability of the following data set for quality improvement activities and EMS Agency review:
 - A. Date of incident
 - B. Location of incident
 - C. Time of discovery
 - D. Bystander CPR applied?
 - E. Initial shock advised?
 - F. Total number of shocks delivered
 - G. Arrival time of EMS
 3. The Agency reserves the right to conduct an on-site inspection of the AED Service Provider's program to ensure compliance with the CCR and the Agency policies and procedures.



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 220.00
Effective Date: 07/1993
Revision Date: 06/2010
Review Date: 06/2012

This policy supersedes any other existing policy on this subject.

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Subject: **EMT CERTIFICATION**

Authority: Health and Safety Code Division 2.5, Section 1797.210, Title 22, California Code of Regulations, Section 100079 and California Penal Code, Section 11105

Definitions: **EMT Certifying Authority** - means an agency or person authorized to certify and recertify, as Emergency Medical Technician, an individual who has complied with the requirements of this policy.

Certifying Examination - means the National Registry of EMTs written and skills examination to test an individual applying for certification as an EMT.

Emergency Medical Technician or EMT - means a person who has successfully completed a basic EMT course which meets the requirements of the California Code of Regulations, Title 22, Division 9, Chapter 2, has passed all required tests and who has been certified by the EMT Certifying Authority.

Agency - means the Merced County Health Department, as the designated Emergency Medical Services Agency for Merced County.

Purpose: The purpose of this policy is to insure that an individual, having met the required standard of training and National Registry certification as set forth in the State of California Code of Regulations will be eligible for certification as an Emergency Medical Technician, or EMT.

Policy: The Agency is the designated EMT Certifying Authority for Merced County.

1. In order to be eligible for certification as an EMT the following criteria must be met:
 - A. Be eighteen (18) years of age or older.
 - B. Complete a criminal record clearance by the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI).

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C. Possesses a current and valid National Registry EMT-Basic certificate.

Procedure: The following procedure shall be followed:

1. The Agency walk-in hours for EMT Certification are Monday thru Friday from 08:00 to 12:00 Noon. Requests for certification outside these posted hours will be by appointment only.
2. Submit an application along with documentation establishing eligibility for certification:
 - A. Current government-issued photo identification.
 - B. Proof that the individual is eighteen (18) years or older.
 - C. Proof of current National Registry Certification as an EMT Basic.
 - D. Sign an affidavit denying preclusion from certification and containing the following statement: "I hereby certify under penalty of perjury that all information on this application is true and correct to the best of my knowledge and belief, and I understand that any falsification or omission of material facts may cause forfeiture on my part of all rights to EMT certification in the state of California. I understand all information on this application is subject to verification, and I hereby give my express permission for this certifying entity to contact any person or agency for information related to my role and function as an EMT in California." .
 - E. Disclose any certification or licensure actions as specified in the CCR Section 100079 (8) (A – C).
 - F. Cause proof of a background criminal record clearance from the California DOJ and the FBI to be sent to the agency and the state EMS Authority. This one time criminal record clearance shall be completed prior to issuing a certificate. The DOJ and FBI report must be received within 30 days of the date of application, or the candidate may be required to reprocess their background record check or certification application. Applicants shall be responsible for all costs associated with completing the criminal record clearance.
 - 1) Pickup a "Request For Live Scan Service" form from the EMS Agency or download from the Agency website at: www.co.merced.ca.us/index.asp?NID=588. Contact a live scan agency and request an appointment for fingerprinting. The current Livescan fee and the agency "rolling fee" will be collected by the fingerprinting agency.
 - 2) Submit the second copy of the completed form as proof of service to the EMS Agency when certifying.
 - G. Pay the established State and Agency fees.
3. The individual will be issued a wallet size certificate after the above steps are completed and the applicant has passed the criminal background clearance.

The effective date of certification shall be the date the individual satisfactorily completes all certification requirements. The certification expiration date will be:

- A. Two years from the date of passing the National Registry's written examination, or
 - B. Two years from successfully completing the EMT Certification requirements.
4. For those individuals that possess a current and valid Paramedic License, the expiration date shall be the same date as the expiration date on the license.
 5. Certification as an EMT shall be valid for a maximum of two (2) years from the date that the individual passes the National Registry EMT-Basic certifying exam, except in the following cases:
 - A. A person who possesses a current and valid out-of-state EMT-Intermediate or Paramedic certification, the expiration date shall be the same expiration date as stated on the out-of-state certification but in no case shall exceed two (2) years from the effective date of EMT wallet-sized certificate card issued by a California EMT certifying entity.
 - B. A person who possesses a valid National Registry issued EMT-Basic, EMT-Intermediate or Paramedic certification, the expiration date shall be two (2) years from the date of passing the National Registry examination, but in no case shall the expiration date of certification exceed two (2) years from the effective date.



**Department of Public Health
Emergency Medical Services Agency**

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Policy #: 221.00
Effective Date: 07/1993
Revision Date: 06/2010
Review Date: 06/2012

This policy supersedes any other existing policy on this subject.

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Subject: **EMT MAINTENANCE AND RECERTIFICATION**

Authority: Health and Safety Code Division 2.5, Section 1797.210, Title 22, California Code of Regulations, Section 100084

Definitions: **EMT Certifying Authority** - means an agency or person authorized to certify and recertify, as Emergency Medical Technician, an individual who has complied with the requirements of this policy.

Certifying Examination - means the written examination and skills examination approved by the State EMS Authority to test an individual applying for certification as an EMT.

Emergency Medical Technician or EMT - means a person who has successfully completed a basic EMT course which meets the requirements of the California Code of Regulations, Title 22, Division 9, Chapter 2, has passed all required tests and who has been certified by the EMT Certifying Authority.

Agency - means the Merced County Health Department, as the designated Emergency Medical Services Agency for Merced County.

Purpose: The purpose of this policy is to insure that an individual, having met the requirements set forth in the State of California Code of Regulations will be eligible for recertification as an Emergency Medical Technician, or EMT.

Policy: The Agency is the designated EMT Certifying Authority for Merced County.

1. In order to maintain certification as an EMT the following criteria must be met:
 - A. Possess a current and valid EMT certificate in the State of California.
 - B. Possess a current CPR certification, American Heart Association Healthcare Provider level or American Red Cross CPR for the Professional Rescuer level or equivalent.
 - C. Successfully complete an approved EMT refresher course or obtain twenty four (24) hours of continuing education hours (CEH) from an approved continuing education provider as required in CCR, Title 22, Chapter 11.
 - D. Submit a completed skills competency verification form pursuant to CCR, Title 22, Sections 100080(f).

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2. In order to be eligible for recertification after lapse in certification the following criteria must be met:
 - A. Individuals, whose certification has a lapse of less than six months, shall comply with the criteria in 1 (b), (c) and (d) above.
 - B. Individuals whose certification has a lapse of six months or more, but less than twelve months, shall comply with the criteria in 1 (b), (c) and (d) above and complete an additional twelve hours of continuing education for a total of thirty six (36) CEH.
 - C. Individuals whose certification has a lapse of twelve months or more, but less than 24 months, shall comply with the criteria in 1 (a) and (b) above and complete an additional twenty four hours of continuing education for a total of 48 CEH and pass the certification examination pursuant to CCR, Title 22, Sections 100079.
 - D. Individuals whose certification has a lapse of greater than twenty-four months shall complete an approved EMT course and comply with requirements for EMT Certification.

- Procedure:
1. Submit an application along with documentation establishing eligibility for recertification:
 - A. Course completion from an EMT refresher course or twenty-four (24) hours of continuing education hours from an approved EMT training program; and
 - B. For certifications with a lapsed of six months or more, but less than 24 months, completion of additional continuing education hours as specified in above policy.
 - C. Current or previously issued EMT certificate that would make the individual eligible for recertification;
 - D. Current CPR certificate.
 - E. Sign an affidavit denying preclusion from certification for reasons specified in Section 1798.200 of the Health and Safety Code.
 - F. Photo Identification (e.g. driver's license), unless EMT Certificate contains current photograph.
 - G. If the individual has not previously completed a background criminal clearance record, proof of a California Department of Justice (DOJ) background criminal record clearance shall be submitted to the agency. This one time criminal record clearance shall be completed prior to issuing or renewing a certificate. The DOJ report must be received by the EMS Agency within 30 days of the date of application, or the candidate may be subject to additional requests to reprocess their DOJ record or certification application. Applicants shall be responsible for all costs associated with completing the criminal record clearance.
 - H. Completion of skills competency verification; or
 - I. For certifications with a lapse of twelve months or more, but less than 24 months, pass the certifying examination as prescribed by the National Registry of Emergency Medical Technicians and present evidence of such successful completion.
 - J. Pay an established fee. The agency may charge additional fees for lapsed certifications.
 2. The individual will be issued a wallet size certificate after the above steps are completed.

3. If maintenance of certification requirements are met within six (6) months prior to the expiration, the effective date of certification shall be the expiration date of the current certificate. The certification expiration date will be the final day of the final month of the two (2) year period.
4. If the maintenance of certification requirements are met greater than six months prior to the expiration date or the certification is lapsed, the effective date of certification shall be the date the individual satisfactorily completes all requirements. The certification expiration date will be the final day of the final month of the two (2) year period.



**Department of Public Health
Emergency Medical Services Agency**

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Policy #: 222.00
Effective Date: 07/1993
Revision Date: 05/2008
Review Date: 05/2010

This policy supersedes any other existing policy on this subject.

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Subject: EMT-1 COURSE COMPLETION BY CHALLENGE

Authority: Health and Safety Code Division 2.5, Section 1797.210, Title 22, California Code of Regulations, Section 100080.

Definitions: **EMT-1 Certifying Authority** - means an agency or person authorized to certify and recertify, as Emergency Medical Technician-1, an individual who has complied with the requirements of this policy.

Certifying Examination - means an examination developed by the State EMS Authority administered or approved by the Authority given to an individual applying for certification as an EMT-1. The examination shall include both written and skill testing portions designed to determine an individual's competence for certification as an EMT-1.

Emergency Medical Technician-1 or EMT-1 - means a person who has successfully completed a basic EMT-1 course which meets the requirements of the California Code of Regulations Title 22, Division 9, Chapter 2, has passed all required tests and who has been certified by the EMT-1 Certifying Authority.

Agency - means the Merced County Health Department, as the designated Emergency Medical Services Agency for Merced County.

Purpose: The purpose of this policy is to ensure that an individual, having met the requirements as set forth in the State of California Code of Regulations will be eligible for course completion by challenge.

Policy: An individual may apply for EMT-1 course completion record if he/she meets one of the following requirements:

- A. The person is a currently licensed physician in one of the states of the United States, a registered nurse, a physician assistant, or licensed vocational nurse.

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- B. The person provides documented evidence of having completed an emergency medical services training program of the Armed Forces of the United States within the preceding two (2) years which meets the Department of Transportation EMT-1 course guidelines. A person who has been active in the last two (2) years in a prehospital emergency medical classification of the Armed Services of the United States may be allowed to challenge after successfully completing an approved refresher course.

Procedure: The following procedure will be followed:

1. Submit an application along with documentation establishing eligibility to challenge for EMT-1 Course Completion:
 - A. Physician, physician assistant, or nursing license; or
 - B. Documentation of military classification; and
 - C. Proof that the individual is eighteen (18) years or older.
2. Pass a Course Challenge Examination.
3. Upon successful completion of the Course Completion Examination, the individual will be issued a course completion certificate and will be eligible to take the National Registry Certification Exam.
4. Individuals may apply for course completion by challenge examination one (1) time only.



**Department of Public Health
Emergency Medical Services Agency**

Tammy Moss-Chandler
Director of Public Health

James Andrews, M.D.
EMS Medical Director

Policy #: 233.00
Effective Date: 07/1993
Revision Date: 12/2010
Review Date: 09/2012

This policy supersedes any other existing policy on this subject.

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Subject: EMT-P ACCREDITATION

Authority: California Health and Safety Code, Division 2.5, Sections 1797.7, 1797.185 and 1797.214. California Code of Regulations, Division 9, Sections 100140 and 100164.

Purpose: The purpose of this policy shall be to provide a mechanism for EMT-Ps to become accredited to practice within Merced County, as established by the California Health and Safety Code and Code of Regulations.

Policy: An individual with a current California EMT-P license shall be immediately accepted so that an individual may be employed utilizing the State of California Basic Scope of Practice for EMT-Ps for a period not to exceed thirty (30) days. During this thirty (30) day pre-accreditation period the EMT-P shall work with an accredited Merced County EMT-P.

Procedure:

1. The candidate shall be issued a pre-accreditation card, valid for thirty (30) days, upon payment of the established accreditation fee and completion of an application to include the following:
 - A. A copy of a current California EMT-P license.
 - B. A copy of a valid ACLS certificate or a signed agreement to complete ACLS training and certification within twelve (12) months from the date of application submission.
 - C. A signed affidavit and waiver of confidentiality confirming that the individual is not precluded from accreditation for any of the reasons listed in the Health and Safety Code, Section 1798.200.
 - D. A signed statement from a local/state agency or approved training program verifying testing in the basic EMT-P scope of practice and any additional drugs or procedures required for Merced County.
2. The candidate must pass an examination with a score of 80% or better on the Merced County Treatment Protocols, Policies and Procedures.
3. A candidate for initial accreditation may be required to successfully complete a pre-accreditation field evaluation to consist of not more than ten (10) ALS patient contacts. All field evaluations shall be conducted by an approved Merced County Field Training Officer.

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4. The candidate shall complete an orientation of the Merced County EMS System which will not exceed eight (8) classroom hours.
5. Pre-accreditation cards shall be issued while the candidate completes the requirements for accreditation and the provider agency's orientation process. The pre-accreditation cards must be surrendered at the completion of the accreditation process or upon the provider agency's termination of the candidate.
6. Upon successful completion of the accreditation process, a Merced County EMT-P accreditation card shall be issued reflecting the remainder of the licensure period.
7. Continuous Accreditation - Once issued, accreditation shall be continuous as long as the following are met:
 - A. Maintenance of California Paramedic License.
 - B. Meets local requirements for updates in local policy, procedure, protocol and local optional scope of practice, and complies with the requirements in the system-wide Quality Improvement (QI) program.
 - C. If any of the above requirements are not met or maintained, accreditation to practice shall be withdrawn until successful completion of the requirement(s).
 - D. A Paramedic whose accreditation has been withdrawn for more than one year shall be required to re-apply for initial accreditation.
 - E. Accredited paramedics shall submit copies of their state license and confirmation of attendance at all required local system updates in policies and procedures and required QI activities. This shall be presented to the EMS Agency at the time of the paramedics' re-licensure with the State EMS Authority. The paramedic shall pay a fee for review and confirmation of the above.
8. Westside Healthcare District Ambulance Paramedic Personnel:
 - A. Must maintain a current California Paramedic License and Mountain-Valley EMS Agency Accreditation.
 - B. All Paramedic personnel must attend the Merced County EMS Agency Orientation. This must be completed within 30 days of employment.
 - C. Westside Paramedic personnel will be allowed to use Mountain-Valley EMS Agency treatment guidelines while providing care in Merced County.
 - D. All MCI operations and patients identified as meeting "STEMI Criteria" will follow Merced County policies.



**Department of Public Health
Emergency Medical Services Agency**

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Policy #: 235.00
Effective Date: 09/1993
Revision Date: 09/2006
Review Date: 09/2008

This policy supersedes any other existing policy on this subject.

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Subject: FIELD TRAINING OFFICERS

Authority: Health and Safety Code Division 2.5 Sections 1797.206 and 1797.220

Purpose: To provide guidelines for the recruitment and training of EMS agency approved field training officers within Merced County.

Policy: Only EMT-P's authorized by the Agency will be allowed to act as Field Training Officers (FTO) in Merced County.

1. Minimum requirements for Field Training Officers are as follows:
 - A. 2 years full-time experience as an EMT-P
 - B. 1 year as a Merced County accredited EMT-P
 - C. must be in good standing with the Agency
 - D. course completion from a Merced County approved FTO class

Procedure:

1. Authorization of Field Training Officers
 - A. Prospective Field Training Officers must submit an application along with documents establishing eligibility for authorization:
 1. Documentation of required work experience.
 2. A letter of recommendation from employer.
 3. Course completion from an approved FTO class.

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- B. Successfully pass an Authorization Examination.
 - 1. The individual will be scheduled for the next available Authorization Examination.
 - 2. An unscheduled Authorizing Examination may be requested in writing by the individual.
- C. The individual will be issued a wallet size authorization card.
- D. Authorization as a Field Training Officer will continue as long as the individual:
 - 1. Maintains EMT-P accreditation within Merced County; and
 - 2. Is an EMT-P in good standing with the Agency.

2. Responsibilities of Field Training Officers

- A. Field Training Officers must ensure that their paramedic student is registered with the Agency by the end of the student's first shift.
- B. Field Training Officers will orient the paramedic student to the Merced County EMS System before the end of the student's first shift.
 - 1. A copy of the Merced County Paramedic Student Orientation Check List will be sent to the Agency with the student registration.
- C. Field Training Officers are responsible for all aspects of prehospital care performed by the paramedic student to include but not necessarily limited to:
 - 1. Ensuring the appropriate treatment guidelines are followed.
 - 2. Ensuring skills performed by the paramedic student are accomplished according to guidelines.
 - 3. Ensuring base hospital contact is made according to EMS Policy 301.00.
 - 4. Ensuring patient contact is documented according to EMS Policy 560.10.

3. Paramedic Student Responsibilities

- A. The paramedic student will ensure that he/she is registered with the Agency.
- B. Upon completion of the field internship, the paramedic student shall complete a Merced County Field Training Officer Evaluation Form and forward it to the Agency.



**Department of Public Health
Emergency Medical Services Agency**

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Policy #: 240.00
Effective Date: 07/1993
Revision Date: 10/2006
Review Date: 10/2008

This policy supersedes any other existing policy on this subject.

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Subject: MICN AUTHORIZATION

Authority: California Health and Safety Code, Section 1798.100 et seq.

Purpose: The purpose of this policy shall be to establish the qualifying standards for authorization as a Mobile Intensive Care Nurse (MICN) within Merced County.

Policy: Individuals in good standing who possess a California MICN course completion certificate and unsuccessfully fulfill MICN requirements as established by the Merced County EMS Agency are eligible for authorization.

1. Candidates must apply and complete all requirements of this policy within six (6) months of MICN course completion, unless the EMS Medical Director approves an extension.
2. The candidate shall submit an application to include:
 - A. Current licensure as a California Registered Nurse.
 - B. Documentation of successful completion of a MICN course which meets or exceeds the requirements of the Merced County MICN course or a course approved by the EMS Medical Director.
 - C. Documentation of six (6) months experience as a Registered Nurse working in an Emergency Department or current CEN certificate.
 - D. Current ACLS certification.
 - E. A signed affidavit that the applicant is not precluded from authorization for any of the reasons listed in the Health and Safety Code, Section 1798.200.
 - F. Payment of the established fee.
 - G. A copy of a photo identification card

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3. Candidates with current MICN authorization from another EMS Agency jurisdiction may submit proof of current MICN Authorization in place of item 2(B).
4. Satisfactory completion of a pre-authorization Base Hospital Evaluation to include:
 - A. No less than ten (10) ALS radio calls.
 - B. No less than three (3) ALS radio calls if the applicant is currently authorized as a MICN in another EMS agency jurisdiction. The Merced County EMS agency shall confirm the applicants standing with said EMS agency prior to application of this section.
 - C. Minimum of eight (8) hours ALS Ambulance ride time to include no less than 3 ALS patient contacts.
 - D. Local EMS system orientation not to exceed eight (8) classroom hours.
5. The candidate must pass an examination with a score of 80% or better on the Merced County Treatment Protocols, Policies and Procedures.
6. Upon completion of the above requirements the Merced County EMS Agency shall issue a MICN Authorization card. Authorization shall be for two years. The authorization expiration date will be the final day of the final month of the two (2) year period.



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 241.00
Effective Date: 07/1993
Revision Date: 10/2007
Review Date: 10/2009

This policy supersedes any other existing policy on this subject.

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Subject: MICN RE-AUTHORIZATION

Authority: California Health and Safety Code, Section 1798.100 et seq.

Purpose: The purpose of this policy shall be to establish the qualifying standards for re-authorization as a Mobile Intensive Care Nurse within Merced County.

Policy: Individuals in good standing that are currently authorized as a Merced County MICN shall be re-authorized upon successful completion of the EMS Agency re-authorization requirements.

1. Prior to expiration of the applicant's current authorization s/he shall submit a completed application to include:
 - A. Current licensure as a California Registered Nurse.
 - B. Current ACLS certification.
 - C. A signed affidavit that the applicant is not precluded from authorization for any of the reasons listed in the Health and Safety Code, Section 1798.200.
 - D. Payment of the established fee.
 - E. A copy of a photo identification card.
2. The applicant shall submit documentation of successful completion of all continuing education requirements during the previous authorization period. Required continuing education for each MICN shall include:
 - A. The applicant shall submit documentation of successful completion of fifteen (15) hours of formal education specifically related to Emergency Services, excluding ACLS, , approved by any California local EMS Agency or the California Board on Nursing (BRN), during the previous authorization period.

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3. The candidate must document a minimum of 32 hours per month employment in a Base Hospital Emergency Department, or document a minimum of twenty (20) ALS radio calls during the previous authorization period.
4. Upon completion of the above required items, the EMS Agency shall issue an MICN Authorization card. Authorization shall be for two years. If the reauthorization requirements are met within six (6) months prior to the expiration date, the effective date of certification shall be the expiration date of the current certificate.⁶ Individuals shall not function as an MICN without current authorization issued by the Agency.
5. Individuals with lapsed MICN authorizations shall be eligible for re-authorization as defined below:
 - A. A lapse of less than one (1) year:
 1. Completion of Sections 1 and 2, above and a prorated amount of continuing education, based on the number of months since the authorization expired, not to exceed a total of thirty six (36) hours. In addition, the candidate shall complete 5 ALS proctored calls and submit documentation of same to the EMS Agency prior to the issuance of an MICN card.
 2. The candidate must pass an examination with a score of 85% or better on the Merced County Treatment Protocols, Policies and Procedures.
 - B. A lapse of one (1) to two (2) years:
 1. Completion of item 5A, above and,
 2. Successful completion of ten (10) proctored ALS radio calls.
 - C. A lapse of more than two (2) years:
 1. Completion of items 5A and 5B, above and,
 2. Any additional training or evaluation deemed reasonable and prudent by the EMS Medical Director.



**Department of Public Health
Emergency Medical Services Agency**

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Policy #: 250.00
Effective Date: 09/1993
Revision Date: 03/2008
Review Date: 03/2010

This policy supersedes any other existing policy on this subject.

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Subject: CONTINUING EDUCATION PROVIDER REQUIREMENTS

Authority: Health and Safety Code, Division 2.5, Section 1797.175 and CCR Section 100390.5

Purpose: The purpose of this policy shall be to establish the requirements for approval of providers of continuing education, within the Merced County EMS area, whose intent is to apply for credit toward the recertification requirements of prehospital care providers.

Policy: Any individual or group meeting the requirements as defined herein may apply for approval as a Continuing Education (C.E.) Provider.

The approved provider shall provide all logistics for each course that offers continuing education credit, including record-keeping, advertising, course content, instructor qualifications and certificates issued.

1. Continuing Education Provider Requirements

A. Each CE provider shall have an approved program director, who is qualified by education and experience in methods, materials and evaluation of instruction, which shall be documented by at least forty hours in teaching methodology. Following, but not limited to, are examples of courses that meet the required instruction in teaching methodology:

- 1) California State Fire Marshal (CSFM) "Fire Instructor 1A and 1B"; or
- 2) National Fire Academy (NFA) "Fire Service Instructional Methodology" course; or
- 3) a training program that meets the U. S. Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors.

B. Each CE provider shall have an approved clinical director who shall be a licensed or certified Physician, Physicians Assistant, Nurse or Paramedic who shall have had two years of academic, administrative or clinical experience in emergency medicine or EMS care within the last five years.

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- C. Other instructors shall be approved by the program and clinical director and:
 - 1) Be currently licensed or certified in his/her areas of expertise, if appropriate, or
 - 2) Show evidence of specialized training which may include but is not necessarily limited to, a certificate of training in a specific subject area, and
 - 3) Have at least one (1) year of experience within the last two (2) years in the specialized area in which he/she instructs.

2. Continuing Education Requirements

- A. Continuing education for EMS personnel shall be in any of the topics contained in the respective National Standard Curricula for training EMS personnel. Each course must be directly relevant to the practice of prehospital emergency medical care, be related to the scientific knowledge or technical skills required in the practice of EMS delivery, or directly or indirectly related to patient care.
- B. Be current and include recent developments in the subject matter.
- C. Be at least one (1) hour in length.
- D. Have written instructional objectives which are measurable and stated in behavioral terms.

3. Certificates and Proof of Completion Documents

- A. Providers must issue a certificate, or other appropriate documentation of completion, to all participants that meet the established criteria for successful completion of the course.
- B. The certificate of completion must contain:
 - 1) Name of participant
 - 2) Participant's certification/authorization number
 - 3) Course title
 - 4) Provider name and address
 - 5) Date(s) of Course
 - 6) Number of Continuing Education contact hours
 - 7) Signature of instructor and/or provider
 - 8) The following two statements:
 - a) "This document must be retained for a period of four years".
 - b) "This course has been approved for (number) hours of (EMT-P and/or EMT) Continuing Education by (Provider Number)".

C. Certificates of completion must be issued within 30 days of the course completion.

4. Provider Records

A. Continuing Education Providers shall keep course records for a minimum of four years including:

- 1) Course Objectives,
- 2) Course Outline(s),
- 3) Qualifications of instructors,
- 4) Participant sign-in rosters,
- 5) Course test(s),
- 6) Course evaluations, and
- 7) Records of documentation issued.

Procedure:

1. Continuing Education Provider Approval Process

A. Provider must submit a completed application to the Merced County EMS Agency which includes:

- 1) Name and qualifications of the Program and Clinical Director(s) including a resume' or curriculum vitae.
- 2) Name of a contact person, hours available for contact and provider physical and email address, phone and fax numbers.
- 3) A sample of:
 - a) a course completion certificate,
 - b) a course instructional objectives,
 - c) a course evaluation instrument,
 - d) an organizational outline for patient care review,
 - e) estimated number of hours of instruction annually.
- 5) The Agency shall approve or disapprove the C.E. Provider application within thirty (30) days of receipt of a completed application. Any notification of disapproval shall be accompanied with a written explanation of the decision.
- 6) Approved C.E. Providers shall be issued a C.E. Provider Number which shall be valid for a four (4) year period from the date of approval.
- 7) All approved C.E. Providers shall be required to update their application every four years, and submit same at least thirty (30) days prior to the expiration of their current approval.

2. Audits

The EMS Agency retains the right to conduct on-site visits, examine course records, or other related activities for the purpose of ensuring compliance with this policy and the pertinent state regulations.



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 251.00
Effective Date: 07/1993
Revision Date: 05/2008
Review Date: 05/2010

This policy supersedes any other existing policy on this subject.

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Subject: EMT-1 TRAINING PROGRAM APPROVAL

Authority: Health and Safety Code Division 2.5, Section 1797.173, Title 22, California Code of Regulations, Section 10065-10079.

Definitions: EMT-1 Approving Authority - means an agency or person authorized to approve an Emergency Medical Technician-1 training program.

EMT-1 Certifying Authority - means an agency or person authorized to certify and recertify, as Emergency Medical Technician-1, an individual who has complied with the requirements of this policy.

Certifying Examination - means an examination developed by the State EMS Authority or the EMS Certifying Authority and administered or approved by the EMT-1 Certifying Authority given to an individual applying for Certification as an EMT-1. The examination shall include both written and skill testing portions designed to determine an individual's competence for certification as an EMT-1.

Emergency Medical Technician-1 or EMT-1 - means a person who has successfully completed a basic EMT-1 course which meets the requirements of the California Code of Regulations Title 22, Division 9, Chapter 2, has passed all required tests and who has been certified by the EMT-1 Certifying Authority.

Agency - means the Merced County Health Department, as the designated Emergency Medical Services Agency for Merced County.

Purpose: To establish standards for development and approval of EMT-1 training programs within the County of Merced.

Policy: The Agency is the designated EMT-1 Approving Authority for Merced County.

1. Program Approval

- A. EMT-1 training may only be offered by approved training program providers. Eligibility for program approval shall be limited to the following:

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- 1) Accredited universities and colleges including junior and community colleges, school districts, and private post-secondary schools.
- 2) Medical training units of a branch of the Armed Forces including the Coast Guard of the United States.
- 3) Licensed general acute care hospitals which meet the following criteria:
 - a) Hold a special permit to operate a basic or comprehensive emergency medical service pursuant to the provisions of Title 22 California Code of Regulations Division 5; and
 - b) Provide continuing education to other healthcare professions.
- 4) Agencies of government
- 5) Public safety agencies
- 6) Local EMS Agencies

2. Application for Training Program Approval.

A. The training program providers shall submit the following items with the application:

- 1) A statement verifying usage of the United States Department of Transportation's EMT-Basic National Standard Curriculum, DOT HS 808 149, August 1994, which includes learning objectives, skills protocols, and treatment guidelines.
- 2) A statement verifying CPR training equivalent to the 2005 American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the Healthcare Provider level is a prerequisite for admission to an EMT-I basic course.
- 3) Samples of written and skills examinations used for periodic testing.
- 4) A final skills competency and written examination.
- 5) The name and qualifications of the program director, program clinical coordinator, and principal instructor(s).
- 6) Provisions for clinical experience, as defined in Section 100068 of Title 22, California Code of Regulations.
- 7) Provisions for course completion by challenge, including a challenge examination (if different from final examination).
- 8) Provisions for a refresher course as required for recertification.
- 9) The location at which the courses are to be offered and their proposed dates.
- 10) Table of contents of the required information listed above with corresponding page numbers.

B. The Agency will notify the training program submitting an application for program approval within seven (7) days of receiving a request that:

- 1) The request was received;
 - 2) It contains or does not contain the information required;
 - 3) Specify what information is missing, if any.
 - 4) Program approval or disapproval will be made in writing by the Agency within three (3) months of receiving all the necessary program documents.
- C. The effective date of the program approval shall be the date the approval notification is mailed.
- D. Program approval shall be for four (4) years following the effective date and may be renewed every four (4) years subject to the procedure for program approval in this policy.

- E. All program materials are subject to periodic review by the Agency.
- F. All programs are subject to periodic on-site evaluation by the Agency.
- G. The program director shall notify the Agency in writing in advance if possible and in all cases within thirty (30) days of any change of course content, hours of instruction, program director, or clinical coordinator.

3. Withdrawal of Program Approval

- A. Noncompliance with this policy or the provisions of Title 22 CCR, Division 9, Chapter 2 may result in withdrawal of program approval.
 - 1) Upon notification of noncompliance the program will have sixty (60) days to correct the deficiencies.
 - 2) A plan of corrections must be filed with the Agency within ten (10) days of receipt of notification of noncompliance.
 - 3) The Agency will acknowledge receipt of the plan of corrections in writing within seven (7) days.
 - 4) If the Program does not correct the deficiencies within sixty (60) days the program approval shall be withdrawn and any classes in progress will be terminated.

4. Program Administration – Teaching Credentials

Each EMT-I training program shall provide for the functions of administrative direction, medical quality coordination, and actual program instruction. Nothing in this policy precludes the same individual from being responsible for more than one of the following functions if so qualified by the provisions herein:

- A. Each EMT-I training program shall have an approved program director who shall be qualified by education and experience in methods, materials, and evaluation of instruction which shall be documented by at least forty hours in teaching methodology. The courses include but are not limited to the following examples:
 - 1) State Fire Marshal Instructor 1A and 1B,
 - 2) National Fire Academy's Instructional Methodology,
 - 3) Training programs that meet the United States Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors such as the National Association of EMS Educators Course.
- B. Duties of the program director, in coordination with the program clinical coordinator, shall include but not be limited to:
 - 1) Administering the training program.
 - 2) Approving course content.
 - 3) Approving all written examinations and the final skills examination.
 - 4) Coordinating all clinical and field activities related to the course.
 - 5) Approving the principal instructor(s) and teaching assistants.
 - 6) Signing all course completion records.
 - 7) Assuring that all aspects of the EMT-I training program are in compliance with this Chapter and other related laws.

- C. Each training program shall have an approved program clinical coordinator who shall be either a physician, registered nurse, physician assistant, or a paramedic currently licensed in California, and who shall have two (2) years of academic or clinical experience in emergency medicine or prehospital care in the last five (5) years. Duties of the program clinical coordinator shall include, but not be limited to:
 - 1) Responsibility for the overall quality of medical content of the program;
 - 2) Approval of the qualifications of the principal instructor(s) and teaching assistant(s).
- D. Each training program shall have a principal instructor(s), who may also be the program clinical coordinator or program director, who shall be qualified by education and experience in methods, materials, and evaluation of instruction, which shall be documented by at least forty hours in teaching methodology. The courses include but are not limited to the following examples:
 - 1) State Fire Marshal Instructor 1A and 1B,
 - 2) National Fire Academy's Instructional Methodology,
 - 3) Training programs that meet the United States Department of Transportation/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors such as the National Association of EMS Educators Course. and who shall:
 - a) Be a physician, registered nurse or physician assistant, or paramedic currently licensed in California; or,
 - b) Be an EMT-II or EMT-I who is currently certified in California.
 - c) Have at least two (2) years of academic or clinical experience in the practice of emergency medicine or prehospital care in the last five (5) years.
 - d) Be approved by the program director in coordination with the program clinical coordinator as qualified to teach the topics to which s/he is assigned.
- E. Each training program may have teaching assistant(s) who shall be qualified by training and experience to assist with teaching of the course and shall be approved by the program director in coordination with the program clinical coordinator as qualified to assist in teaching the topics to which the assistant is to be assigned. A teaching assistant shall be supervised by a principal instructor, the program director and/or the program clinical coordinator.



**Department of Public Health
Emergency Medical Services Agency**

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Policy #: 252.00
Effective Date: 07/1996
Revision Date: 04/2008
Review Date: 09/2010

This policy supersedes any other existing policy on this subject.

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Subject: EMERGENCY MEDICAL SERVICES CONTINUING EDUCATION STANDARDS

Authority: Division 2.5, Health and Safety Code, Sections 1797.175 and 1797.208; California Code of Regulations, Title 22

Purpose: To provide guidelines for EMS Personnel and providers of EMS continuing education (CE) regarding training that meets the standards for EMS CE credit.

Definition: CEH – means Continuing Education Hour which shall be a minimum of 50 minutes. CE courses shall be a minimum of one (1) CEH in length.

Policy: EMS continuing education shall be approved when it meets the standards identified within this policy.

1. Continuing Education Topics

- A. Continuing education for EMS personnel shall be in any of the topics contained in the respective National Standard Curricula for training EMS personnel, except as provided in Section 1 B, below.
- B. Advanced topics in subject matter outside the scope of practice of the certified or licensed EMS personnel but directly relevant to emergency medical care (e.g. surgical airway procedures).
- C. In lieu of completing the required CEH, EMT-I certification can be maintained by successfully completing an approved refresher course pursuant to Section 100080 of Chapter 2, Division 9, Title 22, California Code of Regulations.
- D. All approved CE shall contain a written and/or skills competency based evaluation related to course, class, or activity objectives.

2. CE Delivery Formats and Limitations

Delivery formats for CE courses shall be by any of the following:

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- A. Classroom – didactic and/or skills laboratory where direct interaction with an instructor is possible.
- B. Organized field care audits of patient care records;
- C. Courses offered by accredited universities and colleges, including junior and community colleges (no more than 10 CE hours per course per semester);
- D. Structured clinical experience, with instructional objectives, to review or expand the clinical expertise of the individual;
- E. Media based and/or serial productions (e.g. films, videos, audiotape programs, magazine articles offered for CE credit, home study, computer simulations or interactive computer modules);
- F. Precepting EMS students or EMS personnel as a hospital clinical preceptor, as assigned by an EMS training program, an EMS service provider, a hospital or alternate base station. In order to issue CE for precepting EMS students or EMS personnel, an EMS service provider, hospital or base station must be a CE provider approved by the EMS Agency or the State EMS Authority. CE for precepting can only be given for actual time spent precepting a student or EMS personnel and must be issued by the EMS training program, EMS service provider, hospital or base station that has an agreement or contract with the hospital clinical preceptor or with the preceptor's employer.
- G. Precepting EMS students or EMS personnel as a field preceptor, as assigned by an EMS training program or an EMS service provider approved by the EMS Agency or the State EMS Authority. CE for precepting can only be given for actual time precepting a student and must be issued by the EMS training program or EMS service provider that has an agreement or contract with the field preceptor or with the preceptor's employer. In order to issue CE for precepting EMS students or EMS personnel, an EMS service provider must be a CE provider approved by the EMS Agency or State EMS Authority.
- H. At least fifty percent of the required CE hours must be in a format that is instructor based, which means that instructor resources are readily available to the student to answer questions, provide feedback, provide clarification, and address concerns (e.g., on-line CE courses where an instructor is available to the student). This provision shall not include precepting or magazine articles for CE credit. The CE provider approving authority shall determine whether a CE course, class or activity is instructor based.
- I. During a certification or licensure cycle, an individual may receive credit, one time only, for service as a CE course, class, or activity instructor. Credit received shall be the same as the number of CE hours applied to the course, class, or activity.
- J. During a certification or licensure cycle, an individual may receive credit, one time only, for service as an instructor for one of the following; an approved EMT-I, EMT-II, or paramedic training program, except that the hours of service shall not exceed fifty percent of the total CE hours required in a single certification cycle.
- K. When guided by the EMS service provider's Quality Improvement Program (QIP), an EMS service provider that is an approved CE provider may issue CE for skills competency demonstrations to address any deficiencies identified by the service provider's QIP. Skills competency demonstration shall be conducted in accordance with the respective National Standard

- L. Curriculum skills outline or in accordance with the policies and procedures of the EMS agency medical director.
 - M. An individual may receive credit for taking the same CE course, class, or activity no more than two times during a single certification or licensure cycle.
 - M. If it is determined through a QIP that EMS personnel need remediation in an area of the individual's knowledge and/or skills, the EMS Agency medical director or an EMS service provider may require the EMS personnel to take an approved CE course with learning objectives that addresses the remediation needed, as part of the individual's required hours of CE for maintaining certification.
3. Excluded Courses and/or Training
- The following courses and/or training have been determined unacceptable for C.E. credit by the California EMS Authority:
- A. Courses that focus on self-improvement (e.g. personal growth, self-therapy, self-awareness, weight loss, yoga, etc.).
 - B. Parenting, Lamaze or other courses designed for the lay public.
 - C. Economics
 - D. Liberal arts courses (e.g. music, art, philosophy)
 - E. Workplace orientation (e.g. orientation for local accreditation, employer orientation, etc.)
 - F. Fire science courses
 - G. Precepting students
4. To ensure EMS C.E. credit, prior approval by the Merced County EMS Agency shall be required for any course which is not described herein.



**Department of Public Health
Emergency Medical Services Agency**

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Policy #: 301.00
Effective Date: 09/1993
Revision Date: 08/2006
Review Date: 08/2008

This policy supersedes any other existing policy on this subject.

Subject: BASE HOSPITAL CONTACT

Authority: California Health and Safety Code, Division 2.5, Section 1797.220

Purpose: The purpose shall be to establish guidelines for the timely notification of the Base Hospital by prehospital personnel, so as to effect the most efficient and effective treatment and destination decisions regarding the management of patients in the prehospital setting. In addition, early notification allows receiving facilities to prepare for the arrival of the patient.

Policy: The Base Hospital shall be contacted as provided for in the following:

1. Pre-Alert:

Ambulance crews responding to incidents, in which there is reason to believe that one of the conditions listed below may exist, shall contact the Base hospital and forward as much information as is available at that time:

- A. Explosions
- B. Hazardous Material exposure
- C. Multi-Casualty Incident
- D. Any other information indicating a strong probability of multiple patients or an event of disastrous proportions.

- 2. Initial Base Hospital contact should be established prior to beginning patient transport. While it is recognized that this will not be practical in all situations, adherence with this policy will provide for fewer problems regarding destination decisions, turn-a-round times and allow receiving facilities time to prepare to continue treatment of critical or special need patients.
- 3. This policy shall not apply to routine convalescent transports from an acute to a sub-acute facility, or to pre-arranged transports for scheduled procedures, e.g. radiation therapy, come and go surgery, etc., unless there is deterioration in the patient's condition, at which time Base Hospital Contact shall be initiated

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4. Definitions:

The severity of the patient's problem shall be identified with the following designators when Base Hospital contact is made:

- A. "STAT": potentially life or limb threatening condition, usually where the patient is unstable, in a rapidly changing status, or in extremis as identified by the assessment and vital signs.
- B. "NON-STAT": non life or limb threatening conditions, usually indicated by a normal physical assessment, stable vital signs, including release against medical advice (AMA).
- C. "Medical" or "Trauma- D. "Code Blue": when the patient is pulseless and/or not breathing.

5. Formats:

The following formats will be used when transmitting ETA's, report of a patient's assessment, and/or notification of therapy that has been completed or requesting base physician/hospital only orders:

- A. Information Only Format: This format will be used for all STAT and NON STAT patients where standing orders are being followed and there is no request for Base physician /hospital only orders. Format will include patient profile, GCS, clinical impression and vital signs if unstable. This report should be completed within 30 seconds.
- B. Standard Format: This format will be used for patients who need additional therapy beyond the therapy allowed in the standing orders. Also for all patients requesting to be released against medical advice (AMA).
- C. MCI Format: Refer to Merced County MCI Field Operations Policy 800.00
- D. Base Hospital Response Format: The MICN or Base Hospital Physician shall use a format for communicating with field personnel that briefly highlights the Base Hospital response and key points of the pre-hospital patient report. This includes the patient profile, radio operator's impression of the patient's primary problem and a description of the patient's vital signs when given. An example would be "A 40 year old male with chest pain and stable vital signs".

6. Reporting formats:

Information only format

- ✓ Base Hospital
- ✓ Unit ID & Paramedic ID (Last name only, example Medic 15 paramedic Jones)
- ✓ Severity designation (STAT, NON-STAT, code blue, Medical or Trauma)
- ✓ Destination
- ✓ ETA
- ✓ Patient profile (Age, Gender, wt. GCS)
- ✓ Chief Complaint
- ✓ Vital signs (state stable if applicable)
- ✓ Treatment following standing orders

Standard format

- ✓ Base Hospital
- ✓ Unit ID & Paramedic ID (Last name only, example Medic 15 paramedic Jones)
- ✓ Severity designation (STAT, NON-STAT, code blue, Medical or Trauma)
- ✓ Destination
- ✓ ETA
- ✓ Patient profile (Age, Gender, wt. GCS)
- ✓ Chief Complaint
- ✓ Vital signs (state stable if applicable)
- ✓ Treatment completed/in progress from standing orders
- ✓ Request additional therapy
- ✓ Additional information as time allows:
 - Medical history
 - Allergies
 - Medications
 - Physical exam
- ✓ Unit ID
- ✓ Base Hospital & Radio operator ID (MICN Jones, Doctor Jones, etc.)
- ✓ Brief summary of patient (without repeating specific vitals unless there is a question regarding the vitals)
- ✓ Confirm therapy established when given
- ✓ Order additional therapy if needed
- ✓ Confirm destination and ETA

7. When field personal do not contact the base hospital, or do so with an ETA of two minutes or less from the receiving hospital, it shall constitute a failure to make base hospital contact and an "Advance Life Support without Base Hospital Contact" form shall be completed. Repeated failure to make timely Base Hospital contact shall be reviewed by the EMS Agency for disciplinary action.



**Department of Public Health
Emergency Medical Services Agency**

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Policy #: 401.00
Effective Date: 07/1993
Revision Date: 10/2006
Review Date: 10/2008

This policy supersedes any other existing policy on this subject.

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Subject: PHYSICIAN INVOLVEMENT WITH EMS PERSONNEL

Authority: California Health and Safety Code, Division 2.5, Section 1797.220

Purpose: The purpose of this policy shall be to define the role of the non-base hospital physician in the prehospital setting, and to provide guidance to the prehospital personnel regarding their involvement with these physicians.

Policy: EMT-P personnel operate under standard policies and procedures developed by the Local EMS Agency and approved by the EMS Agency Medical Director under the Authority of Division 2.5 of the California Health and Safety Code. EMT-P personnel shall not respond to the medical direction of any individual other than the on-duty base hospital MICN or physician, or allow the involvement of a non-base hospital physician in the rendering of medical care except as follows:

1. The physician must identify him/herself, by name, as a physician licensed in the State of California. Prehospital personnel may request proof of identity.
2. Once properly identified, the physician may assist in one of the following manners:
 - A. Offer assistance with another pair of eyes or hands, or offer suggestions, but the EMT-P shall remain under the medical control of the Base Hospital, or
 - B. Talk directly to the Base Hospital Physician and offer medical advice, or
 - C. Take total responsibility for the care rendered by the EMT-P personnel, in which case the non-base hospital physician shall remain with the patient during transportation and until care for the patient has been properly assumed by the receiving hospital physician. The non-base hospital physician must sign for all orders given to the EMT-P on the patient care report form.
3. Prehospital personnel shall inform non-base hospital physicians, seeking to become involved in the delivery of prehospital care at the scene, of this policy by giving such physician a summary card provided by the EMS Agency.

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NOTE TO PHYSICIANS ON INVOLVEMENT WITH EMT-Is AND PARAMEDICS

A life support team (EMT-II or Paramedic) operates under standard policies and procedures developed by the local EMS agency and approved by their Medical Director under Authority of Division 2.5 of the California Health and Safety Code. The drugs they carry and 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, CCLHO and BMQA.

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, Section 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 the life support team 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 the life support team and physically accompany the patient until the patient arrives at a hospital 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 Emergency Medical Services Authority



**Department of Public Health
Emergency Medical Services Agency**

John Volanti, M.P.H.
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Policy #: 402.00
Effective Date: 07/1993
Revision Date: 03/2009
Review Date: 03/2011

This policy supersedes any other existing policy on this subject.

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Subject: PATIENT DESTINATION

Authority: California Health and Safety Code, Division 2.5, Sections 1797.220 and 1798.101.

Purpose: To provide guidance in the hospital destination decisions for patients in the prehospital setting.

Policy: The responsibility in hospital destination decisions for patients in the prehospital setting, in the absence of Agency policy to the contrary, rests with the Base Hospital. The following shall be taken into consideration by Base Hospital MICN's and physicians when making these decisions:

1. Patient Preference

The patient's preference of hospital shall be honored unless this conflicts with one of the following:

- A. The patient's condition (e.g. extremis) dictates that the destination shall be a trauma center, burn center, children's center, etc.
- B. Current hospital diversion or round-robin status dictates otherwise.
- C. The patient's preferred hospital has not been designated by the EMS Agency as an ambulance receiving facility.
- D. Disaster Control Facility directed destinations per Multi-Casualty Incident Protocols.

2. Cardiac Patients

- A. For those patients preliminarily assessed with a possible acute myocardial infarction (AMI), as determined by the prehospital 12 lead EKG Printout, refer to EMS Policy No. 550.00, STEMI.

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3. Transfers from Physician Office or Clinic Setting

As a matter of policy, transfers out of county from a physician's office or clinic should be pre-arranged with the transport provider to ensure adequate 911 units in the system and to arrange for the Critical Care Transport Ambulance (CCTA), as needed. When prior arrangement cannot be accomplished, the following shall be confirmed prior to the transport:

- A. The Medical Dispatch Center shall be contacted to confirm release of the unit for transfer.
- B. A physician-to-physician arrangement for such a transfer shall be completed and the name of the accepting physician noted by the sending physician.
- C. The Base Hospital Physician (BHP) shall be contacted for concurrence with the direct transport out of County. The sending physician should speak directly with the BHP if issues or concerns are raised regarding such a transport.

4. North County Transports

Many patients residing in the north part of Merced County utilize physicians and hospitals within Stanislaus County. To facilitate their transport to Stanislaus County hospitals, the following procedures shall be followed:

- A. As indicated in this policy, unless the patient's condition dictates otherwise, the patient's preferred hospital should be the destination. Crews should contact the Base Hospital to ascertain whether the patient's preferred hospital is open to receive ambulance patients (e.g. on Stanislaus County rotation). If an alternate Stanislaus County hospital is available, this should be offered to the patient.
- B. The only reasons to restrict transports directly to Modesto are:
 - 1) The patient is in extremis (e.g. unstable chest pain), wherein the patient should be transported to the closest appropriate facility.
 - 2) The Merced County System Status is very low, (e.g. Status 1 on the East Side of the County). In this case, patients must be advised that they cannot be transported to Modesto due to low 911 system resources, and should be offered Emanuel Hospital, if available.

5. To facilitate an appropriate destination decision, prehospital personnel shall contact the Base Hospital as soon as practical, in accordance with Policy No. 301.00, Base Hospital Contact.



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 403.00
Effective Date: 03/15/09
Revision Date: _____
Review Date: 02/2010

This policy supersedes any other existing policy on this subject.

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- Subject:** Patient Management for Inmates – United States Penitentiary, Atwater
- Authority:** California Health and Safety Code, Division 2.5, Sections 1797.220 and 1798
- Purpose:** To establish the special procedures and patient management guidelines for responding to and transporting inmates from the maximum security penitentiary in Atwater.
- Policy:**
1. The staff and administration at the United States Penitentiary, Atwater (USPA) have established special procedures to be followed in the management of inmates to ensure the safety of both the penitentiary staff and the public. To that end, specific response and transportation procedures have been established herein which shall be adhered to so as to provide for the security and safety of all concerned.
 2. The procedures established below shall apply to those inmates incarcerated within the maximum security facility at the USPA. Usual and customary treatment protocols and policies shall apply to all staff of USPA as well as those inmates at the minimum security facility at USPA, as directed by USPA staff.
 3. All crew members responding to USPA shall have a minimum of a driver's license and an EMS Agency photo certification or accreditation card out and available for inspection by any USPA staff requesting such ID.
 4. Ambulance crews should anticipate delays to patient access due to security requirements of the maximum security facility. This delay will be increased, consistent with the current Federal Threat Level.
 5. Ambulances requested for USPA will proceed directly to the USPA main entrance where they will be met and directed by facility staff. Crew shall follow all directions given by USPA staff.
- Procedure:**
1. Transport of Inmates from the Maximum Security Facility
 - A. Inmates at the Maximum Security Facility shall not be flown by helicopter under any circumstances. All patients transported from this facility shall be transported by ground ambulance, with a lead vehicle, chase vehicle and armed guard riding with the patient, as provided by USPA staff.
 - B. Paramedics shall, in consultation with USPA staff, consider driving inmates from the Maximum Security Facility that meet trauma triage criteria directly to a trauma

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center. Contact the Base Hospital for destination, per Trauma Triage Policy No. 512.25.

- C. All other patients not meeting trauma triage criteria, as well as medical patients, shall be transported to Mercy Medical Center Merced for evaluation.

2. Security During Transport

- A. Security of USPA Inmates is the responsibility of the USPA Correctional Officers, and their direction regarding the type and manner of restraint or conduct around the inmate shall be adhered to strictly. Any communication with the patient shall be for the purpose of necessary medical history or solicitation of complaint or follow-up only.
- B. The paramedic should inquire regarding access to arms and/or the antecubital area if the need for IV access is deemed likely, as restraint to the gurney may be necessary and may need to be established prior to departure.



**Department of Public Health
Emergency Medical Services Agency**

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Policy #: 410.00
Effective Date: 10/2007
Revision Date: 10/2008
Review Date: 03/2010

This policy supersedes any other existing policy on this subject.

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Subject: RESPONSE TO KNOWN OR SUSPECTED HAZARDOUS MATERIALS INCIDENTS

Authority: Health and Safety Code, Division 2.5, Section 1798.6 and 1797.220

Purpose: The purpose of this policy shall be to establish the standards for ambulance operations when responding to known or suspected hazardous materials (HazMat) incidents, and the procedures to follow if the ambulance crew becomes aware of an exposure after arriving on scene and coming into contact with an exposed patient.

Policy: EMS personnel responding to known or suspected HazMat incidents, or those events in which the EMS crew learns of a possible HazMat exposure after coming in contact with a suspected exposed patient, shall follow the procedures and guidelines contained herein.

Procedure: 1. Dispatch

Units dispatched to a possible hazardous materials incident will be advised by dispatch (in addition to the usual information) of the following, when available:

- A. The purpose of the response;
 - 1) Providing support for the hazardous materials response team or fire units
 - 2) Treating and transporting exposed (not contaminated) victims
 - 3) Establishing a requested Medical Branch or Group for a large incident.
- B. A confirmation that a hazardous materials incident response has been activated.
- C. Type of hazmat event; i.e. train derailment, big-rig incident, chemical plant fire.
- D. Type, category, and name of hazardous material(s) involved (if known) (Specific safety considerations for each type of hazardous materials are listed in the North American Emergency Response Guidebook for Hazardous Material incidents (DOT P. 5800.3)).

E. On scene wind direction and recommended approach route - responding unit(s) should coordinate with Incident Commander.

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- F. Estimated number of patients.
- G. Provide location of Incident Commander Post and agency identification of the Incident Commander, if available.
- H. EMS Staging Area location.

2. Recognition of a Hazardous Material ((On-Scene (EMS) or During Transport)):

EMS personnel may become aware of a hazardous material while on scene. If such a situation occurs, EMS personnel will take the following measures:

- A. EMS personnel should consider themselves potentially contaminated;
- B. Evacuate to a safe location (minimize exposure to self and others);
- C. Notify EMS Dispatch and advise them of the potential contamination;
- D. EMS personnel will then request fire department response to the scene for site control and potential emergency decontamination. EMS personnel will follow the direction of the fire department once they arrive.
- E. The scene will be managed as a hazardous materials site using principles of the Incident Command System (ICS).

3. Patient Care

- A. EMS personnel shall not attempt to enter any HazMat scene or render medical aid beyond the support zone. Medical treatment and transportation is secondary to the possibility of spreading the contaminant, and the management of the HazMat incident. Management of the hazardous material and the prevention of further exposure take precedence over patient care. EMS personnel may be requested to receive non-ambulatory patients from the Contamination Reduction Zone after decontamination has been completed.
- B. The hazardous materials response team (fire department) may initiate patient care within the inner perimeter of the exposure area(s). EMS personnel may only provide and/or initiate patient care after the patient has been transferred to them in the designated area (support zone) after decontamination considerations have been addressed.

4. Patient Transportation

- A. Deceased victims shall be left undisturbed at the scene.
- B. Transport of contaminated patients is prohibited. Patients that have been decontaminated should be considered “exposed” and treated accordingly. The type of transport- (air ambulance, ground ambulance, mass transportation, POV) should take into account the type of exposure and the

- potential for secondarily exposing health care providers or private citizens. The hazardous materials response personnel should be consulted regarding the potential for secondary exposure of medical care personnel.
- C. Transport crews shall notify both the Base Hospital and Receiving Hospital of the patient's exposure and that the patient has received decontamination prior to transport (if decontamination was necessary).
- D. If, during patient transport, personnel become aware of information that the patient is a victim of hazardous material exposure or contamination, they shall immediately notify EMS Dispatch. EMS Dispatch shall notify the Fire Department of jurisdiction and request their response for evaluation. The transport unit shall immediately discontinue the transport and find the nearest safe and appropriate location to stop and evacuate themselves and the patient from the ambulance. The crew shall then do the following:
- 1) don personal protection equipment, as appropriate and available;
 - 2) prepare for emergency decontamination;
 - 3) provide supportive care for the patient, as necessary
 - 4) The patient is not to be moved into the hospital until cleared by appropriate fire or HazMat personnel.
5. After the patient is transferred, the emergency crew must leave all equipment, trash, contaminated clothing. etc., in the ambulance and lock its doors. Personnel shall not leave the area, eat or drink and should consider self-decontamination (if decontamination has not already occurred). The ambulance will remain out of service until it has been evaluated for contamination and cleared by the Health Department, Division of Environmental Health.



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 431.00
Effective Date: 09/1993
Revision Date: 02/2012
Review Date: 02/2014

This policy supersedes any other existing policy on this subject.

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Subject: ALS UNIT EQUIPMENT AND SUPPLY INVENTORY

Authority: California Health and Safety Code, Division 2.5, Sections 1797.220 and 1798(a).
California Code of Regulations, Division 9, Section 100167(b)(3).

Purpose: To establish the minimum equipment and drug inventory standards for all ALS units operating within the jurisdiction of the Merced County EMS Agency. ALS Unit equipment and drug inventories shall be established consistent with the current Prehospital Treatment Protocols, and shall be amended concomitantly with changes to said Treatment Protocols, as required.

Policy: It shall be the responsibility of the on-duty paramedic to ensure that his/her assigned ALS Unit is fully stocked with the following minimum equipment and drug inventory at the beginning of each shift. Any ALS Unit found to be missing any items identified in this policy as "Essential" shall place the unit out of service until such time as the discrepancy is corrected. All ALS units shall be fully re-stocked following the completion of each shift and re-stocked after calls as required to remain in compliance with the specifications herein.

If an ALS Unit is requested by the Authorized EMS Dispatch Center to respond for an emergency call prior to being re-stocked, said unit may respond as long as there are no "essential" items missing, and the unit has adequate equipment and drugs to provide proper patient care, as defined by the EMS Treatment Protocols. Should an ALS Unit be requested to respond with inadequate equipment or drugs, as defined above, or with "essential" items missing, said unit may respond in a "first responder" status only, and the EMS Dispatch Center shall simultaneously dispatch a properly equipped and staffed ALS Unit to the scene for care and patient transportation. The provider will file a Situation Report with Agency whenever an ALS Unit responds, in any capacity, to an incident without all essential items.

The equipment and drugs listed in this policy shall be in addition to those required by the California Code of Regulations, Title 13, Sections 1103 and 1103.2.

This policy may be suspended by the EMS Medical Director or his designee in the event of a declared or actual disaster.

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1. COMMUNICATIONS

All ALS Units shall have radios which are capable of transmitting and receiving communications with the Merced County Authorized EMS Dispatch Center.

- * All ALS Units shall have Med-Net radios for the purpose of communicating with the Base Hospital and the Disaster Control Facility within Merced County, and the capability of transmitting and receiving on the appropriate Med-Net frequencies and private line tones for the base hospitals in the surrounding counties. Radios used for communications with the base hospital shall be accessible in the patient compartment.

All ALS Units shall be equipped with no less than one (1) portable radio, capable of communicating with the ALS Unit while on-scene of an emergency.

2. DRUG AND IV SOLUTION MAINTENANCE

All drugs and/or solutions shall clearly display the manufacturer's label indicating the name of the drug/solution, dosage, route of administration, expiration date, and the lot number.

The expiration date of all drugs and IV solutions shall be checked, at a minimum, on the first day of each month. All drugs and/or solutions that will expire within 45 days shall be clearly marked, and must be replaced no later than 48 hours prior to the expiration date.

Drugs shall be maintained in both the ALS Unit and the medical bag carried on-scene by the crew. Each ALS Ambulance Service Provider shall determine the drugs to be carried in the medical bag so as to meet the identified needs of their service area. Controlled drugs shall be stored in accordance with the Agency Controlled Substance Policy.

ALS Ambulance Service Providers shall take provisions to maintain medications and IV solutions within the manufacturer's recommended temperature range. Providers shall maintain two IV bags of normal saline at or near a normal physiological temperature range.

3. DRUGS (MINIMUM SUPPLY)

Adenosine:	Total of 30 mg.
Aspirin:	Chewable, 81mg x 1 bottle
Atropine Sulfate:	1 mg preloads x 2 and 10 mg multi-dose vial
Calcium Chloride:	1 gm pre-load x 2
Dextrose:	25 gm in 50 ml pre-load x 2
Diphenhydramine Injectable:	50 mg x 2
Dopamine:	200 mg/5ml x 2 or 1 pre-mix infusion solution 500 cc 800mcg/cc
Epinephrine:	1 mg of 1:10,000 x 8 1 mg of 1:1000 x 4 30 mg of 1:1000 multi-dose
Furosemide Injectable :	Total of 200 mg
Glucagon:	1 mg x 2
Instant Glucose:	2 tubes
Lidocaine:	100 mg pre-load x 4 and 2 gm for dilution or 1 pre-mix infusion solution 500cc 4mg/cc
Magnesium Sulfate:	2 Preloads (5 gms)

Naloxone:	Total of 10 mg
Nitroglycerin:	1/150 (0.4) SL
Nitroglycerin Paste:	1 tube with 10 patches
Normal Saline:	For dilution - total of 20 ml
Oxygen:	1 fixed large capacity cylinder and 1 portable cylinder capable of delivering 10 lpm oxygen for one hour
Proventil:	0.1 mg/cc x 2
Sodium bicarbonate:	50 meq/50 ml pre-loads x 2

4. CONTROLLED SUBSTANCES (FIXED AMOUNT)

Versed:	5 mg x 4
Morphine Sulfate:	10 mg x 4

5. IV SOLUTIONS AND SUPPLIES

Alcohol Preps:	ample supply
Band-Aids:	
Medication Labels:	
IV Catheter Needles:	14 thru 24 gauge x 5 each 10 or 12 gauge x 2 each 250cc x 2, 1000cc x 8
Normal Saline:	
Macro-drip set (with a minimum of two injection ports):	10-20 gtts/ml x 6
Micro-drip set (with a minimum of two injection ports):	60 gtts/ml x 2
Dial-a-Flow:	x 2
Syringes:	1, 3, 10 and 20 ml x 4, 3 & 5 ml x 5
Syringes, Vanishing Point:	x 4 rolls, at least 1 hypo-allergenic
Tape:	x 3
Tourniquets or IV Start Kits:	ample supply
Disposable Gloves (exam type):	x 6
Sterile Vaseline Gauze:	

6. CARDIAC

- * EKG Monitor/Defibrillator with Paper Printout and Defibrillator with a variable power control with a range capability of 25 to 360 watt seconds
Pediatric Defibrillation Paddles or disposable pads
All Monitor Defibrillators shall have 12 lead capability
All Monitor/Defibrillators shall have the capability to administer synchronized cardioversion
All monitor/defibrillators shall have removable batteries to facilitate immediate replacement
Electrode Pads:
2 bags (25 each bag)
- * Monitor Cables:
Backup Batteries for Monitor/Defibrillator:
x one set (with backup mechanism)
x 1

7. RESPIRATORY

Bougie	Adult x2
King Airways:	Pediatric x2 1 Red 1 Yellow

Oral Pharyngeal Airways (Pediatric through Adult):	x 2
Nasal Pharyngeal Airways (Pediatric through Adult):	x 2
Bag-Valve Device (sterilized disposable)	
* Adult:	x 1
* Pediatric:	x 1
* Neonate:	x 1
* Laryngoscope with two sets of batteries (one set for backup)	
* Laryngoscope Blades (sizes 4 to 1):	1 set curved, 1 set straight
Laryngoscope light bulbs (backup):	1 each size
* Endotracheal Tubes with appropriate adapters:	sizes 2.0 thru 8.0 in 0.5mm increments to fit adult and pediatric tubes
Endotracheal tube styles:	
Mainstream ETCO ₂ detector	x 2
End-tidal CO ₂ detectors:	Adult x2 Pediatric x2 0-15 l/min measure
Two (2) wall mounted flow meters:	x 2
Disposable humidifiers for O ₂ flow meters:	Adult & Child sizes amply supply
McGill forceps:	Adult x 6
Water soluble lubricating jelly:	Pediatric x 4
Nasal Cannula:	Adult and Ped. x 4
Oxygen mask with reservoir:	
Oxygen tubing adapter (x-mas tree style):	x 2
Oxygen Valve wrenches:	x 2
Suction catheters (french):	sizes 8 thru 14
Suction catheters (handle-tip, rigid):	x 2
Non-collapsible suction tubing:	x 2
Nebulizers (hand-held and mask type):	x 2 each (Pediatric & Adult)
* Suction devices (both with 12mm mercury neg. pressure):	1 - stationary 1 - portable x 2
Bite sticks:	

8. TRAUMA AND ORTHOPEDICS

KED or comparable device:	x 1
Scoop (style) stretcher :	x 1
* Long backboards:	2 minimum (1 essential)
Spider straps for backboards:	2 sets minimum (1 essential)
Pediatric immobilization device:	x 1
Burn packs (pre-packaged sterile or autoclaved):	x 2
Rigid cervical collars (stiff-neck style):	sizes pediatric & adult adjustable (1 essential) x 2 (1 essential)
Head Immobilization device:	x 4
Cold packs:	1 - adult, 1 - Ped.
Traction splints:	leg and arm
Extremity splints:	
Intraosseous needles:	sizes 15, 18, x 2 each

9. OBSTETRICAL EQUIPMENT

Commercially available packs, meeting the requirements of Title 22, Section 1103.2(a)(17):	x 2
Commercially available, survival type aluminum-styled blanket for heat conservation in newborns:	x 2

10. MISCELLANEOUS EQUIPMENT

* MCI Vest	x 3
* Blood pressure cuffs (1 - adult BP cuff essential):	2 - adult, 1 - Ped. 1 - extra long, 1-Infant
* Stethoscope (1 - stethoscope essential):	x 2
Normal saline for irrigation:	1000 ml x 4
* Patient Gurney:	x 1
Glucometer (with accessories):	x 1
Pulse Oximeter (with Adult & Peds sensors):	x 1
Broselow Pediatric Tape	x 1

11. PERSONAL PROTECTIVE EQUIPMENT**

Rescue/Work Helmet (NFPA 1951 Standard)	x 2
Reflective Jacket	x 2
Eye Protection Work Goggles	x 2
Bio-protection Kit (hooded suit, goggles, gloves, and shoe Covers)	x 2
N-95 Masks	x 8 (4 each size)
Multi-Use Work Gloves	x 2 pr.
P-100 Masks	x 3

All items listed in this inventory with an asterisk (*) to the left shall be considered essential for the purpose of this policy.

** Personal Protective Equipment must be replaced immediately after use, unless extra stock is available in the ambulance for the crew members.



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 432.00
Effective Date: 09/1993
Revision Date: 08/2006
Review Date: 08/2008

This policy supersedes any other existing policy on this subject.

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Subject: CONTROLLED SUBSTANCES

Authority: California Health and Safety Code, Division 2.5, Sections 1797.220 and 1798(a) California Code of Regulations, Title 22, Division 9, Sections 100146, 100167 and 100168

Definitions: **ALS** Means Advanced Life Support as defined in Section 1797.52 of the Health and Safety Code, Division 2.5.

Agency Refers to the Merced County EMS Agency.

Back-up ALS Unit Means a fully stocked and operational ALS ambulance that is not currently staffed with an EMT-P (not part of the current system plan) responsible for the controlled substances on said ambulance.

BLS Means Basic Life Support as defined in Section 1797.60 of the Health and Safety Code, Division 2.5.

DEA Means the Drug Enforcement Administration, United States Department of Justice.

Out-of-Service ALS Unit Means an ALS ambulance that is not currently operational nor staffed with an EMT-P responsible for the controlled substances on said ambulance.

Controlled Substance(s) or Substance(s) Refers to either Morphine Sulfate or Versed.

Stock Refers to the quantity of controlled substances stored at a providers place of business.

Purpose: To ensure the security of controlled substances utilized and stored by ALS Service providers.

APPROVED:

ON-FILE

John Volanti, MPH
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James Andrews, MD
EMS Medical Director

STRIVING FOR EXCELLENCE

Policy: ALS Service Providers are responsible for the security of controlled substances in accordance with this policy and their approved company policies.

1. All ALS Providers shall have controlled substance policies in place, approved by the Agency, addressing, at a minimum, the following:
 - A. maintenance of logs for stock
 - B. maintenance of logs for each ALS unit
 - C. purchase of stock,
 - D. receipt of stock
 - E. storage and security of stock
 - F. access to stock and security of keys/combinations
 - G. removal of stock from storage
 - H. stocking of ALS units
 - I. removal of ALS units from service
 - J. security of stock in backup ALS units
 - K. documentation and validation of wasting of unused portions of substances
 - L. persons authorized to access or handle controlled substances
 - M. procedures in the event of breakage of a controlled substance container
 - N. procedures in the event of missing or stolen controlled substances and/or discrepancies noted during a controlled substance log update.
 - O. reporting requirements to the local law enforcement agency of jurisdiction and the DEA.
2. Providers shall obtain controlled substances through their provider-based medical director, consistent with the requirements of the DEA for licensing and obtaining DEA Form 222, required for submission to a vendor of controlled substances.
3. Only the following individuals shall be authorized to have access to or handle control substances:
 - A. on-duty Paramedics
 - B. provider management staff authorized by the Agency
 - C. re-supply personnel authorized by the Agency to transport controlled substances for re-supply of remotely stationed ALS units.
4. Controlled substances shall be counted and log entries made anytime the substances are accessed. All controlled substances in ALS units shall be counted, at a minimum, at the beginning of each shift change, and appropriate log entries made by the on-coming and off-going paramedics.
5. The stored controlled substances at the provider's place of business shall be counted at a minimum of every 48 hours or each time accessed, by two authorized individuals, and both shall make an appropriate log entry verifying the count and condition. Copies of all controlled substance logs shall be submitted to the Agency by the 20th day of the month for the previous month's activities.
6. ALS service providers shall submit their controlled substance policy to the EMS Agency for approval within 30 days of the implementation of this policy. Any proposed revisions to ALS service provider controlled substance policies shall be submitted to the EMS Agency for approval prior to implementing such revisions.

7. The Agency shall either approve controlled substance policies or submit to the ALS service provider, in writing, what additional information or policy changes are required to gain approval within ten working days of receipt of the policy.
8. Under no circumstances shall controlled substances be stocked in a BLS unit.
9. ALS service providers shall not be licensed to operate within this EMS jurisdiction unless they have submitted a controlled substance policy for approval by the Agency as outlined in this policy, unless the provider can demonstrate that they are in compliance with a controlled substance policy of a neighboring EMS Agency.



**Department of Public Health
Emergency Medical Services Agency**

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Policy #: 440.00
Effective Date: 05/2001
Revision Date: 10/2006
Review Date: 10/2008

This policy supersedes any other existing policy on this subject.

Subject: PATIENT RESTRAINT

Authority: California Health and Safety Code, Section 1797.220

Purpose: The purpose of this policy shall be to establish the minimum standards for the application of restraints to patients.

Policy:

1. Restraints may be utilized for the following reasons:

A. Patient Safety

The patient's condition is such that the patient may intentionally or unintentionally harm him/herself if not restrained.

B. Safe Access for Medical Procedures

The patient's condition demands medical procedures for stabilization and without the use of restraint's these medical procedures could not be accomplished.

C. Involuntary Treatment of Persons Incompetent to Refuse Treatment

A person who exhibits a danger to him/herself or others (verbally or physically) may be taken into custody under an emergency mental health hold (5150). Law enforcement shall be present during incidents involving involuntary treatment and/or restraint. Patient characteristics that may indicate an imminent need for involuntary treatment and/or restraint would consist of the following:

1. verbal or physical evidence of an acutely suicidal patient
2. a confused intoxicated patient who is injured or ill and refusing treatment/transport
3. an acutely confused patient who is injured or ill and refusing treatment/transport
4. a developmentally disabled or psychotic patient, who is injured or ill and refusing treatment and/or transport
5. An unconscious patient expected to improve who may present with combative ness.

APPROVED:

ON-FILE

John Volanti, MPH
Director of Public Health

James Andrews, MD
EMS Medical Director

STRIVING FOR EXCELLENCE

D. Safety to Field Personnel

The patient's condition is such that he/she exhibits a danger to field personnel.

1) Patients Suspected of Possessing Weapons

For those patients that exhibit unusual aggressiveness; make threatening remarks; are involved in violent incidents; have suspicious items identified during the secondary survey or refuse to allow a secondary survey, and if field personnel suspect that their refusal is related to the possible discovery of weapons, the following steps should be taken for the safety of all involved:

- a) Law enforcement, if not already on-scene, should be summoned
 - b) Adequate personnel (preferably at least four) should be present to control the patient's actions. Overwhelming force is the best protection for all concerned.
 - c) A search of the patient's person and clothing should be requested of law enforcement prior to the EMS personnel assuming responsibility of the patient for transport
 - d) Should the patient continue to exhibit a threatening posture, he/she should be restrained as provided for in this policy.
- 2) EMS personnel shall convey any concerns to law enforcement regarding a patient, family or by-stander that threatens violence, for their resolution. EMS personnel should only attempt to restrain violent patients or others on the scene of an emergency when there is an immediate threat to their safety and law enforcement is not readily available.

2. Types of Restraints Approved for use by EMS Personnel

- A. Leather Restraints - It is strongly suggested that these be used when dealing with patients on PCP or patients who are severely mentally retarded as these patients frequently do not respond to pain. Failure to respond to pain means that the person may continue to exert pressure until such time as the bones supporting the pressure break.
- B. Kerlix - Unroll the Kerlix, put the ends together and use it double-strength. When used in single-thickness, the abrasiveness of the restraint is increased and is damaging to fragile geriatric or diabetic skin conditions.
- C. Soft Sheets or Towels - Not as effective as Kerlix, but may be used.

3. Restraints Not Approved for use by EMS Personnel

- A. Mechanical Restraints (Handcuffs, Ankle Shackles) - Should a patient be mechanically restrained it is necessary to have law enforcement present in the vehicle when transporting the patient. If law enforcement is unwilling to "ride in" with the patient, all mechanical restraints should be removed and the patient should be restrained using an approved method. EMS personnel will not apply mechanical restraints.
- B. Hobble Restraints - Traditionally described as the restraint of a person's hands behind his/her back, ankles tied together, knees flexed, and then ankles tied to his/her restrained

wrists. This restraint method has been associated with several pre-hospital deaths resulting from possible positional asphyxia and is not to be used by EMS personnel.

4. Documentation of Restraints

A. In situations where you have restrained a patient, the following information shall be documented:

1. an emergency existed
2. the need for treatment was explained to the patient
3. the patient refused treatment or was unable to refuse treatment
4. evidence of the patient's incompetence to refuse treatment
5. the failure of less restrictive methods of control such as verbal de-escalation or counsel
6. that the restraints were for the patient's safety
7. that the reasons for the restraint were explained to the patient
8. the type of restraint used
9. the limbs that were restrained
10. injuries or lack of injuries incurred during the restraint procedure
11. circulation checks every 15 minutes distal to the restraints

Procedure:

1. Any form of restraint must be informed restraint. Even when the patient's lack of competence will interfere with their ability to understand your explanation, you must explain why you are restraining the patient prior to restraint.
2. If at any time the patient requires physical restraint, the patient shall remain restrained until delivered to the Emergency Department (ED).
3. Circulation checks before and after the use of restraints are **MANDATORY**.
4. If the patient begins to display seizure activity, the restraints shall be removed. Seizure activity produces violent muscle contractions that can fracture bones.
5. Pregnant women shall not be restrained in the supine position as the weight of the gravid uterus can compress the inferior vena cava and impede venous return to the heart. This can cause hypotension and threaten the life of the fetus. Keep the restrained patient on her left side.
6. A gentle, non-threatening, low profile approach shall be attempted prior to using a more direct intervention. Attempt to "talk down" the patient.
7. Always explain the option of physical restraint to the patient before applying force (give the patient the opportunity to cooperate). If the patient is still unwilling to cooperate, advise him/her that restraint is necessary to protect him/her and others from injury.
8. A minimum of two people (preferably four) is required for safely restraining an uncooperative patient. Personnel shall use accepted methods for restraining uncooperative patients.
9. Patients with needed medical interventions should be transported in the supine position. You may need to transport some patients in the prone position. Continuous monitoring must be done with these patients.

10. You may cover the patient's face with a surgical or oxygen mask if the patient is spitting or biting. If applying a mask to a patient, use one that will not obstruct the airway or decrease oxygen flow.
11. Arms should not be restrained in front of the patient as the patient still maintains the ability to swing his/her arms. Arms should be restrained to the side or back of the patient.
12. The use of force shall be limited to the force necessary to keep the patient from injuring themselves or others, including EMS personnel. Law enforcement personnel are needed if force is necessary. Avoid physical force that may cause injury to the patient.



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 451.00
Effective Date: 03/1993
Revision Date: 09/2006
Review Date: 09/2008

This policy supersedes any other existing policy on this subject.

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Subject: EMERGENCY AMBULANCE DISPATCHING

Authority: California Health and Safety Code, Division 2.5, Section 1797.220

Definitions: **EMD** - Means an Emergency Medical Dispatcher, who is an individual trained and certified to receive emergency medical calls for assistance and, through the use of key questions, establish a priority dispatch for the responding emergency medical field personnel while remaining on-line with the calling party to provide pre-arrival medical instructions.

Priority Dispatching - Shall mean Level Two Priority Dispatching, which is characterized by the use of an approved priority dispatch card system, containing key medical questions which are used to establish the nature of a medical emergency and effect the correct system response, as well as pre-arrival instructions which provide medical guidance to the calling party until the arrival of the emergency medical response team(s).

Priority One - Shall mean potentially life-threatening emergencies. A code three (lights and siren) ALS ambulance response shall be effected concomitantly with a code three response from the first response agency responsible for the area of the emergency call.

Priority Two - Shall mean non-life-threatening emergencies. A code three (lights and siren) ALS ambulance response shall be effected concomitantly with a code three response from the Merced County Fire Department within their areas of responsibility.

Priority Three - Shall mean non-emergency calls. A code two (no lights and siren) ALS ambulance response, without first responders, shall be effected.

PSAP - Public Service Answering Point.

Recognized First Response Agency - Shall be limited to duly authorized Public Safety Agencies operating within Merced County or any incorporated political subdivision thereof.

Purpose: To establish the mechanism by which ambulances shall be dispatched to emergency medical requests for service within the jurisdiction of the Merced County EMS Agency, as well as establish the means for upgrading or downgrading the ambulance response priority or the canceling of an ambulance responding to a medical emergency.

APPROVED:

ON-FILE

John Volanti, MPH
Director of Public Health

James Andrews, MD
EMS Medical Director

Policy:

1. Establishment of the Dispatch Priority

- A. Ambulances responding to emergency medical requests for service within the area of jurisdiction of the Merced County EMS Agency shall be prioritized based solely on the presumed medical need utilizing the approved EMD Priority Dispatch Card System. The priority for the dispatch shall be determined by the EMD with responsibility for the incident.
- B. For those incidents in which the Primary PSAP does not transfer the calling party (e.g. MVA's, Shootings, etc.) the dispatch priority shall be established by the Primary PSAP in coordination with the EMD responsible for the medical incident.

2. Down-grading the Dispatch Priority

- A. The EMD may down-grade a dispatch priority for a response in progress only as provided for below:
 - 1) As further information becomes available from the scene of the incident concerning a change in the patient's condition, or clarifies a previously uncertain patient condition.
 - 2) An update from a recognized first response agency which has personnel on-scene confirming the patient's condition. In each case where a recognized first responder down-grades a Priority 1 or Priority 2 ambulance, the EMS Dispatch Center shall confirm the First Responder Agency responsible for the Down-grade.
 - a) If, at any time, the EMD has reason to suspect the accuracy or validity of the down-grade advisement, s/he shall continue the ambulance at their originally dispatched priority response.

3. Up-grading the Dispatch Priority

- A. Up-grading of an ambulance dispatch priority shall occur when the EMD is presented with any of the following:
 - 1) Further information becomes available advising of a change in the patient's condition, such that first responders should be utilized (based on the EMD Dispatch Priority Cards, e.g.: Priority 1 upgrade from an original Priority 2 dispatch). This up-grade priority shall be established by utilization of the EMD Dispatch Priority Cards.
 - 2) An update from an authorized PSAP.
 - 3) An update on the patient condition as provided by any other reliable source, as deemed appropriate by the EMD.

4. Canceling the Responding Ambulance

- A. Ambulances responding for emergency requests for service may only be cancelled as provided for below:
- 1) A call-back from an authorized PSAP advising that their on-scene unit has confirmed that there is no medical need for the ambulance, or that they are unable to locate a patient. If the cancellation is due to no medical need, the EMD Dispatch Center shall confirm the agency canceling the ambulance.
 - 2) An update from a recognized first response agency advising that there is no need for the ambulance, or that they are unable to locate a patient. If the cancellation is due to no medical need, the EMD Dispatch Center shall confirm the first responder agency canceling the ambulance.
 - 3) Information from a reporting party on-scene advising that there is no longer a need for the ambulance.

5. Dispatching and Cancellation of Mutual Aid Ambulances

- A. A mutual aid ambulance shall be dispatched as follows:
- 1) Whenever the Ambulance Provider responsible for an EMS area where an emergency request for service occurs is unable to immediately affect an ambulance response, with a shorter ETA than the closest mutual aid ambulance, as required by the Agency.
 - 2) Whenever the Ambulance Provider responsible for an EMS area where an MCI occurs has insufficient units to manage the number of patients.
- B. Should the ambulance provider responsible for the area in which the mutual aid ambulance is responding subsequently be in a position to respond a properly equipped and staffed ambulance which has made radio contact with the dispatch center and advised of their available status, the EMD shall only cancel the mutual aid ambulance upon confirmation of a shorter ETA from the responsible ambulance provider's unit. All mutual aid responses that are cancelled by this mechanism shall generate a Merced County EMS Agency Situation Report which shall include, at a minimum, the incident number, date, dispatch priority including the patient's chief complaint and all incident times.

6. Dispatching and Cancellation of Back-up Ambulances

- A. Back-up ambulances shall be dispatched to EMS incidents as provided for below:
- 1) As additional ambulances are indicated by the nature of an incident, as described to the EMD by reporting parties.
 - 2) As requested by an authorized PSAP.
 - 3) As requested by recognized first response, law enforcement, or ambulance personnel who are on-scene at an EMS incident where multiple victims are identified.

- B. Back-up ambulances may only be cancelled as provided for below:
- 1) As requested by an authorized PSAP.
 - 2) As requested by a recognized first response or law enforcement agency with personnel on-scene who are confirming that there is no need for additional ambulances, or as requested by an on-scene ambulance crew.
7. Under no circumstances shall any individuals, other than those identified and provided for in this policy, be allowed to alter, amend, or otherwise effect any change in ambulance dispatching procedures or dispatch priorities, particularly relating to the down-grading or cancellation of ambulances responding for medical emergencies. All concerns relating to the appropriateness of dispatching procedures for a particular incident shall be investigated retrospectively, through the EMS Agency Situation Reporting procedure. Any violation of this policy shall be reported immediately to the EMS Agency for investigation and possible disciplinary action.

8. ALS Ambulance Downgrade or Cancellation Criteria for BLS Personnel

ALS Ambulances may be downgraded or cancelled for patients meeting the following criteria:

A. Mental Status:

The patient must be conscious, alert and oriented to person, place, time and purpose. For patients with pre-existing, diagnosed altered mental status (post CVA, dementia, etc.) the patient's mental status must be confirmed as normal for them by a knowledgeable individual on-scene, e.g. family member, caretaker, etc.

B. Physiologic Status:

The patient must be free from shortness of breath, chest pain, abdominal pain or other acute, undiagnosed pain. The patient must not be either acutely hypotensive or hypertensive, nor shall the ambulance be either cancelled or downgraded if the patient exhibits signs or symptoms of shock, e.g. pale, cool, moist skin; tachycardia, tachypnea, orthostatic findings, etc. The patient should be free from obvious substantive injuries, e.g. extremity deformity, excessive blood loss, etc. There is no hard and fast rule for this assessment; it requires good judgment on the part of the on-scene personnel. Error to the side of the patient and continue the ambulance without change when in doubt.



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 640.00
Effective Date: 09/1993
Revision Date: 02/2012
Review Date: 02/2014

This policy supersedes any other existing policy on this subject.

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Subject: FIRST RESPONSE ALS UNIT UTILIZATION

Authority: Health and Safety Code Division 2.5, Sections 1797.204, 1797.218 and 1797.220

Definitions: **Agency** - means the Merced County Health Department, as the designated Emergency Medical Services Agency for Merced County.

ALS – means Advanced Life Support as defined in the California Health and Safety Code, Section 1797.52.

ALS Unit - means a properly staffed and equipped ALS ambulance, as specified in EMS Policy No. 431.00, "ALS Unit Equipment and Supply Inventory" and Merced County Code, Sections 9.44 et seq.

CAD – means Computer-Aided Dispatch system consisting of associated hardware and software to facilitate call taking, system status management, unit selection, ambulance coordination, resource dispatch and deployment, event time-stamping, creation and real time maintenance of incident database, and providing management information.

ERT or Extended Response Time – means a response time that exceeds the Late Response Time (LRT) as indicated in Table 1, but is not two (2) times the required response time for a given geographic area.

FRALSU – means a First Response Advanced Life Support Unit, which shall be operated by an authorized ALS ambulance provider and be staffed by a minimum of one Paramedic Supervisor with such equipment and supplies as required herein.

PRT or Protracted Response Time – means a response time of two (2) times the required response time or greater for a given geographic area, as indicated in Table 1.

RRT or Required Response Time – means the time within which the Provider must have an ALS unit on-scene for a given geographic area as indicated in Table 1.

APPROVED:

ON-FILE

John Volanti, MPH
Director of Public Health

James Andrews, MD
EMS Medical Director

Purpose: The purpose of this policy is to both authorize the use of FRALSUs in this EMS system and to specify the conditions under which they may be used.

Policy: FRALSUs may be utilized within the Merced County EMS System, subject to the conditions, procedures and specifications established herein. To encourage such system enhancements, an ALS ambulance provider's response time standards and penalties for specific 911 responses may be adjusted when FRALSUs are utilized, subject to the specifications in Section 3 of this policy.

1. EQUIPMENT AND SUPPLIES

FRALSUs shall be staffed and equipped as required by the County for all responses authorized by this policy. The minimum equipment and supplies to be carried on the FRALSU are listed in Appendix 1.

2. STANDARDS FOR USE

- A. FRALSUs may be utilized by authorized ALS ambulance providers to augment their response capabilities, provide backup resources, supervise the provider's field personnel or to assist with the management of a multi-casualty incident.
- B. Under no circumstances shall FRALSUs be used to replace ALS Units otherwise required as part of the Provider's Approved System Status Plan, nor shall the total unit hours required in the System Status Plan be adjusted due to the availability or use of FRALSUs.
- C. The dispatch CAD data shall reflect all responses for the FRALSU and contain all contractually required response data.
- D. All responses by the FRALSU, in which patient contact is made, shall require documentation of the findings and actions of the FRALSU paramedic on the patient care report (PCR). The transporting paramedic shall document and attribute said findings and actions of the FRALSU paramedic on the PCR.

3. RESPONSE TIME PERFORMANCE CONSIDERATION

- A. For those 911 responses in which the FRALSU arrives on-scene prior to the LRT for the ALS Unit, the following shall apply:
 - 1) The RRT, ERT and PRT for the responding ALS unit shall be extended by six (6) minutes for Priority 1 and 2 responses and ten (10) minutes for Priority 3 responses (Response Time Standards are listed in Table 1);
 - 2) ERT penalties shall not apply for the ALS Unit response.
- B. For those 911 responses in which the FRALSU arrives on-scene after the RRT but prior to the ERT for the ALS Unit, the ERT for the ALS Unit shall be extended by four (4) minutes.
- C. Should the FRALSU have an ERT or the ALS Unit have a PRT, neither response time extensions nor waivers of fines shall apply.

4. EVALUATION

- A. Data for all FRALSLU activities shall be collected by the ALS provider and submitted with their monthly compliance reports. The burden for documentation of all response time allowances and the submission of specific response time considerations shall fall to the ALS provider.
- B. The Merced County Contract Compliance Committee shall review and provide recommendations regarding the application of FRALSLU requests for response time considerations.

Merced County Response Time Performance Standards

Table 1

Area	Code 3 (Priority 1 & 2)				Code 2 (Priority 3)			
	RRT	LRT	ERT	PRT	RRT	LRT	ERT	PRT
Urban	< 10 min.	10 - 15 min.	15:01 - 19:59	20 or > min.	< 16 min.	16 - 24 min.	24:01 - 31:59	32 or > min.
Suburban1	< 12 min.	12 - 18 min.	18:01 - 23:59	24 or > min.	< 20 min.	20 - 30 min.	30:01 - 39:59	40 or > min.
Suburban2	< 15 min.	15 - 22 min.	22:01 - 29:59	30 or > min.	< 25 min.	25 - 35 min.	35:01 - 49:59	50 or > min.
Rural	< 20 min.	20 - 30 min.	30:01 - 39:59	40 or > min.	< 30 min.	30 - 45 min.	45:01 - 59:59	60 or > min.
Wilderness	< 40 min.	40 or > min.	*	*	< 60 min.	60 or > min.	*	*

* Best effort & immediate dispatch

RRT = Required Response Time

LRT = Late Response Time

ERT = Extended Response Time

PRT = Protracted Response Time

APPENDIX 1

Inventory of First Response ALS Units (FRALSLU)

RADIOS	1 med net radio with DTMF microphone 1 company radio 1 portable med net radio with DTMF 2 800 mhz disaster radios (1 portable)
Emergency Lights/siren	Must meet California CHP standards
Wireless Telephone	Handheld telephone adaptor kit (Hands Free)
Electronic charting devise and relevant back-up paperwork	PCRs, PCR continuation forms, physician verification of intubation form, ALS without Base Hospital Approval Form, refusal of service form
Flares	Road flares 6 minimum
Misc. Equipment	Auto jumpers, 2 space style blankets, red and yellow bio bags, N95 masks, Extrication helmet with face shield, extrication gloves, exam gloves, flashlight
C-Spine Equip.	1 long board, 2 each adult and pediatric adjustable collars, 1 set spider straps, 2 head immobilization devices
Exam Equipment	Cardiac monitor/defibrillator, B/P cuffs (ExLg, Adult, child, infant), Blood glucose meter, Stethoscope, Pulse oximeter Broselow tape
Airway Equipment	Oxygen tank (D) with regulator 2-15 lpm, Portable suction unit, Adult & Child NRB mask & NC, HHN with adult & pediatric masks, Adult & Child/infant Ambu bags, Combitube or King Airway, complete intubation kit, set of NPAs & OPAs, TTJI needle with BV adapter
IV Equipment	2 each (14-24ga) IV catheters, 1 each IO 15 & 18ga, 1each macro & pedi drip set, 1 each 1000 & 250 bags NS, 2 start packs, syringes 1 each (1-30cc), 1 Chux, sharps container, 2 NS lock kits
Trauma Equipment	1 trauma dressing, 2 kerlix, 2 4x4 packs, 10 2x2s, 2 triangular bandages, 1 each 2" zonas & 1" transpore tape, 10 1x3 Band-Aids, 10 ETOH preps, Cleansing hand wipes,
OB	1 OB kit
Medications	1 each Bicarb 8.4% 50ml, D50 50ml, (1) Oral glucose 15 grams, 100mg Lasix, Diphenhydramine 50mg, Narcan 2mg, Adenocard (1ea) 6mg/12mg, (3) 100mg lidocaine, (3) 1mg epi 1:10,000, (3) 1mg atropine, 1 bottle 81 mg ASA, 1 bottle nitro, (1) epi 1:1000 1ml, (1) Glucagon 1 mg, (2) Albuterol 0.083%,
MCI	MCI Bag with DOT approved vest
IV Warmer	Stocked with 2 1000 ml bags NS with drip sets and 1 D50



**Department of Public Health
Emergency Medical Services Agency**

Tammy Moss Chandler
Director of Public Health

James Andrews, M.D.

Policy #: 470.00
Effective Date: 09/1993
Revision Date: 10/2011
Review Date: 10/2013

This policy supersedes any other existing policy on this subject.

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Subject: EMS AIRCRAFT UTILIZATION

Authority: California Health and Safety Code, Division 2.5, Section 1797.220, and California Code of Regulations, Title 22, Chapter 8, "Prehospital EMS Aircraft Regulations".

Definitions: **Air Ambulance** - Means a rotor or fixed wing aircraft specially constructed, modified or equipped, and used for the primary purpose of responding to emergency calls and transporting critically ill or injured patients, whose medical flight crew has a minimum of two (2) attendants certified and licensed in advanced life support.

Authorizing EMS Agency - Means the local EMS agency that approves utilization of specific EMS Aircraft within its jurisdiction.

Classifying EMS Agency - means the local EMS agency in the jurisdiction of origin except for aircraft operated by the California Highway Patrol, California Department of Forestry, or the California National Guard, which shall be classified by the State EMS Authority.

CAMTS – Commission on Accreditation of Medical Transport Systems.

Designated EMS Aircraft Dispatch Center - Means the Authorized Merced County EMS Dispatch Center.

EMS Aircraft - For the purpose of this policy, except where otherwise noted, EMS Aircraft shall mean a rotor type air ambulance.

Helicopter - Shall mean a rotor type aircraft meeting the qualifications of an air ambulance.

Non-Simultaneous Helicopter Dispatch Zones - Means those areas within Merced County where an air ambulance shall be dispatched based upon probable need, as identified herein.

Simultaneous Helicopter Dispatch Zone - Means those areas of Merced County where an air ambulance shall be dispatched simultaneously with responding ground units for specific incidents as defined herein.

APPROVED:

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STRIVING FOR EXCELLENCE

Recognized First Responder or First Responder - Shall be limited to duly authorized employees of Public Safety Agencies operating within Merced County or any incorporated political subdivision thereof.

Purpose: To maximize the effective and efficient use of EMS aircraft within the Merced County EMS Area.

Policy: EMS Aircraft shall be utilized within the Merced County EMS System as defined in this policy.

1. EMS Aircraft Dispatch

- A. The Authorized Merced County EMS Dispatch Center shall be designated as the EMS Aircraft Dispatch Center (hereinafter "dispatch center"). For each EMS aircraft dispatched, the dispatch center shall serve as the communications coordination center between responding EMS ground units and EMS aircraft responding to EMS incidents within the jurisdiction of the EMS Agency.
- B. The dispatch center shall maintain a listing of all EMS aircraft services authorized by the EMS Agency for service within Merced County. The dispatch center shall maintain records of all EMS aircraft requests/utilization within Merced County. The minimum data to be recorded for each EMS aircraft request shall include:
 1. date of request
 2. time of request
 3. requesting party
 4. canceling party (if appropriate)
 5. time on scene
 6. scene location (including Merced County EMS Grid Number)
 7. patient destination
- C. EMS aircraft dispatch personnel shall be oriented to aircraft dispatch techniques as approved by the EMS Agency. The dispatch center shall ensure that it is updated, at a minimum, at the beginning of each shift as to the availability/status of authorized EMS aircraft.
- D. An EMS helicopter shall be dispatched concomitantly with the closest available ground ambulance when weather conditions and helicopter availability allow, and when the incident location and the presumed nature of the injury are appropriate. With the exception of emergency interfacility transports arranged by physicians, the dispatch center will dispatch a helicopter by any of the following methods:
 1. Simultaneous Dispatch
 2. On Scene Request
 3. Responding Enroute
- E. For the purpose of helicopter dispatching, all EMS Grid designations within Merced County shall be considered "Simultaneous Helicopter Dispatch Areas." The only exceptions are those EMS Grids in the greater Merced-Atwater area with a ten minute

ambulance response time designation, which are designated as "Non-Simultaneous Helicopter Dispatch Areas."

2. Simultaneous Helicopter Dispatch

The dispatch center shall simultaneously dispatch the closest ground ambulance and first responder, as well as an authorized helicopter for all EMS incidents when the incident occurs within a Simultaneous Helicopter Dispatch area and the reporting party information indicates that one of the following may exist:

- ** a) Penetrating trauma to the head or trunk
 - b) Fall greater than 20 feet
 - * c) Auto vs Pedestrian
 - * d) Auto vs Bicycle/Motorcycle
 - * e) Motorcycle accidents
 - * f) MVA with high speed potential
 - g) Explosions
 - h) Electrocution
 - i) Multi-Casualty Incident
 - j) Industrial/Agricultural with critical injuries
- ** A simultaneous helicopter dispatch shall occur, regardless of geographic location.
- * May exclude simultaneous helicopter if reported as minor injuries only, dispatcher discretion.

3. On-Scene Request

An ALS ground unit and an EMS air ambulance shall be dispatched upon the request of any fire or law enforcement agency, ambulance personnel, other first responders or any public safety officer if any of the following conditions exist:

- A. Potential life or limb threatening injuries.
- B. Any other incident where additional ALS assistance is needed.

4. Request by ALS Ground Ambulance

- A. Responding ALS personnel that have knowledge of the scene or additional information beyond that provided by the dispatch center, may request the dispatch of an air ambulance. The requesting crew shall coordinate helicopter requests with the On-scene Incident Commander.
- B. After assessing the scene, the ALS personnel shall immediately verify the need, or lack thereof, of the air ambulance, and either continue, cancel, or initiate the air ambulance response, as appropriate.

5. Required Information for EMS Aircraft Dispatch

The helicopter shall be dispatched as soon as essential information is received from the reporting party. Prior to disconnect with the reporting party, dispatchers at the Merced County

EMS Dispatch Center shall attempt to obtain as much of the following information as possible from the individuals/organization requesting a helicopter.

- A. Requesting agency, location, number of patients, type of incident (e.g. hazmat, MVA, etc.) and extent of injuries.
- B. Landing site information (if possible).
 - 1) coordinates.
 - 2) landmarks identifiable from the air.
- C. Terrain and obstacles.
- D. Weather conditions.
 - 1) wind direction and speed.
 - 2) visibility and temperature.
- E. Radio frequencies of responding ground units.

This information shall be relayed, as requested, to the EMS aircraft service dispatcher when requesting an EMS aircraft to respond to an EMS incident within this County.

6. EMS Aircraft Communications

- A. The EMS Dispatch Center shall facilitate communications between ground personnel and EMS aircraft, including updated information regarding ground radio frequencies, units dispatched to the scene, the designated ground contact and any other information requested by an EMS aircraft during the course of their emergency operations relative to Merced County EMS incidents.
- B. Once an EMS aircraft is on scene, the ground crew in charge of patient care on scene shall, advise the EMS aircraft crew of the patient condition and the designated receiving facility.
- C. All Authorized EMS Aircraft Providers shall ensure that their radio communications equipment is capable of direct voice communications with all helicopter receiving facilities located within their normal operational range, to include all helicopter receiving facilities located within the Mountain-Valley and Fresno, Kings, Madera EMS Agency Jurisdictions.

7. EMS Aircraft Operational Dispatch and Flight Following Service

- A. Each Authorized EMS Aircraft Service shall maintain or contract with an operations dispatch center 24 hours/day, 7 days/week. Said dispatch center shall be capable of confirming the provider's ability to respond to an EMS incident upon notification from the Merced County EMS Dispatch Center.
- B. Each EMS Aircraft Service shall maintain a log of all EMS aircraft requests, relative to their operations within Merced County. The minimum data to be recorded shall include:
 - 1) Date of request.
 - 2) Location of Incident.
 - 3) Type of Incident.
 - 4) Time of Call (TOC)

- 5) Time Dispatched (DSP)
- 6) Enroute Time (ER)
- 7) On scene (OS)
- 8) Enroute hospital (ERH)
- 9) On scene hospital (OSH)

This information shall be relayed, as requested, to the EMS aircraft service dispatcher when requesting an EMS aircraft to respond to an EMS incident within this County.

8. Cancellation of EMS Aircraft

A. All EMS aircraft cancellations shall be coordinated by the Merced County EMS Dispatch Center. Cancellation of EMS aircraft may occur due to:

- 1) Pilot Judgment – In all such cases the Merced County EMS Dispatch Center shall be immediately notified of the cancellation, and the conditions precipitating said cancellation.
- 2) Lack of Medical Need – An EMT-1, EMT-P or recognized first responder on scene of an EMS incident, who has assessed the patient so as to determine the patient's condition, may cancel an EMS aircraft. All such cancellations shall be effected by contacting the Merced County EMS Dispatch Center and providing the reason for the cancellation and the person and agency effecting said cancellation.
- 3) Logistical and/or Safety Considerations – The Incident Commander or his or her designee may cancel the EMS aircraft when s/he feels that landing the aircraft would be unsafe, or there is no patient. Alternate landing sites shall be considered prior to cancellation.

B. Dispatchers will cancel an EMS Aircraft only after documenting:

- 1) Pilot Judgment – verify the reason for cancellation from the pilot.
- 2) Lack of Medical Need – verify from the EMS provider the following:
 - a) The name of the agency canceling the mission, and:
 - b) Confirm that the canceling agency is in scene and has examined all patients.
- 3) Logistical and/or safety considerations - verify from the calling party the following information:
 - a) The agency canceling the mission,
 - b) The logistical and/or safety considerations precipitating cancellation,
 - c) If a medical need still exists, and
 - d) That no reasonable alternate landing sites exist.

If the dispatcher at the Merced County EMS Dispatch Center cannot verify the appropriate cancellation information, the mission shall not be cancelled. The dispatcher shall notify the responding EMS aircraft that an unverified request for cancellation exists.

9. Landing Sites

- A. EMS aircraft landing sites shall conform to appropriate regulations and safety guidelines including: Federal Aviation Regulations 91.3; California Code of Regulations, Title 21, Public Works Chapter 2.5, Division of Aeronautics; National EMS Pilots Association Landing Site Guidelines and EMS Landing Site Safety Standards. Under no circumstances shall the pilot of the responding EMS aircraft be advised/notified as to the patient's age (e.g. pediatric) or severity of the patient's condition. The decision to complete or cancel the mission, including utilization of specific landing sites, shall be based solely on the pilot's judgment, relative to the safety factors involved in completing the mission.
- B. Communications shall be established and maintained with Landing Site Control personnel during all landings and take offs requiring said personnel.
- C. Landing sites to be utilized by EMS aircraft shall include:
 - 1) Heliports and/or airports meeting Title 21 requirements, or
 - 2) Sites chosen at or near the scene of an EMS incident meeting the National EMS Pilots Association Landing Site Guidelines, or
 - 3) EMS Agency designated EMS Landing Sites meeting EMS Landing Site Safety Standards.
- D. Mercy Medical Center Helistop
 - 1) For those incidents that occur in the vicinity of Mercy Medical Center, patients may be transported directly to their Helistop to rendezvous with the air ambulance. Crews transporting patients to the Mercy Helistop for air transport shall comply with the procedure below.
 - a) As soon as the decision is made to rendezvous with the air ambulance at Mercy's Helistop, the crew shall notify Mercy emergency department via Med 8 or landline. This notification must be clear that the transport to Mercy is for "rendezvous only," and that the patient is not being seen at Mercy ED.
 - b) Mercy ED will contact their Public Safety/Security Department and advise that an air ambulance rendezvous is in-bound, and they will secure the area for the ground ambulance to transfer the patient to the air ambulance.
 - c) Once on scene at the Helistop, standard helicopter safety precautions shall apply. Do not approach the helicopter until cleared to do so by the helicopter crew.
 - d) Mercy medical staff will not approach the Helistop during such rendezvous, to avoid complications with EMTALA. However, either the air or ground ambulance crew can request hospital assistance if the patient's condition deteriorates. Once hospital staff make contact with the patient, a Medical Screening Exam must occur, in compliance with EMTALA regulations, and the patient will have to be moved to the ED for treatment.

10. Medical Control

- A. Medical control for the scene of an EMS incident where both ground and EMS aircraft personnel are present shall be the responsibility of the base hospital normally contacted by the ground unit. All treatment decisions shall be made in accordance with the ALS Treatment Protocol Standing Orders. Patient destination decisions shall be in accordance with Triage Policy 512.25 and the Trauma Center rotational schedule. ALS flight personnel shall assist ground personnel in carrying out the decisions of the base hospital, as needed.
- B. The flight crew shall establish contact with the receiving facility as soon as practical, provide an ETA and update the patient condition. If the pilot decides that the designated receiving facility is not appropriate due to flight safety considerations, s/he shall immediately notify the original receiving facility and the new receiving facility of the change in destination. All such cases of re-routing shall be documented on a Situation Report Form and forwarded to the Merced County EMS Agency within 48 hours of any such re-route. Alternately, reports may be filed on the Agency web site at: <http://www.co.merced.ca.us/index.asp?nid=581> and clicking on the "File Incident Report" link.

11. Quality Improvement and Utilization Review

- A. The basis for utilizing EMS aircraft for transportation of patients from within the Merced County EMS System shall be solely due to medical need. All patients transported in such a manner shall be presumed to have injuries or an illness requiring rapid triage and transportation to appropriate critical care/trauma facilities. Such determinations shall be the responsibility of the most medically qualified individual on the scene of EMS incidents, which shall usually be an EMT-P, and shall be consistent with the Triage Protocol.
- B. Unusual occurrences, relative to EMS aircraft, shall be documented on an Agency Situation Report Form and forwarded to the EMS Agency within 48 hours of occurrence. Alternately, reports may be filed on the Agency web site as noted in Section 10B, above.
- C. EMS Aircraft Providers shall ensure that a copy of all patient care report forms for transports originating within Merced County are forwarded to the Merced County EMS Agency on a monthly basis.

12. EMS Rescue Aircraft Utilization

- A. In accordance with the California Code of Regulations, Title 22, Section 100302 (e), ground ALS crews may transfer a patient to the flight crew of an aircraft with lower level of certification/care capabilities when it is determined that rapid transport is the primary treatment of choice for a critical patient. It is the primary responsibility of the EMS dispatch center to dispatch authorized EMS aircraft when air medical assistance is indicated.
- B. If it is determined that the EMS aircraft crew is less medically qualified than the ground personnel, the Base Hospital shall be contacted to determine whether or not the aircraft crew can provide appropriate care and transportation of the patient.
- C. If Base Hospital contact is not possible, the most medically qualified individual on-scene shall make the determination as to whether the treatment needs of the patient will be best served by rapid transport via aircraft, or whether the medical care limitations of the flight crew pose too great a risk to the patient, and shall determine the appropriate mode of transport.

- D. EMS aircraft may utilize ground providers in the transport of a patient when said use will not interrupt the pattern of readiness and response services to the ground provider's service area. The EMS ground provider attending the patient during the flight shall be considered a passenger assisting the patient, and not a member of the flight crew.

13. Authorization of EMS Aircraft

- A. EMS Aircraft Service Providers must be authorized by the Local EMS Agency before they may be included in the prehospital EMS system as an air medical transport service. When an EMS Aircraft service successfully completes the authorization requirements as set forth herein, a certificate of authorization will be issued, and said provider will be included on the authorized EMS aircraft list maintained by the Merced County EMS Dispatch Center.
- B. The EMS aircraft service must submit an application for initial authorization. Completion of the application shall include documentation of self-inventory and classification in accordance with criteria required by the State EMS Authority and policies of the Merced County EMS Agency.
- C. The EMS aircraft service shall submit a copy of their air taxi/commercial operators certificate (Public Safety agencies are exempt from the certification requirements but must document consistency with FAA requirements). The EMS Agency may request a copy of the enforcement and accident history of the operator from the FAA Flight Standards District Office issuing the certificate.
- D. The EMS aircraft service shall submit a copy of its certificate of insurance. The policy must include a 20 million dollar minimum liability and a one (1) million dollar minimum malpractice liability. The EMS Aircraft service is required to notify the EMS Agency thirty (30) days prior to a reduction or change in its liability coverage. Public Safety agencies are exempt from the certification requirement, but must document their ability to assume liability for their actions.
- E. The EMS Aircraft Service shall be accredited by CAMTS. Public Safety agencies are not bound by CAMTS Safety Standards, but are required to document equivalency.
- F. All EMS Aircraft Service providers based outside of the Merced County EMS Area of jurisdiction shall provide proof of classification and authorization from the Local EMS Agency with jurisdiction in their area of origin.
- G. To be authorized as an EMS Aircraft Provider "Regularly" serving the Merced County EMS System, the aircraft provider shall agree to participate in this system as delineated in this policy, relative to simultaneous dispatch of EMS aircraft, and serve those areas of the County as deemed appropriate by the Agency, based on the providers base of operations and travel time to specific areas of the County.
- H. All EMS Aircraft Service Providers whose "Jurisdiction of Origin" is outside of the Merced County EMS Area shall assure that patient records for all transports originating from the Merced County EMS Area contain the required data elements as delineated in the California Code of Regulations, Title 22, Section 100164, and shall forward a copy of all patient care reports for those transports which originate within the Merced County EMS System.

- I. The EMS aircraft service provider shall be required to have a written agreement with the Agency to participate in the Merced County EMS System, which shall clearly delineate the provider's roles and responsibilities as an EMS aircraft provider within this system, as well as adherence to all applicable state, federal and local policies, procedures, regulations and safety guidelines.
- J. Upon successful completion of Section 14. (A-I), the Merced County EMS Agency shall issue a certificate of authorization to the EMS aircraft service.

14. Requirement for Written Agreement with the EMS Agency

- A. In order to maintain authorization, EMS Aircraft Service Providers shall execute a written agreement with the Merced County EMS Agency, as a requirement for participation in the prehospital patient care and transport system, assuring compliance with all applicable state regulations and local policies and procedures. The agreement shall include:
 - accreditation by CAMTS
 - the provision of requested quality assurance information
 - the maintenance of communications as specified by the Agency
 - confirmation of the certification level of the aircraft service, as certified by the EMS agency of jurisdiction in the provider's area of origin
 - the level of participation, relative to simultaneous dispatching
 - the maintenance of drug and equipment standards, as specified by the Agency
 - adherence to all other EMS system guidelines, as appropriate
- B. Upon completion of the authorization process as outlined in Section 14 (A-I), the Agency shall negotiate with the EMS aircraft service provider for the execution of the above referenced agreement. No EMS aircraft service provider shall be considered for regular service within the Merced County EMS system until said agreement has been



**Department of Public Health
Emergency Medical Services Agency**

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Director of Public Health

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Policy #: 480.00
Effective Date: 09/1993
Revision Date: 03/2009
Review Date: 03/2011

This policy supersedes any other existing policy on this subject.

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Subject: CONVALESCENT TRANSPORT PROVIDER STANDARDS

Authority: California Health and Safety Code, Division 2.5, Section 1798, California Code of Regulations, Title 22, Section 51151 et. al., Merced County Code 9.44 et seq.

Purpose: The purpose of the Convalescent Transport Provider Standards Policy is to ensure that all providers of convalescent transportation services meet the personnel, equipment and operational standards adopted by the County to ensure the health and safety of the public served by such providers, and to ensure that such providers operate in a manner consistent with the medical control standards established in Merced County.

Policy: All providers of convalescent transportation services shall adhere to the standards delineated herein with regard to equipment, personnel and operations.

1. Definitions:

- A. *Agency* – means the Merced County EMS Agency.
- B. *Ambulance* – means any vehicle specifically constructed, modified, or equipped and used for the purpose of transporting sick, injured, convalescent, infirmed, or otherwise incapacitated persons and which meets any and all state, federal and/or local licensing requirements.
- C. *Litter Van* – means a vehicle which is modified, equipped and used for the purpose of providing non-emergency medical transportation for those patients with stable medical conditions not requiring the specialized staffing and equipment provided by an ambulance service.
- D. *Wheelchair Van* – means a vehicle which is modified, equipped and used for the purpose of providing non-emergency wheelchair medical transportation for those patients with stable medical conditions not requiring the specialized staffing and equipment provided by an ambulance service.
- E. *Acute Care Setting or Acute Care Facility* shall, for the purpose of this policy, mean a general acute care hospital as defined in the California Code of Regulations, Title 22, Division 5, Section 70005, or a similar facility possessing a license for either basic or standby emergency medical services. Urgent Care Centers shall be considered an acute care facility for the purpose of this policy.

APPROVED:

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F. *Non-acute care setting* shall mean a physician's office, clinic, convalescent or extended care facility, patient's residence, or a free standing diagnostic or therapeutic facility.

2. General Provisions:

- A. All providers of convalescent transportation services shall complete a Convalescent Transportation Provider Application from the Agency and submit same along with any documentation required by said application.
- B. All providers of convalescent transportation services shall have the ability to respond to requests for service 24 hours a day, seven (7) days a week. This requirement may be satisfied by an on-call staff person with the ability to respond to requests for service within 30 minutes of the receipt of said request.
- C. All providers of convalescent transportation services shall provide and maintain at their own expense the following programs of insurance covering their operations. Such programs and evidence of insurance shall be satisfactory to County's Risk Manager. Certificates or other evidence of coverage shall be delivered to County's Emergency Medical Services Agency prior to commencing convalescent transportation services within Merced County.
 - 1) Liability: General liability insurance written on a commercial general liability form covering bodily injury, personal injury and property damage with a combined single limit of not less than \$ \$3,000,000 per occurrence.
 - 2) Workers' Compensation: A program of Workers' Compensation insurance in an amount and form to meet all applicable requirements of the Labor Code of the State of California, covering all persons providing services on behalf of the Convalescent Provider.
 - 3) Automobile Liability: \$1,000,000 combined single limit per accident for bodily injury and property damage, or split limits of \$500,000 per person/\$1,000,000 per accident for bodily injury and \$250,000 per accident for property damage.

3. Vehicle Standards

All providers of convalescent transportation services shall ensure that vehicles utilized to perform convalescent transportation services meet all applicable statutes and regulations regarding the operation of such vehicles, including but not necessarily limited to:

- A. Vehicles safety items such as tire wear, lighting and warning devices, turn signals and emergency flashers, foot and emergency brakes and all general maintenance requirements so as to ensure a reasonable degree of operational reliability.
- B. Wheelchair or litter strapping, restraints, locking devices and/or other mechanisms to ensure the security of the person being transported against injury from sudden movement of the vehicle.
- C. Heating and air conditioning systems adequate to ensure that the interior environment of the transport vehicle can be maintained within a range of 60° - 80° Fahrenheit.
- D. In the case of wheelchair vans, safe and operational lifts and/or ramps to ensure the safe movement of the person being transported between the ground and the vehicle.

- E. Vehicles licensed as wheelchair or litter vans may not display any advertising or labeling of the vehicle using terms such as "ambulance," "emergency," "urgent care" or other terms that might confuse the public regarding the type of service provided. Additionally, wheel chair and litter vans shall not be equipped with any emergency warning devices such as "Beacon Rays" or sirens, which are restricted to licensed emergency vehicles.
- F. Wheel chair and litter vans shall be equipped with a two-way communications device to ensure immediate communications capability. This requirement may be satisfied by either of the following:
 - 1) a radio transmitting and receiving unit capable of directly communicating with the dispatching operation for the convalescent service, or
 - 2) a cellular or digital wireless communications device.
- G. The Agency retains the right to inspect any convalescent transport vehicles licensed pursuant to Merced County Code 9.44 et seq. Such inspections shall be coordinated through and conducted by the California Highway Patrol and Agency staff.

4. Personnel Requirements:

- A. Wheelchair Transportation Services
 - 1) All personnel employed to operate a wheelchair van shall be certified in Basic First Aid (American Red Cross or equivalent) and CPR (American Heart Association or equivalent).
 - 2) All personnel employed to operate a wheelchair van shall be licensed by the State of California, Department of Motor Vehicles with a current Class C license or higher.
- B. Litter Van Transportation Services
 - 1) All litter van transportation services shall be staffed by a minimum of two persons, certified as described below:
 - a) Personnel employed to operate a litter van shall be certified in Basic First Aid (American Red Cross or equivalent) and CPR (American Heart Association or equivalent).
 - b) Personnel employed to operate a litter van shall be licensed by the State of California, Department of Motor Vehicles with a current Class III license or higher.
 - c) Personnel employed to function as an attendant on the litter van shall be currently certified as an EMT-1 and in good standing with the Agency.
- C. All convalescent transport employees with direct patient contact are required to submit a Department of Justice background check prior to employment.

5. Operational Standards

- A. All convalescent transportation services shall ensure that they are in compliance with the following standards with regard to the types of transports that are authorized for either a wheel chair or litter van.
 - 1) The transportation shall be pre-arranged, scheduled and non-emergency in nature. The transportation must originate from a non-acute care setting and terminate at a similar, non-acute care setting. The only circumstance in which a convalescent transport provider may engage in a transportation which delivers a patient at an acute care setting is for a pre-arranged, scheduled appointment for out-patient diagnostic services, and said transportation may not terminate at said acute care facility. Transportations that terminate at an acute care setting shall, by definition, require the services of an ambulance.
 - 2) The transportation may originate at an acute care setting in which the person to be transported has been discharged from the care of said facility and requires transport services to a non-acute care setting.
- B. Under no circumstances shall a wheel chair or litter van service provider transport a person with an acute medical condition or acute alteration of an existing medical condition that has not been diagnosed by a physician and which requires transportation to an emergency department or urgent care center.
- C. If at any time prior to the transport or during the transport of a person, personnel from the convalescent transport provider have any question regarding the appropriateness of transporting a person or the person's condition appears to be inconsistent with the pre-scheduled, non-emergency nature of transports authorized herein, they shall contact the Merced County EMS Dispatch Center via the 911 emergency phone number and request assistance.
- D. Transportations of persons for "rule out" diagnostic service at an acute care setting, wherein the person may be admitted to the acute care facility depending on the outcome of the diagnostic procedure, shall require ambulance transportation to the acute care facility. Return transports of said persons to a non-acute care setting may be performed by a convalescent transport provider.
- E. Convalescent transport providers shall be allowed to transport patient-delivered medication and devices so long as the patient remains in control of the delivery, e.g. oxygen, feeding tube devices, etc. Convalescent transport providers may not initiate the delivery of any medication, including oxygen, to any patient that does not have a prescription for same and their own such medication and device as described above.



**Department of Public Health
Emergency Medical Services Agency**

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Director of Public Health

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Policy #: 501.00
Effective Date: 09/1993
Revision Date: 03/2009
Review Date: 03/2011

This policy supersedes any other existing policy on this subject.

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Subject: BASE HOSPITAL CRITERIA

Authority: California Health and Safety Code, Division 2.5, Sections 1797.220, 1798., 1798.2, 1798.100, 1798.101 and California Code of Regulations, Title 22, Division 9, Sections 100105, 100107, 100127, 100146, and 100167.

Definitions: Agency - Means the Merced County Department of Public Health, designated by the Merced County Board of Supervisors as the Merced County EMS Agency.

ALS - Means Advanced Life Support, as defined in the California Health and Safety Code, Division 2.5, Section 1797.52.

Base Hospital - Means a hospital approved and designated by the Agency to provide immediate medical direction and supervision of prehospital personnel in accordance with policies and procedures established by the Agency.

BLS - Means Basic Life Support as defined in the California Health and Safety Code, Division 2.5, Section 1797.60.

IRP, or Investigative Review Panel - Means an impartial advisory body, the members of which are knowledgeable in health care systems, which may be convened to review facts in a case of negative action against a base hospital designation and provide its findings to the Agency.

Prehospital Care Provider - Means the ambulance service provider authorized by the Agency to provide ALS service within the jurisdictional boundaries of Merced County.

Purpose: To establish standards for the designation, implementation and evaluation of a base hospital(s) within Merced County.

Policy: A base hospital shall provide medical control for prehospital patients destined for their facility, as well as those destined for receiving hospitals in accordance with State and Agency Policies and Procedures.

APPROVED:

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1. A designated base hospital shall have a written agreement with the Agency. This Agreement shall:
 - A. Include, at a minimum, the criteria identified below regarding general eligibility for designation, communications, staff, education, record keeping and supplies, as well as language addressing compliance on the part of all parties.
 - B. Indicate the commitment of hospital administration, medical staff, and emergency department staff to meet the requirements for program participation.
 - C. Be reviewed every two years by the Agency and may be changed, renewed, canceled or otherwise modified as necessary. The Agency may deny, suspend or revoke approval of the base hospital for failure to comply with applicable policies, procedures and regulations.
2. Base Hospital Responsibilities. A hospital shall meet the following criteria to be eligible for base hospital designation:
 - A. General
 - 1) Be licensed by the State Department of Health Services as a general acute care hospital.
 - 2) Be accredited by the Joint Commission on Accreditation of Health Care Organizations.
 - 3) Have a special permit for Basic or Comprehensive Emergency Medical Services pursuant to the provisions of California Code of Regulations, Title 22, Division 5, unless waived pursuant to the Health and Safety Code, Division 2.5, Section 1798.101.
 - 4) Agree to utilize Agency triage protocols for the determination of patient destination.
 - 5) Agree to adhere to all policies and procedures specified by the Agency and to participate in local EMS system planning activities.
 - 6) Agree to accept for treatment and not transfer to another facility any patient who has been treated by prehospital personnel, unless or until, in the judgment of a physician, such a patient is medically able to be transferred and/or such a transfer is in the best medical interest of the patient.
 - 7) Agree to abide by the patient destination policy adopted by the Agency.
 - 8) Participate in the review of patient care records and in the critique of prehospital care with the involved personnel.
 - B. Communications
 - 1) Have and agree to utilize and maintain two-way telecommunications equipment as specified by the Agency, to include the capability of two-way voice communication with the prehospital care providers within the base hospital's service area.
 - 2) Have a dedicated, recorded telephone line for on-line medical control with the prehospital care providers.

- 3) Assure that every prehospital call conducted by radio or dedicated telephone line is recorded. Recordings shall be maintained for a minimum of 100 days to be accessed strictly for educational purposes, audits and case reviews, or to be made available to Agency staff upon request for quality improvement/assurance purposes.
- 4) Provide timely reports of reoccurring radio/telephone problems to the appropriate maintenance contractor and provide written documentation of same to the Agency.

C. Staffing

- 1) Designate a base hospital medical director who shall be a physician on the hospital staff, licensed in the State of California who is certified or prepared for certification by the American Board of Emergency Medicine. The requirement of board certification or prepared for board certification may be waived by the Agency Medical Director when s/he determines that an individual with these qualifications is not available. This physician shall be regularly assigned to the emergency department, have experience in and knowledge of base hospital radio operations and Agency policies and procedures, and shall be responsible for overall medical control and supervision of the prehospital program within the hospital's area of responsibility, including review of patient care records and critique with the involved personnel. This Base Hospital Medical Director should be available for hospital liaison meetings and Agency planning sessions.
- 2) Designate a base hospital MICN, knowledgeable in Agency policies and procedures for prehospital care who shall be regularly assigned to the emergency department as the Base Hospital Nurse Liaison to assist in medical control and supervision of the prehospital personnel within the base hospital's areas of responsibility. The Base Hospital Nurse Liaison shall assist the Base Hospital Medical Director in assuring that all required paperwork is completed and sent to the Agency as required in this policy and shall be available to attend regularly scheduled hospital liaison meetings and Agency planning sessions.
- 3) Agree to staff the emergency department at all times with at least one physician experienced in emergency medical care, licensed in the State of California and oriented in the Agency policies, procedures and treatment protocols, who will be available to provide immediate on-line medical direction to the MICN and prehospital personnel as well as assist in off-line medical control.
- 4) Agree to staff the emergency department at all times with at least one MICN, authorized in accordance with Agency policy, to provide immediate medical direction to prehospital care personnel.

D. Education

- 1) Assure that all emergency department employees are oriented to the base hospital role and pertinent Agency policies and procedures.
- 2) Provide clinical experience with supervision for MICN, EMT-P and EMT-1 trainees, both during initial training and for continuing education. Clinical experience shall include direct patient care experience and/or observation and include the following specialty areas (as available and appropriate):
 - a) Surgery/Anesthesia

- b) Recovery
 - c) Obstetrics
 - d) ICU/CCU
 - e) IV Team
 - f) Emergency Department
 - g) Pediatrics
 - h) Respiratory Therapy
 - i) Clinical Laboratory
- 4) Ensure that a mechanism exists for the replacement of non-disposable supplies and equipment used by advanced life support personnel during prehospital treatment of patients according to policies and procedures of the Agency (e.g., MAST, traction splints, etc.)

E. Record Keeping

- 1) Maintain and release to the Agency all relevant records for program monitoring and evaluation of the EMS system.
- 2) Include the base hospital report form, the prehospital report form and triage tags, as appropriate, in the medical record.
- 3) Prepare periodic reports on base hospital activities and submit said reports to the Agency for review in monitoring base hospital compliance.
- 4) Keep complete records on facility MICN's including CE and ACLS status. These records shall be made available to the Agency upon request.

F. Trauma Receiving Hospital Requirements

- 1) Maintain trauma registry data for selected trauma patients in accordance with Agency policy. Hospital shall be afforded the opportunity to review and offer revision to said policy through the usual Policy and Procedure Committee review process.
- 2) Assign medical staff representation on the Trauma Audit Committee and ensure attendance at regularly scheduled meetings of said committee, in accordance with Agency policy.
- 3) Maintain the confidentiality of its patient records in accordance with all applicable state and federal laws relating to confidentiality. Agency agrees that any patient specific medical records or hospital quality improvement documents submitted by HOSPITAL and reviewed by the Trauma Audit Committee shall be maintained in confidence under the provisions of Evidence Code 1157.7. Further, Agency agrees it will use all reasonable diligence to prevent disclosure except to its necessary personnel. HOSPITAL does not waive its right pursuant to Evidence Code sections 1157 et. seq. This confidentiality provision shall remain in effect notwithstanding any subsequent termination of this Agreement. This obligation shall exclude material or information that is in the public domain by public use, publication, general knowledge or the like.
- 4) Enter into interfacility transfer agreements with the Merced County designated Trauma Centers. Said agreements shall articulate the expectations of the parties regarding the transfer and acceptance of trauma patients without regard to a patient's ability to pay for

said services. Such expectations should include both those patients requiring higher level of care services and those Merced County residents being repatriated following Trauma Center care, once that level of care is no longer necessary.

3. Agency Responsibilities

A. Designation

The Agency shall designate a Base Hospital, either through the designation of an existing Base Hospital, or through an appropriate request for proposal process using the criteria established in this document.

B. Denial, Suspension and Revocation

The Agency may deny, suspend or revoke Base Hospital designation for failure to comply with the applicable policies, procedures or regulations outlined in the written agreement. The Agency shall notify the base hospital of the prescribed action in writing. The notification shall be by registered mail and shall include the reason for the action being taken and the date the action shall become effective.

C. Appeals Process for Denial, Suspension or Revocation

Should a base hospital's designation be denied, suspended or revoked, said hospital may, within fifteen (15) calendar days of the date that written notification of that action is received, request, in writing to the agency that an investigative review panel (IRP) be convened. The agency shall, within twenty one (21) calendar days of receipt of the requests, convene an IRP.

The IRP shall consist of at least three (3) persons knowledgeable in the health care system, at least one of whom shall be a physician. One (1) member of the IRP shall be mutually agreed upon by the said appealing hospital, and the agency. The IRP shall not include any staff member from either the agency or appealing hospital or anyone who was directly involved in any incident which was included in the investigation that brought about the action.

The IRP shall hear all of the facts in the case and, within ten (10) calendar days following the completion of the IRP, provide, in writing, their findings and recommendation to the agency.

Upon receipt of the written findings and recommendation of the IRP, the agency shall make a decision regarding the action taken and notify the appealing hospital of the findings and recommendation of the IRP as well as their decision no more than sixty (60) calendar days following receipt of the initial base hospital written request for an IRP.

Procedure:

1. If an existing Base Hospital, under contract for the services as defined in this policy, submits a request for a continuation of the services provided, a written agreement shall be executed between the Agency and Facility, pursuant to the requirements herein.
2. If an existing Base Hospital does not request designation, the Agency shall pursue an appropriate request for proposal process and documentation of eligibility. A Base Hospital will be selected and a written agreement shall be executed between the Agency and Facility.

3. The base hospital shall abide by the communication, education, staffing, record keeping, and equipment and supplies policies contained in this document.
4. The designated Base Hospital Medical Director with the assistance of the Base Hospital Liaison Nurse shall perform the following duties:
 - A. Formally orient all new physicians to the radio operations and the Agency prehospital treatment guidelines.
 - B. Review all cases where questionable uses of standing orders and/or protocols in the field are identified.
 - C. Review all unusual occurrence reports involving prehospital care in association with the base hospital.
 - D. Ensure representation of that facility at appropriate Agency/County EMS meetings.
 - E. Ensure ongoing evaluation of MICNs, prehospital personnel, and base hospital physicians.
 - F. Ensure that all full-time and part-time base hospital physicians have completed an Orientation on Agency prehospital EMS policies within 30 days of beginning practice in the County. Base hospital physicians are strongly encouraged to have ACLS, (Advance Cardiac Life Support), ATLS (Advanced Trauma Life Support), PALS (Pediatric Advanced Life Support) and ABEM (American Board of Emergency Medicine) certifications.
 - G. Be available for consultation with base hospital and prehospital personnel.
5. The designated MICN liaison shall perform the following duties:
 - A. Base Station Review- assist with planning and coordination of an educational platform for the paramedics and nurses regarding EMS care issues.
 - B. Ensure that ED staff are oriented to state and county rules, regulations, policies and procedures.
 - C. Educate staff on new trends, care, and equipment related to EMS.
 - D. Perform prehospital and hospital patient care audits, to include all deaths, code 3 responses, major traumas, and interfacility transfers.
 - E. Attendance and participation with quality care audit committees such as Trauma Audit, EMS System CQI, and EMCC.
 - F. Sit on the ED Committee to act as liaison between care committees and base hospital physicians.
 - G. Participate in focus studies as deemed appropriate by the hospital and EMS Agency.
 - H. Maintain Trauma Log with the ability to run necessary reports for the agency and the hospital.

- I. Assure that tapes are reviewed and properly maintained for 100 days.
- J. Assist the Base Hospital Medical Director in his/her duties.
- K. Participate in EMS planning activities.
- L. Ensure functional radio equipment for communication and recording with field personnel.
- M. Represent the ER for injury and other prevention activities.
- N. Maintain regular, posted office hours for the purpose of providing counseling and feedback to prehospital personnel.



**Department of Public Health
Emergency Medical Services Agency**

John Volanti, M.P.H.
Director of Public Health

James Andrews, M.D.

Policy #: 511.00
Effective Date: 07/1993
Revision Date: 10/2008
Review Date: 10/2010

This policy supersedes any other existing policy on this subject.

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Subject: RECEIVING FACILITY DESIGNATION

Authority: California Health and Safety Code, Division 2.5, Sections 1797.220, 1798., 1798.101, 1798.170 and California Code of Regulations, Title 22, Division 9, Sections 100105, 100107, 100146.

Definitions: **Receiving Facility** - means an acute care facility authorized pursuant to Agency policy to receive emergency patients treated and/or transported by an ambulance service provider.

Emergency Patient - means a person requiring, emergency medical care who is treated and/or transported by an authorized ambulance service provider.

Ambulance Service Provider - means a company or organization authorized to provide emergency ambulance service by the Merced County EMS Agency.

Agency - means the Merced County Health Department, as the designated Emergency Medical Services Agency for Merced County.

Authority - means the State Emergency Medical Services Authority.

Investigative Review Panel (IRP) - means an impartial advisory body, the members of which are knowledgeable in health care systems, which may be convened to review the facts in a case of negative action against a receiving facility designation and provide its findings to the Agency.

Purpose: To establish standards for the designation, implementation and evaluation of facilities receiving ambulance patients; To develop a mechanism for collecting and evaluating patient care information for patients transported to a receiving facility; And to ensure receiving facilities are included in emergency medical services planning activities.

Policy:

1. The Agency shall approve and designate receiving facilities.
2. Receiving facilities shall have a written agreement with the Agency which indicates that hospital administration, medical staff and emergency department staff will meet the requirements for participation in the EMS system as specified in the Agency's policies and procedures.

APPROVED:

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3. The Agency shall have the authority to deny, suspend or revoke Receiving Facility Designation for a facility's failure to comply with any applicable policy, procedure, regulation or agreement covenant.
4. Hospitals that have up-to-date agreements with the Agency, which designates them as a Base Hospital or Specialty Care Receiving Facility shall be considered as meeting the requirements of this policy.
5. The Agency Medical Director may waive all or some of the requirements of this policy for acute care facilities operated by or for the United States National Park Service, the United States Armed Forces or the United States Department of Veterans Affairs.
6. Emergency patients shall only be transported to designated receiving facilities, except in cases of actual or declared disasters when adopted contingency plans call for the utilization of non-designated facilities.
7. A facility shall meet or exceed the following criteria to be eligible for designation as a Receiving Facility:

A. General Requirements

- 1) Be licensed by the State Department of Health Services as a general acute care hospital with a permit for basic or comprehensive emergency service.
- 2) Be accredited by the Joint Commission on Accreditation of Health Care Organizations.
- 3) Agree to adhere to all applicable Agency policies and procedures and to participate in EMS system planning activities.
- 4) Agree to accept for treatment and not transfer to another facility any patient who has been treated by prehospital personnel unless or until in the judgment of a physician such a patient is medically able to be transferred and/or such a transfer is in the best medical interest of the patient.
- 5) Agree to be formally evaluated at least every two years by the Agency for the purpose of ensuring compliance with these criteria.
- 6) Agree to participate in on-going facility assessment activities related to the emergency medical services responsibilities of the facility.

B. Communications

- 1) Have and agree to utilize and maintain two-way radio communications equipment, as specified by the Agency, capable of direct two-way voice communication with EMS field units, specified base hospitals, the county disaster control facility and other specified receiving facilities for their service area.

- 2) Have a dedicated, non-operator, telephone line into the emergency department for communication between the County Disaster Control Facility, The Base Hospital and other receiving hospitals within this service area.

C. Staffing

- 1) Designate a person who shall be responsible for the overall supervision of the EMS program within the hospital and for assuring that the facility's responsibilities specified by agreement and Agency policy are met.
- 2) Identify an RN with experience in and knowledge of hospital radio operations and Agency policies and procedures as a Receiving Facility Nurse Liaison to be responsible for ensuring the completion of all required Receiving Facility documentation and submitting such documentation to the Agency and appropriate Base Hospitals.
- 3) Agree to staff the emergency department at all times with a physician trained and experienced in emergency medical services and whose practice includes emergency medical care in the hospital, and who shall assume responsibility for physician coverage of the service as follows:
 - a. 24-hour coverage with primary assignment to the emergency department and immediate availability. Physicians assigned to the emergency department may not be called from the area to treat patients of other physicians except in the case of an emergency.
 - b. All emergency department physicians shall have, at a minimum, current American Heart Association Advanced Cardiac Life Support provider certification.
- 4) The nursing service operating within the emergency department shall operate under the following guidelines:
 - a. A registered nurse qualified by education and/or training in emergency medical services shall be responsible for nursing care within the emergency department.
 - b. A registered nurse trained and/or experienced in emergency nursing shall be on duty at all times with primary assignment to the emergency department.
 - c. At least one registered nurse scheduled in the emergency department on each shift shall maintain, at a minimum, current American Heart Association ACLS provider certification. All remaining patient care providers shall maintain current Basic Life Support certification.
 - d. Sufficient Licensed nurses and skilled support personnel shall be utilized, as required, to support the services routinely offered.
 - e. Assure that all Emergency Department personnel are oriented to the receiving hospital role and pertinent Agency policies and procedures.

- 5) To have physician consultation available in accordance with hospital bylaws or pre-established patient transfer arrangements.

D. Record Keeping

- 1) Agree to maintain and make available to the Agency all relevant records for program monitoring and evaluation of the EMS system.
- 2) Maintain and make available receiving hospital records as required for incident investigation and quality improvement purposes.
- 3) Maintain the receiving facility ambulance log and transmit the same to the base hospital on a weekly basis, at a minimum.

E. Medical Supplies and Equipment

- 1) Ensure that a mechanism exists for replacing medical supplies and equipment used by prehospital personnel during treatment of patients, according to policies and procedures established by the Agency.
- 2) Ensure that a mechanism exists for the replacement of narcotics and other controlled substances used by advanced life support personnel during treatment of patients according to the policies and procedures of the Agency.

F. Facility

- 1) Maintain physician and emergency department registered nurse coverage as specified in this policy.
- 2) Maintain 24 hour laboratory coverage by a licensed medical technologist.
- 3) Maintain 24 hour radiology coverage by a licensed radiologic technologist capable of performing basic x-ray service.

G. Quality Improvement

Ensure participation of Receiving Facility staff in Agency quality improvement processes which may include, but not limited to, surveys and reviews of specialty care areas such as: trauma, pediatrics, burns, neonatal, reconstruction/re-implantation, neurologic and cardiac.

8. In remote areas when the transport of a patient to a designated receiving hospital is precluded because of geographic or other extenuating circumstances, the Agency Medical Director, with the approval of the Authority, may authorize patients to be transported to a facility which does not meet the requirements of a receiving facility, if the facility has adequate staff and equipment to provide emergency medical services, as determined by the Agency Medical Director.

If the Agency utilizes any facility which does not meet the requirements of a receiving facility, the Agency shall submit to the Authority, as part of its EMS plan, protocols approved by the Agency Medical Director to ensure that the use of that

facility is in the best interests of patient care. The protocols which govern the use of the facility shall take into account, but not be limited to the following:

- a. The medical staff, and availability of the staff at various times to care for patients requiring emergency medical services.
 - b. The ability of the staff to care for the degree and severity of patient injuries.
 - c. The equipment and services available at the facility necessary to care for patients requiring emergency medical services and the severity of their injuries.
 - d. The availability of more comprehensive emergency medical services and the distance and travel time necessary to make the alternative emergency medical services available.
 - e. The time of day and any limitations which may apply for the facility to treat patients requiring emergency medical services.
9. Any change in the status of a receiving facility authorized to care for patients requiring emergency medical services, with respect to protocols and the facility's ability to care for patients, shall be reported by the facility to the Agency.
10. Appeals Process for the denial, suspension or revocation of a facilities designation.

Should a facility's designation as a Receiving Facility be denied, suspended or revoked, the facility may, within fifteen (15) calendar days from the date that written notification of that action is received, request in writing to the Agency, that an investigative review panel (IRP) be convened.

The Agency shall within twenty-one (21) calendar days from the receipt of the request, convene an IRP. The IRP shall consist of at least three (3) persons, at least one of whom shall be a licensed physician, knowledgeable in the health care system. The appealing facility may request that one (1) member of the IRP be mutually agreed upon by the Agency and the appealing facility. The IRP shall not include as panel members any staff member from either the Agency or appealing facility nor include anyone who was directly involved in any incident which was included in the investigation that brought about the action.

The IRP shall hear all of the facts in the case and, within ten (10) calendar days following the completion of the IRP, provide, in writing, their findings and recommendation to the Agency. Upon receipt of the written findings and recommendation of the IRP, the Agency shall make a decision regarding the action taken. The Agency shall notify the appealing facility of the IRP's findings and recommendation and the Agency's decision within fifteen (15) calendar days following the receipt of the IRP's report.

Procedure:

1. Applications for designation as a Receiving Facility shall be accepted from the administration of all interested facilities.
2. The Agency will review all applications to determine if a facility meets the minimum requirements for designation as a Receiving Facility.
 - A. Facilities will be notified by the Agency if any requirement is not met according to their application.
 - B. Facilities that do not meet the requirements for designation as a Receiving Facility may request in writing, from the Agency Medical Director, an exemption from requirements as described in Section Eight (8) of this policy.
3. Facilities which meet the requirements for Receiving Facility designation, according to their application, shall be contacted by the Agency for the purpose of formalizing and signing a Receiving Facility agreement. The Agency may conduct a site survey of the facility prior to signing an agreement.
4. The agreement shall include, but not necessarily be limited to, all of the requirements contained in this policy.

DEPARTMENT OF PUBLIC HEALTH **EMERGENCY MEDICAL SERVICES AGENCY**

This policy supercedes any other
Existing policy on this subject

Subject: **TRAUMA SYSTEM ORGANIZATION AND MANAGEMENT**

Authority: California Health and Safety Code, Sections 1797.222, 1797.220, California Code of Regulations, Section 100255.

Purpose: The purpose of the Trauma System Organization and Management Policy is to establish the roles and responsibilities of the Merced County EMS Agency (MCEMSA) in the planning, implementation and on-going evaluation of an inclusive trauma system.

Policy: The MCEMSA shall be responsible for the planning, implementation, evaluation and revision to the Merced County Trauma System. In as much as the designated Trauma Centers for Merced County are currently in Stanislaus County, it shall also be the responsibility of the MCEMSA to coordinate and collaborate with the Mountain-Valley EMS Agency in the on-going oversight of those Level II Trauma Centers and the related activities of our respective trauma systems.

Definitions: Trauma Audit Committee (TAC) – Shall mean a quality improvement body made up of participant hospital ED physicians, surgeons and subject matter experts organized to review and provide the EMS agencies and participant hospitals with recommendations regarding the quality of services provided.

Procedure:

1. As the lead agency for the Merced County EMS System, MCEMSA is responsible for planning, implementing, and managing the trauma care system. These responsibilities include:
 - A. Assessing trauma system needs;
 - B. Developing the system design, including the number of trauma centers;
 - C. Assigning roles to system participants, including the designation of local trauma center(s) and recognition of remote trauma centers, as necessary;
 - D. Coordinating system activities with designated trauma center and other system participants, and with neighboring EMS systems on coordination and mutual aid issues;

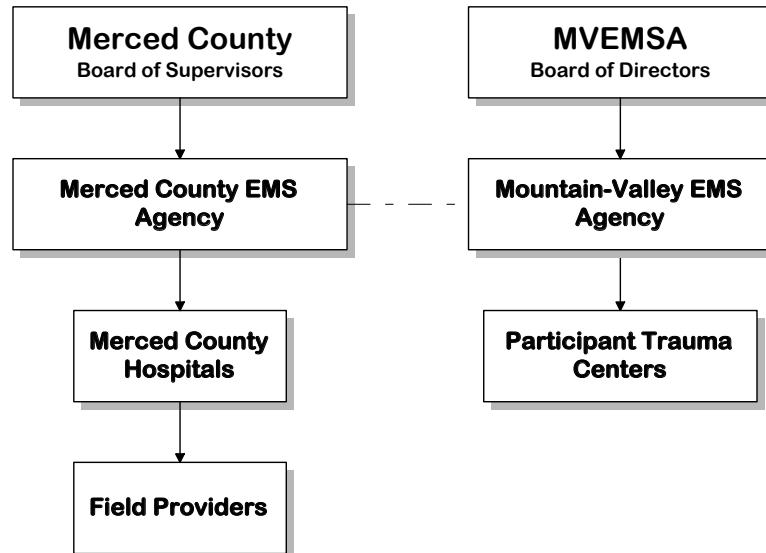
APPROVED:

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- E. Coordination for the collection of trauma data, including a trauma registry at the trauma centers, trauma data collection from participating non-trauma centers, and pre-hospital data collection;
 - F. Monitoring of the system to determine compliance with appropriate state laws and regulations, local EMS agency policies and procedures, and contracts, and taking corrective action as needed;
 - G. Evaluating the impact of the system and revising the system design as needed.
2. To accomplish these various tasks, the MCEMSA Trauma System shall be organized as follows:

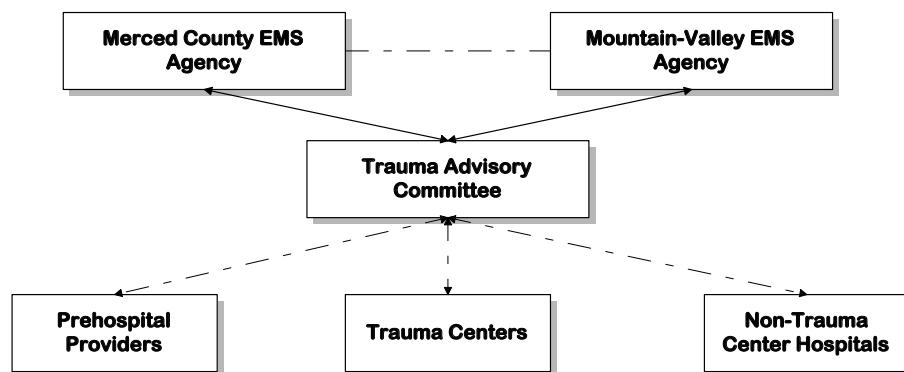
Merced County Trauma System

System Organizational Structure



Merced County Trauma System

Agency Organizational Structure



MERCED

COUNTY

DEPARTMENT OF PUBLIC HEALTH

EMERGENCY MEDICAL SERVICES AGENCY

POLICY NO. 512.10

EFFECTIVE DATE: 11/1/98

REVISION DATE: _____

REVIEW DATE: 5/2004

This policy supercedes any other
Existing policy on this subject

Subject: **TRAUMA FACILITY ADVERTISING AND/OR MARKETING STANDARDS**

Authority: California Health and Safety Code, Section 1798.165(c)

Purpose: To establish marketing, advertising and/or promotional standards for facilities or providers designated by or under contract with the County of Merced for trauma services.

Policy: No health care provider shall use the terms "trauma facility," "trauma hospital," "trauma center," "trauma care provider," "trauma vehicle," or similar terminology in its signs or advertisements, or in printed materials and information it furnishes to the general public, unless the use is authorized by the Merced County EMS agency. The request for the use of such terms by a facility shall be made in writing to the Merced County EMS agency, and the agency shall respond within 30 days of receipt of said written request.

1. Definitions:

- A. "Agency" – means the Merced County EMS Agency.
- B. "MTPRC" – "Major Trauma Patient Receiving Center." A designation by the Agency signifying a hospitals commitment to meet and/or exceed the standards established by the State of California for a Level II Trauma Center and capable of managing the medical care needs of major trauma patients.
- C. "*Level III Trauma Center*" – a designation by the Agency signifying a hospitals commitment to provide specialty trauma services available to respond to trauma patients in a prompt fashion. Level III Trauma Centers are not typically designated to receive major trauma patients unless stabilization is indicated prior to transfer to a higher level of care.
- D. "EDAT" – "Emergency Department Approved for Trauma." A designation by the Agency signifying a hospitals commitment to receive moderately injured patients (and, in rural or isolated areas, major trauma patients) and provide stabilization services until arrangements can be made to transfer the patient to a higher level of care.

APPROVED:

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James Andrews, MD
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2. MTPRC Advertising Standards

- A. In any advertisements, promotional or marketing materials, the following terms may be used when a hospital is under contract with the Agency as a MTPRC:
 - 1) "Major Trauma Patient Receiving Center"
 - 2) "Major Trauma Receiving Center"
- B. The Following terms may not be used unless so designated and authorized by the EMS agency of jurisdiction:
 - 1) "Level I Trauma Center"
 - 2) "Level II Trauma Center"

3. Level III Trauma Center Advertising Standards

- A. In any advertisements, promotional or marketing materials, the following terms may be used when a hospital is under contract with the Agency as a Level III Trauma Center:
 - 1) "Level III Trauma Center"
 - 2) "Trauma Facility" or "Trauma Hospital"
- B. The Following terms may not be used by Level III Trauma Centers:
 - 1) "Trauma Center" without preceding with "Level III"
 - 2) The use of "Trauma Center" with any other designator (e.g. Level I or II)

4. EDAT Advertising Standards

- A. In any advertisements, promotional or marketing materials, the only term that may be used by hospitals under contract with the Agency as an EDAT is "Emergency Department Approved for Trauma" or "EDAT."

5. Other Ambulance Receiving Hospitals

- A. Hospitals not under contract with the Agency for one of the above referenced trauma facility designations may not utilize any of the following terms in any advertisements, promotional or marketing materials:
 - 1) "Trauma Center," either in isolation or with any other designator (e.g. Level I, II or III)
 - 2) "Trauma Hospital" or "Trauma Facility"
 - 3) "Trauma Receiving Center" or "Trauma Receiving Hospital"

- 4) Any other term or terms that might indicate a specific trauma service authorized or designated by the Agency.



**Department of Public Health
Emergency Medical Services Agency**

Tammy Moss Chandler
Director of Public Health

James Andrews, M.D.

Policy #: 512.25
Effective Date: 11/1998
Revision Date: 07/2011
Review Date: 07/2013

This policy supersedes any other existing policy on this subject.

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Subject: TRAUMA AND BURN PATIENT DESTINATION POLICY

Authority: California Health and Safety Code, Section 1798.170 et. seq.

Purpose: To identify those patients whose injuries would most benefit from the services of a trauma or burn center and provide destinations for such patients.

Definitions:

1. *Burn Center* - means a designation signifying a hospital's commitment to meet and/or exceed the standards established by the State of California for a Burn Center and capable of managing the medical care needs of major burn patients.
2. *GCS* - means Glasgow Coma Scale
3. *MHLB* - means Memorial Hospital of Los Banos
4. *Trauma Center or TC* – means a designation signifying a hospital's commitment to meet and/or exceed the standards established by the State of California for a Trauma Center and capable of managing the medical care needs of major trauma patients.
5. *MMC* - means Mercy Medical Center
6. *Trauma* - means a physical injury or wound caused by an external force, a high energy exchange, a rapid deceleration or violence.

Policy: 1. The distribution of trauma and burn patients shall be in accordance with the procedures delineated herein.

2. Destination Decisions:

- A. All injured patients meeting trauma or burn triage criteria shall be transported by the quickest, most appropriate means, ground or air.
 - 1) If environmental conditions or other conditions do not allow air transport, a ground ambulance shall transport to the closest:
 - i) Trauma Center if the patient meets trauma triage criteria and transportation can be done safely and within 60 minutes.

APPROVED:

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Director of Public Health

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EMS Medical Director

- ii) Burn Center if burns meet burn criteria and do not meet trauma criteria, a ground ambulance shall transport to the burn center if transportation can be done safely and within two hours (Please note exceptions under Section 2, Burn Triage Criteria Procedure, page 4). Contact the base hospital for fluid resuscitation instructions with long transports.
 - iii) Otherwise, transport to the closest facility for stabilization and transfer.
 - 2) Patients not meeting Trauma or Burn criteria shall be transported to either MHLB, MMC or Emanuel in Turlock, per patient preference or closest facility.
 - 3) If the trauma patient has a life threatening condition that overrides the need for expedient surgery, they shall be transported to the closest facility for stabilization and transfer arrangements, as appropriate. This includes the following conditions:
 - i. All trauma patients with unmanageable airways shall be transported to the nearest receiving facility.
 - ii. All traumatic arrest patients (not determined dead in the field) shall be transported to the nearest receiving facility via ground ambulance.
- B. For trauma patients meeting trauma triage criteria the patient shall be sent to the TC on rotation. TC rotation schedules are maintained by Stanislaus County and shall be assigned at the time of confirmation of patient transport. Air Ambulances will contact Stanislaus Control enroute to confirm their destination. Ground transports of patients meeting triage criteria are required to make base contact for report and destination confirmation.
- C. For burn patients meeting triage criteria the patient shall be sent to the burn center located at Community Regional Medical Center in Fresno. Air Ambulances will contact Regional Medical Center enroute to provide a patient report. Ground transports of patients meeting triage criteria are required to make base contact for patient report and destination confirmation. Air transport is not usually indicated in the transfer of a burn patient with a stable airway and vital signs.

Procedure – Adult Trauma Patients (Age > 14)

1. To determine the appropriate destination for adult trauma patients, paramedics shall perform the following:
 - A. Conduct the primary survey; and
 - B. Assess vital signs, level of consciousness, determine the anatomy of the injury and determine the GCS.
2. For transportation of inmates at United States Penitentiary, Atwater, personnel shall refer to Policy No. 403.00, "Patient Management for Inmates - United States Penitentiary, Atwater," due to the unique security issues associated with this population.

3. The following trauma patients should be triaged to a TC directly from the field:
 - A. GCS < 14
 - B. Systolic Blood Pressure*
 - < 90mmHg (adult)
 - <85mmHg (child age 7-14)
 - <70mmHg (child age 0-6)
 - * at any time
 - C. Respiratory Rate <10 or >30 breaths/minute;
 - D. Penetrating injury to head, neck, torso, and extremities proximal to elbow and knee;
 - E. Flail Chest;
 - F. Two or more proximal long bone fractures;
 - G. Crushed, degloved, or mangled extremity
 - H. Amputation proximal to the wrist or ankle
 - I. Suspected Pelvic Fracture;
 - J. Open or depressed skull fracture
 - K. Paralysis
4. The following patients may be transported to a TC based on the clinical judgment in each case. The follow criteria should raise the index of suspicion but transport to a TC should be based on tangible signs and symptoms of injury. Decisions should not be based on mechanism of injury or special considerations alone.

Mechanism of Injury:

- A. Falls
 - >20 feet (one story = 10 feet) (adult)
 - >10 feet or 2-3 times the height of child (age 0-14)
- B. High Risk Automobile Crash
 - Intrusion >12 inches at occupant site
 - Ejection (partial or complete) from automobile
 - Unrestrained rollover
 - Vehicle telemetry data consistent with high risk of injury (if available)
- C. Automobile vs. Pedestrian/Bicyclist
 - Pedestrian/bicyclist thrown or run over
 - Significant (>20 mph) impact
- D. Motorcycle Crash
 - >20 mph

Special Considerations:

- A. Age:
 - Older adults: Risk of injury/death increases after age 55
 - Children: Should be triaged preferentially to a pediatric-capable TC (refer to Pediatric Trauma Triage criteria)
- B. Anticoagulation and bleeding disorders
- C. Burns (refer to Burn Center criteria)
- D. Death in the same passenger compartment

- E. End stage renal disease requiring dialysis
- F. Pregnancy >20 weeks with complaint of injury
- G. EMS provider judgment

Procedure - Pediatric Trauma Patients (Age < 15)

1. To determine the appropriate destination for Pediatric trauma patients, paramedics shall perform the following:
 - A. Conduct the primary survey
 - B. Assess vital signs, level of consciousness, determine the anatomy of the injury and determine the GCS.
2. Based on the above assessment, the following pediatric patients should be triaged to a trauma center directly from the field:
 - A. GCS < 13 or a decrease of 2 or more from baseline;
 - B. Age appropriate hypotension (see table, Appendix A)
 - C. Respiratory rate outside of normal limits (see table, Appendix A)
 - D. Penetrating injury to the head, neck or trunk
 - E. Patient < 1 year of age with any visible fractures
 - F. Open and depressed skull fractures
 - G. Flail Chest
 - H. Traumatic Paralysis
 - I. Unstable pelvic fracture
 - J. Two or more proximal long bone fractures
 - K. Paramedic judgment:
 - 1) Paramedic judgment should include a consideration of the mechanism of injury and be based on tangible signs and/or symptoms indicating possible internal injury or compensated blood loss, such as:
 - a) anxiety, nervousness, restlessness, confusion
 - b) tachycardia, SVT
 - c) pallor, cool skin, diaphoresis, trembling
 - d) chest or abdominal pain following an acute traumatic event

Procedure - Burn Triage Criteria

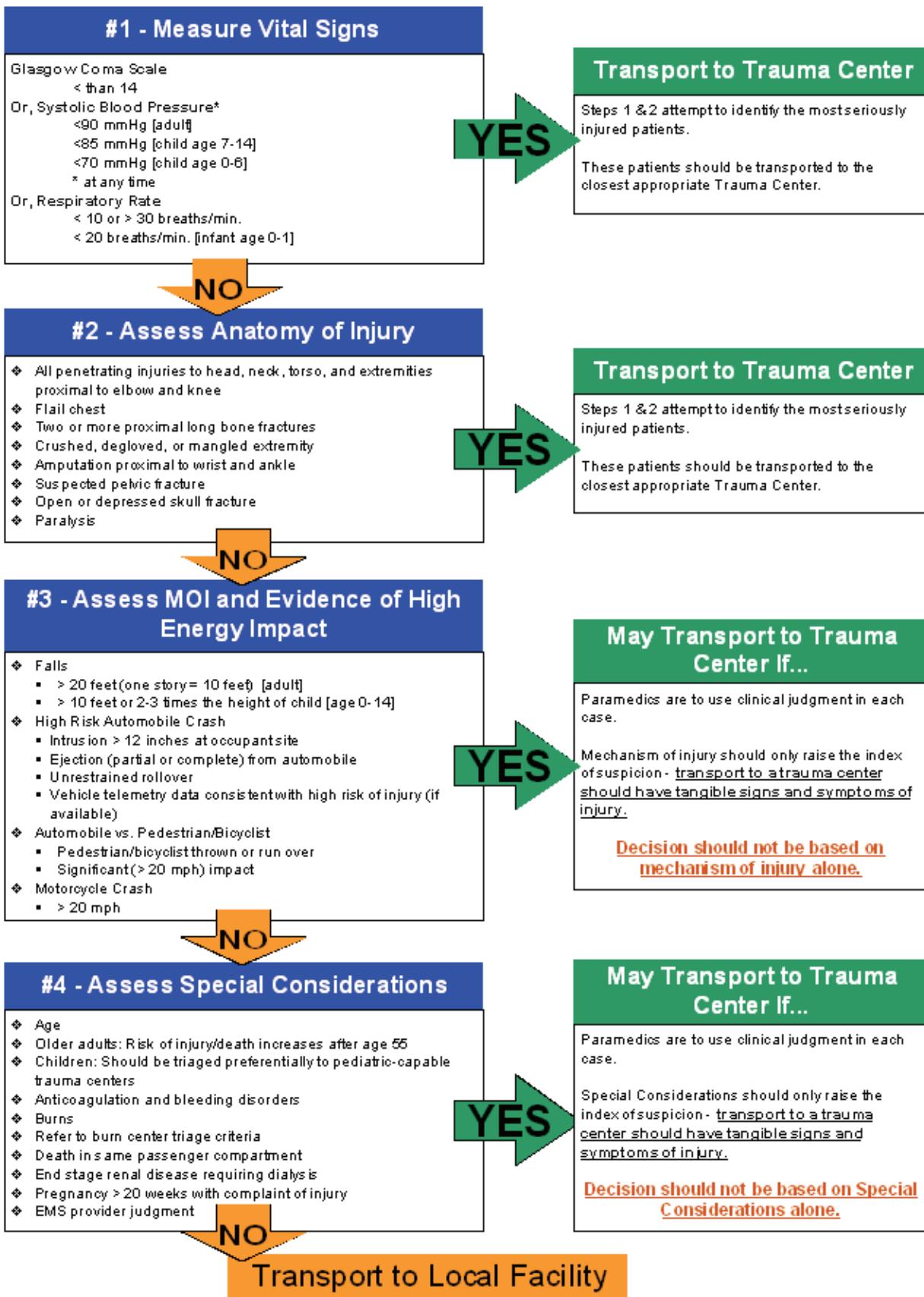
1. A patient (adult or pediatric) whose primary injuries are burns may be transported directly to a Burn Center from the field. These injuries include:
 - A. Partial/full thickness (2nd or 3rd degree) burns involving greater than 15% TBSA without airway compromise
 - B. Patients with partial/full thickness (2nd or 3rd degree) burns greater than 10% TBSA without airway compromise with the following:
 - 1) Greater than 60 years of age
 - 2) Associated trauma meeting Trauma Triage Criteria (and if transport can be completed within 60 minutes)

- 3) Significant co-morbidities (e.g. COPD, major medical disorder, bleeding disorder or anticoagulant therapy, dialysis patients)
 - C. Partial/full thickness (2nd or 3rd degree) burns of face, perineum or circumferential burn to any body part
 - D. Significant electrical injuries with loss of consciousness, voltage in excess of 220, and/or open wounds
 - E. Electrical injuries resulting in a loss of distal pulses
 - F. Significant inhalation injury with successful intubation
 - G. Chemical burns with wounds >5% TBSA
2. All burns with airway compromise, wheezing, stridor, carbonaceous sputum, nasal singeing or significant facial edema must have an evaluation for intubation either by air ambulance personnel or by the emergency physician at the closest appropriate receiving facility prior to transport to the Burn Center, if the ground ambulance is unable to intubate the patient.

APPENDIX A
Pediatric Vital Sign Table

AGE	MINIMUM SYSTOLIC BP	NORMAL HR	NORMAL RR
Premature	40	120-170	40-60
Term	60	100-170	40-60
3 months	60	100-170	30-50
6 months	60	100-170	30-50
1 year	72	100-170	30-40
2 years	74	100-160	20-30
4 years	78	80-130	20
6 years	82	70-115	16
8 years	86	70-110	16
10 years	90	60-105	16
12 years	94	60-100	16

TRAUMA TRIAGE: ADULT



This policy supercedes any other
Existing policy on this subject

Subject: **TRAUMA FACILITY APPLICATION PROCESS**

Authority: California Health and Safety Code, Section 1798.165, California Health and Safety Code, Section 1798.170, California Code of Regulations, Title 22, Division 9, Section 100236 et seq.

Purpose: To delineate the process for hospitals to follow when submitting an application for designation as a specific trauma facility (e.g. Level II, Level III, EDAT).

Policy: To achieve designation as a Level II, Level III Trauma Center or EDAT, hospitals shall submit an application and follow the required process as outlined in this policy.

Procedure: For consideration of a designation as described above, a hospital shall follow the application process as delineated herein whenever designation is sought outside the County Request for Proposal Process:

1. The requesting hospital shall submit a letter of request for trauma facility application to the EMS agency. The letter should be addressed to the EMS Agency Administrator, specify the level of designation sought and should be signed by an individual with the authority to commit the hospital to the specifications as contained in the California Code of Regulations, Section 100236, et seq..
2. The letter should specify the commitment of the hospital to comply with all requirements for designation at the requested level, including, but not necessarily limited to, administrative, operational, clinical and financial commitments of the hospital.
3. Once the letter of request is received, the EMS agency will prepare an application package and forward it to the applicant hospital. The applicant will be given 90 days to complete the application package and submit it to the EMS agency for review. A non-refundable application fee, established through the Health Department Fee Schedule, must be submitted with the application. An invoice will be included with the application package sent to the applicant.
4. The EMS agency will schedule a Site Visit to verify the information contained in the application within 60 days of receipt of the application. The Site Visit will be conducted by a Site Survey Team (SST) made up of at least two experts in the field of trauma services that have no known conflicts of interest with any of the involved parties. The applicant may request exclusion of a specific SST member on the basis of conflict of interest only. The site visit will include objective confirmation of the application information as well as

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subjective evaluation of the hospital's capability and commitment to serve at the level of designation requested.

5. Based upon the SST's review and confirmation of the written application, as well as their subjective review of the applicant facility, they will prepare and submit a draft report and recommendation to the EMS agency regarding designation. If the SST recommends substantive corrective actions prior to designation, the EMS agency may request a Plan of Corrective Action (PCA) from the applicant, to address the areas of deficiency. If requested, a PCA shall be submitted by the applicant within 45 days of its request.
6. PCAs shall be reviewed by the EMS agency and the SST and shall be taken into consideration for the final report and recommendation to the Director of Public Health. Once the application is approved, the applicant and the EMS agency shall execute a contract articulating the trauma system responsibilities and contractual requirements of the parties.
7. If, after review of the PCA, the application is denied, a letter of denial shall be sent to the applicant by certified mail. The letter of denial shall specify the reason(s) for the denial and describe the following appeal process, should the applicant wish to appeal the decision:
 - A. If an application is denied, the applicant may submit a letter of appeal requesting a hearing. Said letter must be received at the EMS agency within 15 working days of receipt of the certified letter denying the application. Expert judgements or analysis of the SST are not subject to appeal.
 - B. Within 45 days of receipt of a qualified letter of appeal, the Director of Public Health shall convene a Hearing Panel. The panel shall include two individuals with expertise in trauma systems and one lay public representative. All panel members shall be screened for any known conflicts of interest. The applicant may request, in writing within seven (7) days of receipt of notice of the date of the hearing, the disqualification of any panel member. The request must state the reasons upon which it is claimed that a fair and impartial review cannot be accorded. The Director of Public Health shall determine within three (3) days of receipt of the request whether the evidence warrants approval of the request to disqualify the specified panel member and so notify the requestor by mail prior to the date of the hearing.

The purpose of the panel shall be to review the pertinent issues involved in the application denial; receive testimony from the appellant and/or the EMS agency; and solicit whatever additional information it deems necessary in order to render an informed recommendation to the Director of Public Health. The appeal process shall be closed to the public and any witnesses called by either party shall be required to wait outside the hearing room until called upon. The Hearing Panel may request additional documentation/information from either party, to be submitted to the panel for their review following the hearing, if such material is deemed pertinent to the issues and is unavailable at the time of the hearing. Any such documentation/information submitted for the panel's review shall also be submitted to the other party to the appeal process for their review and comment to the panel.

- C. The Hearing Panel shall complete its report and recommendation to the Director of Public Health within 30 days of the date of the hearing. The Hearing Panel shall make one of the following recommendations regarding the decision to deny the application:
 - 1) Stay the Application Denial,
 - 2) Reverse the Application Denial, or
 - 3) Approve the Application subject to the applicant meeting specific requirements. Any such specific requirements must be submitted in written form by the panel and included as an addendum to the report.

- D. The Director of Public Health shall review the report and recommendation and render a final decision. Said decision shall be forwarded in written form and by certified mail, along with a copy of the Hearing Panel's recommendation, to the appellant.



**Department of Public Health
Emergency Medical Services Agency**

John Volanti, M.P.H.
Director of Public Health

James Andrews, M.D.

Policy #: 520.00
Effective Date: 07/1993
Revision Date: 05/2008
Review Date: 05/2010

This policy supersedes any other existing policy on this subject.

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Subject: **INTERFACILITY TRANSFER**

Authority: The California Health and Safety Code, Division 2.5, Sections 1797.220, 1798.172 and 1317, et seq.

Definitions:

Interfacility Transfer - shall mean the transfer of a patient from a hospital emergency department or hospital inpatient area, hereafter referred to as "facility", to any acute care facility.

Sub-acute Transfer – shall mean the transfer of a patient from an acute or sub-acute facility to a sub-acute facility or patient's residence.

Emergency services and care - means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and/or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.

Emergency Medical Condition - means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health in serious jeopardy.
2. Serious impairment to bodily functions.
3. Serious dysfunction of any bodily organ or part.

Active Labor - means a labor at a time at which either of the following would occur:

1. There is inadequate time to effect safe transfer to another hospital prior to delivery.
2. A transfer may pose a threat to the health and safety of the patient or the unborn child.

Hospital - means all hospitals with an emergency department licensed by the State Department of Health Services.

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Medical Hazard - means a material deterioration in, or jeopardy to, a patient's medical condition or expected chances for recovery

Within the capability of the facility - means those capabilities which the hospital is required to have as a condition of its emergency medical services permit and services specified on Services Inventory Form 7041 filed by the hospital with the Office of Statewide Health Planning and Development.

Consultation - means the rendering of an opinion, advice, or prescribing treatment by telephone and, when determined to be medically necessary jointly by the emergency and the specialty physicians, includes review of the patient's medical record, examination and treatment of the patient in person by a specialty physician who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient.

Purpose: To assure that all Interfacility transfers occurring within, or originating from within, Merced County are conducted in the best interest of patient care and in compliance with state and federal regulations.

Policy: 1. No person needing emergency services and care may be transferred from a hospital to another hospital unless each of the following are met:

A. A hospital with an emergency department must, within the capabilities of its Emergency Department, provide an appropriate medical screening examination to any individual who comes to the Emergency Department for examination or treatment of a medical condition or of active labor and on whose behalf the examination or treatment is requested. The purpose of the examination is to determine whether the individual has an emergency medical condition or is in active labor.

B. A physician at the transferring hospital has notified and has obtained the consent to the transfer by a physician at the receiving hospital and confirmation by the receiving hospital that the person meets the hospital's admissions criteria relating to appropriate bed, personnel, and equipment necessary to treat the person.

2. If an individual, regardless of eligibility for Medicare benefits, has an emergency medical condition or is in active labor, the hospital must either provide for further examination and treatment (within its capabilities) or make an appropriate transfer of the patient to another medical facility, unless the treatment or transfer is refused. A hospital may not transfer a patient unless:

A. The patient, or a legally responsible person acting on the patient's behalf, requests the transfer, or;

B. A physician, or other qualified medical personnel when a physician is not readily available, has certified that the medical benefits expected from the treatment at the facility outweigh the increased risks to the patient's condition resulting from the transfer.

3. The transferring hospital shall inform all persons presenting to the emergency room, or their representative(s), both orally and in writing, of the reasons for the transfer or refusal to provide emergency services and care, and of the persons right to said

emergency services and care, prior to the transfer, without regard for the persons ability to pay.

4. The transferring hospital shall arrange for appropriate personnel and equipment, which a reasonable and prudent physician in the same or similar locality exercising ordinary care would use to affect the transfer.
5. All the person's pertinent medical records and copies of all the appropriate diagnostic test results which are reasonably available shall be transferred with the person.
6. The records transferred with the person shall include a "Transfer Summary" signed by the transferring physician which contains relevant transfer information. The form of the "Transfer Summary" shall, at a minimum, contain the person's name, address, sex, race, age, insurance status, and medical condition; the name and address of the transferring doctor or emergency department personnel authorizing the transfer; the time and date the person was first present at the transferring hospital; the name of the physician at the receiving hospital consenting to the transfer and the time and date of the consent; the time and date of the transfer, the reason for the transfer; and the declaration of the signor that the signor is assured, both verbally and in writing, of the reason for the transfer. Neither the transferring physician nor transferring hospital shall be required to duplicate, in the "Transfer Summary", information contained in medical records transferred with the patient.
7. Nothing in this policy shall prohibit the transfer or discharge of a patient against medical advice when the patient or the patient's representative requests such a transfer or discharge, and gives informed consent.
8. If the patient needing emergency service is to be transferred for a non-medical reason (such as the person's inability to pay for any emergency service or care or repatriation to a contracted facility), the physician must certify in writing, within reasonable medical probability, that the transfer or delay caused by the transfer will not create a medical hazard to the patient.

Procedure:

1. Direct voice contact between transferring physician and receiving physician shall be made and agreement regarding all aspects of the transfer shall be reached prior to transfer.
2. The following medical records shall accompany the patient or follow by FAX as soon as possible if preparation of records would significantly delay an immediate transfer.
 - A. A summary of care received prior to the transfer.
 - B. Copies of all current pertinent medical records including laboratory data, current physicians and nursing notes.
 - C. Copies/originals of all pertinent x-rays, sonograms, CT scans, ECGs and other diagnostic tests.

- D. Copies of pre-hospital care forms including paramedic run reports and Emergency Department records where applicable.
3. A verbal report on the patient by a nurse or physician shall be made to the transport crew prior to transport.
4. The transferring facility shall call the Merced County EMS Dispatch Center (MCEMSDC) and request the appropriate transportation service.
 - A. If the patient's condition warrants transfer via a Critical Care Transport unit (CCT), arrangements shall be made through the MCEMSDC.
 - 1) If a CCT unit is unavailable and the transferring facility chooses to send a nurse on the transfer with the ambulance crew, the transferring facility shall assume the responsibility for the nurse's actions, treatment and nursing care provided during said transfer and return to the transferring facility. The ambulance contractor's ALS unit charges shall apply.
 - B. The transferring facility shall pre-alert the transport provider as soon as possible, once the need for transfer is confirmed, so as to allow for a call up of an additional crew, if warranted.
 - C. The transferring facility shall request the transfer based on and using the following terms:
 - 1) Immediate Transfer – shall mean an emergency transfer. This shall be requested when any delay in transferring the patient could result in placing the patient's health in immediate jeopardy. The transport provider retains a response time requirement for these transfers just as they would for a 911 request to the facility's location. As these transfers immediately remove an ambulance unit from the 911 system, facilities are expected to only request an immediate transfer when the patient's condition warrants such a response. The patient should be prepared for transfer with all available transfer papers upon the arrival of the transfer unit. Reported abuse of this transfer category shall be investigated for possible sanctions against the offending facility.
 - 2) Delayed Transfer – shall mean a request for transfer as soon as possible. This should be requested when the patient's medical condition requires a timely transport to a facility providing a higher level of care, where a receiving physician is awaiting arrival of the patient or the receiving department is the Emergency Department.

The MCEMSDC shall dispatch a transfer unit promptly, as soon as the 911 system status allows. If the MCEMSDC is aware at the time of request that the contracted transport provider will be unable to initiate the transfer within 60 minutes of the time of request, the MCEMSDC shall contact the transferring facility and offer to arrange for an alternate transport provider.

- 3) Non-Urgent Transfer– This should be requested when the patient's medical condition requires transport to a facility providing a higher level of care but will not be evaluated upon arrival by the receiving physician or is to be directly admitted to a department other than the ED. Unless otherwise agreed to, these shall have a 2 hour response time requirement.
- 4) Pre-arranged Transfer – shall be a pre-arranged/pre-scheduled transfer for a medically stable patient. The timeliness of this type of transfer would have no foreseeable bearing on the patient's medical condition.
 - a) Unless otherwise arranged for and agreed upon by the transferring facility, these transfers shall be initiated within 4 hours of the time requested. If the exclusive provider is unable to accommodate the transfer within this timeline, they shall be required to make arrangements for an alternate provider.
5. Written orders shall be provided for the transport personnel, as appropriate, on the transfer form, and signed by the transferring physician. The transporting personnel shall make Base Hospital contact for confirmation of orders prior to transport. In addition, transporting personnel shall make Base Hospital contact should there be any change in the patient's condition.
6. The transferring facility personnel shall utilize an Interfacility Transfer Form, with checklist and transfer orders, to ensure that the patient has been appropriately prepared for transport. This transfer form shall accompany the patient, and the receiving facility shall review and complete the form when the patient arrives, and forward a copy of the completed form with arrival time to the Merced County EMS Agency on a monthly basis.

This policy supercedes any other
Existing policy on this subject

Subject: **HOSPITAL IMPACT EVALUATION POLICY****Authority:** California Health and Safety Code, Section 1797.220, California Health and Safety Code, Section 1300 (c).**Purpose:** To provide a mechanism for the Merced County EMS Agency to evaluate and report on the potential impact on the EMS system as a result of the reduction or closure of emergency services (ES) in hospitals.**Policy:** It is the policy of the Merced County EMS Agency to ensure, to the degree possible, that EMS system operations are planned in a prospective fashion to allow for the most effective and efficient use of resources. Hospitals that reduce or close emergency services negatively impact system operations. To mitigate the impact upon the EMS system, any hospital intending to reduce or close emergency services shall comply with the provisions herein.**Definitions:** **Agency** - Shall mean the Merced County EMS Agency, a program area within the Department of Public Health Administration, duly appointed by the Board of Supervisors.**Emergency services** - means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. The provision of hospital emergency services requires licensure through the State Department of Health Services.

1. Acute care hospitals intending to implement either a reduction or closure of emergency services shall advise the Agency as soon as possible, but not less than 90 days prior to the proposed change. The proposal must include:
 - A. Reason for the proposed change(s).
 - B. Itemization of the services currently provided and the exact nature of the proposed change(s).

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- C. Description of the local geography, surrounding services, and, for Base Hospitals, the average volume of calls.
 - D. Description of potential impact on the EMS community regarding patient volume and type of prehospital and emergency department services available. Include a pre/post comparison.
 - E. Description of potential impact on the public regarding accessibility of comparable alternative facilities or services. Include a pre/post comparison.
2. Within 45 days of notification from the hospital of their intent to alter the emergency services provided, the Agency will produce a draft needs assessment, including an impact evaluation report, regarding the proposed changes. The criteria which will be addressed in the impact evaluation report include:
 - A. Geography (service population density and relative isolation, travel time and distance to nearest facility, number and type of other available emergency services, availability of prehospital and alternate hospital resources).
 - B. Base hospital designation (number of calls, impact on patients, prehospital personnel and other base hospitals).
 - C. Specialty services provided.
 - D. Patient volume.
 - E. Feedback received from a public hearing on the issue (see Section 4 below).
3. The Agency will facilitate a process for prehospital and hospital input into the impact evaluation report. This process shall include:
 - A. Review by the Emergency Medical Care Committee (EMCC), time permitting.
 - B. Release of the draft impact evaluation report to prehospital and hospital emergency services personnel, with a 10 day comment period.
4. Within 45 days of hospital notification to the Agency of the intent to change emergency services provided by the hospital, the Agency will conduct a public hearing on the matter in conjunction with the Public Health Director, Agency Medical Director, a Board of Supervisors representative and a city counsel representative from the impacted city, if applicable.
5. The hospital will serve notice of the public hearing to the community through standard and reasonable efforts (i.e. local newspapers, television and notices at hospitals) within the effected area.
6. At the completion of the public hearing and comment period on the impact evaluation report (no later than 60 days from the time of notification to reduce or close hospital emergency services), the needs assessment, impact report and a recommendation regarding the reduction in services or closure of the ED will be submitted by the Agency to the State Department of Health Services, the State EMS Authority, the Emergency Medical Care Committee, all area hospitals and interested others.

7. The State Department of Health Services will make the final determination as to the nature of emergency services to be provided, if any, by the hospital seeking reduction or closure.
8. The hospital proposing a reduction or closure of service(s) will be charged a \$1500.00 fee by the Agency for the impact evaluation.



**Department of Public Health
Emergency Medical Services Agency**

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Director of Public Health

James Andrew, M.D.

Policy #: 525.00
Effective Date: 09/1993
Revision Date: 08/2006
Review Date: 08/2008

This policy supersedes any other existing policy on this subject.

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Subject: **CRITICAL CARE TRANSPORTION AMBULANCE AUTHORIZATION**

Authority: Merced County Code, Sections 9.44 et. seq., Health and Safety Code Section 1797.220

Definitions: **Agency** - means the Merced County Emergency Medical Services Agency within the Department of Public Health.

CCTA – means a Critical Care Transportation Ambulance, which, for the purpose of this policy, shall be an Advanced Life Support (ALS) ambulance, staffed and equipped with additional personnel and the equipment necessary to meet the mission statement and scope of medical services provided by such a service.

Promptly Available – means a fully staffed and equipped CCTA capable of responding to requests for service within 30 minutes of the time of request.

Interfacility Transfer - shall mean the transfer of a patient from a hospital emergency department or hospital inpatient area, hereafter referred to as "facility", to any acute care facility.

Purpose: The purpose of this policy shall be to establish the standards for operation, program approval and licensure of CCTA programs, based or operating within Merced County.

Policy: **General Provisions**

1. All CCTA programs based or operating within Merced County shall be licensed by the Agency prior to initiating CCTA services originating from within Merced County, and said operations shall be restricted as contained herein. Program applications submitted for approval shall meet the minimum standards as established by Merced County Code, Section 9.44 et. seq. and this policy. CCTA providers shall not be approved for service until such time as a formal contract for service has been executed with the County of Merced.
2. CCTA operations, as delineated in Merced County Code, Section 9.44 et. seq., are ALS ambulances and shall be subject to the same operational restrictions as an ALS ambulance operation, relative to the application of Merced County ambulance exclusivity authority.

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3. The CCTA provider shall develop a written mission statement which defines the scope of care to be provided by the service. This statement shall also include the criteria establishing which patients are eligible for CCTA transfers.
4. All patient care resources, including personnel and equipment, necessary to the programs' mission must be available in the transport vehicle. This includes all ALS medications and equipment currently required by the County along with those additional medications and equipment as required to fulfill the mission statement and treatment protocols of the CCTA provider.
5. There shall be an educational program and/or printed information made available to the medical professional community regarding services offered through CCT transport as well as the specific patient criteria.
6. CCTA providers shall develop and maintain treatment protocols, separate and distinct from the Agency's treatment protocols, which are consistent with the provider's mission statement and scope of services.
7. CCTA providers, licensed to operate within Merced County, shall be promptly available 24 hours a day, seven days a week, to respond to requests for service.

CCTA Program Medical Director

1. All CCTA providers shall have a formal relationship with a CCTA Program Medical Director, either as an employee of the provider or under a contractual arrangement.
2. The Medical Director(s) shall be licensed and authorized to practice medicine in California. He or she must have board certification or substantial experience in those areas of medicine that are commensurate with the mission statement of the CCTA service. The CCTA Provider may contract with specialty physicians for consultation and training purposes, if no Medical Director with the above qualifications is available.
 - A. The provider shall submit a copy of these contracts to the LEMSA upon application for CCTA program approval.
3. The CCTA provider shall maintain a record of the Medical Director's educational experience and/or board certifications. The CCTA provider shall, if applicable, maintain records of the educational experience and/or board certifications of the specialty physician consultants and make same available for review by the Agency.
4. The Medical Director shall be responsible for the following program areas:
 - A. development and implementation of the program mission statement and patient treatment protocols;
 - B. personnel training program approval;
 - C. quality improvement / medical oversight for the CCTA program and all medical personnel associated with the program;

- D. approval of all CCTA provider policies involving patient care, equipment and medications and patient communications;

CCTA Personnel Standards

1. Minimum CCTA personnel configuration shall be as follows:
 - A. one (1) physician or registered nurse with a minimum of one (1) year of experience in a critical care or emergency department setting; and
 - B. one (1) paramedic with a minimum of; 1) three years of field experience; or 2) certification as a critical care transport paramedic or equivalent and one year of field experience; and
 - C. one EMT-1 driver
2. The CCT provider, with their Medical Director, shall develop and implement a comprehensive personnel training program. This program will address initial training as well as regular competency evaluation and continuing education. The CQI committee findings shall drive the training program.
3. All personnel working the CCTA shall be regularly assigned to the unit.

Quality Improvement

1. The CCTA provider shall establish and maintain an individual in the position of Clinical Care Supervisor. The provider will establish the minimum education and clinical experience of the Clinical Care Supervisor, along with a detailed job description. This individual shall be responsible for coordinating the quality improvement program for the provider.
2. The CCTA provider shall establish a formal continuous quality improvement (CQI) policy and committee. This policy shall clearly specify the following, at a minimum:
 - A. list of quality indicators to be used
 - B. make-up of the CQI committee
 - C. frequency of meetings
 - D. methods used to obtain loop closure
 - E. a description of the process for implementing corrective action, to include both operational and personnel issues
 - F. confidentiality issues

Field Operations

1. CCTA operations shall be restricted to interfacility transfers with the following exceptions:

- A. When functioning in the capacity of a backup ALS unit, CCTAs may not operate as a scheduled 911 response unit.
 - 1) The paramedic on the CCTA shall function as the primary caregiver when responding to 911 calls. The CCTA nurse may function only as an extra set of ALS hands, and may assist with those ALS procedures and medications as delineated within the Merced County EMS Agency ALS Treatment Protocols, and for which they have received training. At no time shall a CCTA nurse be the sole ALS provider on a CCTA.
- B. When responding to a physician's office or other clinical setting outside an acute care hospital to perform a pre-arranged transfer, CCTAs may only respond for such transfers following physician to physician communications confirming that a physician at the receiving hospital has agreed to accept the patient.

Procedure:

- 1. Applicants for CCTA licensure shall complete the following process for consideration of licensure in Merced County:
 - A. submit an application for CCTA provider supplied by the Agency
 - B. submit all supporting documentation as required in the application
 - C. pay the established fee
- 2. Within 10 working days of receipt of the application, the Agency shall send a letter to the applicant stating that either the application is complete and in process, or outlining what elements of the application are missing and a request for their submission.
- 3. Within 30 days of receipt of a complete application, the Agency shall send a letter to the applicant both confirming or denying licensure, and any conditions that may apply. If denied, the letter shall include the criteria for the denial.
- 4. If the application for licensure is denied, the applicant may request reconsideration by the Director of Public Health.
 - A. A hearing with the Ambulance Review Board (ARB) shall be scheduled within 21 days of receipt of a request for reconsideration. The applicant shall be afforded the opportunity to bring representation and state their arguments and present evidence to the ARB for their consideration. The Agency shall present their findings and criteria for denial.
 - B. Within five (5) working days of the hearing, the ARB shall submit its recommendation to both the Director of Public Health and the applicant. The Director of Public Health shall make his/her decision regarding the reconsideration and send a certified letter to the applicant within ten (10) working days of receipt of the recommendation of the ARB. The Director of Public Health's decision shall be final.



**Department of Public Health
Emergency Medical Services Agency**

John Volanti, M.P.H.
Director of Public Health

James Andrew, M.D.

Policy #: 530.00
Effective Date: 09/1993
Revision Date: 08/2006
Review Date: 08/2008

This policy supersedes any other existing policy on this subject.

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Subject: **DETERMINATION OF DEATH IN THE PRE-HOSPITAL SETTING**

Authority: California Health and Safety Code, Division 2.5, Section 1797.220

Definitions: Prehospital Personnel - Shall, for the purpose of this policy refer to any of the following:

- ❖ Law enforcement officers when functioning in the capacity of first responders to a medical emergency
- ❖ Firefighters functioning in the capacity of first responders to a medical emergency
- ❖ Ambulance personnel.

Purpose: To provide criteria and guidance to prehospital personnel on determining death in the prehospital setting and procedures to be followed whenever CPR is not initiated or is discontinued in the prehospital setting in Merced County.

Policy:

1. **OBVIOUS DEATH:**

A. Prehospital personnel shall not initiate/continue CPR on any patient, who is pulseless, non-breathing, mentally unresponsive and has one or more of the following:

1. decapitation
2. incineration of the torso or head
3. decomposition of body tissue
4. exposure, destruction and/or separation of vital internal organs (e.g. brain, spinal cord, liver, heart or lungs) from the body
5. postmortem lividity and/or rigor mortis

B. The prehospital personnel shall make a Declaration of Death and note the time of the same on the PreHospital Care Report Form (PCR) or alternate report form. The original copy of the completed PCR shall remain with the deceased, and the remaining copies shall be for normal distribution.

APPROVED:

ON-FILE

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Director of Public Health

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EMS Medical Director

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- C. The disturbance at the scene shall be minimized, and EMS personnel shall coordinate with the law enforcement agency with jurisdiction concerning scene integrity.
- D. If not already on scene, the prehospital personnel shall notify the County Coroner and/or the appropriate law enforcement agency that there is an OBVIOUS DEATH and shall remain at the scene until released by the coroner or law enforcement agency.
- E. If EMT-1/P Personnel are directed by a law enforcement officer to transport a patient who is an OBVIOUS DEATH, they should comply with that order AFTER informing the law enforcement officer that such transport is inappropriate and that transport is against local EMS Agency policy, that it will be noted on the PCR and an Incident Report will be filed. Contact the Merced County Base Hospital and authorized EMS Dispatch Center to report the mandated transport and proceed to the designated morgue facility.
- F. If the return route for a unit provides close proximity to a designated morgue facility or suitable transfer point and the unit can be placed temporarily out of service without jeopardizing emergency response capability, the EMS Dispatch Center, upon request of the EMT-1/P Personnel, may authorize transport of a patient who has been declared dead.

2. PROBABLE DEATH

- A. For patients who do not meet the criteria of OBVIOUS DEATH, EMT-I/P Personnel shall initiate and continue CPR and Advanced Life Support (ALS) treatment protocols until one of the following occurs:
 - 1. spontaneous effective circulation and ventilation have been restored
 - 2. the resuscitative effort has been transferred to another responsible and properly trained individual who continues it
 - 3. the rescuer is physically exhausted and unable to continue
 - 4. the EMT-1/P Personnel have reported the following to the Merced County Base Hospital Physician who has concluded that the cardiovascular system of the patient has been unresponsive to treatment and will remain so despite further resuscitative efforts, and has authorized CPR to be discontinued.
 - a. the length of time in which there has been an absence of spontaneous respiration and pulses which can be confirmed at two sites
 - b. asystole as confirmed by EKG monitor and auscultation of the chest following at least ten minutes of ALS resuscitation.
 - c. assessment of pupillary response to light
 - d. skin conditions and temperature relative to the environment

- B. When a probable death occurs as the result of a possible homicide or suicide, the following actions may be requested by law enforcement to preserve scene evidence, as they deem necessary:
 - 1. A path into and out of the scene may be identified, and prehospital personnel shall limit their traffic to this pathway.
 - 2. If resuscitation is deemed appropriate, personnel may be requested to extricate the patient to a location outside of the possible crime scene. If so requested, the patient should be removed from the scene via the identified pathway.
 - 3. Additionally, personnel are reminded not to touch objects around the patient. If something must be moved, either request law enforcement assistance, or, if that is not practical, be prepared to identify the original location of the object to the law enforcement incident investigator.
- C. When the Merced County Base Hospital Physician authorizes discontinuation of CPR on the patient, the EMT-1/P shall make a Declaration of Death, and shall document such declaration and time on the PCR and return it to the Base Hospital.
- D. The EMT-1/P Personnel shall notify the County Coroner and/or the appropriate law enforcement agency that a Declaration of Death has occurred and shall remain at the scene until released by the Coroner or law enforcement agency.
- E. If EMT-1/P Personnel are directed by a law enforcement officer to transport a patient who has been declared dead, they shall comply with that order AFTER informing the law enforcement officer that such transport is inappropriate, that transport is against local EMS Agency Policy, that it will be noted on the PCR and an Incident Report will be filed. Contact the Merced County Base Hospital to report the mandated transport and proceed to the designated morgue facility.
- F. If the return route for a unit provides close proximity to a designated morgue facility or suitable transfer point and the unit can be placed temporarily out of service without jeopardizing emergency response capability, the EMS Dispatch Center, upon request of the EMT-1/P Personnel, may authorize transport of a patient who has been declared dead.
- G. In no case will CPR or ALS treatment Protocols be discontinued, as allowed by 2.A.(4)(a) above, nor shall a Declaration of Death be made for patients under the following criteria:
 - 1. Any hypothermia situation (water submersion or cold exposure) except when there is an Obvious Death as defined by this policy.
 - 2. Whenever there are any questions or doubt about the viability of a patient or a particular situation is superseded by a subsequent policy.
 - 3. In these cases, the patient shall be transported to the nearest appropriate health care facility, unless declared dead as provided for above.
- 3. Policies and Procedures relating to medical operation during declared disaster situations or multiple casualty incidents will take priority over this policy.



**Department of Public Health
Emergency Medical Services Agency**

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Policy #: 535.00
Effective Date: 09/1993
Revision Date: 12/2008
Review Date: 04/2009

This policy supersedes any other existing policy on this subject.

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Subject: **Prehospital Advanced Directives**

Authority: California Health and Safety Code, Division 2.5, Sections 1797.220, and 1798, et al., California Code of Regulations, Title 22, Sections 100107 and 100146.

Definitions: **"DNR"** – Means Do Not Resuscitate which, for the purpose of this policy, shall mean that no CPR or advanced resuscitative measures shall be initiated.

"Advanced Directive" - Orders from patients and their physicians regarding what care should be provided or withheld in certain emergent situations. (I.e. Durable power of Attorney, living wills and other instruments such as "Declarations" under the Natural Death Act).

"Durable Power of Attorney for Health Care (DPAHC)" - A document which allows individuals to appoint an "attorney-in-fact" to make health care decisions for them if they become incapacitated. Decisions affecting health care must be outlined in the Durable Power of Attorney for Health Care when the individual completes the form.

"Declaration" - This instrument is a declaration to physicians by adult patients directing the withholding or withdrawal of life sustaining procedures in a terminal condition or permanent unconscious state.

"POLST" – stands for Physician Orders for Life-Sustaining Treatment

Purpose: To define valid prehospital advanced directives and to provide guidance to EMS personnel regarding compliance with such orders.

Policy: 1. There are four (4) valid Prehospital advanced directive instruments in Merced County:

- A. A completed, signed "EMERGENCY MEDICAL SERVICES PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM." A Medic Alert bracelet or necklace with the words "DO NOT RESUSCITATE - EMS" stamped on the medallion may also be utilized by the person with a DNR.
- B. A completed and signed POLST form, indicating the patient's wishes with regard to resuscitation and/or level of care.

APPROVED:

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- C. A Durable Power of Attorney for Health Care.
 - D. A physician's written order at a Skilled Nursing Facility.
1. In licensed skilled nursing facilities, DNR orders written by a physician in the medical record are to be honored. The facility staff must have the patient's chart with the DNR order in it immediately available for EMS field personnel upon their arrival.
 2. Durable Power of Attorney for Health Care (DPAHC) - Individuals who state that they are the "attorney-in-fact" for a patient and decline resuscitative measures on behalf of the patient shall present photo identification and the DPAHC with the appropriate signatures.
 3. Other Advanced Directives not considered appropriate for use in the prehospital setting:
 - A. Living Will - due to the wide variety of these documents and the inability to confirm the legitimacy of the document, they are considered unsuitable for use in prehospital care.
 - B. Declarations - The Declaration should be viewed as a directive to the physician regarding the patient's wishes. It is not suitable for use in prehospital care.
 4. The patient may, at any time, rescind the DNR or POLST order by destroying any copies of said order, including at the time that 9-1-1 is summoned. Should the patient rescind the DNR or POLST order or verbally request treatment (expressed consent), EMS personnel shall honor that action and provide whatever care is consistent with the current treatment protocols.

Procedure:

1. DNR Orders:
 - A. Upon arrival at a scene, if EMS field personnel are presented with a valid DNR order or a Medic Alert bracelet engraved with "Do Not Resuscitate - EMS" CPR shall not be initiated. Palliative or comfort care may be provided, if requested, however no resuscitative measures shall be instituted. If the patient, family or physician requests transport to a health care facility, the EMS field personnel shall comply with that request, continuing any palliative care initiated.
 - B. If the patient's physician is present and assumes medical control in accordance with EMS Policy 401.00, s/he may order the EMS field personnel not to initiate CPR by placing such order in writing at that time.
 - C. If the patient is presumed to be a PROBABLE DEATH, in accordance with EMS Policy 530.00, "Determination of Death In The Prehospital Setting," the EMS field personnel shall contact the Base Hospital and report the existence of a valid DNR order and:
 - 1) the length of time in which there has been an absence of spontaneous respirations and pulses which can be confirmed at two sites;
 - 2) assessment of pupillary response to light.

The Base Hospital Physician may then concur with the EMS personnel in a Declaration of Death. The EMS Personnel shall then note such declaration on the Prehospital Care Report Form (PCR) including the time that the declaration is made.

2. POLST Orders

- A. Section "A" of the POLST form indicates whether or not the patient has requested resuscitation or is a DNR. If the DNR is checked, and the patient is in arrest, personnel shall care for the patient as outlined herein for DNRs. If the patient is not in arrest, refer to the guidance below.
 - B. Sections "B" and "C" of the POLST form describe the "intensity of care" directions for hospital or skilled nursing facilities (SNF), and do not apply to prehospital personnel. Prehospital personnel can only follow standing orders approved by the EMS Agency Medical Director or on-line orders from the Base Physician. The "Additional orders" lines do not apply to prehospital personnel. If the SNF or family have called 9-1-1, the decision to transport has been made. Refer to Section 3 below regarding Comfort Care.
3. The following measures are considered standing orders for comfort care and may be provided to patients requesting such service.
 - A. Oxygen by nasal cannula or mask (no BVM or device that creates tidal volume)
 - B. Pain management. The paramedic may contact the Base for an order for morphine for patients suffering from a terminal illness or severe, diagnosed discomfort, e.g. a patient that is difficult to move due to osteoporosis.
 - C. Intravenous hydration, unless refused by the patient.
 - D. Patients suffering from airway obstruction, major hemorrhage, etc. shall receive appropriate treatment to relieve the immediate medical emergency, however no resuscitative measures shall be employed if the patient has indicated DNR.
 4. If the patient is an Obvious Death, the EMS personnel shall make note of the time that this determination is made, and shall request law enforcement or the Coroner to the scene, if not present. EMS personnel shall remain with the deceased until the arrival of the Coroner or law enforcement agency. If the patient is at a skilled nursing facility, board & care home, residential care or is attended by hospice at a residence, EMS personnel do not need to remain at the scene. Request the Coroner's office and clear the scene. The original copy of the PCR shall be left with, or forwarded to the County Coroners office within 2 hours.
 5. If at any time the patient's family requests resuscitative efforts, personnel shall contact and consult with the Base Hospital Physician.
 6. If there are suspicious circumstances (e.g. possible homicide) and the patient is not an obvious death, resuscitation shall be initiated and law enforcement summoned, if not at scene. If transport of the patient must occur before the arrival of law enforcement, take careful note of the position and location of the patient as well as usual crime scene precautions regarding disturbance of the scene.



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 540.00
Effective Date: 07/1993
Revision Date: 06/2008
Review Date: 06/2010

This policy supersedes any other existing policy on this subject.

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Subject: DOCUMENTATION OF PATIENT CONTACT

Authority: California Health and Safety Code, Division 2.5 Sections 1797.220 and 1798.(a); and California Code of Regulations, Title 22, Section 100169 (a) (6) (A).

Definitions: **Advanced Life Support Call** - Any EMS call in which Advanced Life Support Procedures, as defined in Section 1797.52, Division 2.5 of the Health and Safety Code.

Basic Life Support Call - Any EMS call that does not meet the definition for an Advanced Life Support call.

Health Agent - Refers to any person other than a law enforcement officer or coroner who has authority or responsibility for the disposition of a body. A health agent could be a private physician, a home health nurse or a public health nurse.

Medical Facility - Means any clinic, hospital or physician's office.

Nursing Facility - Means any residence or care facility other than an accredited hospital providing short or long term care for the infirmed, chronically ill, or disabled persons.

Patient - Means any person who has been identified by either medical personnel, first responders, family or bystanders as warranting evaluation, or who has one or more of the following:

1. Signs and symptoms of illness which are substantial enough to warrant medical attention;
2. Experienced a mechanism of injury which is substantial enough to warrant medical attention;
3. Exposure to or suspected exposure to hazardous materials or drugs which is substantial enough to warrant medical attention.

Patient Contact - Refers to anytime during the course of an EMS call when a person is identified as a patient, as defined in this policy, and the paramedic has arrived at the scene of the incident.

Prehospital Care Report or PCR- Refers to the form (electronic or hardcopy) used for the documentation of prehospital medical care as specified by the Merced County Emergency Medical Services Agency.

APPROVED:

ON-FILE

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Prescheduled - Means appointments made in advance in which there has been no acute decline in the patient's condition in the past 24 hours.

Triage Tag - Refers to the patient documentation tag currently in use within the Merced County EMS Area for the prioritization of patients of a disaster or multi-casualty incident.

Purpose: To identify required patient information and to establish a mechanism for gathering, recording and reporting this information.

- Policy:
1. It is the policy of the EMS Agency that PCRs are left with the receiving facility prior to the ambulance departing at least 90% of the time or greater. Repeated violations of this requirement may result in disciplinary action.
 2. A PCR shall be completed for the following:
 - A. On all patients transported by ambulance from a field scene, nursing facility or a medical facility to a facility of higher care for the purpose of non-prescheduled diagnosis and treatment.
 - B. On all patients transported from one hospital to another hospital for the purpose of continuation of treatment.
 - C. In all cases of prehospital death, a completed original PCR shall be faxed to the County Coroner, Law Enforcement, or Health Agent with jurisdiction over the scene within 2 hours.
 - D. In all cases during transport when a patient's condition worsens while enroute.
 3. In all cases where patient contact is made but the patient is refusing treatment and/or transportation, a Patient Refusal Form provided by the employer and approved by the EMS Agency shall be completed and signed as specified in policy No. 542.00, Consent/Refusal of Care. All fields need to be completed, particularly those that document the patient's findings, e.g. mental status, vital signs, etc.
 4. In the following circumstances, A Prehospital Care Report will not be required if the date, times and location of the call, as well as the identification of the patient, crew unit number and destination are documented on the California Highway Patrol, or other log approved by, and made available to, the EMS Agency.
 - A. Ambulance transports to a private residence or a facility of lower care for the purpose of rehabilitation, recuperation, or long term care.
 5. For disaster scenarios or multi-casualty incidents, Triage Tags shall be utilized for immediate prioritization and patient identification. A PCR which contains complete patient information and treatment, to include the patient's original triage priority, must replace each Triage Tag that has been generated.
 - A. When a Triage Tag is used, the tag shall remain on the patient until such time that a regular hospital record is established. Once such record is established, the Triage Tag number shall be documented on the emergency room patient chart.
 - B. If the ambulance crew needs to leave prior to completion of a PCR, the crew shall remove a perforated corner of the Triage Tag, which contains the patient ID number, for later patient identification and documentation.

Procedure:

1. The complete medical record copy of the PCR shall be given to the physician or nurse receiving the patient prior to the ambulance personnel's departure from the department or

ward receiving the patient, except as noted in Section 1 (c), (under Policy) for cases of death.

- A. An ambulance crew may respond to an emergency call prior to completing required patient documentation, if requested to do so by the authorized EMS dispatch center.
 - 1) If an ambulance crew is dispatched to an emergency call prior to completing required documentation, the complete medical record copy of the PCR shall be delivered or faxed to the department or ward which has received the patient as-soon-as-possible and no later than two (2) hours after the completion of the call.
 - 2) The care provider completing the report must note on the bottom narrative portion of the PCR the time the report was delivered and the reason why the report was not submitted on time.
 - 3) A request from an authorized ambulance dispatch center for an ambulance to return to their area of responsibility will not be considered an emergency call.
 - 4) A request from an authorized ambulance dispatch center for an ambulance to respond to a priority post may, for the purpose of this policy, be considered an emergency call. For each incident where an ambulance is posted as noted above within 15 minutes of arrival at the receiving facility, the EMS Dispatch Center shall document same on the incident record, for submission to the Agency monthly. The posting of ambulances within 15 minutes of arrival at a receiving facility should not occur more than 10% of the time and excessive early posting shall be considered a violation of this policy.



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 542.00
Effective Date: 09/1993
Revision Date: 04/2008
Review Date: 04/2010

This policy supersedes any other existing policy on this subject.

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Subject: **CONSENT/REFUSAL OF CARE**

Authority: California Health and Safety Code, Division 2.5, Section 1797.220

Definitions: For the purpose of this policy, the following shall apply:

5150 – Shall mean an individual who has been determined by a peace officer or mental health professional to be a danger to themselves or others, or gravely disabled, pursuant to Section 5150, Welfare and Institutions Code of the State of California.

Adult - shall mean (1) an individual at least 18 years of age, or (2) a legally married minor under 18 years of age, or (3) a minor on active-duty status with the armed forces, or (4) an emancipated minor, or (5) a minor represented by a conservator or durable power of attorney for health care decisions for the patient.

Competent or Competence - means the ability of a person to clearly understand the nature of their suspected illness or injury and the potential consequences of refusing prehospital medical care and transportation.

Emancipated Minor - means a minor who possesses legal documentation of release from parental custody, control and supervision and, as such, identifies said competent minor as legally responsible for his/her own decisions regarding the acceptance or refusal of prehospital medical care and transportation.

Expressed Consent - means the voluntary verbal or written agreement to receive prehospital medical care and transportation, by a competent person having the legal right to agree to that care and transport.

Implied Consent - means either: 1) a non-verbal or non-written agreement by a patient to accept prehospital medical care and transportation, such as an affirmative nod or his/her voluntary, cooperative actions; or 2) in the case of a patient who is unable to provide expressed consent, as in the case of incompetence or unconsciousness, the determination by a reasonable person that if the patient was capable of making the decision to seek medical care and transportation, they would agree to such care and transport.

APPROVED:

ON-FILE

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Release of Medical liability or Against Medical Advice (AMA) - means the process by which a competent person with the legal right to exercise their own judgment, relative to the acceptance or refusal of prehospital medical care and transportation, refuses the services of prehospital personnel. Said refusal should include the patient's signature on the refusal form, or, if the patient refuses to sign, appropriate notation and witness signatures

Purpose:

To provide direction to prehospital personnel regarding the procedures to be followed when a patient is refusing prehospital medical care and transportation, when the patient is a minor, or when the patient is acutely or chronically incompetent to make such medical decisions.

Policy:

1. Patient Evaluation

- A. Prehospital personnel shall evaluate all persons at the scene of a prehospital medical emergency, whom they reasonably believe to be a patient, for the need of treatment and transportation to an appropriate medical facility.
- B. All persons at the scene of a prehospital medical emergency who are competent adults shall be allowed to make informed decisions regarding their medical care or the medical care of the minor they represent, including the refusal of evaluation, treatment and transport.
- C. Patients not meeting the definition of an adult that do not have a parent or legal guardian present shall be cared for as follows:
 - (1) If the patient has minor injuries not requiring ambulance transportation or the patient is refusing care deemed necessary, law enforcement shall be summoned to the scene to evaluate placing the individual in custody under the authority of Section 300, Welfare and Institutions Code (WIC).
 - (2) If the patient has immediately life or limb threatening injuries, care and transportation to the closest appropriate medical facility is mandatory, regardless of the patient's wishes.
- D. Patients not meeting the definition of an adult that have a parent or legal guardian present, shall be cared for as follows:
 - (1) If the parent or legal guardian of the patient refuses care and transportation for the patient, said parent or legal guardian shall sign the refusal of care form for the minor they represent. If the parents refuse to sign the release form, it should be so noted on the release and witnessed by a third party (e.g. 1st responders, etc.).
 - (2) If the patient has immediately life or limb threatening injuries and his/her parent or legal guardian are refusing care and transportation, the base hospital physician shall be consulted. In addition, law enforcement shall be summoned to the scene to evaluate placing the individual in custody under the authority of Section 300, WIC.

E. Persons who are adult, as defined in this policy, and are competent to make self determinations regarding the acceptance or refusal of prehospital medical care may refuse any or all medical care and transportation. Their decision to refuse care may include:

- (1) Refusal of all evaluation, treatment and transportation, or
- (2) Refusal of treatment and transportation but acceptance of evaluation, or
- (3) Acceptance of evaluation and limited treatment and transportation, or
- (4) Refusal of evaluation and/or treatment but acceptance of transportation

F. Any person at the scene of a prehospital emergency who the paramedic or base hospital physician reasonably believe to be in need of medical evaluation and care, as evidenced by the presence of one of the following conditions, shall be considered incompetent to make a self-determination of medical care:

- (1) Altered mental status from any cause including influence of drugs and/or alcohol, head trauma or acute medical emergency.
- (2) Attempted suicide or verbalizing a suicidal intent.
- (3) Acting in an irrational manner to the extent that a reasonable person would believe that the individual's ability to make a competent decision is compromised, such as an individual refusing care and transportation in an immediately life-threatening medical emergency.
- (4) Any individual held on the authority of Section 5150 or 5170 of the WIC.

Patient consent in sections F (1-4) is considered implied, in that another reasonable, competent adult would allow the appropriate medical care under similar circumstances. Law enforcement shall be summoned to the scene and EMS personnel shall describe those medical concerns prompting the request that the patient be placed under 5150 hold.

2. Patient Transport

A. All patients transported by ground ambulance shall be in accordance with EMS Policy No. 402.00 "Patient Destination". All patients transported by Air Ambulance shall be in accordance with EMS Policy No. 470.00 "EMS Aircraft".

B. Refusal of Care, Against Medical Advice (AMA)

- (1) If a patient refuses care deemed necessary by prehospital personnel, and meets the criteria for self-determination as defined in Section 1 (B), no further evaluation or treatment is required. Appropriate documentation shall be completed as required in the "Procedure" section of this policy.
- (2) If the patient refuses care deemed necessary by the prehospital personnel, and the patient does not meet the criteria for self-determination as defined above, law enforcement shall be summoned to the scene.
 - (a) If law enforcement agrees to place the patient under 5150 hold, then transport shall be to the closest appropriate facility and accomplished consistent with Policy No. 440.00, Patient Restraint.

- (b) If law enforcement does not agree to place the patient under 5150 hold, then EMS personnel shall request that the law enforcement officer sign the EMS refusal form indicating that decision, and EMS personnel may then clear the scene.

Procedure:

1. Refusal Form Documentation

A Patient Care Record and an EMS Agency approved Refusal of Care form shall be used to document all responses which result in a refusal of prehospital care and transportation. At a minimum, the following information must be documented on the form:

- A. Nature of call
- B. Chief Complaint (if verbalized)
- C. Available vital statistics (e.g. name, age, DOB, etc.)
- D. Location of call
- E. Time elements of call
- F. Mental status assessment (orientation)
- G. Confirmation of loss of consciousness (if known)
- H. Presence or absence of alcohol and/or drug use suspicion
- I. Determination of patient age (e.g. 18 or older)
- J. Any care rendered
- K. Explanation given to patient regarding condition and potential consequences of refusal
- L. Patients own words verbalizing an understanding of subsection (k) above.
- M. The patient's competency and criteria of self determination for medical care decisions (including name, age and guardian, as appropriate).
- N. If patient is a minor, name and relationship of parent or guardian if released to that person
- O. Name and badge number if released to law enforcement

2. Patient's Signature

Obtain the patient's signature on the Refusal of Care form. The paramedic obtaining the signature shall sign as a witness to the patient's signature. If the patient refuses to sign the Refusal of Care form, the refusal shall be so documented by the paramedic and witnessed by law enforcement, a fire service representative, a family member or, if none of the foregoing are available, by the paramedic's partner.

3. Refusal of Care Form Distribution

The three copies of the Refusal of Care form shall be distributed as follows:

- ✓ White copy - Patient
- ✓ Yellow Copy - Provider Agency
- ✓ Pink Copy - EMS Agency



DEPARTMENT OF PUBLIC HEALTH
Emergency Medical Services Agency

EMS

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Policy #: 550.00
Effective Date: 12/2007
Revision Date: 06/2010
Review Date: 06/2012

This policy supersedes any other existing policy on this subject.

SUBJECT: ST Elevation Myocardial Infarction (STEMI)

AUTHORITY: Health & Safety Code, Division 2.5, Sections, 1798

DEFINITIONS: **ST Elevation Myocardial Infarction (STEMI):** An acute MI that generates ST-segment elevation on the prehospital 12-lead electrocardiogram (EKG).

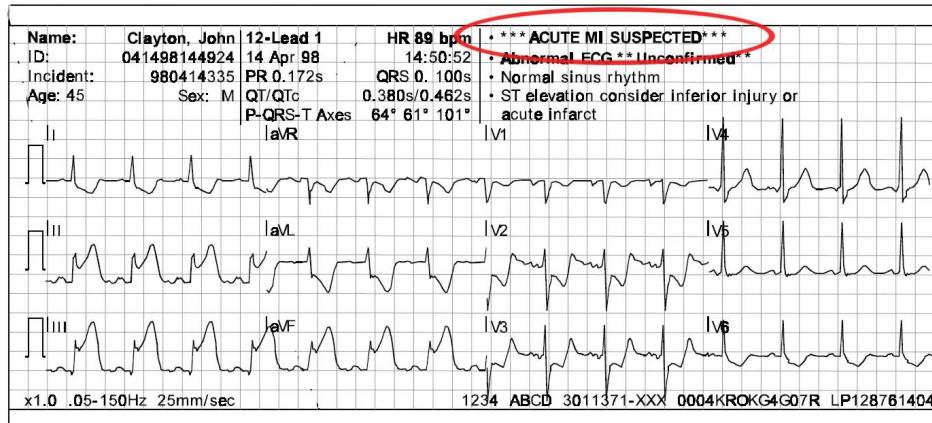
STEMI Receiving Center or SRC: A facility licensed for an interventional cardiac catheterization laboratory by the Department of Health Services License and Certification Division and recognized by the Merced County EMS Agency as a SRC.

PURPOSE: To ensure that 9-1-1 patients with ST-elevation myocardial infarction are transported to a facility with interventional cardiac catheterization capabilities.

POLICY:

1. Responsibility of the Ambulance Provider:

- A. The 12-lead EKG shall be acquired on patients who complain of chest pain/discomfort of suspected cardiac etiology and/or patients who the paramedics suspect are experiencing an acute cardiac event, e.g. age > 50, syncope, hypotension, unexplained acute onset of CHF/PE, unexplained SOB, etc.
- B. Contact the EMS Dispatch Center for destination for all patients whose 12-lead EKG demonstrates "****ACUTE MI SUSPECTED****" or the manufacturer's equivalent reading of an acute STEMI.



APPROVED:

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EMS Medical Director

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- C. Label each pre-hospital 12-lead EKG performed with the corresponding:
 - 1) Patient Care Report Number
 - 2) Patient name
 - 3) Date and time
 - D. The prehospital 12 lead EKG shall be left with the SRC staff prior to departure.
2. Transportation of STEMI Patients to a SRC:
- A. All STEMI patients shall be transported to the most appropriate SRC if ground transport is 60 minutes or less. Unless the patient expresses a preference between Emanuel Medical Center, Doctor's Medical Center or Memorial Medical Center, the patient shall be transported to the closest SRC. Dispatch is to notify transporting unit if there is a diversion status at receiving facility.
- Note: This includes hypotensive patients with signs and symptoms consistent with cardiogenic shock.**
- B. If ground transport time to a SRC is greater than the maximum allowable time of 60 minutes, the patient shall be transported to the most accessible receiving facility.
 - C. Patient will be diverted to the closest appropriate facility if CPR is in progress or if the paramedic is unable to intubate or establish a patent BLS airway.
3. Diversion of STEMI Patients from a SRC
- The SRC may request diversion of 9-1-1 ALS units only when:
- A. The hospital is unable to perform emergent PCI because the cardiac cath staff is already fully committed to caring for STEMI patients in the catheterization laboratory; or
 - B. The facility is on internal disaster.
 - C. Equipment failure
- Note: ED diversion does not prohibit a STEMI patient's transport to an open SRC.**
4. General SRC Requirements
- A. Personnel
 - 1) Medical Director - The SRC shall designate a medical director for the cardiovascular program who shall be certified through the American Board of Internal Medicine with a subspecialty in Cardiovascular Disease and privileges in Interventional Cardiology. The Medical Director shall ensure compliance with current practice standards and perform on-going quality improvement as part of the hospital QI program.
 - 2) Clinical Manager - The SRC shall maintain a clinical manager that will serve as a liaison to the EMS Agency and will ensure data extractions are completed in a timely manner.
 - 3) Interventional cardiologists shall meet ACC/AHA criteria for competence. Interventional cardiologists shall perform at least 11 primary PCI procedures per year and 75 total PCI procedures per year.

B. Center Standards

- 1) The SRC shall meet ACC/AHA criteria for volume and perform a minimum of 36 primary PCI procedures and 200 total PCI procedures annually.
- 2) The SRC must meet all licensing requirements by the California Department of Health Services regarding STEMI operations including the availability of immediate cardiac surgery 24 hours a day, 365 days a year.

C. Policies - Internal policies shall be developed for the following:

- 1) Criteria for patients to receive emergent angiography or emergent fibrinolysis, based on physician decisions for individual patients.
- 2) Rapid administration of fibrinolytic therapy.
- 3) Goal to primary PCI (medical contact-to-dilation time).

D. Data Collection

The following data shall be collected on an on-going basis and submitted to the EMS Agency on a quarterly basis:

- 1) Number of Merced County patients identified in the field with a STEMI and transported for emergent care.
- 2) Number of above patients who receive a primary PCI.
- 3) Number of 9-1-1 transported patients with acute myocardial infarction, door-to-infusion time for fibrinolysis, and door to balloon time for primary PCI.
- 4) Number of myocardial infarction admissions per year (all patients including 9-1-1 transports).
- 5) Number of percutaneous coronary procedures, both diagnostic and interventional, per year on all STEMI patients.
- 6) Other specific data elements identified on Attachment I

E. Quality Improvement

- 1) A hospital quality improvement program shall be established to review and collect outcome data for 9-1-1 transported patients on the following:
 - a) In-hospital mortality.
 - b) Emergency coronary artery bypass graft rate.
 - c) Vascular complications (PCI access site complication, hematoma large enough to require transfusion, or operative intervention required).
 - d) Cerebrovascular accident rate (peri-procedure).

- 2) A summary of quality improvement activities shall be submitted to the EMS Agency on an annual basis.

ATTACHMENT I

PCI DATA ELEMENTS

PREHOSPITAL DATA ELEMENTS

Patient care report number
Estimated time of chest pain onset
ALS Arrival Time
Date and time of EKG
Interventions provided (e.g. ASA, Morphine, Nitro, etc.)
Defibrillated in Field

HOSPITAL-BASED DATA ELEMENTS

Patient Age
Patient Gender
Patient Race
Date and Time of Confirmation of ST elevation MI
Date and Time of ED Arrival
Cath Lab Arrival Time
Cardiologist call back time
Cardiologist arrival time
Cardiac Cath Team arrival time
Date of CABG
Date and Time Cardiac Catheterization/balloon
Door to Balloon time
Date and time of Emergency Department admit and hospital discharge
Discharge Status

(Data elements are subject to change as the program progresses)



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 552.10
Effective Date: 11/1998
Revision Date: 11/2006
Review Date: 11/2008

This policy supersedes any other existing policy on this subject.

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Subject: PEDIATRIC ORAL ENDOTRACHEAL INTUBATION

Authority: California Health and Safety Code, Division 2.5, Sections 1797.220 and 1798., and the California Code of Regulations, Title 22, Division 9, Section 100145.

Purpose: To provide for guidelines in the proper utilization and performance of advanced airway management of pediatric (less than 15 years of age) patients.

Policy: Field personnel shall use the guidelines contained herein in the management of pediatric patients presenting with respiratory distress.

1. Background

Pediatric Cardiopulmonary Failure is rarely a sudden event, but rather is usually the end-result of a progressive deterioration in respiratory, and in the later stages, circulatory function. It is therefore imperative that field personnel provide a thorough assessment of the child's respiratory function.

Early Assessment and Early Aggressive Intervention is the key to effective intervention in preventable cardiopulmonary failure and arrest in children.

2. Assessment

Cardiopulmonary failure/arrest should be anticipated in children presenting with any of the following:

- A. Tachypnea (relative to age)
- B. Bradypnea (particularly ominous)

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- C. Diminished level of consciousness or response to pain:
 - 1) Difficult to arouse, lethargy.
 - 2) Child > two months fails to recognize parents (often described by parents as simply "something wrong").
- D. Cyanosis (a late and inconsistent sign):
 - 1) If present in mucous membranes of mouth or nailbeds, usually a respiratory component.
 - 2) If present only in extremities, usually circulatory failure.
- E. Poor skeletal muscle tone.
- F.* Increased respiratory effort:
 - 1. Nasal flaring.
 - 2. intercostal, subcostal and/or suprasternal inspiratory retractions.
 - 3. Head bobbing, grunting, stridor or prolonged expiration.

*note - **Fatigue must be considered.** An infant with tachypnea will tire. A decreasing respiratory rate under these circumstances is an ominous sign.

3. Indications for Intubation

It must be emphasized that proper and early use of high concentration O₂ can often times resolve respiratory distress in children. In cases of inadequate ventilatory rate or volume, a BVM device with 100% O₂ is, in most cases, adequate to provide the necessary ventilatory assistance. The following should be used to guide the Paramedic in determining the need to perform pediatric endotracheal intubation:

- A. Cardiopulmonary arrest.
- B. Whenever airway protection is indicated.
- C. Failure to improve the patient's condition despite assisted ventilations with BVM (e.g. inability to affect a mask seal).

5. Complications

- A. Esophageal Intubation
- B. Right Mainstem Bronchus Intubation
- C. Laryngeal and/or oral/dental trauma

In cases of suspected spinal cord injury, the patient's head should be maintained in a neutral position, with an assistant securing the head and neck during intubation.

Procedure:

1. Ensure adequate ventilation with 100% O₂ via BVM and appropriate mask size.
2. Choose an appropriate ET tube size.
3. Place the child in a supine "sniffing" position, do not hyperextend the neck.
4. Enter the oropharynx (preferably with a straight blade) from the right side of the mouth and "sweep" the tongue to the left.
 - A. Keep in mind that the pediatric glottis is elevated, relative to the adult anatomy.
 - B. If difficulty is encountered in visualizing the larynx, pull back slightly and "track" along the length of the tongue to its base, and visualization should be effected.
5. Each attempt shall not exceed 30 seconds. The patient's cardiac rhythm must be monitored, and if the patient becomes bradycardic, the attempt should be suspended and the patient hyperventilated with 100% O₂ via BVM.
6. Do not attempt "Blind" intubation. If unable to visualize the larynx, transportation should be initiated, and ventilation effected with BVM.
7. Once the ET tube is placed through the vocal cords into the trachea, confirmation of proper placement shall be instituted as follows:
 - A. Placement of an end-tidal CO₂ detector with positive color change noted.
 - B. Confirm the absence of air movement or "gurgling" over the epigastrium during ventilation.

- C. Confirm equal breath sounds via auscultation of at least two locations over each lung, preferably one bronchial and one vesicular location on each side.
 - D. Confirm equal chest rise, and observe for abdominal distention frequently.
8. Unless the paramedic is absolutely secure with the proper placement of the ET Tube as described above, the patient shall be extubated and hyperventilated with 100% O₂ via BVM for at least one minute prior to any re-attempt.
9. The tube should be secured with tape or a prepackaged ET tube holder.
10. Frequent re-assessment should be performed (each time the patient is moved or the tube or bag handled), to include assessment of skin and mucous membranes, to ensure that no displacement has occurred.



Department of Public Health
Emergency Medical Services Agency

Policy #: 552.35
Effective Date: 02/2004
Revision Date: 10/2007
Review Date: 10/2009

This policy supersedes any other existing policy on this subject.

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Subject: TRANSCUTANEOUS PACING

Authority: California Health and Safety Code, Section 1797.220, California Code of Regulations, Title 22, Division 9, Chapter 4

Purpose: To establish the conditions under which Transcutaneous Pacing may be used, and the procedures to be followed during such use.

Policy: Transcutaneous Pacing may be used for adult patients in the prehospital setting in Merced County only under the conditions and for the patients specified herein.

Definitions: **Agency** - means the Merced County EMS Agency, duly appointed by the Board of Supervisors.

Bradycardia or Bradycardic – means a patient with a cardiac rate of less than 60 beats per minute

TCP – means Transcutaneous Pacing, the external delivery of electrical energy for the purpose of stimulating a cardiac contraction (capture).

Unstable – for the purpose of this policy, may be defined as a systolic blood pressure less than 90 mmhg, with any of the following signs or symptoms:

- Severe chest pain;
- Severe shortness of breath
- Acutely altered mental status
- Signs or symptoms of shock
- Pulmonary edema

1. Indications

TCP may be utilized for the following patients after 2 mg of Atropine have been administered:

A. Hemodynamically unstable bradycardic adult patients unresponsive to drug therapy.

APPROVED:

ON-FILE

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- B. Patients in Asystole following electrocution, with a down time of less than 10 minutes
 - C. For patients on the order of a physician who is initiating an interfacility transfer. Under these circumstances, the paramedic should confirm the pacing settings from the transferring physician.
2. Contraindications:
- A. Hemodynamically or symptomatically stable patients.
 - B. Any patient in Asystole except as indicated above in section 1(B).

Procedure:

1. Consider administration of Morphine Sulfate for pain and/or Versed for sedation, as indicated in the Adult Treatment Protocols.
2. Place pads on the patient's chest and back. Set initial TCP rate at 80 beats per minute (bpm).
3. Begin output at 0 millamps (mA). Increase by 10mA until capture/pulses are noted. Once capture is confirmed, continue pacing at a slightly higher output level (10%).
4. If capture is maintained but the patient remains symptomatic of inadequate tissue perfusion (BP < 90 systolic, altered level of consciousness), consider increasing rate by 10 bpm until symptoms resolve or 100 bpm is achieved.

Troubleshooting:

1. Make sure the pads are properly placed and have good contact with the skin.
2. Check the batteries of the pacer.
3. Use adequate energy to capture the rhythm.
4. Use adequate analgesia and sedation to minimize patient discomfort.

MERCED

POLICY NO. 580.10

COUNTY

EFFECTIVE DATE: 7/1/93

REVISION DATE: 10/97

REVIEW DATE: 10/99

DEPARTMENT OF PUBLIC HEALTH **EMERGENCY MEDICAL SERVICES AGENCY**

This policy supercedes any other
Existing policy on this subject

Subject: **MONITORING OF IV'S BY EMT-1'S**

Authority: California Health and Safety Code, Division 2.5, Section 1797.220, and California Code of Regulations, Title 22, Section 100063.

Purpose: To provide guidance for the monitoring of IV's by EMT-1's.

- Policy:
1. EMT-1's may transfer patients who are receiving peripheral intravenous glucose or balanced isotonic salt solution (including Ringer's Lactate) fluids as long as:
 - A. the patient is receiving no other ALS treatment, and
 - B. there is no medication added to the IV fluid, and
 - C. the patient does not require intravenous fluids for stabilization (e.g. a patient in a hypovolemic state).
 2. The physician responsible for the patient at the sending facility is responsible for making the assessment that EMT-1 care is appropriate for the patient.
 3. The EMT-1 may not increase the rate of flow of the IV during transit. If any problems develop with the intravenous fluid they should contact the base hospital for orders or, if that cannot be accomplished, they should turn the IV off.

APPROVED:

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Director of Public Health

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EMS Medical Director



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 610.00
Effective Date: 07/1993
Revision Date: 12/2006
Review Date: 12/2008

This policy supersedes any other existing policy on this subject.

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Subject: **EMERGENCY MEDICAL SERVICES INCIDENT INVESTIGATION, DETERMINATION OF ACTION, AND NOTIFICATION PROCESS**

Authority: California Health and Safety Code, Division 2.5, Chapter 4 and 5, the California Code of Regulations, Title 22, Chapter 6; and the Merced County Ordinance 1656.

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

Investigative Review Panel (IRP)- means an impartial advisory body, the members of which are knowledgeable in the provision of prehospital emergency medical care and local EMS system policies and procedures. This panel may be convened to review allegations against an applicant for or holder of an EMS prehospital emergency medical care certificate/authorization, assist in establishing the facts of the matter, and provide its findings and recommendations to the Medical Director of the local EMS agency.

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

Purpose: To establish a policy and procedure governing reportable situations and the evaluation and disposition of those situations.

Policy: Any information received from any source, including discovery through medical audit or routine follow-up on complaints, which purports a violation of, or deviation from, state or local EMS laws, regulations, policies, procedures or protocols will be evaluated pursuant to this policy.

Procedure:

Section A Reportable Situations

- I. The following situations shall be reported by all EMS personnel to the Merced County EMS Agency:

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- a. Suspected violations of treatment protocols by County prehospital medical care personnel.
 - b. Prehospital emergency medical care personnel acting outside of their scope of practice or outside of medical control.
 - c. Suspected violations of transfer protocols by ambulance personnel and/or hospital personnel.
 - d. Suspected dispatch or PSAP errors or violations.
 - e. Suspected violations involving training programs.
 - f. Suspected violations of Merced County ordinance 1656.
 - g. Suspected violations of Merced County EMS Policies and Procedures.
 - h. Suspected violations of Health and Safety Code, Division 2.5.
 - i. Suspected violations of California Code of Regulations, Title 22.
 - j. Any threat or potential threat to the public health and safety.
 - k. Any complaint lodged by a citizen against the EMS system.
 - l. Any complaint lodged against the base hospital or base hospital personnel.
 - m. Any complaint lodged by a public agency against an EMS provider.
 - n. Knowledge of any criminal activity or suspected criminal activity.
2. The Base Hospital Nurse Liaison who, in the context of assigned duties, determines that a particular case or situation meets the criteria of Section A, I, a through n, shall report the situation to the EMS Agency.
3. Repeated violations of treatment protocols or any other EMS regulation discovered through the Quality Improvement process shall also be reported to the EMS Agency. In addition, any policy and/or procedural violation that may constitute an imminent threat to the public health and safety, discovered through any mechanism including a quality improvement process, shall be forwarded immediately to the EMS Agency for evaluation.
4. Disciplinary action may be taken by the agency against certified/authorized EMS personnel, hospital personnel, or providers who willfully fail to report a situation listed in this policy as reportable.

Section B Procedure for Reporting Situations for EMS Personnel

- I. Situations should be reported by completing a Merced County Emergency Medical Services Situation Report Form. The reporting party should include on the report form the following:
- a. Date and time the incident took place.
 - b. Location of incident.
 - c. People present during incident.
 - d. The patient(s) name(s).
 - e. EMS provider involved.
 - f. Hospital(s) involved.
 - g. A copy of the prehospital report form (PCR), if applicable.
 - h. A narrative description of the situation, including any actions taken after the situation.
 - i. The reporting party's name, certification/authorization level, daytime phone number, address, signature and date reported. The name of the reporting party may be kept confidential upon request.

2. A Merced County EMS Situation Report form need not be used if all the above information is submitted in writing.
3. The report may be submitted in person, by mail or electronic mail, posting through the "Incident Reporting" link on the Agency website or by facsimile to the EMS Agency.
4. The EMS Agency shall contact the reporting party to acknowledge receipt of the situation report within 72 hours of receiving of a situation report.

Section C Procedure for Private Citizen Reports

- I. A citizen may report an unusual occurrence to the EMS Agency in any manner.
2. The EMS Agency shall collect the following information from the private citizen:
 - a. Date and time the incident took place.
 - b. Location of incident.
 - c. People present during incident.
 - d. The patient(s) name(s).
 - e. EMS provider involved.
 - f. Hospital(s) involved.
 - g. A narrative description of the situation, including any actions taken after the situation.
 - h. The reporting party's name, daytime phone number, address, signature and date reported. The name of the reporting party may be kept confidential upon request.

Section D Evaluations/Investigations performed by the Merced County EMS Agency

- I. The medical director shall evaluate information received from a credible source, including information obtained from an application, medical audit or complaint, alleging or indicating the possibility of a threat to the public health and safety by the action of an applicant for, or holder of, a certificate issued pursuant to Division 2.5.
2. If the medical director determines, following evaluation of the information, that further inquiry into the situation is necessary or that disciplinary action may be warranted, the medical director may conduct an investigation of the allegations, as indicated below.
 - a. Determine if the allegation is within the jurisdiction of the EMS Agency for investigation.
 - I) If the allegation is not within the jurisdiction of the Merced County EMS Agency, the situation report or information shall be submitted to the appropriate person or agency having jurisdiction for the situation, and the reporting party shall be advised of the transfer of the situation report.
 - 2) If the allegation is within the jurisdiction of the Merced County EMS Agency, the Agency shall initiate an investigation of the allegation.
 - b. Enter the report into the Situation Report (SR) Log and assign the situation an SR number.

- c. Obtain all pertinent documentation and evidence of the situation.
- d. Obtain written and/or verbal statements from personnel involved in the situation.
- e. Obtain written and/or verbal statements from witnesses to the situation.
- f. After reviewing the situation report and all appropriate information determine whether:
 - 1) The allegation is unfounded.
 - 2) The evidence is inconclusive.
 - 3) There is credible evidence to support the allegation.
- g. After a determination is made, write a report that includes:
 - 1) A summary of the situation.
 - 2) A list of all source material obtained during the evaluation and used to make a determination.
 - 3) A list of all findings uncovered during the evaluation.
 - 4) Any action taken by the EMS Agency.
 - 5) Recommendation for action to be taken by the Merced County EMS Medical Director or the Director of Public Health.
 - 6) Disposition of the Situation Report.
 - 7) Signature of the EMS Agency Investigator and the date signed.

Section E Disposition of EMS Agency Evaluations/Investigations

- 1. If an allegation is determined to be unfounded, the EMS Agency shall:
 - a. Complete a written report of the situation.
 - b. Notify the reporting party, in writing, of the appropriate findings of the evaluation and why the allegation was determined to be unfounded.
 - c. Complete the Situation Report Log entry for this situation.
 - d. Retain the Situation Report and all applicable source material for local EMS agency records.
- 2. If the evidence is inconclusive, the EMS Agency shall:
 - a. Complete a written report of the situation.
 - b. Notify the reporting party, in writing, of the appropriate findings of the evaluation and why the allegation was determined to be inconclusive.
 - c. Complete the Situation Report Log entry for this situation.
 - d. Retain the Situation Report and all applicable source material for EMS Agency records.

3. If there is credible evidence to support the allegation, the EMS Agency shall:
 - a. Complete a written report of the situation.
 - b. Notify the reporting party in writing, of the appropriate findings of the evaluation and that action has been or will be taken to resolve the situation.
 - c. The medical director shall determine what disciplinary action, if any, relative to the individual's certificate(s) shall be taken as a result of the findings of the investigation. Upon determining the disciplinary action to be taken relative to an individual's certificate(s), the medical director shall complete, and place in the record, a statement certifying the decision made by him/her and the date the decision was made. The decision must contain findings of fact and a determination of issues, together with the disciplinary action and the date the disciplinary action shall take effect. An immediate suspension shall take effect upon the date the notice required by Section 100213, California Code of Regulations, is mailed to the certificate holder. For all other disciplinary actions, the effective date shall be thirty days from the date the notice is mailed to the applicant for, or holder of, a certificate unless a review by an Investigative Review Panel (IRP) is requested. If an IRP is requested, the effective date of the disciplinary action shall be thirty days from the date the notification is mailed to the applicant for, or holder of, a certificate of the medical director's final decision following the IRP. The statement shall include the signature of the medical director, the date signed, and the location where the statement was signed.
 - f. Complete the Situation Report Log entry for this situation.
 - g. Retain the Situation Report and all applicable source material for EMS agency records.

Section F

Actions which may be taken with Emergency Medical Care Personnel

In order to place a certificate/authorization holder on probation or deny, suspend, or revoke a certificate/authorization, the Medical Director must first determine there exists a potential threat to the public health and safety, as evidenced by the occurrence of any of the actions listed in Section 1798.200 (c) of Division 2.5 of the Health and Safety Code by the applicant or certificate/authorization holder. All licensed/certified individuals shall be notified via certified mail regarding any disciplinary actions and the individual's right to appeal.

I. Formal Counseling.

After an evaluation is complete, the Merced County EMS Agency may require formal counseling of involved Emergency Medical Care Personnel.

a. Formal Counseling shall consist of:

1. Reviewing the findings of the evaluation.
2. Discussing the appropriate policies and protocols that governed the situation.

3. Discussing how to resolve the situation and insure that the situation will not repeat itself.
 - b. Formal Counseling sessions will be documented on the situation report and placed in the certificate/authorization holder's file at the EMS agency for a period of three (3) years.
2. Probation
 - a. Pursuant to Section 100207, California Code of Regulations, the medical director may place a certificate holder on probation any time an infraction or performance deficiency occurs which indicates a need to monitor the individual's conduct in the EMS system in order to protect the public health and safety. The term of the probation and any conditions, such as satisfactory completion of remedial training, shall be determined by the medical director based on the facts of the case. The individual's performance shall be reviewed periodically during the probationary period.
 - b. The frequency and manner of performance review shall be determined by the medical director, but in no case shall be less frequent than monthly. Such review may include, but not necessarily be limited to; skills review, patient care report audits, completion of specified training or other methods of validating that the requirements of the probation have been satisfactorily completed.
3. Immediate Suspension.
 - a. Pursuant to California Health and Safety Code Section 1798.202 (a), the Medical Director of the EMS Agency may temporarily suspend, prior to a hearing, a paramedic license upon a determination that: (1) the paramedic has engaged in acts or omissions that constitute grounds for revocation; and (2) the paramedic poses an "imminent threat" to public health and safety if allowed to continue as a paramedic. If the Medical Director suspends a paramedic license, the EMS Agency shall transmit to the EMS Authority all relevant documentary evidence via facsimile or overnight mail. The Director of the EMS Authority has two (2) days after receipt of the evidence to determine whether the temporary suspension order shall continue. If the Director of the EMS Authority determines that the temporary suspension order should continue, the EMS Authority has 15 days after receipt of the evidence to serve a temporary suspension order and accusation on the affected paramedic. If the paramedic files a notice of defense, Section 1798.202(d) requires that a hearing be held within thirty (30) days of the filing of the notice of defense. The director of the EMS Authority has fifteen (15) days after receipt of the administrative law judge's proposed decision to make a final decision.
 - b. The EMS Medical Director may immediately suspend a prehospital emergency medical care certificate/authorization if the Medical Director determines that immediate suspension is necessary to ensure the public health and safety. The following procedures shall apply to an immediate suspension:

- I) The EMS agency Medical Director shall notify the certificate/authorization holder and his/her relevant employer(s) prior to or concurrent with initiation of the suspension. Notification shall be by registered mail and contain the following information:
 - a) The specific allegations which resulted in the investigation.
 - b) A summary of the findings of the investigation.
 - c) The action being taken and the effective date(s) of the action, including the duration of the action.
 - d) Which certificate/authorization the action applies to in cases of multiple certificate/authorization holders.
 - e) The right to request an IRP as described herein to review the facts that necessitate the immediate suspension.
 - f) A statement that the certificate/authorization holder must report the action to any other local EMS agencies in whose jurisdiction s/he uses the certificate/authorization.
 - g) A statement that the certificate/authorization holder must report the suspension if s/he applies for any certification or authorization from another local agency during the period of the suspension.
- c. If the affected individual's certificate/authorization is being immediately suspended pursuant to this provision and the facts of the case have not yet been reviewed by an IRP, the certificate/authorization holder may:
 - I) Within fifteen (15) calendar days of the date that written notification of suspension is received, request in writing and submitted in person or by certified mail to the EMS Agency that a IRP be convened to review the facts which necessitate an immediate suspension.
 - 2) Within fourteen (14) days of receipt of such a request, the EMS Agency Medical Director shall convene a IRP to review the facts which necessitate an immediate suspension of the individual's Certificate/Authorization.
- d. IRP's will be conducted pursuant to and in accordance with Title 22, Chapter 6.
- e. Immediate suspension shall remain in effect until:
 1. The immediate suspension is removed by the Merced County EMS Medical Director, or
 2. The formal investigation process is complete and final action is taken on the case.

4. Suspension of a Certificate/Authorization

- a. The Medical Director may suspend an individual's certificate/authorization for a specified period of time for actions listed in Section 1798.200 (c) of Division 2.5 of the Health and Safety Code in order to protect the public health and safety.
- b. The term of the suspension and any conditions for reinstatement, such as satisfactory completion of remedial training, shall be determined by the Medical Director based on the facts of the case.
- c. Upon the expiration of the term of suspension, the individual's certificate/authorization shall be reinstated if all conditions for reinstatement have been met. If the conditions for reinstatement have not been met, or the individual cannot demonstrate that s/he retains the necessary knowledge and skills or it can be proven the individual practiced emergency medical care, pursuant to the certificate/authorization, during the term of suspension, the medical director shall continue the suspension until all conditions for reinstatement have been met.
- d. If the suspension period will run past the expiration date of the certificate/authorization, the individual must meet the recertification requirements for certificate renewal prior to the expiration date of the certificate/authorization.

5. Denial or Revocation of a Certificate/Authorization

- a. An application for certification/authorization or recertification/reauthorization shall be denied without prejudice and does not require an IRP, when an applicant does not meet the requirements for certification/authorization or recertification/reauthorization, including but not limited to, failure to pass a certification/authorization or recertification/reauthorization examination, lack of sufficient continuing education or documentation of a completed refresher course, failure to furnish additional information or documents requested by the EMS Agency, or failure to pay any required fees. The denial shall be in effect until all requirements for certification/authorization or recertification/reauthorization are met. If a certificate/authorization expires before recertification/reauthorization requirements are met, the certificate/authorization shall be deemed a lapsed certificate/authorization and subject to the provisions of a lapsed certificate/authorization.
- b. The medical director may deny or revoke any certificate/authorization for any actions listed in Section 1798.200 (c) of Division 2.5 of the Health and Safety Code.
- c. The medical director may deny an application for a certificate/authorization from any person whose certificate/authorization has been denied or revoked, for any actions listed in Section 1798.200 (c) of Division 2.5, unless that person submits documentation which, in the opinion of the medical director, demonstrates that the threat to the public health and

safety, which was the basis for the denial or revocation, is no longer applicable.

- d. Any person who has ever had a certificate or authorization or other health care certificate or license denied or revoked for any actions listed in 1798.200 (c) of Division 2.5 shall report that denial or revocation at any time s/he applies for any certificate/authorization. Failure to report may be grounds for denial, suspension or revocation of a certificate/authorization.

Section G Proceedings

I. Request for Discovery

After initiation of an investigation in which a certificate holder or an applicant for certification (respondent) has requested an IRP in accordance with this policy, is entitled to (1) obtain the names and addresses of witnesses to the extent known by the Agency, including, but not limited to, those intended to be called to testify at the hearing, and (2) inspect and make a copy of any of the following in the possession or custody or under the control of the Agency:

- a. A statement of a person, other than the respondent, named in the investigation, when it is claimed that the act or omission of the respondent as to this person is the basis for the investigation;
- b. Statements pertaining to the subject matter of the investigation made by any party to another party or person;
- c. Statements of witnesses then proposed to be called by the Agency and of other persons having personal knowledge of the acts, omissions or events which are the basis for the investigation, not included in A or B above;
- d. All writings, including, but not limited to, reports of mental, physical and blood examinations and things which the Agency then proposes to offer in evidence;
- e. Any other writing or thing which is relevant and which would be admissible in evidence;
- f. Investigative reports made by or on behalf of the Agency or other party pertaining to the subject matter of the investigation, to the extent that these reports (1) contain the names and addresses of witnesses or of persons having personal knowledge of the acts, omissions or events which are the basis for the investigation, or (2) reflect matters perceived by the investigator in the course of his or her investigation, or (3) contain or include by attachment any statement or writing described in (a) to (e), inclusive, or summary thereof.

Nothing in this section shall authorize the inspection or copying of any writing or thing which is privileged from disclosure by law or otherwise made confidential or protected as an attorney's work product.

2. Petitions to Compel Discovery

- a. Should respondent claim that respondent's request for discovery pursuant to Section 6 above has not been complied with may file a motion with County Counsel to compel discovery, naming the Agency as the party refusing or failing to comply with the Request for Discovery. The motion shall state facts showing the Agency failed or refused to comply with Section 6, a description of

the matters sought to be discovered, the reason or reasons why the matter is discoverable under that section, that a reasonable and good faith attempt to contact the Agency for an informal resolution of the issue has been made, and the ground or grounds of the Agency's refusal so far as known to the respondent.

- b. The motion shall be delivered to the Agency and filed with the County Counsel's office within 15 days after the respondent first evidenced failure or refusal to comply with Section 6.
- c. The hearing on the motion to compel discovery shall be held within 15 days after the motion is made, or a later time that the County Counsel's own motion for good cause determine. The Agency shall have the right to serve and file a written answer or other response to the motion before or at the time of the hearing.
- d. Where the matter sought to be discovered is under the custody or control of the Agency and the Agency asserts that the matter is not a discoverable matter under the provisions of Section 6, or is privileged against disclosure under those provisions, the County Counsel may order lodged with it matters provided in subdivision (b) of Section 915 of the Evidence Code and examine the matters in accordance with its provisions.
- e. The County Counsel shall decide the case on the matters examined in camera, the papers filed by the parties, and such oral argument and additional evidence as the County Counsel may allow.
- f. Unless otherwise stipulated by the parties, the County Counsel shall no later than 15 days after the hearing make its order denying or granting the motion. The order shall be in writing setting forth the matters the respondent is entitled to discover under Section 6. A copy of the order shall forthwith be served by mail by the County Counsel upon the parties. Where the order grants the motion in whole or in part, the order shall not become effective until 10 days after the date the order is served. Where the order denies relief to the respondent, the order shall be effective on the date it is served.

3. Hearings / Evidence

- a. Oral evidence shall be taken only on oath or affirmation.
- b. Each party shall have these rights: to call and examine witnesses, to introduce exhibits; to cross-examine opposing witnesses on any matter relevant to the issues even though that matter was not covered in the direct examination; to impeach any witness regardless of which party first called him or her to testify; and to rebut the evidence against him or her. If respondent does not testify in his or her own behalf he or she may be called and examined as if under cross-examination.
- c. The hearing need not be conducted according to technical rules relating to evidence and witnesses, except as hereinafter provided. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence

- of any common law or statutory rule which might make improper the admission of the evidence over objection in civil actions.
- d. Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but over timely objection shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions. An objection is timely if made before submission of the case or on reconsideration.
 - e. The rules of privilege shall be effective to the extent that they are otherwise required by statute to be recognized at the hearing.
 - f. The presiding officer has discretion to exclude evidence if its probative value is substantially outweighed by the probability that its admission will necessitate undue consumption of time.

4. Affidavits

- a. At any time 10 or more days prior to a hearing or a continued hearing, any party may mail or deliver to the opposing party a copy of any affidavit which he proposes to introduce in evidence, together with a notice as provided in subdivision B. Unless the opposing party, within seven days after such mailing or delivery, mails or delivers to the proponent a request to cross-examine an affiant, his right to cross-examine such affiant is waived and the affidavit, if introduced in evidence, shall be given the same effect as if the affiant had testified orally. If an opportunity to cross-examine an affiant is not afforded after request therefore is made as herein provided, the affidavit may be introduced in evidence, but shall be given only the same effect as other hearsay evidence.
- b. The notice referred to in subdivision A shall be substantially in the following form:

The accompanying affidavit of (here insert name of affiant) will be introduced as evidence at the hearing in (here insert title of proceeding). (Here insert name of affiant) will not be called to testify orally and you will not be entitled to question him unless you notify (here insert name of proponent or his attorney) at (here insert address) that you wish to cross-examine him. To be effective your request must be mailed or delivered to (here insert name of proponent or his attorney) on or before (here insert a date seven days after the date of mailing or delivering the affidavit to the opposing party).



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 611.00
Effective Date: 07/01/2010
Revision Date: NA
Review Date: 01/01/2011

This policy supersedes any other existing policy on this subject.

Tammy Moss
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Equal Opportunity Employer

Subject: EMERGENCY MEDICAL TECHNICIAN INCIDENT INVESTIGATION, DETERMINATION OF ACTION, NOTIFICATION AND ADMINISTRATIVE HEARING PROCESS

Authority: California Health and Safety Code, Division 2.5, Chapter 4 and 5, the California Code of Regulations, Title 22, Chapter 6; and the Merced County Ordinance 1656.

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

Certifying entity - as used in this policy, means the medical director of the Merced County EMS Agency or a public safety agency if the agency has a training program for EMT personnel that is approved pursuant to the standards established in Section 1797.109 of the Health and Safety Code.

Certification Action - means those actions that may be taken by the MCEMSA medical director that include denial, suspension, revocation of a certificate, or placing a certificate holder on probation.

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

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

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

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

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

APPROVED:

ON FILE

Tammy Moss
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James Andrews, MD
EMS Medical Director

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

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

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

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

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

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

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

Procedure:

Section A Responsibilities of Relevant Employer

1. Under the provisions of the CCR and this policy, relevant employers:
 - a) May conduct investigations to determine disciplinary cause.
 - b) Shall notify the MCEMSA medical director within three (3) working days after an allegation has been validated as potential for disciplinary cause.
 - c) Upon determination of disciplinary cause, the relevant employer may develop and implement a disciplinary plan, in accordance with the MDOs.
 - 1) The relevant employer shall submit that disciplinary plan to the MCEMSA along with the relevant findings of the investigation related to disciplinary cause, within three (3) working days of adoption of the disciplinary plan.
 - 2) The employer's disciplinary plan may include a recommendation that the medical director consider taking action against the holder's certificate to include denial of certification, suspension of certification, revocation of certification, or placing a certificate on probation.
 - d) Shall notify the medical director within three (3) working days of the occurrence of any of following:

- 1) The employee is terminated or suspended for a disciplinary cause,
- 2) The employee resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause, or
- 3) The employee is removed from employment-related duties for a disciplinary cause after the completion of the employer's investigation.

Section B Jurisdiction of the MCEMSA Medical Director

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

Section C Evaluation of Information

1. A relevant employer who receives an allegation of conduct listed in Section 1798.200 (c) of the Health and Safety Code against a certificate holder and once the allegation is validated, shall notify the MCEMSA medical director, within three (3) working days, of the certificate holder's name, certification number, and the allegation(s).
2. When the MCEMSA receives a complaint against a certificate holder, the MCEMSA shall forward the original complaint and any supporting documentation to the relevant employer for investigation, if there is a relevant employer, within three (3) working days of receipt of the information. If there is no relevant employer or the relevant employer does not wish to investigate the complaint, the medical director

- shall evaluate the information received from a credible source, including but not limited to, information obtained from an application, medical audit, or public complaint, alleging or indicating the possibility of a threat to the public health and safety by the action of an applicant for, or holder of, a certificate issued by the MCEMSA or pursuant to Division 2.5, H&SC.
3. The relevant employer or medical director shall conduct an investigation of the allegations in accordance with the provisions of this policy, if warranted.

Section D Investigations Involving Firefighters

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

Section E Due Process

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

Section F Determination of Action

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

Section G Temporary Suspension Order

1. The MCEMSA medical director may temporarily suspend a certificate prior to hearing if there is a valid complaint that the certificate holder has engaged in acts or omissions that constitute grounds for denial or revocation according to Section 100216(c) of the CCR and, if in the opinion of the medical director, permitting the certificate holder to continue to engage in certified activity would pose an imminent threat to the public health and safety.
2. Prior to, or concurrent with, initiation of a temporary suspension order of a certificate pending hearing, the medical director shall consult with the relevant employer of the certificate holder.
3. The notice of temporary suspension pending hearing shall be served by registered mail or by personal service to the certificate holder immediately, but no longer than three (3) working days from making the decision to issue the temporary suspension.

The notice shall include the allegations that allowing the certificate holder to continue to engage in certified activities would pose an imminent threat to the public health and safety.

4. Within three (3) working days of the initiation of the temporary suspension by the MCEMSA, the MCEMSA and relevant employer shall jointly investigate the allegation in order for the MCEMSA medical director to make a determination of the continuation of the temporary suspension.
 - a) All investigatory information, not otherwise protected by the law, held by the MCEMSA and the relevant employer shall be shared between the parties via facsimile transmission or overnight mail relative to the decision to temporarily suspend.
 - b) The MCEMSA shall serve within fifteen (15) calendar days an accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code (Administrative Procedures Act).
 - c) If the certificate holder files a Notice of Defense, the administrative hearing shall be held within thirty (30) calendar days of the MCEMSA's receipt of the Notice of Defense.
 - d) The temporary suspension order shall be deemed vacated if the LEMSA fails to serve an accusation within fifteen (15) calendar days or fails to make a final determination on the merits within fifteen (15) calendar days after the Administrative Law Judge (ALJ) renders a proposed decision.

Section H Final Determination of Certification Action by the Medical Director

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

Section I Placement of a Certificate Holder on Probation

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

Section J Suspension of a Certificate

1. The medical director may suspend an individual's EMT certificate for a specified period of time for disciplinary cause in order to protect the public health and safety.
2. The term of the suspension and any conditions for reinstatement shall be in accordance with the MDOs.
3. Upon the expiration of the term of suspension, the individual's certificate shall be reinstated only when all conditions for reinstatement have been met. The medical

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4. director shall continue the suspension until all conditions for reinstatement have been met.

4. If the suspension period will run past the expiration date of the certificate, the EMT shall meet the recertification requirements for certificate renewal prior to the expiration date of the certificate.
- Section K Denial or Revocation of a Certificate

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

6. Nothing in this Section shall negate an individual's right to appeal a denial of an EMT certificate pursuant to this policy.
7. Certification action by the MCEMSA medical director shall be valid statewide and honored by all certifying entities for a period of at least twelve (12) months from the effective date of the certification action. An EMT whose application was denied or an EMT whose certification was revoked by the MCEMSA medical director shall not be eligible for EMT application by any other certifying entity for a period of at least twelve (12) months from the effective date of the certification action. EMT's whose certification is placed on probation must complete their probationary requirements with the EMS Agency that imposed the probation.

Section L Notification of Final Decision of Certification Action

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



**Department of Public Health
Emergency Medical Services Agency**

John Volanti, M.P.H.
Director of Public Health

James Andrews, M.D.

Policy #: 620.00
Effective Date: 12/2002
Revision Date: 03/2009
Review Date: 03/2011

This policy supersedes any other existing policy on this subject.

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Equal Opportunity Employer

Subject: CONTRACT COMPLIANCE OVERSIGHT

Authority: California Health and Safety Code, Sections 1797.204, 1797.220

Purpose: The purpose of this policy is to establish the process by which the EMS Agency shall provide an opportunity for stakeholder input into the review and analysis of ALS ambulance contractor compliance with the specifications and obligations contained within their contract(s) with the County of Merced.

Policy: The Merced County Contract Compliance Committee (M4C) is hereby established and shall have those review and recommendation responsibilities as established herein. The M4C shall routinely meet with the EMS Agency, in an advisory capacity, to review and provide recommendations regarding the monthly and annual contract compliance obligations of the contracted ALS ambulance providers. The M4C shall periodically provide reports on its activities to the Merced County Emergency Medical Care Committee.

1. Definitions:

- A. **Agency** – means the Merced County EMS Agency.
- B. **EMCC** - Means the Merced County Emergency Medical Care Committee.
- C. **System Status Plan** - A planned protocol or algorithm governing the deployment and event-driven redeployment of ambulance resources, both geographically and by time of day/day of week.
- D. **Total Unit Hours** - A measurement of the total number of ambulance units and their hours on-duty over a seven (7) day period. For example, one ambulance on-duty 7 days a week, 24 hours a day would equal 168 total unit hours per week.

APPROVED:

ON-FILE

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STRIVING FOR EXCELLENCE

2. M4C Membership

There shall be a Standing Membership of the M4C, as well as those attendees whose expertise or experiential knowledge may be deemed as valuable to the review process of the M4C. Each of the contracted ALS ambulance providers shall be represented on the M4C as ex-officio, non-voting members. Due to the need for EMS system operational expertise, the Standing Membership shall include the following

- A. City of Merced Fire Department
- B. City of Atwater Fire Department
- C. City of Los Banos Fire Department
- D. One Battalion Chief selected by the County Fire Chief and one (1) representative selected by the County Fire Chief from either the County Fire Department or a volunteer fire company from within each of the following compliance zones, if available:
 - 1) Zone 24A
 - 2) Zone 24B
 - 3) Zone 24C
 - 4) Zone 24D

There shall be a Chair of the M4C, who's term shall be for one year. The Chair shall be elected by a vote of the membership of the M4C, at its first meeting and annually thereafter. The M4C shall also elect a Vice-Chair, who shall serve in the capacity of Chair during any absences of the Chair. The term of the Vice-Chair shall be the same as the Chair, and elections for both positions shall be conducted at the same meeting. The Chair shall preside over meetings of the M4C and ensure that written records of the actions of the committee are properly recorded. The EMS agency shall staff the meetings of the M4C and facilitate the documentation of the M4C activities.

3. Meetings of the Committee

- A. The M4C shall meet on a monthly basis, following submission of the required monthly compliance reports by the contracted ALS ambulance providers. Meetings shall be held at the Merced County Health Department, to facilitate data extraction as may be required for the review process. The meetings shall be regularly scheduled and the time and day of the month for the meetings shall be established by the EMS Agency after consultation with the membership.
- B. Actions of the M4C are a recommendation to the EMS Agency. Recommendations shall be made by a simple majority vote of the members present. A quorum of the membership is not required to make such recommendations. Voting by alternates or proxies is not permitted.
- C. The M4C shall not review or make recommendations regarding medical quality of care nor personnel certification/licensure issues. Any such reports shall be referred to the EMS agency for review and action. No issues shall be brought to the M4C which, in the opinion of staff, could constitute a violation of the Health Insurance Portability Accountability Act, Title 42 USC 1320d et. seq.

4. Contractual Elements to be Reviewed

For each meeting of the M4C, EMS agency staff shall prepare a brief summary of the compliance report submitted by each of the contracted ALS ambulance providers. This summary shall highlight the following elements:

- A. Response time compliance summary
- B. Exemption requests
- C. Listing of any extended or protracted responses (see Table 1 for definitions of response times)
- D. Vehicle failures
- E. Insufficient Units/Mutual Aid report
- F. System status plan (if applicable)
- G. Unusual incident reports (non-confidential issues)

Merced County Response Time Performance Standards

Table 1

Area	Code 3 (Priority 1 & 2)				Code 2 (Priority 3)			
	RRT	LRT	ERT	PRT	RRT	LRT	ERT	PRT
Urban	< 10 min.	10 - 15 min.	15:01 - 19:59	20 or > min.	< 16 min.	16 - 24 min.	24:01 - 31:59	32 or > min.
Suburban1	< 12 min.	12 - 18 min.	18:01 - 23:59	24 or > min.	< 20 min.	20 - 30 min.	30:01 - 39:59	40 or > min.
Suburban2	< 15 min.	15 - 22 min.	22:01 - 29:59	30 or > min.	< 25 min.	25 - 35 min.	35:01 - 49:59	50 or > min.
Rural	< 20 min.	20 - 30 min.	30:01 - 39:59	40 or > min.	< 30 min.	30 - 45 min.	45:01 - 59:59	60 or > min.
Wilderness	< 40 min.	40 or > min.	*	*	< 60 min.	60 or > min.	*	*

* Best effort & immediate dispatch

RRT = Required Response Time

LRT = Late Response Time

ERT = Extended Response Time

PRT = Protracted Response Time

5. Review of Additional Allowance Requests

The following shall be considered by the M4C upon request from the Provider:

- A. Multiple, simultaneous interfacility transfers. 1) 2 or more ALS units transporting out of County (Emanuel & Madera hospitals not included) 2) Provider must be staffed to SSP; 3) exemption will only extend to 1 hour after the second unit is dispatched.
- B. Multiple, simultaneous out of County 9-1-1 transports. 1) must be in Plan; 2) units transporting must be from same geographical plan (Eastside or Westside); 3) transport to out of county hospital must be authorized by A) Protocol or B) the Base hospital AND the Dispatch Center.
- C. Zone C/D Overload. Defined as a second call occurring within ten (10) minutes of an initial Zone C/D call. 1) must be in Plan; 2) Chute time for posting units must be within 180 seconds and be supported by AVL; 3) exemptions only apply to the C&D Compliance Zone and until 1st unit is available at the hospital; 4) Does not apply for 2nd in units.

6. Review Process

While the membership may review and discuss any issue regarding the monthly compliance reviews, the primary focus and purpose of the M4C shall be the review and

recommendation regarding response time compliance, exemption requests and extended/protracted response evaluations. To that end, the following is outlined to provide guidance to that process:

- A. The EMS agency staff will present any exemption requests to the committee with the explanation provided by the ALS provider. The Provider representative may provide further information regarding the exemption request, if useful for the committee's evaluation. The membership may request additional data, dispatch tapes or other available information to assist in their evaluation. To the extent possible, the EMS agency staff will attempt to have those items available at the meeting, if their need is anticipated.
- B. Following this discussion and review, the Chair will poll the membership regarding their recommendation for either granting or not granting the exemption request or allowance on an extended or protracted response, and staff shall record the recommendation of the committee.
- C. The recommendations of the M4C shall be forwarded to the EMS Agency Administrator for review. Should the EMS Administrator disagree with a recommendation of the M4C, the matter shall be appealed to the EMCC. Associated fines and/or penalties shall not be assessed until action of the EMCC is taken.

7. Appeals of Exemption Request Decisions

- A. Denials of response time exemption requests or exemption requests for extended or protracted responses may be appealed to the EMCC. The Provider requesting the appeal shall submit a written request for the appeal to the EMS Agency within 30 days of notification of the action or intended action . The EMS Agency shall forward the appeal for the review and action of the EMCC at its next regularly schedule meeting. The decision of the EMCC shall be final. Associated fines and/or penalties shall not be assessed until action of the EMCC is taken.
- B. Decisions related to compliance issues by the EMS Administrator that are contrary to the recommendation of the M4C shall be appealed to the EMCC. The EMS Administrator shall submit written notification of the appeal to the M4C within 10 days of receiving the recommendation. The EMS Agency shall forward the appeal for the review and action of the EMCC. The decision of the EMCC shall be final. Associated fines and/or penalties shall not be assessed until action of the EMCC is taken.



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 650.00
Effective Date: 07/1996
Revision Date: 06/2008
Review Date: 06/2010

This policy supersedes any other existing policy on this subject.

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Subject: EMS QUALITY IMPROVEMENT COMMITTEE

Authority: California Health and Safety Code, Division 2.5, Sections 1797.202, 1797.204, 1797.220 California Code of Regulations, Division 9, Chapter 12, Sections 100400 – 100405, California Evidence Code, Section 1040, 1157, 1157.5, 1157.7.

Purpose: Emergency Medical Services (EMS) Quality Improvement Committees are professional standards committees that act in an advisory capacity to the EMS Medical Director. The purpose of the Merced County EMS Quality Improvement Committee shall be to provide a confidential forum for the review and evaluation of the provision, necessity and quality of prehospital emergency medical care and training, and to provide organized reporting and recommendations for the improvement of said activities to the EMS Agency Medical Director.

All proceedings, documents and discussions of the Quality Improvement Committee are confidential and protected from discovery under Section 1040 1157, 1157.5, 1157.7 of the Evidence Code of the State of California. It shall not be the purpose or function of this committee to become directly involved in the certificate review process of any specific individual. The authority for certificate review is vested in the Merced County EMS Agency Medical Director in accordance with Section 1798.200, Division 2.5, California Health and Safety Code, and EMS Policy No. 610.00.

Policy:

1. **COMMITTEE MEMBERSHIP**

Members shall be appointed by the EMS Agency Medical Director, who shall act as the Committee Chairperson. In the absence of the Medical Director, the EMS Agency Staff shall perform the duties of the Chairperson. Membership shall include the following:

- A. EMS Agency Medical Director
- B. EMS Agency Public Health Nurse
- C. Emergency Room Physician (s)
- D. Base Hospital Nurse Liaison
- E. Receiving Hospital Nurse Liaisons
- F. Primary ground ambulance training officer
- G. Primary ground ambulance provider QI Coordinator
- H. Emergency Medical Dispatch QI Coordinator
- I. One primary air ambulance provider representative
- J. Two first response agency representatives

APPROVED:

ON-FILE

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2. ATTENDANCE

- A. Members shall notify the EMS Agency at least five (5) working days in advance if they will be unable to attend any scheduled meetings. He or she is responsible for having a replacement to represent his/her agency. Attendance for each position should remain above 85%.
- B. Resignation from the committee may be submitted, in writing, to the EMS Agency, and is effective upon receipt, unless otherwise specified and approved by the Medical Director.
- C. At the discretion of the EMS Medical Director or Agency staff, other invitees may participate in the medical audit review of specific cases when their expertise is relevant to the cases being reviewed.

3. MEETINGS

The committee shall meet on a monthly basis at a time and place agreed upon by a consensus of the committee membership.

4. COMMITTEE PURPOSE

It shall be the primary purpose of the committee to advance the concept of continuous quality improvement within the Merced County EMS System. To this end the committee shall:

- A. Define the quality standards for prehospital patient care
- B. Develop a systematic process for collection, evaluation and analysis of data
- C. Define quality indicators, performance measures, and audit filters. This should be completed by using the State of California EMS Quality Improvement Guidelines to establish the minimum system indicators.
- D. Define adverse outcomes / deviations from the standards
- E. Develop a process for implementing corrective action and reevaluating the effect of said corrective action
- F. Recommend training activities for system constituents

5. SCOPE OF REVIEW

The committee may review any prehospital patient care or scene management case discovered through the base hospital audit process, EMS agency incident reporting process or specific database extractions as approved by the EMS Agency Medical Director.

6. CASE PRESENTATIONS

Cases shall be selected by the Medical Director or his/her designee for presentation at the committee meetings. At the conclusion of each committee meeting, a consensus of the committee shall be reached regarding the type of cases to be reviewed at the next meeting, and agency staff shall prepare the cases for review.

7. MEETING PROCEEDINGS

Proceedings of all Merced County EMS Quality Improvement Committee meetings shall be administered by the County EMS Agency staff. All printed materials will be distributed to the members and guests at each meeting. Due to the confidentiality of the committee, minutes and documents will be collected by the EMS agency staff at the close of each meeting. No other means of documenting meeting proceedings shall be used other than the aforementioned minutes.

8. CONFIDENTIALITY

All proceedings, documents and discussions of the EMS Quality Improvement Committee are confidential and are protected from discovery under Section 1157, 1557.5, and 1157.7 of the Evidence Code of the State of California. The committee is established by a local government agency as a professional standards review organization which is organized in a manner which makes available professional competence to monitor, evaluate and report on the necessity, quality and level of specialty health services, including, but not necessarily limited to, prehospital care services. The prohibition relating to the discovery of testimony provided to the committee shall be applicable to all proceedings and records of this committee.

All members and guests shall be required to sign a confidentiality statement in which they agree not to discuss or disclose in any way information that would have been obtained solely through membership of the EMS Quality Improvement Committee or attendance at meetings of said committee.



**Department of Public Health
Emergency Medical Services Agency**

Policy #: 655.00
Effective Date: 07/1993
Revision Date: 10/2006
Review Date: 10/2008

This policy supersedes any other existing policy on this subject.

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Subject: QUALITY IMPROVEMENT PROGRAM APPROVAL

Authority: California Code of Regulations, Title 22, Division 9, Section 100141 and 100167

Definitions: **Quality Improvement**- means a method of evaluating services provided, which includes defined standards, evaluation methodologies and utilization of evaluation results for continued system improvement. Also referred to as Quality Assurance, QA, and QI.

ALS Provider - shall mean any private or public entity or person operating one or more advanced life support (ALS) ambulances licensed to provide such services by the Merced County EMS Agency.

Local EMS Agency - means the Merced County Health Department, as the designated Emergency Medical Services Agency for Merced County.

Purpose: The purpose of this policy shall be to establish guidelines for the development and approval of ALS provider-based Quality Improvement Programs within the County of Merced.

Policy: All licensed ALS Providers shall have a Quality Improvement program approved by the EMS Agency. Program proposals submitted for approval shall meet the minimum standards as established herein.

Procedure:

1. Providers shall submit to the local EMS Agency a proposal that outlines the Quality Improvement Program, describing in detail the components of the QI process, i.e., Plan, Do, Study, and Act, along with the following minimum criteria:
 - A. Field Personnel Standards of quality care.
 - B. Selection criteria for QI Committee membership.
 - C. Evaluation Methodology, i.e., audit filters, customer surveys, satisfaction forms, data collection, etc., which analyze current trends as well as effectiveness of corrective actions.
 - D. Copy of Bylaws for the QI committee.

APPROVED:

ON-FILE

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- E. A copy of program objectives and organizational structure.
 - F. A description of the proposed process for implementing corrective action, to include both system and individual issues.
 - G. Copies of Peer Audit forms and any other forms used in the QI process.
 - H. A written plan describing how the provider will report system and/or individual issues to the local EMS Agency. This shall detail when events are to be reported to the local EMS Agency, i.e.: program triggers, etc.
 - I. A written administrative endorsement for the QI process to include committee authority to act on or recommend policy, procedural, and/or protocol changes which may affect patient care.
2. QI review shall include the following minimum components:
- A. Dispatch functions
 - B. Prehospital care
 - C. Interfacility Transfers
 - D. Community Relations/Awareness/Prevention
3. Program Approval Process
- A. Provider must submit the completed plan to the Merced County EMS Agency.
 - B. The Agency shall approve or disapprove the plan within thirty (30) days of receipt of the completed plan. Any notification of disapproval shall be accompanied with a written explanation of the decision and recommended changes.
 - C. Providers whose plan is approved shall be required to update their plan every two years, and submit the plan thirty (30) days prior to the expiration of their current approval.

MERCED

COUNTY

DEPARTMENT OF PUBLIC HEALTH

EMERGENCY MEDICAL SERVICES AGENCY

POLICY NO. 660.00

EFFECTIVE DATE: 11/1/98

REVISION DATE: _____

REVIEW DATE: 5/2004

This policy supercedes any other
Existing policy on this subject

Subject: **TRAUMA SYSTEM EVALUATION POLICY**

Authority: California Health and Safety Code, Section 1798.163, California Code of Regulations, Section 100256

Purpose: The purpose of the Merced County Trauma System Evaluation Policy shall be to assure that there are periodic medical audit and performance evaluations of each of the designated Major Trauma Patient Receiving Centers (MTPRC) and non-designated trauma receiving facilities as required by the County of Merced and the State of California.

Policy: All acute care hospitals within Merced County and facilities under contract for trauma services with Merced County shall ensure that they are in compliance with the quality improvement evaluation provisions, as appropriate for their facility and as described herein.

1. Definitions:

- A. “*Agency*” – means the Merced County EMS Agency.
- B. “*MTPRC*” – “Major Trauma Patient Receiving Center.” A designation by the Agency signifying a hospital’s commitment to meet and/or exceed the standards established by the State of California for a Level II Trauma Center and capable of managing the medical care needs of major trauma patients.
- C. “*Level III Trauma Center*” – a designation by the Agency signifying a hospital’s commitment to provide specialty trauma services available to respond to trauma patients in a prompt fashion. Level III Trauma Centers are not typically designated to receive major trauma patients unless stabilization is indicated prior to transfer to a higher level of care.
- D. “*EDAT*” – “Emergency Department Approved for Trauma.” A designation by the Agency signifying a hospital’s commitment to receive moderately injured patients (and, in rural or isolated areas, major trauma patients) and provide stabilization services until arrangements can be made to transfer the patient to a higher level of care.

APPROVED:

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2. Trauma Evaluation System:

The trauma system evaluation consists of three major elements: 1) an internal process within each MTPRC and non-designated trauma receiving facility; 2) an on-going external periodic trauma system medical audit of case reviews by the Trauma Screening Committee and the Trauma Audit Committee (TAC); and 3) a periodic audit of each MTPRC by the EMS Agency.

A. Internal and External Quality Improvement:

1) Internal Quality Improvement

- a. Both MTPRC's and non-designated receiving facilities must have a formal and fully functional internal medical quality improvement program for their trauma service. As such, each facility shall have a written Quality Improvement Plan, which describes this program.
- b. Responsibility for the trauma care at each institution, as well as compliance with the Merced County Trauma Plan and Trauma Standards, is that of the Medical Director of the Trauma Service at each of the MTPRC's and a physician representative from each trauma receiving facility.

2) External Quality Improvement, Trauma System Medical Audit:

The trauma system quality improvement process recognizes the multidisciplinary nature of trauma care and includes two key components:

a. Medical Audit Review Process:

1. MTPRC Standards of Care: Standard of care for the trauma patient, which is expected to be provided at the designated MTPRC, include the medical care rendered and the audit filters for monitoring purposes. The minimum medical audit filters which are acceptable for assessing the care rendered to a trauma patient at a designated MTPRC are defined in Appendix A. Trauma cases (including all deaths) and those cases, which do not meet the minimum medical audit filters, are identified by the Trauma Services Director for external quality improvement review.
2. Trauma Receiving Facilities Standards of Care: Standard of care for the trauma patient, which is expected to be provided at a non-designated trauma receiving facility, include the medical care rendered and the audit filters for monitoring purposes. The minimum medical audit filters, which are acceptable for assessing the care rendered to a trauma patient at a non-designated trauma receiving facility, are defined in Appendix B. Trauma Cases (including all deaths) and those cases which do not meet the minimum medical audit filters, are identified by the E.D. Medical Director for external quality improvement review.
3. Trauma Screening Committee: This confidential committee performs the initial screening of MTPRC and trauma receiving facility cases which meet the minimum medical audit criteria for case review, or have a special educational or scientific value. The Trauma Service Directors, the E.D.

Medical Directors, the Trauma Screening Committee, and/or the Merced County EMS Medical Director may select specific cases for review. This committee is comprised of: trauma coordinators from the designated MTPRC's; a nursing representative from each of the trauma receiving facilities; as well as, the Merced County EMS Medical Director and the Merced County EMS Specialty Services Operations Nurse. Selected cases shall be forwarded to the Trauma Audit Committee (TAC) where they will be presented and evaluated.

4. **Trauma Audit Committee (TAC):** The TAC conducts detailed mortality and morbidity review of cases which meet one or more of the medical audit filter criteria as determined by the Trauma Screening Committee. Other cases may also be reviewed which are regarded as having exceptional educational or scientific benefit. The TAC shall be comprised of representatives from surgical and non-surgical specialties, Trauma Nurse Coordinators, Prehospital ALS providers, Medical Directors, and the Merced County EMS agency.

b. On-Site Facility Visits:

1. **Designated MTPRC Audits:** Periodic reviews may be performed by the Merced County EMS Agency or an expert site survey team to assure MTPRC contract compliance. The audits may include random chart reviews, trauma registry data, and other records and documents as deemed necessary to confirm compliance with the trauma system standards.
2. **Non-designated Trauma Receiving Facilities:** Periodic reviews may be performed by the Merced County EMS agency to assure contract compliance. These audits may include random chart reviews, trauma registry data, and other records and documents.

3. Trauma Audit Committee (TAC)

- A. The Committee is established and maintained pursuant to section 1157.7 of the Evidence Code, State of California. The TAC is charged with the responsibility of providing quality improvement for the trauma care system. The TAC discusses the appropriateness of medical care rendered and makes recommendations either to the provider organization or the EMS Agency (as appropriate) for improved care or system improvements. The TAC serves in an advisory capacity to the EMS Agency on other trauma care systems issues and may appoint subcommittees, either standing or AD Hoc, as needed to fulfil its functions.
- B. Membership: The Committee shall be made up of a variety of individuals responsible, directly or indirectly for care of the trauma patient. Voting members shall include:
 - 1) A medical staff representative from each non-designated trauma receiving facility in Merced County
 - 2) Trauma Service Director from each MTPRC
 - 3) Trauma Nurse Coordinator from each MTPRC

- 4) Emergency Dept Medical Director from each MTPRC
- 5) Emergency Dept Medical Director from each non-designated trauma receiving facility in Merced County
- 6) A nursing staff representative from each of the non-designated trauma receiving facilities in Merced County (this nurse should be staff in one of the following depts: E.D., O.R. Critical Care)
- 7) A general surgeon from Merced County
- 8) EMS Agency Medical Director

The following positions are not required to routinely attend TAC meetings, but will be requested when a case being reviewed would benefit from their particular area of expertise:

- 9) An orthopedic surgeon
- 10) A neurosurgeon from each of the MTPRC's
- 11) A pediatric surgeon (if available from VCH)
- 12) A Pediatrician
- 13) Critical Care Directors from each MTPRC
- 14) Paramedic Representatives of the air ambulance services and ALS ground transport providers
- 15) Other EMS Community leaders as appointed by the TAC Chairman and in consultation with the EMS Agency

C. Appointment of Members:

- 1) Chairmanship: The TAC selects a member to serve as TAC chairperson for a one-year term. The chairperson shall have been an active member of the Trauma Audit Committee for at least one year (except for initial appointment) and shall be a surgeon unless one is unavailable for appointment. Elections are held every year on or before the regularly scheduled June meeting. The chairperson may appoint a vice-chairperson to fill his/her duties during absences. The chairperson presides over the committee and arranges for documentation of the results of the committee discussions. The chairperson corresponds or follows-up on committee matters as directed by the membership.
- 2) Election of Chairperson: Solicitation of nominations is mailed to committee members on or before May 1 of an election year. Nominations must be made to the EMS Agency in writing. Upon receipt and confirmation of eligibility of nominees and their willingness to serve, the EMS Agency shall mail a ballot to all members of the committee. Committee members are required to respond in writing or by fax, indicating their selection of the Chairperson, to the EMS Agency on or before June 1 of the election year. The EMS Agency tallies the return votes and reports the final result at the regularly scheduled June meeting. The newly elected chairperson will assume his/her responsibilities at the June meeting.

- 3) Quorum: On matters brought before the TAC requiring voting (i.e., election of chairperson and determination of case review) a quorum is required. A quorum consists of one voting member from each of the MTPRC's and five additional committee members.
- 4) Attendance: To be considered as an active voting member, a voting member must attend 80% of the annual scheduled meetings or receive an excused absence for good cause.

D. Meetings:

The TAC meets six (6) times a year. Periodically; trauma experts are invited to critique cases and to provide an educational presentation. Each MTPRC is responsible to assist the Merced County EMS Agency in providing one (1) guest lecture per year for the Trauma Audit Committee. Continuing education credits are provided for physicians, nurses, and paramedics in attendance. The EMS Specialty Services Operations Nurse facilitates the process of obtaining the credits from various providers. Minutes/correspondence of the TAC are maintained in a binder in the Merced County EMS Agency by the Specialty Services Operations Nurse to maintain confidentiality.

E. Preparation of Cases for TAC Review:

- 1) Each MTPRC and each non-designated trauma receiving facility prepares appropriate materials of its cases to be presented to the TAC, to include:
 - a. Clinical information
 - b. All pertinent radiologic examination, and
 - c. Autopsy findings, when appropriate
- 2) The EMS Medical Director, or designated representative, provides the Pre-Hospital Care Report and pre-hospital component for presentation when pertinent to the care of the trauma patient.
- 3) The EMS Agency provides staff support for:
 - a. preparation of overheads to be used during the meeting
 - b. distribution of meeting announcements/materials
 - c. preparation of TAC agenda
 - d. maintenance of the binder of proceedings

F. Conclusion of Trauma Audit Committee Case Review:

1) Categorization of Trauma Related Deaths:

Following presentation of trauma related deaths; a quorum of committee members present must make the determination as to the preventability of death. The Probability of Survival numeric designation shall serve as a guideline to the committee in its deliberations, and not an absolute as to the scoring of the case. Each trauma related death must be assigned one of the following designations:

NonP = non-preventable

- a. Anatomic injury or combination of injuries considered non-survivable with optimum care.

- b. Physiologic state at time of arrival of first responder important but not critical to judgment of non-preventability. Evaluation and management appropriate to ACLS and ATLS guidelines; suboptimal care, if identified, is deemed not to have influenced outcome.
- c. Probability of survival (P.) < 0.25.

PotenP = potentially preventable

- a. Anatomic injury or combination of injuries considered as very severe but survivable under optimal conditions.
- b. Physiologic state at time of arrival of first responder critical to judgment of potential survivability.
- c. Evaluation and management generally appropriate to ACLS and ATLS guidelines; any suboptimal care directly or indirectly implicated in patient's demise.
- d. $0.50 > P. > 0.25$

ProbP = probably preventable

- a. Anatomic injury or combination of injuries considered survivable.
- b. Physiologic state at time of arrival of first responder critical to judgment of preventability; patient generally stable; if unstable, patient becomes stable with treatment.
- c. Suboptimal care clearly related to unfavorable outcome.
- d. $P. > 0.5$.

Contributing Factors: The following factors may be considered related to morbidity/mortality:

- a. delay in diagnosis
- b. error in diagnosis
- c. error in judgment/error in interpretation
- d. error in technique
- e. patient disease
- f. system failure
- g. inadequate protocol
- h. care appropriate
- i. care inappropriate

- 2) Information feedback to the MTPRC or the non-designated trauma receiving facilities is critical to the audit process. The members of the committee, in determining whether a death was potentially preventable or probably preventable, will provide justification for that determination.

G. Level of Care

- 1) All cases reviewed by TAC, in which patient care was administered, will receive a grade. This grade will be recorded as part of the permanent record. The grades shall be assigned based on the following criteria:
 - A. 4.0 - Exceeds expected Trauma Center care
 - B. 3.0 - Meets expected Trauma center care
 - C. 2.0 - Marginally acceptable care

D. 1.0 - Unacceptable or inappropriate care

- 2) Each grade must also have one of the following qualifiers:

- + The patient had a good or better than expected outcome
- The patient had a poor or worse than expected outcome

H. Action Steps:

At the conclusion of each case review, the Committee will discuss the case and arrive at a conclusion for action that may, among others, include one or more of the following:

- 1) No further comment or action is indicated
- 2) Request a follow-up report from the involved institution
- 3) Make a recommendation to the involved institution that is pertinent to the case
- 4) Request additional information for a subsequent meeting to allow for further discussion
- 5) Suggest that a specific educational program or action be implemented

I. Confidentiality of Committee Proceedings and Records:

- 1) The proceedings and records of this committee are confidential and are protected under Section 1157.7 of the Evidence Code, of the State of California.
- 2) Persons who are members of the Trauma Audit Committee and the Trauma Screening Committee are required to complete and sign a Statement of Confidentiality as a condition of membership on the committees and to participate in their proceedings. The Statement of Confidentiality will be reviewed on an annual basis.
- 3) Because of the confidentiality requirements, meetings of the TAC are closed to the public. Attendance at the meetings is limited to members of the Committee with the exception of special invitation approved by the TAC membership and the EMS agency.

J. Standing Committees:

Standing committees are ongoing committees that meet regularly to accomplish a specific function as requested by TAC. The TAC Chairperson or the EMS Medical Director can appoint members to a Standing or Ad Hoc Committee.

- 1) Trauma Screening Committee (TSC): The TSC is composed of the Merced County EMS Medical Director, the EMS Agency Specialty Services Operations Nurse, and the Trauma Coordinators from each trauma receiving facility.
- 2) Registry Users Group (RUG): The RUG is composed of the Trauma Coordinators and Trauma Registrars within the community. The RUG meets bi-monthly and more frequently as necessary to plan, implement, and monitor the trauma registry.
- 3) Ad Hoc Committees: Ad hoc Committees are time-limited committees with specific functions designed to assist the Trauma Audit Committee in achieving its overall objectives, and may be appointed as required.

APPENDIX A
MINIMUM RECOMMENDED SCREENING STANDARDS

Major Trauma Patient Receiving Centers

- The absence of an ambulance report on the medical record for the patient transported by prehospital EMS personnel (system filter)
- Any failure or delay of the trauma surgeon's response in accordance with existing policy
- Delay or failure to activate trauma team according to internal triage criteria
- A patient with a GCS of <14 who does not receive a CT scan of the head within 2 hours of arrival at the emergency department.
- A comatose trauma patient (GCS of <9) leaving the emergency department before a definitive airway is established.
- A patient sustaining a gunshot wound to the abdomen who is managed nonoperatively
- Patients with abdominal injuries and who are hypotensive (SBP <90mm HG) who do not undergo laparotomy within 1 hour of arrival in the ED; other patients undergoing laparotomy performed >4 hours after arrival in ED.
- Patients with epidural or subdural brain hematoma receiving craniotomy >4 hours after arrival at emergency department, excluding those performed for ICP monitoring.
- Interval of >8 hours between arrival and the initiation of debridement of an open tibial fracture, excluding a low velocity gunshot wound
- Abdominal, thoracic, vascular, or cranial surgery performed >24 hours after arrival
- A major trauma patient admitted to the hospital to a non-surgical service
- Unexpected return to the operating room after initial surgery
- Hourly determination and recording of B/P, pulse, respirations, and GCS, not done.
- Nonfixation of femoral diaphyseal fracture in patients greater than twenty four (24) months
- Missed diagnosis
- Readmission to hospital for complications related to prior admission
- All trauma deaths
- All outgoing trauma transfers performed within 24 hours of arrival
- Any case the MTPRC feels would benefit from a TAC review.

NOTE: The minimum audit filters are those identified in the ACS document "Resources for Optimal Care of the Injured Patient, 1993" and the Tri-Analytics Trauma registry. Trauma receiving centers may add additional audit filters for internal use for trends or sentinel events.

APPENDIX B
MINIMUM SCREENING STANDARDS
Trauma Receiving Facilities

- All trauma deaths
- Trauma patient transfer to a MTPRC or other specialty center
- Return of patient to surgery within 24 hours
- Emergency Department stay of greater than 2 hours with systolic B/P less than 90 mmhg.
- All trauma patients transported code 3 to the facility
- Any case the Trauma Receiving Facility feels would benefit from a TAC review.



**Department of Public Health
Emergency Medical Services Agency**

Tammy Moss-Chandler
Director of Public Health

Policy #: 710.00
Effective Date: 11/01/10
Revision Date:
Review Date: 05/01/11

This policy supersedes any other existing policy on this subject.

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Subject: Protected Health Information and Patient Confidentiality

Authority: Confidentiality of Medical Information Act (Civil Code, Section 56 et. seq.) Title 22, Division 9, Sections 100075, 100159, Health Insurance Portability and Accountability Act (HIPAA).

Purpose: To describe the conditions and circumstances by which protected health information may be released and provide guidance regarding issues of patient confidentiality.

Definitions: Protected Health Information (PHI) – HIPAA regulations define health information as “any information, whether oral or recorded in any form or medium” that:

- ❖ “is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse” and,
- ❖ “relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual.”

Social Media – shall, for the purpose of this policy, mean any medium used to transmit or share information in an open, public forum, such as Facebook, Twitter, MySpace, etc. as well as blogs or other venues for posting information.

Policy: A. PERSONAL HEALTH INFORMATION

1. All prehospital provider agencies shall have policies in place regarding the disclosure of PHI of EMS patients and the use of social media and patient confidentiality.
2. Prehospital provider agencies shall designate a Public Information Officer (PIO) or other designated person(s) authorized to release operational or general information, as authorized by State and Federal law.
3. PHI may not be disclosed by prehospital personnel, except as follows:
 - A) To other care givers to whom patient care is turned over, for continuity of patient care (including the prehospital patient record).
 - B) To the Merced County EMS Agency, Base Hospital or provider agency quality improvement program (including the provider agency supervisory personnel).

APPROVED:

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- C) To the patient or legal guardian.
 - D) To law enforcement officers in the course of their investigation under the following circumstances:
 - 1) As required by law (e.g. court orders, court-ordered warrants, subpoenas and administrative requests).
 - 2) To identify or locate a suspect, fugitive, material witness or missing person.
 - 3) In response to a law enforcement official's request for information about a victim or suspected victim of a crime.
 - 4) To alert law enforcement of a person's death if the covered entity suspects that criminal activity caused the death.
 - 5) When a covered entity believes that PHI is evidence of a crime that has occurred on the premises.
 - 6) In a medical emergency and it is necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and/or the perpetrator of the crime.
 - E) To the provider agency's billing department, as needed for billing purposes.
 - F) In response to a properly noticed subpoena, court order or other legally authorized disclosure.
4. Any prehospital records (recorded or written), used for training or continuing education purposes, must be edited to remove identifying patient/incident information.

B. USE OF SOCIAL MEDIA IN EMS

- 1. Any disclosure of patient identifying information through any public medium is prohibited, unless authorized by the patient, the patient's legal representative or as otherwise permitted by law.
- 2. Pictures or videos of patients shall not be taken by EMS personnel without the written consent of the patient.
- 3. Patient identifying information must be viewed broadly and taken into proper context. In a small community, any of the below examples¹ could reveal patient identifying information:
 - A) the location and date of a motor vehicle crash;
 - B) an uncommon characteristic such as a condition, extremes of age (e.g. patient that is 108 years of age or a newborn could be easily identified), etc.
- C) an incident that took place in a public location with witnesses.
- 4. EMS Personnel should avoid posting on or responding to blogs or other public information mediums regarding EMS incidents with which they are familiar.
- 5. Discussion on such sites regarding policies, protocols, current research, etc. can be very valuable and a good forum for such dialogue.
- 6. Personnel should refer questions regarding the appropriateness of specific discussions with their HIPAA Compliance Officer or supervisor. Questions may also be directed to the EMS Agency.

¹ These are used for reference only. Many other scenarios could reveal patient identity.



**Department of Public Health
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Policy #: 810.00
Effective Date: 10/2003
Revision Date: 08/2008
Review Date: 08/2010

This policy supersedes any other existing policy on this subject.

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Equal Opportunity Employer

- Subject:** MULTIPLE CASUALTY INCIDENT (MCI) - Field Operations
- Authority:** California Health and Safety Code, Division 2.5
- Purpose:** To establish the standard for pre-hospital personnel in providing care during Multiple Casualty Incidents (MCI).
- Policy:** All Multiple Casualty Incident operations within Merced County shall follow the Incident Command System and the procedures established herein. All medical resource requests shall be coordinated with the Incident Commander.

1. Multi-Casualty Incident

An MCI shall be declared for any incident with four (4) or more patients of any category

2. MCI Alert to Control Facility (CF)

An MCI alert to the Control Facility (CF), Mercy Community, should occur as soon as there is information that an MCI may exist. If this occurs at the time of dispatch or while responding to the incident, the CF will be contacted and advised of an "MCI Alert". Information concerning the location and County, approximate number of victims (if known), and a description of the incident should be given (i.e. Hazmat, Trauma, Medical).

3. Authority for and Confirmation of MCI

Immediately upon arrival on-scene or upon patient count update from on-scene first responders, the first arriving ALS crew or Supervisor unit shall:

- A. Confirm or cancel the MCI alert with the CF.
- B. Confirm location and County of MCI to the CF.
- C. Number of Patients

APPROVED:

ON-FILE

John Volanti, MPH
Director of Public Health

James Andrews, MD
EMS Medical Director

4. **MCI Management**

A. **Medical Group Supervisor** - Once it has been determined that an MCI exists, the first arriving paramedic shall coordinate with the Incident Commander (IC) and, if assigned, assume the Medical Group Supervisor position. All additional positions and functions will be assigned as necessary to mitigate the incident and shall be consistent with the Incident Command System (ICS). The following positions fall under the Medical Group Supervisor:

- 1) Triage Unit Leader
- 2) Treatment Unit Leaders
- 3) Medical Supply Coordinator
- 4) Transportation Group Supervisor

B. **Transportation Group Supervisor** – responsible for coordinating all patient transportation and for completion of the Field Disposition Summary form. The following positions fall under the Transportation Group Supervisor:

- 1) Medical Communications Coordinator
- 2) Air Ambulance Coordinator
 - a. Landing site coordination shall be the responsibility of the fire agency with jurisdiction for the area of the incident.
 - b. Ground Ambulance Coordinator

5. **MCI Operations** – The first ALS ambulance/Supervisor on scene will, if assigned by the IC, assume Medical Group Supervisor, Medical Communications Coordinator and Treatment Unit Leader, until resources allow for assignment to other personnel.

6. **Triage**

Initial triage shall be performed utilizing the S.T.A.R.T. method. (see attached Field Guide)

A. **Triage Categories:**

- 1) Immediate
- 2) Delayed
- 3) Minor
- 4) Deceased

B. If staffing allows, re-triage shall be more precise than the initial S.T.A.R.T. method.

7. **Treatment**

A. During an MCI ALS personnel will function under standing orders.

B. CPR shall not be initiated unless appropriate treatment and transportation are available for the immediate treatment of all immediate and delayed patients.

8. **Transportation**

- A. The CF will advise the Medical Group Supervisor of hospital and resource capability.
- B. The Medical Group Supervisor or designee will be responsible for determining transportation mode for all patients on scene.
- C. The Medical Group Supervisor or designee shall notify the CF of patient destinations, categories, and counts.
- D. Patients must meet trauma triage criteria to be sent to a trauma center, unless directed there by the CF.

9. **Communications**

During an MCI, it is imperative that all radio/phone transmissions be kept to a minimum. To ensure adequate radio/phone time, the following guidelines shall be adhered to:

- A. During transport – updates with the CF by transporting units will only be made if there is a change (worsening) in the patients triage category.
- B. All Other System Radio/Phone Traffic:
 - 1) Only that communication which is necessary for patient/personal safety or operational integrity shall be conducted during an MCI.
 - 2) All necessary communication shall be less than thirty (30) seconds and only contain information regarding patient stability (stable vs. unstable), destination, and ETA.

10. **Documentation**

- A. **Triage Tags** - Upon arrival at the scene, the Medical Group Supervisor will distribute Fire Scope approved triage tags to qualified triage personnel. These tags will be completed in accordance with the Merced County Patient Documentation Policy.
- B. **Base Hospital Routing Log** – Copies of the Base Hospital Routing Log will be forwarded to the EMS Agency by the next business day.
- C. **Field Disposition Summary Form** - Copies of the Field Disposition Summary Form will be forwarded to the EMS Agency by the next business day.
- D. All patient contact will be documented in accordance with the Merced County Patient Documentation Policy.

S.T.A.R.T. Field Guide

