



COUNTY OF ORANGE HEALTH CARE AGENCY
Regulatory/Medical Health Services
EMERGENCY MEDICAL SERVICES
405 W. Fifth Street, Suite 301A, Santa Ana, CA 92701
(714) 834-3500



FACILITIES ADVISORY SUBCOMMITTEE

Tuesday, September 13, 2022 – 9:00 a.m.

Join Zoom Meeting

<https://us06web.zoom.us/j/83258012715?pwd=MGZCMFZHRHFwem8ydDdCRnFkdnZuZz09>

Meeting ID: 832 5801 2715

Passcode: 513179

Note: If you are calling into the meeting (via phone), OCEMS staff ask that you please contact us in advance and give us the phone number you will be using. This only needs to be once (please send an email to emsdutyofficer@ochca.com if you have not already done so). Due to added security measures, we are unable to give you access without this information. Thank you.

THIS COMMITTEE MEETING IS OPEN TO THE PUBLIC, YOU MAY ADDRESS THE COMMITTEE ON ANY AGENDA ITEM BEFORE OR DURING CONSIDERATION OF THAT ITEM, AND ON OTHER ITEMS OF INTEREST WHICH ARE NOT ON THE AGENDA, BUT WHICH ARE WITHIN THE SUBJECT MATTER JURISDICTION OF THE COMMITTEE.

A G E N D A

- **CALL TO ORDER**
- **INTRODUCTIONS/ANNOUNCEMENT**
- **APPROVAL OF MINUTES**
 - *Action Item: Approval of July 12, 2022 Minutes* (Attachment #1)
- **OCEMS REPORT**
 - OCEMS Report
 - Specialty Centers (CCERC, SNRC, CVRC, Trauma)
 - Ambulance Patient Off-Load Time (APOT) Report (Attachment #2)
 - Bi-Directional Data Exchange Project
- **UNFINISHED BUSINESS**
 - Increasing APOTs and Diversion Hours
- **NEW BUSINESS**
 - Policy Updates with Letter #4427 - October 1, 2022 (Attachment #3)
 - Letter #4410 Hospital Bypass APOT (Attachment #4)
- **NEXT MEETING** – November 8, 2022, 09:00 am
- **ADJOURNMENT**



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Santa Ana, CA 92701



FACILITIES ADVISORY COMMITTEE

Tuesday, July 12, 2022 – 9:00 a.m.
Meeting held via Zoom Video Conferencing

MINUTES

MEMBERSHIP / ATTENDANCE

MEMBERS

- ☒ Peter Anderson, MD (exc.)
- ☒ Michael Lekawa, MD
- ☒ Chien Sun, MD, MD
- ☐ Mary Birkle, RN
- ☐ Kenneth McFarland
- ☒ Cyndie Strader, RN
- ☐ Sheryl Riccardi, RN
- ☒ Anabella Anderson, RN
- ☐ Bryan Johnson, RN
- ☒ Mary Slattery, RN

REPRESENTING

- OCMA/ED Physicians
- Trauma Medical Directors
- Managed Health Care Physicians
- Base Hospital Administrators
- ERC Hospital Administrators
- Base Hospital Coordinators
- OC ED Nursing Leadership
- Trauma Program Coordinators
- Fire Chiefs EMS Committee
- Trauma Program Coordinators

Carl Schultz, MD
Gagandeep Grewal, MD
Laurent Repass, NRP
Danielle Ogaz
Meng Chung, EMT-P
Irma Chavando
Jason Azuma, EMT-P
Erica Moojen
Eileen Endo

OCEMS STAFF PRESENT

- EMS Medical Director
- Associate EMS Medical Director
- EMS Information Systems Chief
- EMS Systems & Standards Chief
- BLS Coordinator
- EMS Staff Assistant
- OC-MEDS Coordinator
- EMS Office Supervisor
- Office Specialist

GUESTS PRESENT

NAME

Sharon Richards
Nicholas Berkuta
Drew Bernard
Ruth Clark, RN
Chris Waddell
Karen Sharp, RN
Christopher Leo
David Gorin
Luke Schademan

REPRESENTING

- Hospital Association of Southern California
- OC Heart
- Emergency Ambulance Service
- Orange County Global Medical Center
- Huntington Beach Hospital
- Saddleback Memorial Medical Center
- UCI Medical Center
- Saddleback Memorial Hospital

NAME

Nicole Miller, RN
Rhonda Rosati
Robert Viera
Augustus (Titus) Ynares, RN
Heidi Yttri, RN
Kim Zaky, RN
Julia Afrasiabi
Meghann Ord, RN
Juliann Larsen

REPRESENTING

- Mission Hospital
- Brea/Fullerton Fire Department
- Care Ambulance Service
- Los Alamitos Medical Center
- St. Jude Medical Center
- Children's Hospital of Orange County
- UCI Medical Center
- Hoag Memorial Hospital
- Saddleback Memorial Medical Center

I. CALL TO ORDER

The meeting was called to order by Peter Anderson, MD, Chair.

II. INTRODUCTIONS/ANNOUNCEMENTS

Dr. Almaas Shaikh is hired as the County of Orange Deputy Health Officer. She is involved with ongoing aspects of the County and makes a substantial contribution to all facets of the County of Orange Health Care Agency.

III. APPROVAL OF MINUTES

Minutes from March 8, 2022, meeting was approved with noted corrections needed on page 2 first paragraph change Stroke Policy 300.30. That is not the stroke policy. It is the data entry policy. Page 3 contracted diversion hours should be 36 hours, not 36,000 hours.

IV. OCEMS REPORT

• OCEMS Report:

Dr. Gagandeep Grewal – COVID-19 positivity case rates are up 100 per 300K. Above 25, positivity is up to 18% higher with antigen tests only. There is a significant increase in hospitalization with 287 patients. It

is not a big spike but is still increasing. ICU is flat with COVID. A lot of hospitalizations are non-incidental. Transports increase for APOT diversion times. Monkey Pox increased 10,000 worldwide. There are over 100 cases in California. Vaccine is released to public health for lab workers.

AOC is looking to deactivate. Mobile pods are limited. Test kits supply of professional test kits are available. If facilities are interested, order them. Regular operations at Health Emergency Management (HEM) are getting Health Care Coalition (HCC) and other Facilities involved. A few members are on board. Training Exercises are going. There are HCC trainings in August and September. Various topics like ICS, Communications, Leadership, Situational Awareness. Training is in person. Sign up for these valuable, excellent courses.

Dr. Carl Shultz – July has a significant turnover of Base Physicians because residency is over. Welcome to ten new Base Hospital Physicians at UCI. EMS is continuing to move forward with standing orders and IFT-ALS into one standing order. It is working well. The requirement for 911 Base Hospital Contact once done is no longer required to make Base Hospital contact. 77,000 IFT-ALS runs in the past 5 years had no base hospital contact. It is voluntary on October 1st then mandated on April 1, 2023.

Danielle Ogaz – The waivers for state credentialing expired June 30, 2022. EMT is back to normal training. We are still in recruiting process for a Facilities Coordinator. Send anything that you normally sent to David to Danielle.

- **Specialty Centers (CCERC, SNRC, CVRC, Trauma):**

Anabella Anderson at Mission we are working with Trauma program managers collaborative working with Jason on getting on the same page for gap analysis.

Dr. Carl Schultz mentioned the UCI group stroke society meeting is next week. We are looking at suggestions from the stroke society.

Kim Zaky online CCERC Bi-yearly looking at I-20 to adjust.

- **Ambulance Patient Off-Load Times (APOT):**

Laurent Repass reported on the APOT reports for January through May. June APOT report is completed. The county wide ambulance transport is increasing, which causes an increase in APOT times. Month of June 50,643. APOT time in June is 38% of the 90th percentile. APOT continues to increase gradually. 10-15 hospitals APOT is over 30 minutes on any given day.

- **Bi-Directional Data Exchange Project**

Laurent Repass - The Bi-Directional Data project is underway. Draft contracts going to Board of Supervisors for approval next week Tuesday. After that, signatures can be obtained from hospitals participating in the project. Kaiser was not planning to participate, but we received a letter that they are now interested. UCI is going to be the first customer. We will continue to provide updates.

Dr. Lekawa asked about how common it is EMS wide? Laurent replied that it is not common. It is pursued across the state LEMSAS. Orange County is not the first one. Test it to be a big benefit to EMS system. It provides record in real time. Data on patient outcomes and closes the loop. It allows hospital regulatory requirements for outcome data.

Dr. Schultz asked input on Diversion hours. Volume cut out APOT time. Impaction backing up patients. A lot of sick calls and exhaustion. What can be done to the system regulatory changes? Not allowing people to go down. Once center ramp up. Number of combinations of burn out, situation general employees group staff emergency departments. A lot of people are out sick with COVID and cannot work. The people who were previously vaccinated and boosted are getting COVID now. We don't know the level of protection. Facilities knows best at what they're doing. They might be able to suggest what can be done. Diversion goes away then APOT goes through the roof. It is not going to get fixed soon. When speaking with other directors, any suggestions? It once worked for the moment to cancel surgery to free up beds. It is not the solution unless it is a mandate from the state. Seems to be gradually getting worse. Hoping for solutions.

UCI decompresses. Psych hospital Anaheim hills no clue how they run their system. Issue we would like to try to fix. Need to get patients out of ER to another facility. We don't have facilities available now.

Augustus Ynares reviewed flow throughput. Concerns about staffing nurse burnout. Consider leaders in SNF area taking patients from hospital. That might be something we can pay attention to.

- **UNFINISHED BUSINESS**

None discussed.

- **NEW BUSINESS**

None discussed.

VII. **NEXT MEETING** – Tuesday, September 13, 2022, at 9:00 a.m.

IX. **ADJOURNMENT**

With no further business, the meeting was adjourned at 9:38.



Ambulance Patient Offload Time (APOT-1) Report
June 2022

Hospital	2022 Totals			June 2022				
	90th Percentile APOT Time Diversion			90th Percentile Mean Median APOT Time APOT Time APOT Time Diversion				
	Transports	(Min:Sec)	* Hours *	Transports	(Min:Sec)	(Min:Sec)	(Min:Sec)	* Hours *
Anaheim Global Medical Center	1,650	33:57	55	357	35:49	16:40	10:52	25
Anaheim Regional Medical Center	2,966	37:06	10	509	40:06	18:07	13:44	8
Chapman Global Medical Center	341	9:07	1	97	8:15	5:32	3:58	0
Children's Hospital of Orange County	2,140	15:32	0	390	15:26	8:07	6:45	0
Foothill Regional Medical Center	510	30:47	12	99	25:27	14:14	9:26	6
Fountain Valley Reg Hosp and MC	3,742	38:00	285	643	40:22	18:26	12:00	117
Garden Grove Hosp and MC	2,618	36:23	54	475	34:27	16:49	12:01	10
Hoag Hospital Irvine	3,833	22:19	534	524	21:52	11:54	10:00	218
Hoag Memorial Hosp Presbyterian	10,032	16:24	117	1,776	15:43	9:38	8:54	37
Huntington Beach Hospital	2,616	38:52	36	475	42:12	20:03	11:50	8
Kaiser Permanente - Anaheim MC	2,615	43:53	166	440	57:22	26:04	18:41	65
Kaiser Permanente - Irvine MC	2,669	36:44	41	496	73:02	28:39	17:38	33
La Palma Intercommunity Hospital	1,566	30:58	0	305	34:43	16:36	7:43	0
Los Alamitos Medical Center	3,395	58:51	208	567	56:17	25:11	17:13	104
Mission Hospital - Laguna Beach	1,925	38:10	63	391	45:24	21:01	14:57	35
Mission Hospital Regional MC	7,855	36:55	353	1,323	40:07	19:31	14:08	138
Orange Coast Memorial MC	2,962	31:26	318	500	28:51	16:19	12:02	110
Orange County Global MC	4,258	27:35	144	766	33:19	15:27	8:17	86
Placentia Linda Hospital	2,449	23:52	0	439	21:11	10:27	7:54	0
Saddleback Memorial MC	4,701	25:01	261	870	25:28	14:44	11:53	95
South Coast Global Medical Center	1,128	21:44	2	209	25:47	12:44	8:01	0
St. Joseph Hospital	6,171	26:54	199	1,011	29:06	14:12	10:16	98
St. Jude Medical Center	7,346	37:30	81	1,296	38:54	18:31	13:43	35
UCI Medical Center	5,822	32:49	878	905	32:11	13:13	6:58	275
West Anaheim Medical Center	4,376	57:52	72	780	57:36	24:53	16:58	11

Median Hospital 90th Percentile APOT Time 32:49
InterQuartile Range 26:26, 37:37

34:27
25:28, 40:22

OC EMS System Total (Aggregate)	89,686	32:49
OCEMS System Mean APOT Time	15:53	
Standard Deviation	+/- 18:05	
OCEMS System Median APOT Time	10:44	
InterQuartile Range	6:12, 18:29	

15,643	35:08
16:41	
+/- 18:38	
11:02	
6:23, 19:26	

Diversion Hours	1512
Diversion Days	30 of 30
Hospitals/Day Range	3-15/day
Incidents w/ APOT 30-60min	1435
Incidents w/ APOT >60min	539

* Diversion Hours modified rounding calculation resulting in small decreases *

2022 Totals highlighted facilities decreased 1-4hrs



Ambulance Patient Offload Time (APOT-1) Report
July 2022

Hospital	2022 Totals			July 2022				
	Transports	90th Percentile APOT Time (Min:Sec)	Diversion Hours	Transports	90th Percentile APOT Time (Min:Sec)	Mean APOT Time (Min:Sec)	Median APOT Time (Min:Sec)	Diversion Hours
Anaheim Global Medical Center	2,031	35:42	84	381	44:41	18:12	11:52	29
Anaheim Regional Medical Center	3,567	38:02	71	601	39:42	18:39	12:58	61
Chapman Global Medical Center	463	9:37	9	122	12:20	7:06	4:15	8
Children's Hospital of Orange County	2,534	15:05	0	394	12:51	7:13	5:50	0
Foothill Regional Medical Center	634	31:43	25	124	46:30	19:50	10:45	13
Fountain Valley Reg Hosp and MC	4,290	38:02	495	548	38:37	17:19	11:17	210
Garden Grove Hosp and MC	3,111	39:12	159	493	53:10	23:53	15:29	105
Hoag Hospital Irvine	4,562	22:43	638	729	25:23	13:08	10:33	104
Hoag Memorial Hosp Presbyterian	11,936	16:29	147	1,904	16:42	10:03	9:00	30
Huntington Beach Hospital	3,106	39:50	88	490	44:37	19:57	12:47	53
Kaiser Permanente - Anaheim MC	3,126	45:02	202	511	55:00	24:57	17:04	36
Kaiser Permanente - Irvine MC	3,167	36:46	53	498	37:14	19:18	14:48	12
La Palma Intercommunity Hospital	1,936	36:26	5	370	64:55	23:59	11:47	5
Los Alamitos Medical Center	3,982	58:56	403	587	60:13	28:58	20:39	195
Mission Hospital - Laguna Beach	2,262	39:15	105	337	51:50	24:29	17:21	42
Mission Hospital Regional MC	9,196	36:46	497	1,341	34:59	17:57	14:25	144
Orange Coast Memorial MC	3,482	31:57	481	520	35:37	17:24	12:51	164
Orange County Global MC	4,926	27:53	350	668	32:00	14:48	8:11	206
Placentia Linda Hospital	2,954	24:20	18	505	26:00	13:36	8:08	18
Saddleback Memorial MC	5,589	25:02	356	888	25:04	13:52	11:51	96
South Coast Global Medical Center	1,403	22:11	6	275	23:56	12:09	8:28	4
St. Joseph Hospital	7,316	26:54	306	1,145	27:23	13:37	10:03	107
St. Jude Medical Center	8,689	38:05	139	1,343	41:20	20:48	14:57	59
UCI Medical Center	6,617	32:20	1295	795	27:48	11:48	6:22	417
West Anaheim Medical Center	5,186	58:47	162	810	65:36	27:52	19:36	91

Median Hospital 90th Percentile APOT Time 35:42
InterQuartile Range 26:26, 38:22

37:14
26:00, 46:30

OC EMS System Total (Aggregate)	106,065	33:19
OCEMS System Mean APOT Time	16:04	
Standard Deviation	+/- 18:11	
OCEMS System Median APOT Time	10:50	
InterQuartile Range	6:16, 18:42	

16,379	36:00
17:04	
+/- 18:44	
11:20	
6:36, 20:00	

Diversion Hours 2207
Diversion Days 31 of 31
Hospitals/Day Range 6-19/day
Transports w/ APOT 30-60min 1555
Transports w/ APOT >60min 592



CLAYTON CHAU, MD PhD
DIRECTOR

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ASSISTANT AGENCY DIRECTOR

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DATE: September 7, 2022

TO: BASE HOSPITAL COORDINATORS
ERC MEDICAL DIRECTORS
911 PROVIDER EMS COORDINATORS/MANAGERS
IFT-ALS NURSE COORDINATORS
PARAMEDIC TRAINING CENTERS

FROM: CARL H. SCHULTZ, MD
ORANGE COUNTY EMS MEDICAL DIRECTOR

CXS

SUBJECT: NEW POLICIES and CLARIFICATIONS/UPDATES OF EXISTING EMS
DOCUMENTS

Typically, the Orange County EMS Agency reviews, updates, and edits its policies, procedures, and standing orders on a biannual basis. New policies may also be added. From time to time, the agency may also need to issue updates on an impromptu basis, as such actions can't wait until the next cycle. It is now time to publish our next scheduled update. I am listing, immediately below, the documents that will be added to the Upcoming section of our website (<https://www.ochcahealthinfo.com/ems>) for October 1, 2022.

OCTOBER 1, 2022 EMS UPDATES

The OCEMS Agency is in the process of creating just one set of policies, standing orders, and procedures for paramedics working in Orange County. Effective October 1, 2022, we will be incorporating language from the IFT-ALS standing orders into existing policies and standing orders, with plans to sunset the IFT-ALS specific documents on April 1, 2023. We will keep the old IFT-ALS documents on the books for the usual 6-month period while everyone learns to use the updated information. But they will completely disappear on April 1, 2023.

There will be essentially no change to what both 911 and IFT-ALS paramedics do. It is just that the information describing IFT-ALS protocols will be moved to other locations. There are 2 small changes that will be new affecting paramedic practice. IFT-ALS paramedics will have the option to make BH contact, and the same option will be extended to 911 paramedics. Previously, IFT-ALS paramedics could not make base hospital contact and 911 paramedics engaged in an inter-facility transfer were required to make BH contact. Now both groups of paramedics will have the option of making BH contact unless this is required by other OCEMS protocols. Regarding making BH contact for IFT-ALS paramedics, they will have 6 months to obtain training for this practice (October 1, 2022 – April 1, 2023). That should be enough time

for all IFT-ALS providers to acquire this skill. The second change is that 911 paramedics will have more flexibility in managing hospice patients in the field.

The policies that required updating to make the entire transition possible are included below. They will all be listed as updated Upcoming documents for October 1.

To make things easier, I will list here how to crosswalk from the old IFT-ALS standing orders to the updated existing policies and standing orders:

- 1) Delete IFT-SO-1: Replace with the Upcoming SO-ALS-General that is already posted and the following current standing orders that are already in effect: SO-C-15, SO-M-15, SO-M-35, SO-P-20, SO-P-25, SO-P-95, SO-T-10, SO-T-15, and SO-T-20
- 2) Delete IFT-SO-2a: Replace with current SO-C-10 and SO-P-40
Delete IFT-SO-2b: Replace with current SO-C- 20 thru 40, Upcoming SO-P-45
- 3) Delete IFT-SO-3: Replace with updated 310.20 (will be listed as Upcoming for October 1).
- 4) Delete IFT-SO-4: Replace with updated 310.10 (will be listed as Upcoming for October 1).

POLICIES

- 310.10 Determination of 911 Dispatched Patient Transport to an Appropriate Facility - Hospice: More specific language was added regarding hospice patients to better clarify how to care for them on-scene. Besides just some wordsmithing, the added language addresses hospice care, assisted suicide, and leaving certain hospice patients on-scene. Originally, this information was contained in IFT-SO-4. But since this standing order will sunset on April 1, 2023, and it applies equally to 911 and IFT-ALS paramedics, this information was added here.
- 310.20 Service Provider Transport and Dispatch Criteria for Interfacility Transfers between Acute Care Hospitals: Added BLS and ALS interfacility transfer dispatch criteria from IFT-SO-3 to 310.20 and changed the policy name slightly to reflect this addition, given the standing order will sunset April 1, 2023. Also, Policy 310.20 is where IFT-ALS and 911 paramedics are both given the option to make BHC for IFTs unless required by OCEMS policy. Currently it is required for 911 paramedics and this requirement will be removed. Lastly, I have added language prohibiting transfer of ICU in-patients using IFT-ALS paramedics.
- 315.00 OCEMS EMT Scope of Practice: EMT-OCEMS Accredited: Minor changes updating the policy to bring it in line with California State regulations (adding "pain level, skin signs" to section III.3. on the first page; adding pacemaker, AICD, and surgical drainage device to III.2. at the bottom of page 2).

- 325.00 Advanced Life Support (ALS) Provider Unit Minimum Inventory: Some 911 providers have requested authorization to use Impedance Threshold Devices. While there is no strong evidence that these work, there is also no evidence they are harmful. As such, these will be added as optional approved supplies and will be approved after submission of training and procedure documentation by the requesting provider.

PROCEDURES

- PR-135 Supraglottic Airway Device Placement – Adult/Adolescent: In the CONTRAINDICATIONS section, changed the limitation of trismus such that it remains a contraindication if still present after administration of 5 mg of versed. This is in response to expanding SO-M-80 to include the use of versed for a clenched jaw when trying to place an LMA.

STANDING ORDERS

- SO-M-80 Sedation for Endotracheal or LMA Intubation - Adult/Adolescent: Expanded this standing order to include sedation with versed for placement of an LMA for a clenched jaw. Emphasized that versed could not be used to suppress a gag reflex from an LMA.
- SO-FR-01 First Responder: Naloxone Administration: Under item #4 in the sections Standing Order (poor breathing) and Standing Order (not breathing), there is no limit to the number of naloxone treatments that can be given if the patient is not responding. Now it says to stop delivering naloxone intranasally after 12 mg if the patient remains unresponsive.

Lastly, we want to clarify some confusion regarding 2 BLS standing orders currently listed on the website. These are listed as SO-AMA and SO-REL. As it turns out, these are actually older standing orders from the ALS section that were inadvertently placed in the BLS section during the 2 website reconfigurations that have occurred over the last 2 years. As the AMA process is not generally considered part of the EMT scope of practice, we will remove the standing order listed as SO-AMA from the BLS section of the website. We will update the SO-REL policy to reflect the EMT scope of practice, re-label it as SO-B-REL, and make it consistent with the ALS version posted in the ALS section of the website.

- SO-B-REL Evaluation without Treatment or EMS Transport (Release in Field): This is a new policy written to address when either a 911 BLS unit is dispatched or a non-911 response occurs with just EMTs, and they encounter an individual without a medical or psychiatric condition who does not require any intervention and who refuses treatment or transport.



DETERMINATION OF 911 DISPATCHED PATIENT TRANSPORT TO AN APPROPRIATE FACILITY

I. AUTHORITY:

California Health and Safety Code, Division 2.5, 1797.220; 1798 (a), (b)

II. APPLICATION:

This policy describes considerations that include requests by patients, parents of minors, and caretakers for determination of an appropriate receiving facility for 911 dispatch patients transported by an Orange County EMS (OCEMS) basic life support (BLS) or advanced life support (ALS) unit. Included in this policy are 911 dispatch patient transport determinations for the special circumstances of a 5150 Hold and 911/IFT-ALS dispatch transport determinations for hospice care patients.

III. DEFINITIONS:

5150 Hold means a patient is legally detained as authorized by the California Welfare and Institutions Code Section 5150.

ERC means an Emergency Receiving Center approved by OCEMS.

Diversion means formal notification of the EMS system through ReddiNet® by an ERC that it is not physically or medically safe for that facility to accept further patients.

Hospice care patient means a patient who is terminally ill without possibility of cure who is enrolled in a certified hospice-palliative care program.

Specialty Center means a facility that provides a specialized medical service as defined in OCEMS Policy # 240.30.

Transported patient means a patient transported by BLS or ALS ambulance.

ALS Escorted patient means a patient transported and accompanied by a paramedic.

IV. CRITERIA:

- A. A BLS or ALS transported patient not expressing a facility preference shall be transported from the scene of the incident to the closest (within the shortest transport time) appropriate hospital showing open on ReddiNet®
- B. ALS or BLS crews will provide the receiving hospital staff with a verbal report and completed prehospital care report per OCEMS policy 300.10. The PCR shall be completed and posted electronically or provided in paper form prior to leaving the ERC or specialty center.
- C. A physician at the scene may assume full responsibility and must accompany the patient to the receiving hospital per the "Physician at Scene" policy (reference OCEMS P/P 310.15).

V. PATIENT, PARENT OF MINOR, OR CAREGIVER REQUESTS:

ERC destination preference expressed by a patient or a patient's legal guardian or other persons lawfully authorized to make health care decisions for the patient shall be honored **unless**:



DETERMINATION OF 911 DISPATCHED PATIENT TRANSPORT TO AN APPROPRIATE FACILITY

- A. *Such request is not medically in the best interest of the patient as determined by OCEMS Standing Order or the Base Hospital; or*
- B. *The preferred facility is beyond a reasonable transport time (estimated 20 minutes) from the incident scene; or*
- C. *The preferred facility has declared it is on Emergency Department diversion status (by ReddiNet®). This exception to preferred transport destination does not apply when a patient is scheduled to bypass the Emergency Department for direct admission to an available in-patient bed or diagnostic site (e.g. CT Scan, MRI, GI laboratory).*

Specialty hospital destination for a trauma, cardiovascular center, stroke-neurology receiving center, burn, and replant center is determined by an OCEMS Base Hospital.

VI. SPECIAL CIRCUMSTANCE SITUATIONS:

A. LAW ENFORCEMENT OR MENTAL HEALTH PROVIDER 5150 HOLD:

A patient being detained under a 5150 hold shall be transported to the nearest ERC **unless:**

- 1. Such transport is not medically in the best interest of the patient as determined by OCEMS Standing Order or the Base Hospital; or
- 2. The preferred facility has declared it is on Emergency Department Saturation diversion status (by ReddiNet®). This exception to preferred transport destination does not apply when a patient is scheduled to bypass the Emergency Department for direct admission to an available in-patient bed or diagnostic site (e.g. CT Scan, MRI, GI laboratory).

Specialty center transport destination to a trauma, cardiovascular center, stroke-neurology receiving center, burn, and replant center is determined by an OCEMS Base Hospital.

B. HOSPICE CARE PATIENT:

This section applies when an Orange County 911 or IFT-ALS Provider is dispatched to a patient who is enrolled in a certified hospice/palliative care program.

A hospice care patient can be treated to improve comfort on scene (example: placed on oxygen for shortness of breath, treated for hypoglycemia, or provided pain relief) and referred to the patient hospice program nurse for further care and evaluation without ambulance transport from the scene.

- 1. Upon arrival, review the patient's hospice/palliative care documentation with caregiver/patient to confirm enrollment in the program. Obtain contact information for the hospice care provider (usually a nurse).
- 2. Upon confirmation that a patient is in hospice care, EMS personnel should request the patient's POLST form or other advanced directive (refer to OCEMS Policy # 330.51) and honor any patient requests provided on the form.
- 3. If the patient has administered an aid-in-dying drug as defined in the CALIFORNIA END OF LIFE ACT OPTION, confirm the final attestation and refer to OCEMS Policy #330.51.



DETERMINATION OF 911 DISPATCHED PATIENT TRANSPORT TO AN APPROPRIATE FACILITY

4. EMS personnel (BLS or ALS) should contact by telephone or in-person the patient hospice nurse and provide a report of the patient's condition and any treatment provided. Unless otherwise requested by the patient or caregiver, the patient may be evaluated and treated on scene with care transferred to the hospice provider upon their arrival. If the patient is stabilized, care may be transferred to the hospice provider by telephone and the scene cleared.
5. If the hospice nurse is present on-scene, EMS personnel can still provide treatment of the patient, but must remain within the appropriate Orange County Scope of Practice.
6. If transport from the scene is requested by the patient or caretaker, the patient should immediately be transported to an appropriate ERC. The request should be documented as was stated by the patient or caregiver on the PCR.
7. If transport from the scene is not requested by the patient or caretaker, the patient may be left on scene without signing an AMA. The refusal of transport should be documented as stated by the patient or caregiver on the PCR.
8. If possible, include the hospice provider's information and recommendations in the PCR narrative section, and also include a copy (photograph) of the POLST, other advanced directive, or final attestation.

Approved:

Carl H. Schultz, MD
OCEMS Medical Director

Tammi McConnell, MSN, RN
OCEMS Administrator

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Effective Date: 10/01/2022



SERVICE PROVIDER TRANSPORT AND DISPATCH CRITERIA FOR INTERFACILITY TRANSFERS BETWEEN ACUTE CARE HOSPITALS



I. AUTHORITY: *Health and Safety Code, Division 2.5, Sections 1797.220, 1798, 1798.170, and 1798.172. U.S. Sec 1867.[42 U.S.C. 1395dd], DHHS/CMS 42 CFR Part 489; Calif H&S Code-HSC Sec 1317.1, 1317.2*

II. APPLICATION:

Guidelines for transport of a patient with an emergency medical condition from an emergency receiving center (ERC) to a different ERC or to a higher level of care (specialty) center.

III. DEFINITIONS:

“BLS Ambulance” means ambulance staffed with certified emergency medical technicians (EMTs) (refer to Attachment A).

“Emergency Medical Condition” means a medical-surgical condition manifesting itself by acute symptoms or sufficient severity such that the absence of immediate medical attention could be expected to result in the following:

- (1) Placing the person’s health in jeopardy
- (2) Impairment to bodily functions
- (3) Dysfunction of any bodily organ or part

“EMTALA” means the U.S. Department of Health and Human Services Emergency Medical Treatment and Active Labor Act (*DHHS/CMS 42 CFR Part 489*).

“ERC” means an acute care hospital designated by Orange County EMS for receiving 911-dispatch response patients.

“Health and Safety Code” (HSC) means California Health and Safety Law.

“Interfacility Transfer” means ambulance transport of a patient between one health care facility and another. This policy is specific for transport of patients between acute care hospitals.

“IFT-ALS” (Interfacility Transport-Advanced Life Support) means an Orange County licensed ambulance staffed with OCEMS accredited paramedics and EMTs, designated by OCEMS to perform advanced life support (paramedic) level interfacility transports (refer to Attachment A).

“Scope of Practice” means the California defined medical capabilities of an EMS provider category (EMT or paramedic). Refer to Attachment A.

“SCT Transport” means “Specialty Care Transport” as defined by the Centers for Medicare and Medicaid Services (CMS) which is an ambulance staffed with a Registered Nurse and other staff as required (such as Respiratory Therapist) that transport a critically ill patient requiring management above the scope of practice of a Paramedic (refer to Attachment A).

IV. SERVICE PROVIDER TRANSPORT GUIDELINES:

- A. Clarification of Interfacility transport and acute care receiving centers on diversion status:
Per OCEMS diversion policy (OCEMS Policy # 310.96), no patient is to be transported to an Emergency Department that is on formal diversion status (“diversion” entered into the ReddiNet system).



SERVICE PROVIDER TRANSPORT AND DISPATCH CRITERIA FOR INTERFACILITY TRANSFERS BETWEEN ACUTE CARE HOSPITALS



1. Patients in the direct admission category may be transported to a hospital when the Emergency Department is on diversion status to be directly admitted to an inpatient bed or receiving center treatment area other than the emergency department.
 2. If a receiving center enters into diversion status during the active transport of a patient to that center, the patient will continue to be transported to that center and cannot be re-routed or turned away upon arrival.
 3. If Interfacility transport is requested to an Emergency Department on diversion status, the physician or health organization ordering the transport should be contacted through the ambulance dispatch office to determine an appropriate alternate destination.
 4. Base hospital contact by 911 and IFT-ALS Units transporting interfacility transfers is permitted and is optional (unless required by OCEMS protocols), indicated by the needs of the patient and paramedic judgment.
- B. Any patient transfer between an ERC and specialty center or other ERC must be in compliance with EMTALA Rules and Regulations and California HSC Law.
- C. The following transport options are available in Orange County for transfer of a patient with an emergency medical condition, as determined by the transferring (not receiving) physician and in compliance with federal EMTALA Rules and Regulations and California HSC (also see Attachment A for Scope of Practice for EMTs and paramedics):
1. BLS ambulance staffed by Orange County certified EMT (Attachment A) ambulance attendants.
 2. IFT-ALS paramedic unit staffed with Orange County accredited paramedic(s) (Attachment A).
 - Not to be used for ICU to ICU transfers.
 3. 911 transfers utilizing fire department based or private emergency response paramedic (Attachment A) units (fire engine and/or ambulance).
 - Reserved for 911 fire department based or 911 private paramedic transfers for trauma, cardiovascular, and stroke patients presenting to an emergency department (not hospital in-patients) who require immediate specialty center intervention. For ED patients needing emergent transport not going to a specialty care center, can use 911 paramedics for ED transfers if IFT-ALS paramedics not available
 - Transferring physician must have arranged accepting physician at receiving facility (per California HSC Law).
 4. Specialty Care Transport (SCT) ambulance staffed with a Registered Nurse and other staff as appropriate for patient condition.
 5. Licensed air ambulance staffed by paramedic(s) and/or flight Registered Nurse.
 6. BLS EMT staffed ambulance, with Respiratory Therapist or Registered Nurse and/or appropriate support personnel from the transferring facility.
 - Registered nurses accompanying patients (usually for medications or devices required during transport that are out of the scope of practice for an EMT or paramedic) are



SERVICE PROVIDER TRANSPORT AND DISPATCH CRITERIA FOR INTERFACILITY TRANSFERS BETWEEN ACUTE CARE HOSPITALS



not authorized to issue treatment orders to EMTs or paramedics (who, in this circumstance, are under OCEMS standing orders or base contact if available).

7. Pediatric SCT transport, staffed by a Registered Critical Care Nurse and/or Pediatric physician.
- D. Copies of transfer documents, x-rays and laboratory data shall be available for transfer with the patient when the transport unit arrives or may be electronically sent or delivered by courier to the receiving ERC or specialty center to avoid transport delay.

V. DISPATCH CRITERIA

IFT-BLS Dispatch Criteria: Patients transported by Interfacility Transport Basic Life Support (IFT-BLS) must not require services that are beyond the "OCEMS EMT Scope of Practice" (OCEMS Policy # 315.00). The IFT-BLS service transport level is suitable if deemed the appropriate level of transport by a physician or attending physician-designated allied health professional and falls within the parameters of action included in the EMT Scope of Practice Policy #315.00.

IFT-ALS Dispatch Criteria: The IFT-ALS service transport level is appropriate if deemed the appropriate level of transport by a physician or attending physician-designated allied health professional and falls within the paramedic scope of practice. A currently accredited OCEMS IFT-ALS or 911 Provider may be dispatched to transport patients with any of the following advanced life support situations:

- A. Acute stroke, cardiac, burn, replantation, or trauma from an ERC to a specialty center
- B. The following intravenous solutions infused by an external pump at a flow rate predetermined by the transferring physician if the paramedic is trained to manage IV pumps:
 - Amiodarone*
 - Benzodiazepines [including midazolam (Versed), lorazepam (Ativan), diazepam (Valium)]
 - Dopamine
 - Fentanyl
 - Heparin*
 - Insulin
 - Lidocaine
 - Nitroglycerin*
 - Normal saline, Ringers Lactate, dextrose solutions, solutions with KCL (potassium chloride) at no more than 20 meq/liter.
 - Magnesium Sulfate
 - Morphine
 - Sodium Bicarbonate
 - Tissue Plasminogen Activator (tPA)*
 - Total Parenteral Nutrition (TPN) / Intravenous Lipid Emulsions

* Orange County EMS Agency Optional Scope

Pump-trained paramedics may discontinue any of these infusions if the patient decompensates during transport.

- C. Requiring cardiac monitoring with approval for use of any appropriate Cardiac Standing Order (OCEMS # SO-C-10, SO-C-20 through 40, SO-P-040 and 045).
- D. Clinically significant hypoglycemia that may require blood glucose monitoring with potential glucose



**SERVICE PROVIDER TRANSPORT AND DISPATCH
CRITERIA FOR INTERFACILITY TRANSFERS BETWEEN
ACUTE CARE HOSPITALS**



administration.

- E. Respiratory distress requiring albuterol administration and/or use of CPAP while in route.
- F. Maintenance of circulatory status with intravenous fluid infusion, push-dose epinephrine, or dopamine infusion at a constant rate.
- G. Endotracheal intubation requiring sedation and neuromuscular blocking agents (paralytic medication) to maintain stability.
- H. Co-transport with respiratory therapist or nurse of intubated/trached ventilator-dependent patient.
- I. Use of transport ventilator provided that paramedic meets OCEMS ventilator competencies (PR-240).
- J. Use of external cardiac pacing to maintain circulation.

Transfer of IFT-ALS Dispatch Requests to the 911 System

The following types of dispatch calls not originating from an acute care hospital are to be referred to the OCEMS 911 system:

- Patients for whom a 12-lead ECG is performed on site by the caller and is read as showing “acute MI” or “suspected MI”.
- Mass Casualty Incidents (MCI) or any incident with more than one patient at a time at a single scene.
- Patients with blunt or penetrating injury who meet Trauma Triage Criteria (See OCEMS Policy #310.31).
- Burn patients, defined as equal to or greater than 10% body-surface area second degree burn, any third degree burn, any electrical burn, and any burn of a hand, foot, groin area, or eye.
- Amputation injuries, excluding finger tips or toe tips.
- Automatic Internal Defibrillator discharging twice or more times in less than fifteen minutes.
- Triage decisions in which the IFT Dispatcher believes activation of the 911 system is appropriate.
- Abdominal and/or back pain in patient with known or suspected abdominal aortic aneurysm.

EXCEPTION: After IFT-paramedic arrival at the transferring facility, if a patient is suspected of meeting cardiovascular, stroke-neurology, burn, replantation, or trauma center criteria, the dispatch center should be notified and the patient immediately transported to the nearest appropriate specialty center without calling 911.

Approved:

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Tammi McConnell, MSN, RN
OCEMS Administrator

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OCEMS EMT SCOPE OF PRACTICE: EMT-OCEMS ACCREDITED

I. AUTHORITY:

Health and Safety Code, Sections 1797.107, 1797.109, 1797.160, 1797.170 and California Code of Regulations, Title 22, Division 9, § 100061, 100063 and 100064.

II. APPLICATION:

To define the scope of practice of an OCEMS Accredited Emergency Medical Technician (EMT) operating in Orange County.

III. POLICY:

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

1. Evaluate the ill and injured by means of a primary and secondary exam (OCEMS Procedure # B-O1, B-O2).
2. Render basic life support, rescue and emergency medical care to patients.
3. Obtain and monitor diagnostic signs to include, but not limited to, temperature, blood pressure, pulse and respiration rates, pulse oximetry, level of consciousness, pain level, skin signs, and pupil status.
4. Perform cardiopulmonary resuscitation, which may include the placement and use of a mechanical external chest compression device in the management of basic cardiopulmonary resuscitation.
5. Administer oxygen.
6. Use the following adjunctive airway and breathing aids:
 - a. Oropharyngeal airway
 - b. Nasopharyngeal airway
 - c. Suction devices
 - d. Basic oxygen delivery devices for supplemental oxygen therapy including, but not limited to, humidifiers, partial rebreathers, and venturi masks; and
 - e. Manual and mechanical ventilating devices designed for prehospital use including continuous positive airway pressure.
7. Use stretchers and spinal motion restriction or immobilization devices including: long boards; short boards; KED boards; pediatric immobilization devices; and cardboard, air, or vacuum splints.
8. Provide initial prehospital emergency care to patients, including, but not limited to:
 - a. Placement of FDA approved tourniquets for control of external extremity bleeding
 - b. Use of hemostatic dressings for control of external hemorrhage from a list approved by the Authority
 - c. Extremity splinting, including traction splinting
 - d. Administer oral glucose or sugar solutions.
 - e. Extricate entrapped persons.
 - f. Perform field triage based on OCEMS policies and procedures including MCI policy #900.00.
 - g. Transport patients based on OCEMS Policies, & Procedures, and Treatment Guidelines.



OCEMS EMT SCOPE OF PRACTICE: EMT-OCEMS ACCREDITED

- h. Apply mechanical patient restraints.
- i. Set up for ALS procedures, under the direction of an Advanced EMT or Paramedic.
- j. Perform automated external defibrillation.
- k. Assist patients with the administration of physician-prescribed devices including, but not limited to, patient-operated medication pumps, sublingual nitroglycerin, and self-administered emergency medications, including epinephrine devices. Examples of approved activities include:
 - i. Monitor and maintain intravenous infusions of the following medications when set at a preset rate of flow by a nurse or physician:
 - a) Total parenteral nutrition (TPN)
 - b) Folic Acid
 - c) Thiamine
 - d) Multivitamins
 - e) Antibiotic, antifungal, and antiviral agents
 - ii. Transport patients with subcutaneous or intravenous implanted or external patient-operated infusion pumps that are infusing at a preset rate the following:
 - a) Insulin
 - b) Morphine
 - c) Total parenteral nutrition (TPN)
 - iii. Transport patients with skin patches including Nitrobid, nitroglycerine patches and paste, fentanyl patches, or clonidine patches previously placed on the patient.
 - iv. If available and indicated, *assist* a patient with their own physician prescribed medications:
 - a) Nitroglycerine aerosol or tablets
 - b) Albuterol and/or ipratropium (Atrovent®) inhalation - metered dose inhaler or nebulizer
 - c) Epinephrine auto-injector
 - d) Aspirin

In addition to the activities authorized by the above subdivision of this policy, the medical director of the LEMSA may also establish policies and procedures to allow a certified EMT or a supervised EMT student who is part of the organized EMS system and in the prehospital setting and/or during interfacility transport to:

1. Monitor intravenous lines delivering glucose solutions or isotonic balanced salt solutions, including Ringer's Lactate for volume replacement. Monitor, maintain, and adjust if necessary in order to maintain, a preset rate of flow and turn off the flow of intravenous fluid;
2. Transfer of a patient who is deemed appropriate for Basic Life Support transfer by the transferring physician, who has any of the following:
 - a. Nasogastric tubes
 - b. Gastrostomy tubes
 - c. Heparin locks
 - d. Tracheostomy tubes
 - e. Dialysis shunts (both subcutaneous and external)
 - f. Long-term established central venous lines (e.g. PIC lines)
 - g. Cardiac pacemaker (implanted)
 - h. Automatic internal defibrillator (implanted)
 - i. Colostomy bags
 - j. Urostomy bags
 - k. Foley catheters
 - l. Enteric feeding tubes
 - m. Continuous flow oxygen
 - n. Thoracostomy (chest) tube(s) clamped or attached to closed drainage system
 - o. Surgical drain suction devices with preset parameters



OCEMS EMT SCOPE OF PRACTICE: EMT-OCEMS ACCREDITED


- ❖ **All arterial lines are excluded from EMT transport.**
- ❖ **Central vascular lines used for patient monitoring or infusing intravenous fluid and medications are excluded from EMT transport.**


3. Administer naloxone or other opioid antagonist by intranasal and/or intramuscular routes for suspected narcotic overdose.
4. Administer epinephrine by auto-injector for suspected anaphylaxis and/or severe asthma.
5. Perform finger stick blood glucose determination.
6. Assist ALS providers in placement of 12-lead ECG leads.
7. Assist ALS providers during placement of advanced airway devices.
8. Place pulse oximetry probes and record oxygen saturation results. If patient is short of breath and pulse oximetry reading is less than 95%, administer oxygen 6 liters/minute by nasal cannula or 10 liters/minute by mask.
9. Administer atropine and 2-PAM by means of Duodote® or Mark-1 kit to self or to others under ALS direction.
10. Withhold resuscitation of a patient meeting declared dead criteria as identified in OCEMS policy 330.50 and honor a DNR request, Advanced Healthcare Directive or California POLST form as defined by OCEMS policy 350.51.

The scope of practice of an EMT shall not exceed those activities authorized in this policy, Section 100064, and Section 100064.1.

During a mutual aid response into another jurisdiction, an EMT may utilize the scope of practice for which s/he is trained and authorized according to the policies and procedures established by the LEMSA within the jurisdiction where the EMT is employed as part of an organized EMS system.

Approved:


Carl H. Schultz, MD
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Tammi McConnell, MSN, RN
OCEMS Administrator

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ADVANCED LIFE SUPPORT (ALS) PROVIDER UNIT MINIMUM INVENTORY

I. AUTHORITY: California Health and Safety Code Division 2.5, 1797.200. California Code, Title 22, Div 9, sec 100170.a.2

II. APPLICATION:

This policy describes the standard minimum drug and equipment inventory for an Advanced Life Support (ALS) unit in Orange County.

Title 8 CCR Section 5193, Bloodborne Pathogens, requires sharps injury prevention/needleless products to be utilized when appropriate.

All equipment and supplies must be latex free.

III. DEFINITIONS:

“**Optional**” means equipment, supplies, or pharmaceuticals that are not required in the minimum inventory, but which ALS providers are authorized to include in unit inventories.

“**or**” means either equipment, supply, or pharmaceutical is appropriate and effective. It does not imply that both must be stocked in inventory, rather either or both can be stocked.

IV. CRITERIA:

The number or amount of each item listed is at the discretion of the ALS provider based on a specific unit's needs for its service area. Equipment, supplies, and drug inventory that is not part of the authorized Orange County ALS Scope of Practice is not permitted without formal approval of the California EMS Authority upon request of the Orange County EMS Agency. Inventory for special ALS units (tactical, fire line, search and rescue) are defined in other OCEMS policies.

V. EQUIPMENT:

BAG-VALVE DEVICE WITH OXYGEN INLET AND RESERVOIR: Adult and Pediatric

BANDAGE SCISSORS

BACKBOARD: Adult, X-ray transparent. Minimum of three straps

AUTOMATIC CHEST
COMPRESSION DEVICE:
(Refer to Note #1 below) U.S. Food and Drug Administration approved with continuous hands free chest compression, portable, and battery driven.
Compression constriction band design or chest encircling band with plunger design.
Pass through defibrillator capable or design that allows for cardiac defibrillation with device in place.

LARYNGOSCOPE: Blades: Adult - curved/straight #3 and #4 recommended
Pediatric - straight #1 and #2 (for direct laryngoscopy foreign body removal)

MAGILL FORCEPS: Adult and Pediatric; closed tip



**ADVANCED LIFE SUPPORT (ALS) PROVIDER UNIT
MINIMUM INVENTORY**

MONITOR / DEFIBRILLATOR:	Biphasic, adjustable output, defibrillator with oscilloscope (FDA approved) Defibrillator-pacer pads with functional cables and connectors ECG pads with functional cables and connectors Synchronizer: designed to deliver a synchronized defibrillating pulse, timed to avoid the T-wave of the cardiac cycle. 12-lead ECG capability with internal interpretation protocol to identify an acute myocardial infarction and ability for transmission to CVRC. Transcutaneous pacing module End-tidal CO ₂ monitor with either single or continuous wave-form reading output Recorder: Must be able to produce a paper print out of high quality. Batteries/Charge Units as Main Power Source
SPHYGMOMANOMETER:	Assorted cuff sizes, including adult and pediatric
STETHOSCOPE:	Disposable or non-disposable diaphragm type
SUCTION UNIT:	Portable, with disposable canister
TOURNIQUET:	Manufactured, hemostatic, FDA and California EMS Authority approved
TRACTION SPLINTS:	Lightweight, portable: adult, pediatric (BARRIER PROTECTION ACCEPTABLE)

NOTE #1: Automatic Chest Compression Device:

Deployed as determined by ALS provider to be immediately available to maintain continuation of CPR when patient is physically moved and chest compression by hand will be interrupted [such as loading onto gurney (stretcher) or during transport and off-loading].

OPTIONAL APPROVED EQUIPMENT:

AUTOMATIC TRANSPORT VENTILATOR:	Pressure or volume cycled with adjustable tidal volume and rate, audible and visible alarms and alerts with digital monitor screen. Battery powered (not pressure cycled from oxygen cylinder). Must be FDA approved.
BREAKAWAY FLAT:	Vertically stable for full spinal immobilization
BACKBOARDS:	Pediatric
EXTRICATION SPLINT:	Horizontal flexible, vertical rigidity; stabilizes head, neck and back
END-TIDAL CO₂ NASAL/BVM:	End-tidal CO ₂ nasal cannula and adapter for BVM.
RESUSCITATOR:	40 L/min maximum delivery capability, portable, lightweight, minimum 6' length hose to head, constant flow valve 0-15 L/min demand valve head
SLIDING (TRANSFER) FLAT:	Required for IFT- ALS units.
INFUSION PUMP:	Adjustable rate for Intravenous medication delivery at volume (milliliters) per minute or hour; battery operated with digital delivery readout and visual/audible malfunction alarms. Must be FDA approved. Required for IFT- ALS units.



ADVANCED LIFE SUPPORT (ALS) PROVIDER UNIT MINIMUM INVENTORY

VIDEO LARYNGOSCOPE: Battery powered portable. (internal memory card optional).

VI. SUPPLIES:

Airway adapters: standard 15mm ID X 22mm OD both ends

Airway, nasopharyngeal: 4.5mm - 9.0mm or adult and pediatric sizes

Airway, oral: Adult and pediatric sizes

Alcohol wipes

Arm board: short, with rigid insert, padded (BARRIER PROTECTION ACCEPTABLE)

Arm board: long, with rigid insert, padded (BARRIER PROTECTION ACCEPTABLE)

Atomizer for nasal administration of medications

Bags (for trash)

Basin, emesis (BARRIER PROTECTION ACCEPTABLE)

Blanket, disposable

Burn dressing: Clean sheet or commercial burn covering sheet

Cannulas, nasal oxygen: Adult and pediatric

Catheter, suction: sizes #6, #10, #14

Cold packs, chemical (BARRIER PROTECTION ACCEPTABLE)

Combitubes® or equivalent: Regular and Small Adult

AND/OR

King® Airway or equivalent: Sizes 4, 5 (size 3 optional)

AND/OR

Supraglottic Airway (Laryngeal Mask Airway): Sizes 4, 5 (size 3 optional)

Dressings: Kerlix or equivalent

Gauze 4 in. x 4 in. /2 in. X 2 in.

OP Site® or equivalent, approx. 2" x 3" (for IV sites)

ET tubes: soft cuff, assorted adult sizes with stylets

Flexible intubation guide

Gloves: Assorted sizes, including clean and sterile packaged

Glucometer with non-expired test strips and lancets

Intraosseous (IO) needles with or without introducer device

IV catheters, over needle type: assorted sizes and saline lock chambers (fittings)

IV tubing: Macro drip, with flow rate regulator and two medication injection sites and a "Y" adapter.

Masks, disposable ventilation: sizes Neonate, infant, and child

Mask, oxygen non-rebreather: adult and pediatric

Nebulizer, Acorn type, with mouth piece and mask attachments

Needle-ARS type for chest decompression OR Needle chest decompression kit

Needles for IM injection, assorted sizes

Needle (sharps) disposal unit

OB kit with bulb syringe



**ADVANCED LIFE SUPPORT (ALS) PROVIDER UNIT
MINIMUM INVENTORY**

Pediatric length-based resuscitation tape
Personal protective equipment (OSHA compliant masks, gowns, gloves, eye shields)
Pulse oximetry device, may be incorporated within defibrillator

Razors, disposable
Restraints: Soft

Solution, sterile; NS 1000 ml (for irrigation)
Suction, tonsil tip; semi rigid or rigid, large bore (Yankauer suction tip)
Syringes, assorted sizes

Tape (paper, plastic hypoallergenic): assorted sizes and types
Tourniquets, for facilitating IV placement

Petroleum (such as Vaseline®) gauze

Underpads (such as CHUX®)/protective pads)

OPTIONAL APPROVED SUPPLIES:

Band-Aids

CO₂ detector – End tidal CO₂ detector attachable to endotracheal tube (colorimetric)

Dressings: Abdominal gauze
Eye pads
Hemostatic gauze

ET tube holders

Impedance Threshold Device

Infant Transport Mattress, heated, consistent temperature not to exceed 42 degrees centigrade
IV tubing: Micro drip, 60 drops/mL

One-way 'flutter' valve
Penlight/flashlight

Restraints: Hard restraints padded and quick release per Policy 330.57.

Solution, sterile; NS 1000 mL (for irrigation)

Thermometer; temporal, otic, or oral; electronic with disposable patient contact probes
Tubing, oxygen connecting

**ADVANCED LIFE SUPPORT (ALS) PROVIDER UNIT
MINIMUM INVENTORY****VII. PHARMACEUTICAL INVENTORY:**

<u>PHARMACEUTICAL</u>	<u>PREPARATION</u>
Adenosine	12 mg/ 4mL vial or prefilled syringe or 6 mg/2 mL vial or prefilled syringe
Albuterol (for nebulizer inhalation)	3.0 mL (2.5 mg) of a 0.083% solution
Amiodarone	50 mg/mL, vial or prefilled syringe
Aspirin, chewable	81 mg tablet individually packaged or 325 mg tablet individually packaged
Atropine	1 mg ampule, vial or prefilled syringe
Dextrose 10%	250 mL IV bag, 10% solution
Diphenhydramine (Benadryl™)	50 mg/mL, 1 mL single dose vial or carpject
Epinephrine 0.1 mg/mL	1 mg/10 mL prefilled syringe
Epinephrine 1.0 mg/mL	1 mg/1 mL ampule, 1 mg/1 mL vial, or 30 mL vial
Glucose, oral solutions	Various formulations
Glucagon	1 mg ampule with diluent
Lidocaine 2% solution	100 mg / 5 mL, 5 mL prefilled syringe
Midazolam	5 mg/1 mL vial or carpject
Morphine sulfate (may carry or replace with optional fentanyl)	10 mg/10 mL, prefilled syringe or 4 mg/ 1 mL, carpject; or 10 mg/1 mL, 1 mL vial
Naloxone (Narcan®)	Various IV/IM formulations ampules, vials, prefilled syringe, or carpjects; or 4mg/0.1 mL preloaded nasal spray
Nitroglycerin	0.4 mg/metered dose spray, 0.4 mg/tabs or 0.4 mg powder (single dose packets)
Normal saline for nebulized inhalation	10 mL prefilled syringe or vial without preservative
Normal saline	1000 mL or 500 mL or 250 mL sterile IV bag
Ondansetron (Zofran®)	4 mg oral dissolving tablet (ODT) or 4 mg/2 mL prefilled syringe or 4 mg/2 mL single dose vial
Sodium bicarbonate	1mEq/mL, 50 mL prefilled syringe (8.4%) or 44.6 mEq/50 mL prefilled syringe (7.5%)



**ADVANCED LIFE SUPPORT (ALS) PROVIDER UNIT
MINIMUM INVENTORY**

OPTIONAL APPROVED PHARMACEUTICALS

PHARMACEUTICAL

PREPARATION

Albuterol metered dose inhaler	18 gram canister (200 inhalation doses) (SINGLE PATIENT USE ONLY)
Atropine	0.4 mg/mL, 20 mL vial
Duodote Autoinjector	Prepackaged kit containing Atropine and 2-PAM
Epi Pen Auto Injector	0.3 mg Auto injector
Epi Pen Auto Injector Junior	0.15 mg Auto injector
Fentanyl (may carry in addition to morphine or as primary opioid in place of morphine)	100 mcg/2 mL vial or carpuject
Hydroxocobalamin	5 gm in 200 mL 0.9% normal saline, 25 mg/mL

Approved:

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Effective Date: 4/01/2020; 07/07/2021; 10/01/2022



Supraglottic Airway Device Placement – Adult/Adolescent

INDICATIONS:

A supraglottic airway (SGA) is indicated for securing an airway during resuscitation of an unconscious patient. An SGA is an advanced airway technique to assist with oxygenation and ventilation.

An SGA may be placed by an Orange County Accredited Paramedic in the following situations:

- Primary advanced airway for an unconscious adult/adolescent patient lacking a gag reflex in need of airway protection and ventilation.
- Advanced airway if intubation is anticipated to be difficult and rapid airway control is necessary.
- Advanced airway in adult cardiac arrest when attempts at intubation are likely to interrupt continuous chest compressions.
- Advanced airway when intubation has been unsuccessful.

CONTRAINDICATIONS:

- Intact gag reflex
- Known caustic substance ingestion
- Unresolved upper airway obstruction
- Trismus or limited ability to open the mouth such that the device cannot be inserted after sedation with 5 mg of midazolam IV, IO, or IM
- Oral trauma with bleeding, swelling or unstable jaw fracture
- Distorted anatomy that prohibits proper placement (such as oropharyngeal mass or abscess)
- Patients under 50 kg
- Known esophageal disease
- Laryngectomy patient with stoma (open tracheostomy site or tube)
- Ability to maintain adequate ventilation and oxygenation with less invasive method

PROCEDURE:

1. Secure Required Equipment:

Personal protective equipment (gloves need not be sterile)
SGA (Appropriate size for patient)*
Bag-valve-mask
Stethoscope
Water-based lubricant
Means for securing SGA
Waveform end tidal CO2 capnography
Pulse oximetry monitoring
Cardiac monitor
(Optional size 12F or 14 F gastric tube)

2. Clear airway with suction; pre-ventilate with BVM 100% oxygen and select appropriate size SGA.*

Approved:

Carl Schultz, LEO

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Supraglottic Airway Device Placement – Adult/Adolescent

3. If SGA has inflatable cuff, test cuff for leaks and then deflate before insertion.
4. Prepare SGA for insertion and lubricate SGA following manufacturer instructions.
5. Position the head into the “sniffing position”. Neutral position for suspected cervical spine injury.
6. Hold mouth open and apply chin-lift maneuver (jaw-thrust for suspected c-spine injury).
7. Introduce the leading SGA soft tip into the mouth in a direction towards the roof of the mouth (hard palate).
8. Glide the device downwards and backwards along the hard palate with a continuous but gentle push until resistance to further advancement is felt.
9. The SGA cuff should be located against at the top of laryngeal framework, and the incisors should be resting on the bite-block region of the SGA.
10. Confirm proper positioning with breath sounds, chest rise, and capnography waveform . Monitor capnography, pulse oximetry, and cardiac rhythm until patient care is transferred to receiving center staff (to assure continued proper positioning).
11. If SGA is of inflatable cuff design, inflate gently to allow for sealing upper airway to allow adequate assisted ventilation.
12. Secure SGA. Optional - insert gastric tube (12F for SGA size 4 / 14F for SGA size 5)
13. If vomiting or forceful gagging occurs, turn patient to side and remove SGA airway device; suction thoroughly and support ventilation further with BVM during transport.
14. Document the following in the ePCR:
 - a. Size of the SGA
 - b. Number of attempts to place the SGA and if successful
 - c. Pulse oximetry
 - d. End-Tidal CO₂ – as a numerical value AND as a method of airway confirmation.

Airway removal

Once an SGA is placed, it ideally should not be removed. Circumstances that necessitate removal of the device may include inadequate ventilation with the device, return of a gag reflex, or vomiting.

Removal of the device may cause vomiting, use the following steps:

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ORANGE COUNTY EMERGENCY MEDICAL SERVICES
ADVANCED LIFE SUPPORT PROCEDURES

#: PR- 135
Page: 3 of 3
Original Date: 10/05/2018
Revised: 08/15/2022

Supraglottic Airway Device Placement – Adult/Adolescent

1. Position patient on side, maintain spinal motion restrictions as needed.
2. Have suction immediately available and remove the airway.
3. Reassess airway and breathing to evaluate the need for further assisted ventilation.

* Note: The iGel® and LMA Supreme® are supplied in an adult regular (medium) and large size:
Size 4.0 for 50 kg to 90 kg (110 lbs. to 200 lbs.)
Size 5.0 for greater than 90 kg (200 lbs.)

Approved:

Col Schultz NO

Review Date: 8/2022
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ORANGE COUNTY EMERGENCY MEDICAL SERVICES
PREHOSPITAL ALS STANDING ORDERS
**SEDATION FOR ENDOTRACHEAL OR LMA INTUBATION -
ADULT/ADOLESCENT**

#: SO-M-80
Page: 1 of 1
Org. Date: 10/01/2017
Revised: 08/15/2022

This standing order is for use when endotracheal intubation is indicated and sedation is required for support of the procedure (usually due to retained muscle tone, “clenched jaw”) or when an intubated patient requires continued ventilation support, but is having difficulty tolerating an endotracheal tube that is in proper position (usually reflex coughing or choking).

The order also applies to placement of an LMA when sedation is needed to relieve increased muscle tone involving the jaw. This is the only indication for sedation in placing an LMA. It does not apply in patients with a retained gag reflex. The LMA is contraindicated for patients who are gagging and sedation will not be used to suppress a gag reflex. Should a gag reflex develop after the LMA is placed, the tube must be removed.

ALS STANDING ORDERS:

1. Assess perfusion and blood pressure, if systolic blood pressure greater than or equal to 90, consider Sedation:
 - ▶ *Midazolam 5 mg IV, IO, or IM once*
2. Re-assess blood pressure, if below 90 systolic after midazolam:
 - ▶ *Give 250 ml normal saline bolus and reassess blood pressure*
3. Do not extubate an endotracheally intubated patient after midazolam sedation. If an LMA is placed after sedation and the patient develops a gag reflex, the tube must be removed.
4. Notify Base Hospital that sedation has been required to support maintenance of intubation ventilation support.
5. ALS escort to nearest facility appropriate for the patient (CVRC, trauma center, ERC, etc) and re-contact Base Hospital as needed.

Approved:

Carl Schultz, MD

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Indication: Suspected narcotic overdose:

- Environment is suspicious for illegal or prescription use of narcotics, AND
- Victim is poorly responsive and respiratory (breathing) rate appears slow or shallow; or victim is unresponsive and not breathing.

Standing Order (poor breathing and decreased consciousness):

1. Assure 9-1-1 EMS medical dispatch is notified.
2. Use personal protective equipment (gloves, face shield).
3. Stimulate victim to determine if the person will awaken.
4. If no response to stimulation and continued poor breathing, administer:

NARCAN™ Nasal Spray 4 mg preloaded single dose device

- a. Administer full dose in one nostril
- b. If partial response in breathing or consciousness, repeat 4 mg preloaded dose in nostril opposite to first dose; may repeat additional doses as needed to maintain breathing and consciousness.

OR

Naloxone (generic):

- c. Assemble 2 mg syringe and atomizer
- d. Administer 1 mg into each nostril (1/2 total dose into each nostril)
- e. If partial response in breathing or consciousness, repeat 2 mg, 1 mg into each nostril; may repeat additional doses as needed to maintain breathing and consciousness.

If the patient does not respond to a total of 12 mg of intranasal Narcan, further doses will not be effective and are not indicated. In a patient that does not respond, the maximum Narcan dose is 12 mg intranasal.

5. After NARCAN™ or Naloxone administration, observe for improved breathing and consciousness; if no improvement, assist breathing if bag-valve-mask if available or begin CPR if no pulse and no breathing detected.
6. If awakened by NARCAN™ or Naloxone, be alert for sudden, agitated behavior or symptoms of opioid withdrawal, such as vomiting, abdominal cramps, or sweating.
7. If CPR not necessary and it is possible, place patient on left side to avoid inhaling any possible vomit.
8. Report administration of naloxone to EMS personnel for documentation in the EMS Patient Care Record.

Approved:

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9. Complete report per first responder agency protocol.

Standing Order (not breathing, unresponsive):

1. Assure 9-1-1 EMS medical dispatch is notified.
2. Use personal protective equipment (gloves, face shield).
3. Begin CPR (chest compressions with ventilation if bag-valve-mask available).
4. When possible: administer either:

NARCAN™ Nasal Spray 4 mg preloaded single dose device

- a. Administer full dose in one nostril
- b. If no response, immediately begin chest compression CPR
- c. If partial response in breathing or consciousness, repeat 4 mg preloaded dose in nostril opposite to first dose; may repeat additional doses as needed to maintain breathing and consciousness.

OR

Naloxone (generic):

- d. Assemble 2 mg syringe and atomizer
- e. Administer 1 mg into each nostril (1/2 total dose into each nostril)
- f. If no response, immediately begin chest compression CPR
- g. If partial response in breathing or consciousness, repeat 4 mg preloaded dose in nostril opposite to first dose; may repeat additional doses as needed to maintain breathing and consciousness.

If the patient does not respond to a total of 12 mg of intranasal Narcan, further doses will not be effective and are not indicated. In a patient that does not respond, the maximum Narcan dose is 12 mg intranasal.

5. After NARCAN™ or Naloxone administration, observe for improved breathing and consciousness; if breathing or consciousness do not improve, assist breathing if bag-valve-mask if available or begin CPR if no pulse and breathing detected.
6. If awakened by NARCAN™ or Naloxone, be alert for sudden, agitated behavior or symptoms of opioid withdrawal, such as vomiting, abdominal cramps, or sweating.
7. If CPR no longer necessary and it is possible, place patient on left side to avoid inhaling any possible vomit.
8. Report administration of naloxone to EMS personnel for documentation in the EMS Patient Care Record.
9. Complete report per first responder agency protocol.

Approved:

Carl Schertz, MD

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**EVALUATION WITHOUT TREATMENT OR EMS TRANSPORT
(RELEASE IN FIELD)**

Date: 09/17/2015
Revised: 08/08/2022

PATIENT QUALIFICATION CRITERIA

This standing order applies when either a 9-1-1 response has occurred for which a BLS unit was dispatched or a non-911 BLS ambulance was requested for a patient who has no emergency medical or psychiatric condition, and no injury or illness that requires EMT or paramedic treatment/intervention, and for whom transport is not medically indicated or requested.

I. STANDING ORDER: ADULT RELEASE IN THE FIELD

1. A capable adult or capable emancipated minor who meets patient qualification criteria above and declines transport from the field may do so without being asked to sign AMA (see SO-AMA) when ALL of the following conditions are met:
 - A. An appropriately focused primary and secondary exam along with vital signs confirm that no medical or psychiatric emergency exists for the patient and no EMT or paramedic treatment/intervention is indicated.
 - B. The patient clearly communicates that they do not request EMS services and declines EMS transport.
 - C. The patient has been advised and communicates they understand that they may seek further assessment from a health care provider.
 - D. The scene and situation in which the patient is being left is not a threat to their health and personal safety.

II. STANDING ORDER: UNDER AGE OF CONSENT (LESS THAN 18 YEARS-OLD) RELEASE IN THE FIELD:

1. Capable patients less than 18 years-old who meet patient qualification criteria above and decline transport from the field may do so without being asked to sign AMA (see SO-AMA) when ALL of the following conditions are met:
 - A. An appropriately focused primary and secondary exam along with vital signs confirm that no medical or psychiatric emergency exists for the minor and no EMT or paramedic treatment/intervention is indicated.
 - B. The minor's parent or legal guardian has been contacted or is present at the scene and does not request EMS services and declines EMS transport. If the parent or legal guardian is not available, a self-sufficient minor (see Guidelines below) may still be released at scene after all appropriate attempts are made and documented to locate the parent or legal guardian.

Approved:

Implementation Date: October 01, 2022
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**EVALUATION WITHOUT TREATMENT OR EMS TRANSPORT
(RELEASE IN FIELD)**

Date: 09/17/2015
Revised: 08/08/2022

- C. The parent or legal guardian, if available, has been advised and communicates they understand that they may seek further assessment from a health care provider.
- D. If the parent or legal guardian is unavailable or cannot be contacted, a minor who is not self-sufficient may be released to a responsible adult/caregiver (babysitter, teacher, older sibling, adult neighbor, etc) at the scene. If none is present, a minor who is not self-sufficient needs transport.
- E. The scene and situation in which the minor is being left is not a threat to their health and personal safety.

DOCUMENTATION:

PCR documentation is required for any patient or minor released in the field. Confirmation and description of how each criterion required for release is met must be documented in the narrative and the patient disposition coded as "No Treatment Required".

GUIDELINE EXPLANATIONS:

Self-sufficient minor is one who is capable of understanding the risks for declining transport, who is able to contact their parent, legal guardian, or responsible adult/caregiver, and who is able to care for themselves given the circumstances at the scene.

EMT or paramedic treatment/intervention means any procedure or treatment included in the OCEMS EMT or Paramedic scope of practice; does not include basic first aid, vital signs, or paramedic exam (assessment).

Appropriate attempts to locate the parent or legal guardian include attempts to contact by telephone or mobile device with voice message left if not answered.

Approved:

A handwritten signature in blue ink, reading "Carl Schultz" followed by a stylized flourish.

Implementation Date: October 01, 2022
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MEDICAL HEALTH SERVICES

EMERGENCY MEDICAL SERVICES

DATE: August 15, 2022

TO: Ambulance Providers
Emergency Receiving Centers (ERCs)
ERC Medical Directors
Base Hospital Coordinators
911 Service Providers
MICNs

SUBJECT: AUTHORIZATION FOR BYPASSING HOSPITALS WITH 90% APOTs OF 60 MINUTES OR GREATER BY 911 SERVICE PROVIDERS AND AMBULANCES

As many of you are probably aware, the County's 90% APOT numbers have been averaging above the 30-minute standard for several months, with the average being 35 minutes or greater for the last 4 weeks. Some days have been as high as 47 minutes. Individual hospitals have experienced 90% APOTs greater than 2.5 hours without going on diversion. This has never happened in the history of OCEMS and is occurring at the same time that demand for 911 service has increased by almost 40,000 runs this year compared to last year. To try and support adequate 911 service for Orange County citizens, additional interventions are now required to maintain care.

Effective immediately, OCEMS is authorizing ambulances and 911 providers to request the current 90% APOT for their destination hospital from their dispatchers while in the field. This information is available 24/7 from the EMS website: <https://www.ochca.com/about-hca/medical-health-services/emergency-medical-services/ems-system-reports/ambulance-patient>. Ambulances may now bypass their nearest ERC regardless of diversion status if it has a 90% APOT of 60 minutes or more, and travel to the next closest most appropriate ERC with lower APOT numbers even if it is outside their normal 20-minute transport time. OCEMS is hopeful this will result in shorter overall times to off-load patients and return to service.

This directive will remain in effect for the next 6 months and may be extended based on EMS system data.

A handwritten signature in blue ink that reads 'Carl Schultz, MD'.

Carl H. Schultz, MD
EMS Medical Director