EMERGENCY MEDICAL CARE COMMITTEE MEETING AGENDA

Thursday, January 19th, 2023 at 8:30 A.M.
2995 McMillan Ave, Ste #178, San Luis Obispo

MEMBERS
CHAIR Jonathan Stornetta, *Public Providers, 2020-2024*
VICE – CHAIR Dr. Brad Knox, *Physicians*, *2022-2026*
Bob Neumann, *Consumers*, *2022-2026*
Matt Bronson, *City Government, 2020-2024*
Alexandra Kohler, *Consumers, 2020-2024*
Chris Javine, *Pre-hospital Transport Providers, 2022-2026*
Michael Talmadge, *EMS Field Personnel, 2020-2024*
Jay Wells, *Sheriff's Department, 2020-2024*
Julia Fogelson, *Hospitals*, *2022-2024*
Diane Burkey, *MICNs*, *2022-2026*
Dr. Rachel May, *Emergency Physicians*, 2022-2026

EX OFFICIO
Vince Pierucci, *EMS Division Director*
Dr. Tom Ronay, *EMS Medical Director*

STAFF
Rachel Oakley, *EMS Coordinator*
David Goss, *EMS Coordinator*
Ryan Rosander, *EMS Coordinator*
Denise Yi, PHEP Program Manager
Sara Schwall, Administrative Assistant

AGENDA	ITEM	LEAD
Call To Order	Introductions	J. Stornetta
	Public Comment	
Action/Discussion	Approval of minutes: November 17, 2022 Minutes (*attached)*	J. Stornetta
	• Staff Report for addition of Supraglottic Airway to approved policies and procedures: ○ Amend Policy # 602 (Airway Management), ○ Amend Policy #205A (EMS Equipment and Supply List) ○ Add Procedure #717 (Endotracheal Intubation) ○ Add Procedure # 718 (Supraglottic Airways)	D. Goss
	• 2023 Strategic Planning Discussion	J. Stornetta / V. Pierucci
Staff Reports	• Health Officer • EMS Agency Staff Report • EMS Medical Director Report • PHEP Staff Report	P. Borenstein V. Pierucci T. Ronay D. Yi
Committee Members Announcements or Reports	Opportunity for Board members to make announcements, provide brief reports on their EMS-related activities, ask questions for clarification on items not on the agenda, or request consideration of an item for a future agenda (Gov. Code Sec. 54954.2[a][2])	Committee Members
Adjourn	**Next Meeting: Thursday, March 16th *2023 at 8:30am***	

Emergency Medical Care Committee
Meeting Minutes
Thursday November 17th, 2022.
Meeting Held Virtually via ZOOM

Members
- ☒ CHAIR Dr. Rachel May, *Emergency Medicine Physicians*
- ☒ VICE CHAIR Jonathan Stornetta, Public Providers
- ☒ Bob Neumann, *Consumers*
- ☐ Alexandra Kohler, *Consumers*
- ☐ Matt Bronson, *City Government*
- ☒ Chris Javine, Pre-Hospital Transport Providers
- ☒ Michael Talmadge, *EMS Field Personnel*
- ☒ Dr. Brad Knox, *Physicians*
- ☒ Jay Wells, *Sheriff's Department*
- ☒ Julia Fogelson, *Hospitals*
- ☐ Diane Burkey, *MICNs*

Ex Officio
- ☒ Vince Pierucci, *EMS Division Director*
- ☒ Dr. Thomas Ronay, *LEMSA Medical Director*

Staff
- ☒ Rachel Oakley, EMS Coordinator
- ☒ David Goss, EMS Coordinator
- ☐ Vacant, EMS Coordinator
- ☐ Denise Yi, *PHEP Program Manager*
- ☒ Sara Schwall, Administrative Assistant

Guests – Tim Benes, CCHD; Rob Jenkins, CAL Fire; Natasha Lukasiewich, FHD ED Director; Gerry Perez, CHP; Doug Weeda, CHP

AGENDA ITEM / DISCUSSION	ACTION
CALL TO ORDER	Meeting called to order at 08:37 AM
Introductions	
Public Comment	No comments
Approval of May 19h, 2022 Meeting Minutes –	B. Knox Motions. B. Neumann 2nds. All in favor.
EMCC Elections – Nomination and Election **Chair Nomination:** Jonathan Stornetta is nominated and motioned by B. Knox, R. May, and M. Talmadge. All in favor. Motion carries. **Vice Chair Nomination:** Dr. Brad Knox is nominated and motioned by J. Stornetta, M. Talmadge and R. May. All in favor. Motion carries.	V. Pierucci Motion carries, J. Stornetta elected as Chair. Motion carries, B. Knox elected as Vice Chair.
Staff Report for Revisions to Policies # 350 and 351, including attachments A-E (MICN): • For initial application, proposed to waive requirement of one year ED experience if the RN worked as an accredited paramedic in SLO County in the last two years. • Proposed that an MICN Liaison be the point person at each base hospital for collecting and submitting applications. As well as submitting letters of separation. • Added to the initial application policy is a four-hour ride along with an ALS provider using the MICN Field Orientation Checklist. Proposed to waive this requirement for RNs who worked as an accredited paramedic in SLO County in the last two years. • MICN Med Com Orientation is also four hours and follows a checklist. • Fees are required in the new fiscal year to align with paramedic and EMT fees. • Policy 351 was adjusted to mirror changes in policy 350.	R. Oakley

Discussion: R. May asks how much the fee will be. V. Pierucci is still being determined but will align with the State fees charged for EMT certification. M. Talmadge asks if the field orientation hours are FTO specific or if it can be anyone designated by the agency. C. Javine says he would feel comfortable letting a non-FTO paramedic do an orientation. R. Oakley says she will change the language in the policy to remove "FTO" and use "accredited paramedic" to conduct a field orientation.	R. May motions to approve revisions. B. Knox 2nds. All in favor, revisions approved.
Ambulance Transport RFP Update: EMSA hired a consultant from Healthcare Strategist. The consultant team consists of Chief Powers, Steve Athey and Dave Ghilarducci, MD. They will do a system assessment including a ride along and interviews. The consultants will bring back a report in January, which will be used to develop an RFP by early Fall. The new contract will take effect in July 2024.	V. Pierucci
Staff Report: We have been dealing with a surge of RSV for the past two weeks. Sierra Vista has become our pediatric center and at one point had 12 children admitted. The hospital had to open their old ICU to house all the patients. A mutual aid supply of albuterol was facilitated. At a meeting with the hospitals last week, coordination was worked out to keep the sick, younger kids at Sierra Vista and move non-RSV positive patients to French. B. Knox says thank you to French for accommodating the transfer of patients. He is expecting the cases to get worse in the next few weeks. It does weigh on the EMS system with transports to hospitals. RSV is nothing new, but we think it has been more aggressive because these kids have been isolated. **EMS Medical Director Report:** At the airway lab this summer, paramedics and EMTs were able to use the iGel Supraglottic airway. As we move toward an introduction, I thank everyone for thinking broadly about this new skill. I do recognize there is a ripple effect when a new tool is introduced into the system. The staff is working on Alternate IV access issues. Two weeks ago, David Givot, Esq. gave a lecture here on EMS documentation. The EMS Commission, under Title 22, passed Behavioral Health Alternate Care Destinations. Congrats to Paso Robles for instituting full public access defibrillators in Downtown Paso Robles! **PHEP Staff Report:** Thank you to everyone who helped at the PPODs this year!	V. Pierucci T. Ronay D. Yi
Announcements: J. Wells: There is an uptick in overdosing and Narcan use. We have seen 50-60 reversals, however. All locations and vehicles are stocked with Narcan and the State sent a large supply. We need to refresh the length of time between Narcan dosing. V. Pierucci: All the reports are showing solid work with the Narcan use and seeing good results. Behavioral Health is discussing creating "nalox-boxes" for the public.	

C. Javine: There has been paramedic shortages and San Luis Ambulance is working with Best Practices to contract five travelling medics. All are going through training. Their term is 3 months with an opportunity for extension. Joe Piedalue retired from SLA and promoted Kris Strommen to Operations Manager and Serena Genusso to a new Clinical Manager position. Vince says there has been positive feedback about these medics. The program operates under the Governor's COVID Executive Order. J. Stornetta: The medical professionals on this committee are some of the best in the county. We need to set goals for the new year. One thing to look at homelessness. Let's show our leadership and make a difference with this committee. N. Lukasiewich: We are going for a geriatric accreditation and working on pediatric readiness. We also are working on an emergency psychiatry program to make sure we have all the right people and equipment to support these types of crises. J. Fogelson: On the 28th, the new hospital president starts his tenure. We have had adult RSV patients and not licensed for pediatrics, nor are the staff insured to care for pediatric patients. We will continue to help offload what we can, however. J.Stornettta asks if there will be an impact to transports with the geriatric accreditation. N. Lukasiewich answers no, it is not a destination but will hold us accountable to provide the best care for these patients.	
Future Agenda Items: Make goals for the new year.	B. Neuman motions to adjourn. R. May 2nds. Meeting adjourned 9:50 AM
Next Regular Meeting Next meeting will be held Thursday, January 19th, 2022, at 08:30 AM at EMS Agency.	

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
PUBLIC HEALTH DEPARTMENT
Penny Borenstein, MD, MPH *Health Officer/Public Health Director*

MEETING DATE	January 19th, 2023
STAFF CONTACT	David Goss, EMS Coordinator 805.788.2514 dgoss@co.slo.ca.us
SUBJECT	Supraglottic Airway Implementation
SUMMARY	Procedure #718: Supraglottic Airways (New) • Addition of Procedure #718 outlines proper use of Supraglottic Airways for ALS Provider utilization. This outlines SGA usage as an Option for Primary advanced airway along with a backup option following Endotracheal Intubation usage. • Procedure #718 allows i-Gel SGAs to be utilized as an advanced airway. Procedure #717: Endotracheal Intubation (New) • Addition of Procedure #717 outlines proper use of Endotracheal Intubation in conjunction with Procedure #718, making ETI and SGA interchangeable depending on the needs of the patient. • Both procedures include language allowing primary usage for either procedure, but Procedure #717 includes language allowing ALS providers to abandon ETI efforts during attempts if SGA will be better suited for placement Protocol #602: Airway Management (Edited) • Protocol #602 now includes the addition of Procedure #717 and #718 in ALS Standing orders. • Another addition is in notes outlining verification of advanced airway placement and the different methods allowed. Policy #205A: EMS Equipment and Supply List (Edited) • Addition of Supraglottic airways and the different sizes for each level of ALS utilization. Cost specifics will be outlined in the presentation. All policies have been reviewed and approved by Clinical Advisory Subcommittee and Operations Subcommittee. Both subcommittees recommend these policies for EMCC approval.

REVIEWED BY	Clinical Advisory Subcommittee, Operations Subcommittee, Vince Pierucci, Dr. Thomas Ronay, SLOEMSA Staff
RECOMMENDED ACTION(S)	Recommend SGA for EMCC Approval and implementation.
ATTACHMENT(S)	Operations PowerPoint Presentation, Policy #205A, #602, #717, #718

AIRWAY MANAGEMENT

ADULT	PEDIATRIC (≤34 kg)
BLS	

• Universal Protocol #601
• Administer O_2 as clinical symptoms indicate (see notes below)
• Pulse oximetry
• Patients with O_2 Sat ≥ 94% without signs or symptoms of hypoxia or respiratory compromise should not receive O_2
• When applying O_2 use the simplest method to maintain O_2 Sat ≥ 94%
• Do not withhold O_2 if patient is in respiratory distress
 	
• **Foreign Body/Airway Obstruction**
  ○ Use current BLS choking procedures
  ○ Basic airway adjuncts and suctioning as indicated and tolerated
	Same as Adult (except for newborns)
	• Newborn (< 1 day) follow AHA guidelines – Newborn Protocol #651

BLS Elective Skills	
• **Moderate to Severe Respiratory Distress** ○ **CPAP** as needed – CPAP procedure #703	CPAP not used for patients ≤34 kg
ALS Standing Orders	

• **Foreign Body/Airway Obstruction**
If obstruction not relieved with BLS maneuvers
  ○ Visualize and remove obstruction with Magill forceps
  ○ If obstruction persists consider – Needle Cricothyrotomy Procedure #704
  ○ Upon securing airway monitor O_2 Sat and $ETCO_2$ – Capnography Procedure #701
• Endotracheal intubation – as needed to control airway – Procedure #717
• Supraglottic Airway – as needed to control airway if indicated – Procedure #718
• Needle thoracostomy with symptoms of tension pneumothorax – Needle Thoracostomy Procedure #705
	• **Foreign Body/Airway Obstruction**
	If obstruction not relieved with BLS maneuvers
	  ○ Visualize and remove obstruction with Magill forceps
	  ○ If obstruction persists consider – Needle Cricothyrotomy Procedure #704
	  ○ Upon securing airway monitor O_2 Sat and $ETCO_2$ – Capnography Procedure #701
	• Needle thoracostomy with symptoms of tension pneumothorax – Needle Thoracostomy Procedure #705

Base Hospital Orders Only	

• **Symptomatic Esophageal Obstruction**
  ○ **Glucagon** 1mg IV followed by rapid flush. Give oral fluid challenge 60 sec after admin - check a blood sugar prior
• As needed
	• **Symptomatic Esophageal Obstruction**
	  ○ **Glucagon** 0.1mg/kg IV not to exceed 1mg followed by rapid flush. Give oral fluid challenge 60 sec after admin - check a blood sugar prior

	• As needed

Notes

- Oxygen Delivery
  - Mild distress – 0.5-6 L/min nasal cannula
  - Severe respiratory distress – 15 L/min via non-rebreather mask
  - Moderate to severe distress – CPAP 3-15 cm H2O
  - Assisted respirations with BVM – 15 L/min
- Pediatric intubation is no longer an approved ALS skill – maintain with BLS options
- Patients requiring an advanced airway will decide which airway to use based on the complexity of the patient's anatomy. If the patient's vocal cords are easily visualized, then Endotracheal Intubation will be performed. If the patient's vocal cords are difficult or unable to be visualized, then a Supraglottic Airway Device will be utilized.
- After placement of any advanced airway, providers will verify placement via a minimum of two different methods. These methods can be any two of the following:
  - Auscultation of lung and stomach sounds.
  - In-Line ETCO2 placement.
  - Colorimetric CO2 Detector Device.
  - Esophageal Bulb Detection Device.

Endotracheal Intubation

FOR USE IN PATIENTS >34 KG

BLS

Universal Protocol #601

Pulse Oximetry – O_2 administration per Airway Management Protocol #602

ALS Standing Orders

- Indications:
  - Patients with a respiratory compromise.
  - ROSC patients requiring airway stabilization
  - Situations where the airway cannot be adequately maintained by BLS techniques.
- Contraindications:
  - Intact gag reflex
- If patient presents with an easily accessible airway (able to visualize the patient's vocal cords), ETI will be indicated.
- Prepare, position, and oxygenate the patient with 100% Oxygen. Ideal positioning is keeping the ears in line with the sternal notch.
- Consider use of video laryngoscopy when available.
- Select appropriate size ET tube and consider the need for endotracheal introducer (Bougie); have suction ready.
- Using the laryngoscope, visualize vocal cords.
- Determine how accessible the patient's airway is. If the patient has a complex airway (unable to visualize the vocal cords due to surrounding anatomy) which would be difficult and time consuming to intubate, consider the use of a supraglottic airway device Procedure # 718.
- Visualization of vocal cords will take no longer than 10 seconds.
- Visualize tube/bougie passing through vocal cords.
- Inflate the cuff with 3-10mL of air.
- Apply waveform capnography (reference Policy #701).
- Auscultate for bilaterally equal breath sounds and absence of sounds over the epigastrium.
- If ET intubation efforts are unsuccessful after the 1st attempt, continue with a BLS airway, re-evaluate the airway positioning before the 2nd attempt. After first failed attempt, consider use of Supraglottic Airways (reference Procedure #718).
- If ET intubation efforts are unsuccessful after the 2nd attempt, continue with a BLS airway and proceed to Supraglottic Airway Procedure #718.
- Patients who have an advanced airway established should be secured with tape or a commercial device. Devices and tape should be applied in a manner that avoids compression of the front and sides of the neck, which may impair venous return from the brain.

- If the patient has a suspected spinal injury:
    - Open the airway using a jaw-thrust without head extension.
    - If airway cannot be maintained with jaw thrust, use a head-tilt/chin-lift maneuver.
    - Manually stabilize the head and neck rather than using an immobilization device during CPR.

Base Hospital Orders Only

As needed

Notes

- During the initial visualization of the patient's airway if the ALS provider determines the airway to be difficult (unable to visualize the patient's vocal cords), ETI will not be utilized and ALS providers will reference Procedure 718 for SGA.
- After placement of the Endotracheal Tube, providers will verify placement via a minimum of two different methods. These methods can be any two of the following:
    - Auscultation of lung and stomach sounds.
    - In-Line ETCO2 placement.
    - Colorimetric CO2 Detector Device.
    - Esophageal Bulb Detection Device.

Supraglottic Airway Device

FOR USE IN PATIENTS >34 KG

BLS

Universal Protocol #601

Pulse Oximetry – O_2 administration per Airway Management Protocol #602

ALS Standing Orders

- Patients who meet indications for **Endotracheal Intubation Procedure #717**
- Patients who after the ALS Provider has visualized the patient's airway and has determined that their airway will be difficult to access.
- SGA use is not approved for pediatric use. SGA shall only be used for patients >34kg.

I-GEL

- Monitor End-tidal capnography throughout use.
- Select appropriate tube size.

	3	Small Adult	30-60kg
	4	Medium Adult	50-90kg
	5	Large Adult	90+kg

- While preparing tube, have assistive personnel open the airway, and clear of any foreign objects. Pre-oxygenate with 100% oxygen via bls airway and BVM.
- Apply water soluble lubricant to the distal tip and posterior aspect (only) of the tube, taking care to avoid introduction of the lubricant into or near the ventilatory openings.
- Grasp the lubricated i-gel firmly along the integral bite block. Position the device so that the i-gel cuff outlet is facing towards the chin of the patient.
- Position patient into "sniffing position" with head extended and neck flexed. The chin should be gently pressed down before proceeding to insert the i-Gel.
- Introduce the leading soft tip into the mouth of the patient in a direction towards the hard palate.
- Glide the device downwards and backwards along the hard palate with a continuous but gentle push until a definitive resistance is felt.
- At this point the tip of the airway should be located into the upper esophageal opening and the cuff should be located against the laryngeal framework. The incisors should be resting on the integral bite-block.
- Attach a BVM. While gently bagging the patient to assess ventilation, carefully withdraw the airway until ventilation is easy and free flowing (large tidal volume with minimal airway pressure).
- Confirm proper position by auscultation, chest movement and verification of ETCO2 by waveform capnography.
- The i-gel should be secured down per manufacturer recommendation.
- Patients who have an advanced airway established should be secured with tape or a commercial device. Devices and tape should be applied in a manner that avoids compression of the front and sides of the neck, which may impair venous return from the brain.
- Ensure proper documentation of placement of the Supraglottic airway including verification methods.

Base Hospital Orders Only
As needed
Notes
Contraindications •Gag reflex. •Caustic ingestion. •Known esophageal disease (e.g., cancer, varices, or stricture).
• Following visualization of the patient's airway and determining the patient's airway to be accessible (able to visualize the patient's vocal cords), SGA will not be utilized and ALS providers will reference Procedure #717 for ETI. • To verify patency and placement of the SGA Device, providers will verify placement via a minimum of two different methods. These methods can be any of the following: ○ Auscultation of lung sounds ○ In-Line ETCO2 placement ○ Colorimetric CO2 Detector Device ○ Esophageal Bulb Detection Device

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum † *Elective skills as required*
MEDICATIONS						
Activated charcoal	50 gm bottle (aqueous solution)	1	1	0	0	0
Adenosine	6 mg/2 mL	5	3	3	3	0
Albuterol unit dose	2.5 mg/3 mL solution	4	2	2	2	0
Aspirin	81 mg nonenteric coated chewable	1 bottle	1 bottle	4 tablets	4 tablets	1 bottle
Atropine	1 mg/10 mL	2	2	2	2	0
Atropine	8 mg multi-dose vial	1	1	0	0	0
Calcium Chloride 10%	1 gm/10 mL	1	1	0	0	0
Dextrose 10%	25 gm/250 mL bag	2	2	1	1	0
*Dextrose 50%	25 gm/50 mL	2	2	1	0	0
Diphenhydramine	50 mg/1 mL	2	2	2	2	0
Epinephrine	1:1,000 1 mg/1 mL	4	2	2	2	0
†Epinephrine Auto-Injector	Pediatric and Adult	0	0	0	0	†1 each
Epinephrine	1:10,000 1 mg/10 mL (10 mL preload)	8	6	3	6	0
Fentanyl	100 mcg/2 mL	2	2	2	2	0
Glucagon	1 mg/1 mL	1	1	0	0	0
Glucose gel	15 gm	2 tubes	2 tubes	2 tubes	2 tubes	2 tubes
Lidocaine 2%	100 mg/ 5 mL	6	4	3	3	0
Midazolam	5 mg/1 mL	2	1	1	1	0
Naloxone	2 mg (vial or pre-load)	2	2	2	2	0
†Naloxone IN Kit	§2 mg pre-load and Atomizer	0	0	0	0	†2
Nitroglycerine	SL tablets or spray	2	1	1	1	0
Nitro Paste 2%	1 gm single dose packet	3	3	0	0	0
Ondansetron	4 mg /2 mL injectable	3	3	0	0	0
	4 mg dissolvable tablets	3	3	1	1	0
Sodium Bicarbonate	50 mEq/50 mL	2	2	0	0	0
Tranexamic Acid (TXA)	100 mg/1 mL 10 mL vial	2	1	0	1	0
Because variations in medication supply occur, equivalent total dosage quantities may be substituted						
Variations in the concentration of medications being stocked, due to medication supply shortages, must be approved by Medical Director						
***Dextrose D50 is being phased out in favor of Dextrose D10**						
†Elective skills equipment required for participating agencies						
Alternate Medications to be Stocked <u>ONLY</u> with Medical Director Approval						
§Other pre-packaged single dose intranasal naloxone delivery devices that may be used with Medical Director Approval		0	0	0	0	†2
Diazepam (alternate to be stocked by order of Med Dir **ONLY**)	10 mg	2	1	1	1	0
Morphine (alternate to be stocked by order of Med Dir **ONLY**)	10 mg	3	2	2	2	0

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum † *Elective skills as required*
IV SOLUTIONS/EQUIPMENT						
0.9% Normal Saline	1,000 mL bag (or equivalent total	6	4	2	4	0
100 mL Saline Delivery Equipment	0.9% NS 100 mL bag **OR** Burette	2	1	0	0	0
0.9% Normal Saline	10 mL Vials/Flush	5	5	2	2	0
IV Tubing	60gtt/mL	4	2	0	0	0
IV Tubing	10-20gtt/mL	6	3	2	2	0
IV Catheters	Sizes 14, 16, 18, 20, 22, 24 gauge	2 each	2 each	2 each	2 each	0
Syringes	Assorted - 1mL, 3mL, 6mL-20mL	2 each	2 each	1 each	1 each	0
Needles Assorted	- ½", 1", 1 ½" - 18-30 gauge	2 each	2 each	2 each	2 each	0
Intraosseous (IO) single needle device	(FDA approved) adult and pediatric	1 each	1 each	1 each	1 each	0
Tourniquets (for IV start)		2	2	2	2	0
Saline locks		4	2	2	2	0
Luer-Lock adaptors	(Not required but recommended for use with STEMI patients)	2	2	0	0	0
Alcohol and betadine swabs		10 each	10 each	10 each	10 each	†10 each
TRAUMA						
Bandages and bandaging supplies:						
Bandaids	Assorted	10	10	5	5	10
Sterile bandage compresses or equivalent	4"x4"	12	10	10	10	10
Trauma dressing	10"x30" or larger universal dressing	2	2	2	2	2
Roller gauze	3" or 4"	12 rolls	8 rolls	2 rolls	2 rolls	8 rolls
Cloth adhesive tape	1, 2, or 3"	1 roll	1 roll	1 roll	1 roll	1 roll
Triangular bandages with safety pins		4	2	1	1	2
Tourniquet	See approved list for commercial	2	2	1	1	2
Vaseline gauze	3"x8", or 5"x9"	2	2	1	1	2
Tongue blade or bite stick		2	2	2	2	2
Burn Sheets (sterile or clean) –	may be disposable or linen (with date of sterilization indicated)	2	2	0	2	2
Cervical collars	Stiff. Sizes to fit all patients over one year old	1each	1 each	1 each	1 each	1 each
Cold packs		2	2	2	2	2
Irrigation equipment and supplies:						
Saline, sterile	250mL	4	2	1	2	2
Long spine board and light weight head immobilizer blocks	(or equivalent immobilization device)	2	1	0	0	1
Straps to secure patient to boards		2 sets	1 set	0	0	1 set
Splints, traction	Adult and pediatric (or a single device suitable for both)	1 each	1 each	0	0	1 each

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum † *Elective skills as required*
TRAUMA CONT.						
Splints, cardboard or equivalent	arm and leg splint	2 each	2 each	1 each	2 each	2 each
K.E.D. or equivalent		1	1	0	0	0
Pediatric spinal immobilization board	(or equivalent immobilization device)	1	1	0	0	0
Sheet or commercial pelvic binder		1	1	0	0	1
Infection Control						
Meet the minimum requirement per crew member as stated in the California Code of Regulations Title 8 (All Providers)						
Transportation Equipment						
Collapsible gurney cot with adjustable contour feature		1	0	0	0	0
Stair chair or equivalent device		1	0	0	0	0
Sheets, pillow, pillow case, towels, blankets (cloth or disposable)		2	0	0	0	0
Scoop stretcher with straps		1	0	0	0	0
Flat vinyl/canvas stretchers with		1	0	0	0	0
MISCELLANEOUS						
Blood pressure cuffs (portable):	Adult	1	1	1	1	1
	Large adult or thigh	1	1	0	0	1
	Pediatric	1	1	0	1	1
Obstetrical kit - sterile, prepackaged		1	1	0	0	1
Restraints - non-constricting wrist and ankle		1 set each	1 set each	0	0	1 set each
Stethoscope		1	1	1	1	1
Trash bags/receptacles		2	2	1	1	2
Blanket	Disposable	1 each	1 each	1 each	1 each	1 each
Bandage scissors (heavy duty)		1	1	1	1	1
Emesis basins or emesis bags with containers		2	2	1	1	2
Water, potable		1 liter	1 liter	0	1 liter	1 liter
Maps, entire county		1	1	0	0	1
Penlight		1	1	1	1	1
Triage tags		20	20	20	20	20
Bed pan		1	0	0	0	0
Urinal		1	0	0	0	0
†Glucometer	with ≥10 test strips, lancets, and other appropriate supplies	1	1	1	1	†1
Puncture proof sharps container	small	2	2	1	1	†1
Thermometer		1	1	0	0	0
Automatic External Defibrillator	With AED pads	* For EMT-D Provider Agencies (1)				

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum † *Elective skills as required*
AIRWAY						
Endotracheal tubes:	sizes-3.0, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5, 9.0	1 each	1 each	1 each	1 each	0
Laryngoscope handles, with extra batteries		2	2	1	1	0
Laryngoscope blades:	Miller # 0, 1, 2, 3, 4 Macintosh # 1, 2, 3,	1 each	1 each	1 each	1 each	0
i-Gel Supraglottic Airways	Size 3 and Size 5	1 each	1 each	1 each	1 each	0
i-Gel Supraglottic Airways	Size 4	2 each	2 each	1 each	1 each	0
Magill forceps (pediatric and adult)		1 each	1 each	1 each	1 each	0
Adult stylets		2 each	1 each	1 each	1 each	0
10-20 mL syringe, sterile lubricant		2 each	1 each	1 each	1 each	0
Needle Cricothyrotomy kit with:	10 or 12 ga needle, 10-20 mL syringe, alcohol and betadine wipes and oxygen supply adapter	1	1	1	1	0
	Or other FDA approved percutaneous cricothyrotomy kit	1	1	1	1	0
Capnography Device	Qualitative or Quantitative	1	1	1	1	0
Hand held nebulizer for inhalation therapy		2	2	1	1	0
Medrafter or equivalent		1	1	0	0	0
Portable, battery powered, cardiac monitor-defibrillator with 12-lead ECG capability with the ability to perform computerized ECG readings and provide hard copy ECG tracings, with:		1	1	1	AED w.manal defib and w/EKG	0
	Patient ECG cable	1	1	1	0	0
	ECG recording chart paper	1	1	1	0	0
	Adult ECG electrodes	4 sets	4 sets	2 sets	2 sets	0
	Defibrillation pads or equivalent - Adult and Pediatric	1 set each	1 set each	1 set each	1 set each	0
	Conductive defibrillation pads,	4	4	2	2	0
	or tubes of conductive gel	2	2	1	1	0
IV catheter for pleural decompression	10 gauge/3 inch	2	2	1	1	0
Asherman chest seal or equivalent open wound dressing		1	1	1	1	1
Pulse oximeter		1	1	1	1	1
†Continuous Positive Airway Pressure (CPAP) Ventilator	portable/adjustable pressure settings, FDA Approved with an oxygen supply	1	1	0	0	†1
Nasopharyngeal airways (soft rubber)	Medium and Large adult sizes	2 each	2 each	1 each	1 each	2 each
Lubricant, water-soluble jelly (K-Y)		2	2	2	2	2
Oropharyngeal airways	(sizes 5.5 – 12 or equivalent)	2 each	1 each	1 each	1 each	1 each
Adult non-rebreather masks		2	2	1	1	2

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum † *Elective skills as required*
Pediatric/infant non-rebreather mask		2	2	1	1	2
Adult nasal cannula		4	2	1	1	2
Oxygen Cylinders	D or E size cylinder with regulator capable of delivering 2-15 LPM	1	1	1	1	1
	M, H, or K cylinder with wall outlet(s) and constant flow regulator(s)	1	0	0	0	0
AIRWAY CONT.						
Oxygen reserve:						
	D or E cylinders	1	1	0	0	1
Face masks for resuscitation (clear)		2	1	1	1	1
Bag-valve mask with O2 reservoir and supply tubing						
	Adult	1	1	1	1	1
	Pediatric	1	1	1	1	1
	Infant	1	1	1	0	1
Suction equipment and supplies:						
Rigid pharyngeal tonsil tip		2	2	0	0	2
Spare suction tubing		1	1	0	0	1
Suction apparatus (portable)		1	1	1	1	1
Suction catheters	at least 2 sizes suitable for adult and	2 each	1 each	1 each	1 each	1 each
	pediatric endotracheal suctioning					