Operations Subcommittee
of the Emergency Medical Care Committee

Meeting Agenda:
9 A.M., Thursday December 5th, 2024
Location: SLOEMSA Conference Room
2995 McMillan Ave, STE #178, San Luis Obispo

Members
Jay Wells, *Sheriff's Department, CHAIR*
Tim Nurge, *Ambulance Providers*
Scotty Jalbert, *Office of Emergency Services*
Jennifer Mebane, *Med-Com*
Adam Forrest, M.D., *Hospitals*
Kris Strommen, *Ambulance Providers*
Rob Jenkins*, Fire Service*
Lisa Epps, *Air Ambulance Providers*
Dennis Rowley, *Air Ambulance Providers*
Jon Ontiveros, *CHP*
Deputy Chief Sammy Fox, *Fire Service*
Vacant, *Law Enforcement*
Chief Casey Bryson, *Fire Service*
Chief Dan McCrain, *Fire Service*
Roger Colombo, *Field Provider-Paramedic*
Heidi Hutchison, *Hospitals*

Staff
STAFF LIAISON, Ryan Rosander*, EMS Director*
Bill Mulkerin, M.D., *Medical Director*
Rachel Oakley, *EMS Coordinator*
Kaitlyn Blanton, *EMS Coordinator*
Eric Boyd, *EMS Coordinator*
Alyssa Vardas, *Administrative Assistant*

AGENDA	ITEM	LEAD
Call to Order	Introductions Public Comment	Jay Wells
Summary Notes	Review of Summary Notes October 3rd, 2024	
Discussion	**Policy Development:** • Policy #TBD Public Safety-First Aid and CPR Training Program Approval • Policy #TBD Public Safety-First Aid and CPR Training Program Approval Attachments A & B • Policy #TBD Public Safety-First Aid Optional Skills Approval • Policy #TBD Public Safety-First Aid Optional Skills Approval Attachments A & B	Rachel Oakley

Discussion	**Protocol and Procedure Revisions:** • Protocol #601 Universal • Protocol #611 Allergic Reaction/Anaphylaxis **Policy Revisions:** • Policy #219 Assisting Patients with their Emergency Medications • Policy #152 STEMI Triage and Destination • Policy #153 Trauma Patient Triage and Destination	Ryan Rosander
Adjourn	Declaration of Future Agenda Items: - EMS Personnel Policy Revisions - Roundtable Next Meeting Date: February 6th, 2025, 9:00 A.M. Location: SLOEMSA Conference Room 2995 McMillan Ave, STE #178, San Luis Obispo	Jay Wells

DRAFT

Operations Subcommittee
of the Emergency Medical Care Committee

Summary Meeting Minutes
Thursday October 3th, 2024
SLO EMSA Conference Room – 2995 McMillan Ave, Suite 178, San Luis Obispo

Members		Staff	
☒	CHAIR Jay Wells, Sheriff's Department	☒	STAFF LIASON Ryan Rosander, EMS Director
☐	Tim Nurge, Ambulance Providers	☐	Bill Mulkerin, MD, Medical Director
☒	Scotty Jalbert, OES	☒	Rachel Oakley, EMS Coordinator
☒	Jennifer Mebane, Med-Com	☐	Vacant, EMS Coordinator
☐	Adam Forrest, MD, Hospitals	☒	Alyssa Vardas, EMS Administrative Assistant
☒	Kris Strommen, Ambulance Providers		
☒	Rob Jenkins, Fire Service		
☐	Lisa Epps, Air Ambulance Providers		
☒	Dennis Rowley, Air Ambulance Providers		
☐	Doug Weeda, CHP	**Public**	
☐	Vacant, South County Fire Representative	☒	Kristin Edler, SLO PHD
☒	Roger Colombo, Field Provider, Paramedics		
☒	Chief Dan McCrain, Fire Service	☒	Shannon Wilkinson, SLOSO
☒	Chief Casey Bryson, Fire Service	☒	Ray Hais, SLOFD
☐	Vacant, Law Enforcement		
☐			
☐			

AGENDA ITEM / DISCUSSION	ACTION / FOLLOW-UP
CALL TO ORDER—9:00 am	
Introductions	
Public Comment – None	
APPROVAL OF MINUTES – R. Jenkins motioned, D. McCrain 2nd. Approved.	
DISCUSSION ITEMS	
Review of Policy, Protocol, and Procedure Revisions: SLOEMSA and SLOPH would like to update the Contagious Disease Exposure Policy. SLOEMSA would like to update the Public Safety-First Aid and CPR Training Program Approval and the Public Safety-First Aid and Optional Skills Approval Policies. SLOEMSA is taking the cardiac arrest protocols through the committee process for a recommendation for adoption. SLOEMSA is taking Upgrade/Downgrade and Assisting Patients with their Emergency Medications through the committee process. - Proposes revising the Contagious Disease Exposure policy so that patients are evaluated through the worker's compensation provider. - Increased awareness of the Contagious Disease Exposure policy. - Adding PSFA policies and procedures to align the programs with State Regulations. - Adding changes to the cardiac chest pain protocol, mainly by adding large-bore IVs. - Discussion of adding vector-change defibrillation to treat refractory VFIB and pulseless VTACH. - Removed language regarding Law Enforcement from the upgrade/downgrade policy. - Advocacy groups have reached out to request the possibility of a policy to assist patients with their emergency medications. **R. Oakley presents Contagious Disease Exposure Policy.** **Discussion** R. Jenkins asks why we are directing people away from the ED.	R. Rosander

AGENDA ITEM / DISCUSSION	ACTION / FOLLOW-UP
R. Oakley says it is because we don't want to inundate our ED with additional testing. K. Edler says that the main concern is that we can't discuss results to anyone but the work comp provider. R. Jenkins says that he does not understand why the EMSA would get involved with this. R. Oakley says that this is our policy but it's on behalf of public health because of their process, so that's why I worked closely with their staff to revise this. But we can take these concerns back and discuss it. D. McCrain says to remove after-hours because then you can just do what is appropriate for the agency. R. Jenkins suggests adding an attachment for following what an exposure is as this is confusing for folks. Says there is nothing in here about an unknown exposure that this is identifying HIV and Hepatitis specifically, but what if we don't know what it is and what to do? D. Rowley asks if we can know when a fax was received. He has sent in these in before and they have gone unrecognized and had to call the EMSA who doesn't know about them. J. Wells suggests an easier method would be email to email. R. Oakley says that Kristin and her have plenty to talk about. **R. Oakley presents the PSFA Policies.** **Discussion** R. Jenkins says that he thinks Section P of the Public Safety-First Aid and CPR Training Program Approval should remain separate since they are two different things. R. Oakley says there are two different things and she included it because the LEMSA is approving the program, then we also have the authority to approve the AED service provider. It's just a simple addition to the training program that's being approved, and that's why I included it. R. Jenkins also says it is confusing since AED is already combined with the minimum requirements of PSFA training. We are combining two policies, and it is his recommendation to keep them separate so that we don't cross two separate things in the future. R. Oakley says that we are combining two separate issues. We use this training material that's already approved. Here's our trained list of personnel so I can make sure that everyone's in compliance. And if they want to use AEDs, they submit the orientation material to me that they orientate their employees on, and it's marked on that training log. So, it's very minimal oversight, because they do their training. I just didn't think it was enough to make a whole policy off it, rather than kind of like a check box on an application. S. Jalbert asks what the negatives of leaving it in here are other than it is confusing. R. Oakley says it doesn't affect me. So that's just my recommendation. Ask if there is any other feedback about this. R. Jenkins says that if we bring it in like this, it causes an opportunity for error. Mentions that if you want to keep it in just link it back to the other policy. Which one do I follow? Which? Why am I authorizing a training program instead of an EMS provider? Because they're two separate things, right? In Title 22 We have an A to B service provider policy. It keeps them separate and clearer that way. That's the only reason. R. Oakley asks if they would be open to her pointing to the existing policy and then revising it. It's much more extensive. I've simplified it because the program is pretty simple. J. Wells asks if we need to clarify that they are oriented to the appropriate equipment. R. Oakley asks if anyone else has any comments. Any public comments? I'm sorry. What's your name, sir? Thank you for coming. Do you have any comments on the basic public safety for the state portion? **R. Oakley presents PSFA Optional Skills.** **Discussion** R. Jenkins says that the Public Safety-First Aid Optional Skills Approval policy is too long for what the need is. This parrots the same policy is very similar to the first one. That's all included in the required items of a training program title 22 R. Oakley says I don't think we intend to duplicate any training if that training is covered in their basic training that can be submitted and approved. So, it's my	

AGENDA ITEM / DISCUSSION	ACTION / FOLLOW-UP
understanding from our medical director, unfortunately, he's not here, is that we want to make sure that that training is in place. R. Jenkins also mentions that most counties do this with a one or one-and-a-half-page letter and no extra things. He says this could be clearer to providers and that all is needed is just authorization of the Title 22 optional skills, and no administrative workload is required. R. Oakley asks if there are any other comments. R. Jenkins says I think I've looked at some policies with Ryan. We looked at one from the valley. We looked at one from Santa Barbara. I would recommend taking one of those examples and maybe starting from there. R. Rosander says that the policy could be quite short in comparison and that it could be simplified to what Dr. Mulkerin wants to authorize. J. Wells says that that would be a lot more direct. D. McCrain says it would be helpful if it was more clearly outlined. R. Jenkins says that these are not new skills and that they do get used already. That a blanket approval of those optional skills would be better. **R. Rosander presents on his material, cardiac arrest protocols, Upgrade/Downgrade and Assisting Patients with their Emergency Medications.** **Discussion** K. Strommen asks if they would have to carry all the equipment for those skills whether they are used or not. R. Jenkins asks if the STEMI group expressed a preference for where the pads were placed. R. Columbo asks what happens if the pads must be taken off. D. Rowley mentions that you could put the pads on but not put the sticky, but then the pads are out of the bag. R. Columbo says you could just put in a line with having the pads ready. K. Strommen says that they had a case where they did a vector change, and it worked. D. McCrain mentions how the Upgrade/Downgrade policy looks good and that he does not have any suggestions. K. Strommen says that he likes how this is its own policy, but that it is ambiguous. Mentions how it would be good to give people steps. S. Jalbert says that he thinks everything we do is judgment-based and how would we write a step for what we see and it being judgment. He says he thinks EMTs, and Paramedics should make their judgment. R. Jenkins says that they must make judgment calls and that you can put in all these steps and never remove the judgment. K. Strommen brings up have we are going to end up with so many different outcomes without having steps. D. McCrain says we could put four pages of parameters here and that medics are still going to make their own judgment. R. Rosander says that even the most basic thing can end up life-threatening. S. Jalbert says how it comes back to human nature and that we shouldn't make it more complicated. R. Jenkins says that these are two separate issues, one is an EMD issue, and one is an upgrade/downgrade issue. S. Wilkinson mentions how the EMD program is being rewritten and they are trying to train all their employees. D. McCrain mentions how Policy 219 is very narrow and asks about other medical conditions. Asks if we could just put something about calling Base about other conditions and medication. R. Jenkins says that you could tailor this to make it more generic to all medications and that this more specific information could live as an attachment. D. Rowley mentions how he would like to know the specific side effects of the medication. R. Columbo mentions that the people in the field are familiar with it. D. McCrain says a generic policy with an attachment for the medications and side effects. **Motion to Approve Items moving forward** **Items Moving Forward** Upgrade/Downgrade Policy, Protocol #640, Protocol #641	D. McCrain motions / C. Bryson seconds / Approved.

AGENDA ITEM / DISCUSSION	ACTION / FOLLOW-UP
Items to revise Contagious Disease Exposure, Public Safety-First Aid, and CPR, Public Safety-First Aid Optional Skills, and Policy # 219.	
ADJOURN – 10:30 am	
Next Meeting: December 5th, 2024, 09:00 A.M. Location: SLO EMSA - 2995 McMillan Ave, Suite 178, San Luis Obispo	

MEETING DATE	OPS, December 5th, 2024
STAFF CONTACT	Rachel Oakley
SUBJECT	New Public Safety First Aid (PSFA) and Cardio Pulmonary Resuscitation (CPR), PSFA Optional Skills, Policy, Procedure, and Attachments
SUMMARY	San Luis Obispo County Emergency Medical Services Agency (SLOEMSA) developed a several PSFA policies and procedures, primarily for law enforcement agencies requesting to utilize the optional skill of naloxone administration. Prior versions that will be replaced are: • Policy #213, Naloxone for Public Safety First Responders Requirements (dated 3/1/18) • Policy #214, Naloxone for Public Safety First Responders, which is a clinical procedure guide (dated 2/1/19). The purpose of the new PSFA program approval policies is to align the applicable programs with California State regulations that apply to all Public Safety personnel in SLO County (peace officers, firefighters, and lifeguards). A clear process to apply and get approved for operating such programs are outlined, along with an application to assist. SLOEMSA also removed the requirement to submit use reports and annual reporting, however, expects the individual organizations that have approved programs to have a robust quality assurance (QA) and quality improvement (QI) program in place. Feedback and recommendations based off of QA/QI activities are welcome and appreciated by SLOEMSA. Most of the content in the policies are taken straight from regulation and some parts align with current SLOEMSA operational procedures.
REVIEWED BY	EMSA Staff
RECOMMENDED ACTION(S)	Approve and recommend to move to EMCC
ATTACHMENT(S)	PSFA/CPR Training Program Approval, PSFA Optional Skills Approval, and all Attachments (Policy numbers TBD)

POLICY # ( ): PUBLIC SAFETY FIRST AID AND CPR TRAINING PROGRAM APPROVAL

I. PURPOSE

A. To establish criteria as defined by Title 22, Division 9, Chapter 1.5 of the California Code of Regulations (CCR), for approval of Public Safety First Aid (PSFA) and Cardiopulmonary Resuscitation (CPR) training programs in the County of San Luis Obispo (SLO).

II. SCOPE

A. As determined by the employing agency, Public Safety personnel who are not otherwise covered by the following approving authorities: California Department of Forestry and Fire Protection (CAL FIRE), Commission on Peace Officer Standards and Training (POST), California Department of Parks and Recreation (DPR), Department of the California Highway Patrol (CHP), and approved Emergency Medical Services (EMS) training programs.

B. Except those whose duties are primarily clerical or administrative, the following regularly employed public safety personnel, lifeguard, firefighter, and peace officer, shall be trained to administer first aid, CPR and use an automated external defibrillator (AED).

III. DEFINITIONS

- Primarily Clerical or Administrative: the performance of clerical or administrative duties accounts for 90% or more of the time worked each pay period.
- Public Safety First Aid: Immediate care for injury or serious illness, including medical emergencies, by public safety personnel prior to the availability of medical care by licensed or certified health care professionals.
- Public Safety AED Service Provider: An agency, or organization which is responsible for, and is approved to operate, an AED.
- Public Safety Personnel:
  - Firefighters: Any officer, employee or member of a fire department or fire protection or firefighting agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California or any member of an emergency reserve unit of a volunteer fire department or fire protection district.
  - Lifeguards: Any officer, employee, or member of a public aquatic safety department or marine safety agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California.
  - Peace Officers: Any city police officer, sheriff, deputy sheriff, peace officer member of the California Highway Patrol, marshal or deputy marshal or police

officer of a district authorized by statute to maintain a police department or other police officer required by law to complete PSFA training.

- Regularly Employed: Being given wages, salary, or other remuneration for the performance of those duties normally carried out by lifeguards, firefighters, or peace officers.

IV. POLICY

A. Initial training requirements shall be satisfactorily completed within one (1) year from the effective date of the individual's initial employment and, whenever possible, prior to assumption of regular duty in one of the public safety personnel categories.

B. The initial course of instruction shall be at least twenty-one (21) hours in first aid and CPR.

C. The content of initial training listed in CCR shall prepare personnel to recognize injury or illness, render basic first aid level treatment, and shall be competency based.

D. Applicable agencies shall apply and be approved to teach the skills listed in section (H) of this policy, prior to training implementation and authorization of personnel to perform PSFA and CPR skills.

1. Approved PSFA and CPR Training Programs in operation prior to policy implementation are valid for the current approval term listed on an official approval letter.

E. A PSFA and CPR Training Program applicant must have and submit a procedure for an EMS quality improvement program (EMSQIP).

F. Initial and retraining courses shall test the knowledge and skills specified in CCR and have a passing standard for course completion and shall ensure the competency of each skill.

1. Each course shall include a written and skills examination which tests the ability to assess and manage all of the conditions, content, and skills listed in CCR.

2. The passing standards shall be established and approved by the San Luis Obispo Emergency Medical Services Agency (SLOEMSA) before administration of the examination.

G. Initial training shall include content on bloodborne pathogens and SLOEMSA Policy #123, Contagious Disease Exposure.

1. Refresher training shall include content on bloodborne pathogens.

H. After completion of training and demonstration of competency to the satisfaction of an approved training provider, personnel are authorized to perform the following emergency medical care while at the scene of an emergency:

1. Evaluate the ill and injured.

2. Provide treatment for shock.
3. Support airway and breathing with manual airway opening methods, including head-tilt and/or jaw thrust, manual methods to remove an airway obstruction in adults, children, and infants, and use the recovery position.
4. Spinal immobilization.
5. Splinting of extremities.
6. Eye irrigation using water or normal saline.
7. Assist with administration of glucose.
8. Assist patients with administration of physician prescribed epinephrine devices and naloxone.
9. Assist with childbirth.
10. Hemorrhage control using direct pressure, pressure bandages, principles of pressure points, and tourniquets. Hemostatic dressings may be used from the list approved by the State EMS Authority.
11. Apply chest seals and dressings.
12. Simple decontamination techniques and use of decontamination equipment.
13. Care for amputated body parts.
14. Provide basic wound care.

I. Patient care provided by public safety personnel will be reported and handed off to any arriving EMS personnel who is authorized at a higher medical level, as soon as is feasible.

J. Retraining is required at least once every two years by successful completion of either:

1. An approved course which includes review of the topics and demonstration of skills prescribed in CCR, which consists of at least eight (8) hours of first aid and CPR including AED.
2. Maintaining current and valid certification or licensure as an Emergency Medical Technician (EMT), Paramedic, Registered Nurse, Physician Assistant, Physician, or current and valid National Registry of Emergency Medical Responder (EMR), EMT, Advanced EMT, or Paramedic.
3. Successful completion of a competency based written and skills pretest of the topics and skills prescribed in CCR. Appropriate retraining of topics indicated by the pretest shall be completed in addition to any new developments in first aid and CPR. A final test shall be provided covering the topics included in the retraining for personnel failing to pass the pretest. The hours for retraining may be reduced to the hours needed to cover topics indicated by the pretest.

K. Training in PSFA and CPR shall be conducted by an instructor who is currently licensed in California (CA) as a Physician, Physician's Assistant, Registered Nurse, or Paramedic, or certified in CA as an EMT, or is approved by SLOEMSA, and who meets the following criteria:

1. Proficient in the skills taught.
2. Qualified to teach by education or experience.

L. Validation of all instructor's qualifications shall be the responsibility of the agency whose training program has been approved by SLOEMSA.

M. A PSFA training program shall have a Program Director, to ensure that the program is compliant with this policy and CCR.

1. The Program Director may also be an instructor.

N. Every trainee who successfully completes an approved course of instruction that includes successfully passing the competency based written and skills exams shall be given a certificate or written verification of completion that shall include:

1. Initial or refresher training course.
2. Number of training hours completed.
3. Date of issue.
4. Date of expiration, which shall be two (2) years from the date of course completion.

O. An approved PSFA and CPR Training Program shall maintain a record of the names of trainees and the dates on which training courses have been completed on a Public Safety First Aid and CPR Training Record – Attachment B.

1. This record shall be retained for at least four (4) years.
2. This record shall be submitted to the SLOEMSA upon completion of initial training, retraining, and every four (4) years with a Public Safety First Aid and CPR Training Program Application – Attachment A.

P. If a SLOEMSA approved PSFA and CPR Training Program has or plans to acquire AEDs for intended use by trained personnel, an application and approval for Public Safety AED Service Provider, Policy #204, shall be obtained prior to the usage of AEDs.

1. AED authorized personnel will be indicated on the Public Safety First Aid and CPR Training Record – Attachment B.
2. State and federal agencies are approved by the EMS Authority.

Q. All course material and records shall be subject to oversight and must be made available for periodic review as determined by SLOEMSA.

R. Course approval is valid for four (4) years from the date of approval, and shall be reviewed every four (4) years by submitting a Public Safety First Aid and CPR Training Program Application – Attachment A.

S. An approved PSFA and CPR Training Program shall notify SLOEMSA, in writing, within thirty (30) calendar days of any change in Program Director, instructor(s), or course materials.

1. Changes are subject to SLOEMSA review and must be approved prior to implementation.

T. Program approval and renewal is contingent upon continued compliance with all required criteria and provisions in this policy and CCR and may be revoked by SLOEMSA if the program fails to remain compliant.

1. SLOEMSA will follow the procedures set forth in CCR regarding withdrawal of program approval.

U. All current CCR will be followed if different than the requirements outlined in this policy.

V. Allow sufficient time to apply for approval or renewal, as program review can take up to twenty-one (21) business days, which does not include time for program remediation. Additional turn time would be required if there are deficiencies noted.

W. A non-refundable fee will be collected as part of the application and review requirements. An applicant whose check returns for insufficient funds may result in denial or suspension until fee is paid and will incur additional fees as outlined in SLOEMSA Policy #101 – Fee Collection.

V. PROCEDURE

A. Submit a complete application, Attachment A – Public Safety First Aid and CPR Training Program Application, to SLOEMSA and provide the required items below:

1. A letter of intent.
2. A copy of all course materials, including but not limited to course outline, objectives, and presentations or handouts used for instruction.
3. A copy of course written and skills tests.
4. Passing standards for course written and skills tests.
5. Program Director and Instructor(s) resumes that specify eligibility for program roles.
6. A copy of the course completion certificate (template).
7. A copy of the EMSQIP.

B. Submit payment.

C. A written response will be sent to confirm that the application has been received.

D. Allow up to twenty-one (21) business days for a program review, which will result in a written response detailing whether there is any missing information.

E. A letter of program approval or disapproval will be issued by SLOEMSA as soon as the decision has been reached.

1. The program approval letter will indicate the program effective date and expiration.

F. Submit a Public Safety First Aid and CPR Training Record – Attachment B, upon completion of initial training and after retraining.

VI. AUTHORITY

- Title 22, Division 9, Chapter 1.5

VII. ATTACHMENTS

A. Public Safety First Aid and CPR Training Program Application

B. Public Safety First Aid and CPR Training Record

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

PUBLIC SAFETY FIRST AID AND CPR TRAINING PROGRAM APPLICATION

Check One: □ Initial Application □ Renewal

APPLICANT INFORMATION	
Public Safety Provider Name:	
Public Safety Provider Address:	Public Safey Provider Phone Number:
Program Director Name:	Program Director Phone Number:
Program Director Email:	Alternate Contact:

SUBMIT THE FOLLOWING WITH THIS APPLICATION
☐ Letter of intent.
☐ Copy of all course materials, including but not limited to course outline, objectives, and presentations or handouts used for instruction.
☐ Copy of course written and skills tests.
☐ Passing standards for course written and skills tests.
☐ Program Director and Instructor(s) resumes that specify eligibility for program role.
☐ Copy of the course completion certificate.
☐ Copy of the EMS Quality Improvement Program.
☐ Submit current application fee.

ATTESTATION OF PSFA&CPR APPLICANT	
I hereby certify that I have reviewed and understand the County of San Luis Obispo EMS Policy #XXX, Public Safety First Aid and CPR Training Program Approval and Title 22, Div. 9, Ch. 1.5.	
Signature of PSFA & CPR Applicant:	Date:

*****EMS AGENCY USE ONLY BELOW THIS LINE*****	
Received Date:	☐ Email confirmation of application received.
Initial Review (w/in 21 work days), Date:	Letter of approval or disapproval, Date:
Update State Database:	Update SLO EMSA records:
☐ Submit Attachment B upon completion of initial training.	

PUBLIC SAFETY FIRST AID AND CPR TRAINING RECORD

Public Safety Provider Name:				
Employee Name:	PSFA Exp	Medic/EMT Exp	CPR/AED Exp	AED Authorized (Yes or No)

POLICY # ( ): PUBLIC SAFETY FIRST AID OPTIONAL SKILLS APPROVAL

I. PURPOSE

A. To establish criteria as defined by Title 22, Division 9, Chapter 1.5 of the California Code of Regulations (CCR), for approval of Public Safety First Aid (PSFA) optional skills in the County of San Luis Obispo (SLO).

II. SCOPE

A. In addition to the skills authorized by an approved PSFA and Cardiopulmonary Resuscitation (CPR) training program, public safety personnel may perform optional skills specified in this policy, when authorized by the Medical Director of SLO Emergency Medical Services Agency (SLOEMSA).

III. DEFINITIONS

- Primarily Clerical or Administrative: the performance of clerical or administrative duties accounts for 90% or more of the time worked each pay period.
- Public Safety First Aid: Immediate care for injury or serious illness, including medical emergencies, by public safety personnel prior to the availability of medical care by licensed or certified health care professionals.
- Public Safety Personnel:
  - Firefighters: Any officer, employee or member of a fire department or fire protection or firefighting agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California or any member of an emergency reserve unit of a volunteer fire department or fire protection district.
  - Lifeguards: Any officer, employee, or member of a public aquatic safety department or marine safety agency of the State of California, or any city, county, city and county, district or other public or municipal corporation or political subdivision of California.
  - Peace Officers: Any city police officer, sheriff, deputy sheriff, peace officer member of the California Highway Patrol, marshal or deputy marshal or police officer of a district authorized by statute to maintain a police department or other police officer required by law to complete PSFA training.
- Regularly employed: Being given wages, salary, or other remuneration for the performance of those duties normally carried out by lifeguards, firefighters, or peace officers.

IV. POLICY

A. The following optional skills are available for public safety personnel:

1. Administration of naloxone for suspected narcotic overdose.

2. Administration of epinephrine by auto-injector for suspected anaphylaxis.
3. Supplemental oxygen therapy using a non-rebreather face mask or nasal cannula, and bag-valve-mask ventilation.
4. Administration of auto-injectors containing atropine and pralidoxime chloride for nerve agent exposure for self or peer care, while working for a public safety provider.
5. Use of oropharyngeal airways (OPAs) and nasopharyngeal airways (NPAs).

B. Interested public safety providers shall apply and be approved for the optional skills listed in section (A) of this policy, prior to training implementation and authorization of personnel to perform the optional skills.

1. Approved PSFA Optional Skills that providers have in operation prior to policy implementation are valid for the current approval term listed on an official approval letter.

C. A PSFA Optional Skills applicant must have and submit a procedure for an EMS quality improvement program (EMSQIP).

D. Approved providers must ensure competency of each skill applied for by providing an orientation to the specific equipment and supplies, before utilized by personnel.

E. Orientation shall include content on bloodborne pathogens and SLOEMSA Policy #123, Contagious Disease Exposure.

F. Retraining shall be conducted more frequently as determined by the EMSQIP.

G. Patient care provided by public safety personnel will be reported and immediately handed off to any arriving EMS personnel who is authorized at a higher medical level.

H. PSFA optional skills training shall be overseen by a Program Liaison, to ensure that the program is compliant with this policy and CCR.

I. An approved PSFA Optional Skills provider shall maintain a record of the names of oriented personnel and the dates on which PSFA and CPR training courses have been completed on a Public Safety First Aid Optional Skills Training Record – Attachment B

1. This record shall be submitted to SLOEMSA when updated and every four (4) years with a Public Safety First Aid Optional Skills Application – Attachment A.

J. PSFA Optional Skills approval is valid for four (4) years from the date of approval and shall be reviewed every four (4) years by submitting a Public Safety First Aid Optional Skills Application - Attachment A.

K. All current CCR will be followed if different than the requirements outline in this policy.

L. Allow sufficient time to apply for approval or renewal, as program review can take up to twenty-one (21) business days, which does not include time for program remediation. Additional turn time would be required if there are deficiencies noted.

M. A non-refundable fee will be collected as part of the application and requirements. An applicant whose check returns for insufficient funds may result in denial or suspension until fee is paid and will incur additional fees as outlined in SLOEMSA Policy #101 – Fee Collection.

V. PROCEDURE

A. Submit a complete application, Attachment A – Public Safety First Aid Optional Skills Application, to SLOEMSA and provide the required items below:

1. A copy of the EMSQIP.

B. Submit payment.

C. A written response will be sent to confirm that the application has been received.

D. Allow up to twenty-one (21) business days for a program review, which will result in a written response detailing whether there is any missing information.

E. A letter of program approval or disapproval will be issued by SLOEMSA as soon as the decision has been reached.

1. The program approval letter will indicate the program effective date and expiration.

F. Submit a Public Safety First Aid Optional Skills Training Record – Attachment B, upon completion of initial training and after retraining.

VI. AUTHORITY

- Title 22, Division 9, Chapter 1.5

VII. ATTACHMENTS

A. Public Safety First Aid Optional Skills Application

B. Public Safety First Aid Optional Skills Training Record

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

County of San Luis Obispo Public Health Department | Policy XXX Attachment A
Division: Emergency Medical Services Agency | Effective Date: XX/XX/2023

PUBLIC SAFETY FIRST AID OPTIONAL SKILLS APPLICATION

Check One: □ Initial Application □ Renewal

APPLICANT INFORMATION	
Public Safety Provider Name:	
Public Safety Provider Address:	Program Liaison Name:
Program Liaison Phone Number:	Program Liaison Email:

OPTIONAL SKILLS APPLYING FOR:
☐ Administration of naloxone for suspected narcotic overdose.
☐ Administration of epinephrine by auto-injector for suspected anaphylaxis.
☐ Supplemental oxygen therapy using a non-rebreather face mask or nasal cannula, and bag-valve-mask ventilation.
☐ Administration of auto-injectors containing atropine and pralidoxime chloride for nerve agent exposure for self or peer care, while working for a public safety provider.
☐ Use of oropharyngeal airways (OPAs) and nasopharyngeal airways (NPAs).

SUBMIT THE FOLLOWING WITH THIS APPLICATION:
☐ Copy of the EMS Quality Improvement Program.
☐ Submit current application fee.

ATTESTATION OF PSFA OPTIONAL SKILLS APPLICANT	
I hereby certify that I have reviewed and understand the County of San Luis Obispo EMS Policy #XXX, Public Safety First Aid Optional Skills Approval and Title 22, Div. 9, Ch. 1.5.	
Signature of PSFA Optional Skills Applicant:	Date:

*****EMS AGENCY USE ONLY BELOW THIS LINE*****	
Received Date:	☐ Email confirmation of application received.
Initial Review (w/in 21 work days), Date:	Letter of approval or disapproval, Date:

PUBLIC SAFETY FIRST AID OPTIONAL SKILLS TRAINING RECORD

Public Safety Provider Name:				
Employee Name:	PSFA Exp	Medic/EMT Exp	CPR/AED Exp	Optional Skills Authorized Yes/No

MEETING DATE	December 5th, 2024
STAFF CONTACT	Rachel Oakley
SUBJECT	EMS Personnel Policy Revisions
SUMMARY	It was determined that a discussion is needed with stakeholders before drafting revisions to EMS personnel policies. It is the intent of the EMS Agency to clarify intent to suggested revisions listed below and to allow an opportunity for more items to be suggested and captured in new draft policies. **EMT Certification:** Only 1 suggestion collected since last revision in March 2023: • Employer: o Add requirement to report employer information within 3 days of employed status, when using EMT certification for job functions. **MICN Authorization:** Only a couple suggestions have been collected since last revision in March 2023. Suggestions: • Med Com Orientation: o Change hours from 4 to 2. Only 2 hours are needed to complete this task (section III. C. 3. c.). o This has been temporarily approved by Dr. Mulkerin until policy revision. • Clarify Application Process: o To align with other EMS personnel application processes, the application, review of eligibility, and permission to proceed is the first step (sections III. C. and IV. A.). • Remove from application the requirement to provide court documentation and police reports, however, a written statement will be required (application page 2, declaration and attestation). o Include requirement in policy. **Paramedic Accreditation and Reaccreditation:** Since the last revision of the Paramedic Accreditation and Reaccreditation revisions in March 2023, there have been several suggestions for revision collected. Suggestions: • Accreditation Exam: o State that only 2 attempts will be provided.

	○ Increase passing score from current 80%. ○ Provide procedure if test is not successfully completed (section IV. A. d.) or follow Medical Director review and recommendation (section III. J.). • Skills: ○ Clearly state that one "Paramedic Skills Annual Verification Tracking Sheet-Attachment B" (AVT Sheet), is required to be completed within every 12 months (section V. A. 4.). ○ Eliminate requirement for provider agencies to retain "Skills Verification Checklist-Attachment D" for 4 years (section V. A. 4.). ○ Require an initial skills testing form to be completed as part of the accreditation process (it's currently listed on the "Paramedic Accreditation Field Evaluation Completion Form-Attachment B"). ○ To standardize the process, provide more details on proration of skills testing with reduced accreditation timeframes (section IV. L.). ○ Bring back skills testing to the Annual EMS Update Classes hosted by the EMS Agency. ○ Add FTO/skills evaluator name and P# to AVT Sheet-Attachment B. ○ Change "field evaluation" to AVT sheet-Attachment B (section IV. M.). • Base Station Meetings (BSM): ○ To standardize the process, provide more details on proration of BSM with reduced accreditation timeframes (section IV.L.). • Paramedic Liaison: ○ To align with other EMS personnel policies, each provider agency will have a designated liaison to submit and track all accreditation and reaccreditation applications with the EMS Agency. • Lapse: ○ Remove or change the 90 day lapse criteria that includes leaves of all kinds (section IV. I., J., and K.). ▪ Consider accreditation valid until no longer employed with ALS provider or job function is no longer in EMS response. ▪ Individual provider agency responsible for ongoing training requirements to ensure employees are up to date with policies, procedures, protocols, and skills.
REVIEWED BY	EMSA Staff.
RECOMMENDED ACTION(S)	Discuss and propose revisions for EMS personnel draft policies.
ATTACHMENT(S)	N/A. Review current policies as needed on County website.

MEETING DATE	December 05th, 2024
STAFF CONTACT	Ryan Rosander, EMS Director 805.788.2512 rrosander@co.slo.ca.us
SUBJECT	Assisting patients with their emergency medications, STEMI and trauma catchment areas, fluid bolus in universal protocol, anaphylaxis revision.
SUMMARY	Several Congenital Adrenal Hyperplasia advocacy groups have reached out to SLOEMSA proposing a policy that addresses the need for paramedics to assist patients with their emergency medications, especially for patients in adrenal crisis. This policy will allow paramedics to receive base hospital orders to assist the parents or caregivers in drawing up and administering medications such as Solu-Cortef. It covers not only patients with Congenital Adrenal Hyperplasia but also any patient who needs assistance from a paramedic with their physician-prescribed emergency medications. Over the past year, several stakeholders have approached SLOEMSA with a request to incorporate catchment areas into the STEMI and Trauma destination policies. Currently, the field operates without a defined boundary or cutoff for decisions on transporting STEMI or trauma-alert patients to SVRMC/FHMC (SLO County) or MRMC (SB County). The proposed policy revision will help operations by providing clear boundaries. With SLOEMSA's 2024 EMS Update Class currently underway, numerous paramedics have mentioned that they would like to see a 500mL fluid bolus (with repeat) within the Universal Protocol. This would eliminate the need for paramedics to call a base hospital for orders to administer fluids. During our last CAC, an MD mentioned that they are seeing an increase in anaphylaxis patients being brought into the ED without EPI administered. This was discussed, and a possibility might be the lack of language clarity surrounding an "unstable" patient within the protocol. This has been addressed within the revision.
REVIEWED BY	Dr. William Mulkerin, SLOEMSA Staff
RECOMMENDED ACTION(S)	Policy #219, Policy #152, Policy #153, Protocol #601, and Protocol #611, recommended for approval by Operations and moved to the Clinical Advisory agenda.
ATTACHMENT(S)	Policy #219: Assisting Patients With Their Emergency Medications, Policy #152: STEMI Triage and Destination, Policy #153: Trauma Triage and Destination, Protocol #601: Universal, Protocol #611 Allergic Reaction/Anaphylaxis

UNIVERSAL

MEDICAL	TRAUMA
BLS Procedures	

• Evaluate Scene Safety/Personal Protective Equipment
• Assess, establish and maintain airway
  ○ Suction as needed
• Pulse Oximetry
  ○ O_2 administration per Airway Management Protocol #602
• Evaluate breathing and circulation
• Assess chief complaint
• Focused physical exam and vital signs:
  ○ Pulse
  ○ Blood pressure
  ○ Respiratory rate
  ○ Lung sounds
  ○ Skin signs
• BLS treatment protocols
	• Evaluate Scene Safety/Personal Protective Equipment
	• Assess, establish and maintain airway
	  ○ Suction as needed
	• Pulse Oximetry
	  ○ O_2 administration per Airway Management Protocol #602
	• Evaluate breathing and circulation
	• Control life-threatening bleeding
	• Remove patient's clothing to expose and identify injuries
	• Ensure patient warmth – cover patient after clothing removal to maintain core body temperature
	• Spinal motion restriction (SMR) if indicated per Spinal Motion Restriction Procedure # 702
	• BLS treatment protocols

BLS Elective Skills	
Obtain Blood Glucose Level if indicated by: • Policy #612 ALOC • Policy #620 Seizures • Policy #621 CVA/TIA • As directed by ALS provider	
ALS Procedures	
• Vascular access – Procedure #710 • Consider 12-lead ECG early • Capnography (if available/applicable) • Blood Glucose Measurement • Transport Determination • ALS Treatment Protocols • Normal Saline up to 500mL IV ○ May repeat x1 for persistent hypotension	• Trauma Triage and Destination • ALS Treatment Protocols
Base Hospital Orders Only	
• Determined on patient needs • If applicable, see Policy #219: Assisting Patients with Their Emergency Medications	• Determined on patient needs
Notes	
• Use Pediatric Policies for patients ≤34 kg and consider use of Broselow tape or equivalent	

ALLERGIC REACTION/ANAPHYLAXIS

ADULT	PEDIATRIC (≤34 KG)
BLS	
• Universal Protocol #601 • Pulse Oximetry ○ O_2 administration per Airway Management Protocol #602 • May assist with the administration of patient's prescribed medication (i.e. Epi Auto-injector, inhaler, etc.)	Same as Adult
BLS Elective Skill (Approved Providers Only)	

Unstable
~~(Dyspnea/Wheezing/Shock)~~
 	
(One or more of the following: hypotension, severe respiratory distress, wheezing, oral swelling, altered mental status, chest tightness, GI symptoms)
 	
• **Adult 0.3 mg Epinephrine Auto-Injector** administered in anterolateral thigh
  ○ May repeat, if indicated, every 5 min, max 3 doses
	Unstable
	~~(Dyspnea/Wheezing/Shock)~~
	
	(One or more of the following: hypotension, severe respiratory distress, wheezing, oral swelling, altered mental status, chest tightness, GI symptoms)
	
	Pediatric (≥15 kg) 0.15 mg Epinephrine Auto-Injector administered in anterolateral thigh
	  ○ May repeat, if indicated, every 5 min, max 3 doses

BLS Optional Scope Skill (Approved Providers Only)	

Unstable
~~(Dyspnea/Wheezing/Shock)~~
 	
(One or more of the following: hypotension, severe respiratory distress, wheezing, oral swelling, altered mental status, chest tightness, GI symptoms)
 	
Adult Epinephrine 1:1000 0.3 mg IM
  ○ May repeat, if indicated, every 5 min, max 3 doses
	Unstable
	~~(Dyspnea/Wheezing/Shock)~~
	
	(One or more of the following: hypotension, severe respiratory distress, wheezing, oral swelling, altered mental status, chest tightness, GI symptoms)
	
	• **Pediatric (≥15 kg), Epinephrine 1:1000 0.15 mg IM anterolateral thigh**
	  ○ May repeat, if indicated, every 5 min , max 3 doses

ALS Standing Orders	
Stable (Itching/rash) • **Diphenhydramine** 50 mg IV/IM **Unstable** ~~(Dyspnea/Wheezing/Shock)~~	**Stable** (Itching/rash) • **Diphenhydramine** 2 mg/kg IV/IM – not to exceed 50 mg **Unstable** ~~(Dyspnea/Wheezing/Shock)~~

(One or more of the following: hypotension, severe respiratory distress, wheezing, oral swelling, altered mental status, chest tightness, GI symptoms)
 	
• **Albuterol** 2.5-5 mg via HHN/Mask/CPAP/BVM with adjunct, over 5-10 min
  ○ repeat as needed
• **Epinephrine 1:1,000** 0.01 mg/kg IM – not to exceed 0.5 mg
  ○ may repeat every 5 min, max 3 doses
• **Diphenhydramine** 50 mg IV/IM
 	
~~**Extremis**~~
• ~~**Epinephrine 1:1,000** 0.01 mg/kg SL – not to exceed 0.5 mg~~
  ○ ~~may repeat every 5 min, max 3 doses~~
	(One or more of the following: hypotension, severe respiratory distress, wheezing, oral swelling, altered mental status, chest tightness, GI symptoms)
	
	• **Albuterol** 2.5-5 mg via HHN/Mask/BVM with adjunct, over 5-10 min
	  ○ repeat as needed
	• **Epinephrine 1:1,000** 0.01 mg/kg IM – not to exceed 0.3 mg
	  ○ may repeat every 5 min, max 3 doses
	• **Diphenhydramine** 2 mg/kg IV/IM – not to exceed 50 mg
	
	~~**Extremis**~~
	• ~~**Epinephrine 1:1,000** 0.01 mg/kg SL – not to exceed 0.3 mg~~
	  ○ ~~may repeat every 5 min, max 3 doses~~

Base Hospital Orders Only	
Unresponsive to previous therapy • **Epinephrine 1:10,000** 0.01 mg/kg slow IV titrated – not to exceed 0.5 mg • As needed	Unresponsive to previous therapy • **Epinephrine 1:10,000** 0.01 mg/kg slow IV titrated – not to exceed 0.3 mg • As needed
Notes	
• Auto-injector injection site should be exposed and cleansed with aseptic technique prior to injection. • Follow manufacturer's instructions when using Epinephrine auto-injector. • If unsure between stable or unstable, follow **unstable** standing orders.	

POLICY #219: ASSISTING PATIENTS WITH THEIR EMERGENCY MEDICATIONS

I. PURPOSE

A. To allow paramedics in San Luis Obispo County to assist patients in administering physician-prescribed, self-administered emergency medications.

II. POLICY

A. Paramedics may be requested to assist with the administration of a specific, physician-prescribed emergency medication.

B. Paramedics may assist patients with the administration of physician-prescribed devices, including, but not limited to, patient-operated medication pumps and self-administered emergency medications.

C. Please note that this policy applies not only to one condition but any condition in which the patient needs emergency medications administered.

III. EXAMPLE CONDITION

A. Some children are born with a genetic defect (Congenital Adrenal Hyperplasia) that prevents their body from producing adequate amounts of Cortisol. The signs & symptoms of an adrenal crisis include nausea, fever, pallor, confusion, weakness, tachycardia, tachypnea, hypoglycemia, hypotension, and shock, symptoms that might lead to their death.

B. Families with such a child should be very aware of their condition. When these children experience an adrenal crisis, the proper treatment is the IM administration of the drug, e.g., hydrocortisone (Solu-Cortef). During this emergency, the parents or caregivers may be unable to deliver the IM medication properly and might request assistance from the EMS system. In this type of emergency, paramedics can assist the parents or caregivers with drawing up and administering the Solu-Cortef. The family members should be familiar with the proper dosage and have the necessary equipment, if available. In some cases, such as when a child is at school, the school personnel may have medication and instructions available.

IV. PROCEDURE

A. State law authorizes a paramedic to assist a patient or parents who request help administering an emergency medication outside the ordinary scope of practice.

B. Base Hospital shall be contacted to determine the appropriate course of action if faced with this rare situation. With Base Hospital orders, paramedics may assist patients/families in drawing up and administering emergency medication.

C. All patients who have received emergency medication administered by EMS shall be transported to the hospital.

V. AUTHORITY

- Title 22, Chapter 2, § 100063

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

POLICY #152: STEMI TRIAGE AND DESTINATION (Telemetry Trial)

I. PURPOSE

A. To establish guidelines for Emergency Medical Services (EMS) personnel to identify and transport patients with acute ST-segment Elevation Myocardial Infarction (STEMI) who could benefit from the rapid response and specialized services of a STEMI Receiving Center (SRC).

II. SCOPE

A. This policy applies to adult patients with chest pain or other symptoms indicative of Acute Coronary Syndrome (ACS) with a 12-lead ECG demonstrating elevated ST-segments indicating a specific type of myocardial infarction.

III. DEFINITIONS/GLOSSARY

- Percutaneous Coronary Intervention (PCI): A broad group of percutaneous techniques utilized for the diagnosis and treatment of patients with STEMI.
- Return of Spontaneous Circulation (ROSC): The return of a palpable pulse after cardiac arrest.
- STEMI: An acute myocardial infarction that generates a specific type of ST-segment elevation on a 12-lead ECG.
- "STEMI Alert": A report from EMS personnel that notifies a STEMI Receiving Center as early as possible that a patient has a specific computer-interpreted prehospital 12-lead ECG indicating a STEMI, allowing the SRC to initiate the internal procedures to provide appropriate and rapid treatment interventions.
- "12-Lead Consultation" – Contact SLO County STEMI Receiving Hospital (French Hospital Medical Center) when the patient does not meet a STEMI ALERT Criteria and transmitting the 12-lead ECG would benefit the consultation.
- STEMI Receiving Center (SRC): A facility licensed for cardiac catheterization laboratory and recognized as an SRC by the County of San Luis Obispo Emergency Medical Services Agency (EMS Agency).
- STEMI Referral Hospital (SRH): An acute care hospital in the County of San Luis Obispo (SLO) that is not designated as a STEMI Receiving Center.
- SLO STEMI Receiving Center (SLO SRC) – refers to the STEMI Receiving Center in San Luis Obispo County (French Hospital Medical Center) to be used for medical direction and or destination decisions.

IV. POLICY

A. Determine if patient condition meets STEMI Patient Triage Criteria.

B. "STEMI Alert" notifications - contact the nearest SRC **(French or Marian)** as soon as possible

C. "12- Lead ECG Consultations" and/or "Destination" consultations - contact the SLO SRC **(French)**

V. PROCEDURE

A. Determine if patient condition meets STEMI Patient Triage criteria:

1. Patients meeting EMS Agency Protocol Adult Chest Pain #640: or with indications for 12-lead ECG per EMS Agency 12-lead ECG Policy #707 with computerized interpretation of an accurately performed pre-hospital 12-lead ECG indicating ***STEMI*** (or equivalent computerized interpretation).

B. Destination and Notification

1. Transport to nearest SRC (French or Marian) or as directed by a SLO SRC (French).

a. Patients meeting the STEMI Patient Triage Criteria are considered a "STEMI Alert" and must be transported to the nearest SRC.

b. Patients with ROSC regardless of 12-lead ECG reading

c. The SRC Emergency Department must be notified as early as possible of the incoming "STEMI Alert" and /or ROSC to activate the SRC's internal STEMI/PCI system.

d. The closest SRC center for patients being transported within San Luis Obispo County shall be defined as follows:

1. A unit on scene of a call that is located within San Luis Obispo County south of El Campo Rd should proceed to Marian Regional Medical Center.

2. A unit on scene of a call that is located within San Luis Obispo County north of El Campo Rd should proceed to French Hospital Medical Center.

3. In any other area west or east of El Campo Rd, crews should use discretion in determining which SRC is closest or fastest for patient transport.

2. An Emergency Department physician at the SLO SRC **(French)** must be consulted to determine patient destination in the following:

a. "STEMI Alert":

(1) The patient is unstable with a SBP<90mmHg and transport time to the SRC would add more than 30 minutes to the transport time to a STEMI Referral Hospital (SRH).

(2) Patient is uncooperative with the procedure and/or expresses a personal preference for destination other than the SRC; see EMS Agency Policy #203: Patient Refusal of Treatment or Transport.

b. Questionable 12-Lead ECG

c. Patients who, while enroute, develop unmanageable airway or cardiac arrest without ROSC must be transported to the closest hospital, with the transporting provider notifying the intended SRC of the change in destination.

d. When a patient is diverted to another hospital the SLO SRC (French) shall notify the receiving hospital and provide information regarding the destination decision.

C. Contact the nearest SRC as soon as possible with "STEMI Alert" Notification

1. For patients with identified STEMI, destination must be promptly determined after the prehospital 12-lead ECG is completed and read. The SRC must be notified as soon as possible.

2. The "STEMI Alert" notification must contain the following information:

a. Call identified as a "STEMI Alert".

b. ETA to SRC.

c. Patient age and gender.

d. Confirmation of ECG reading and whether it appears to be free of significant artifact.

e. Confirmation that the appropriate treatment protocol is being followed.

f. Results of any medications given.

g. Additional information if required:

(1) Any confusion regarding chief complaint or treatment.

(2) Destination decision assistance.

3. ECG Transmission:

a. With a STEMI Alert or ROSC and the equipment is available, the ALS provider shall transmit a 12-lead ECG to a SRC (French or Marian);

(1) Notify the SRC that you are capable of 12-lead ECG transmission and that you have transmitted or are about to transmit the 12-lead ECG previously obtained.

(2) Include on the transmitted 12-lead ECG the patient age and sex required for the ECG monitor to accomplish its interpretation and be used as an identifier for the SRC.

(3) Do not include the name of the patient with the transmission of the 12-lead ECG.

b. When "Consulting" with a SLO SRC (French) and transmitting the 12-lead ECG would benefit the consultation:

(1) Notify the SLO SRC (French) that you are capable of 12-lead ECG transmission and that you have transmitted or are about to transmit the 12-lead ECG.

(2) Include on the transmitted 12-lead ECG the patient age and sex required for the ECG monitor to accomplish its interpretation and be used as an identifier for the SRC

(3) Do not include the name of the patient with the transmission of the 12-lead ECG.

4. Documentation

a. Findings of prehospital 12-lead ECGs, the time of the “STEMI Alert,” and patient identification must be documented on the 12-lead ECG and the prehospital PCR.

b. Two copies of the prehospital 12-lead ECG (multiple if performed) must be made, with one delivered to the receiving hospital responsible for the continued care of the patient, and one included with the prehospital PCR.

VI. AUTHORITY

- California Health and Safety Code, Division 2.5, Sections 1797.67,1798, 1798.170.

POLICY #153: TRAUMA PATIENT TRIAGE AND DESTINATION

I. PURPOSE

A. To establish guidelines for EMS personnel to identify and transport "significantly injured" patients who could benefit from the rapid response and specialized services of a trauma center.

II. SCOPE

A. This policy applies to both adult and pediatric injured patients, unless stated otherwise.

III. PROCEDURE

A. Trauma Activation Criteria

1. "**STEP 1 or STEP 2 TRAUMA ALERT" -** Patient meeting any one of the Physiologic (Step 1) and/or Anatomic criteria (Step 2) following a traumatic event shall be designated a "**TRAUMA ALERT"** and transported to the closest trauma center.

2. "**STEP 3 TRAUMA CONSULTATION**" - Patient meeting (Step 3) Mechanism of Injury - contact with the County of San Luis Obispo (SLO) Trauma Center for patient destination.

3. **"STEP 4 TRAUMA CONSULTATION"**- Shall be made with the SLO Trauma Center to determine destination when the paramedic identifies a significantly injured patient that DOES NOT meet the Step 1 (Physiologic), Step 2 (Anatomic) or Step 3 (Mechanism of Injury) criteria but meets one or more of the special patient or system considerations

B. Trauma Patient Criteria

Patients meeting any one of the Physiologic and/or Anatomic criteria following a traumatic event shall be a "TRAUMA ALERT" and transported to the closest trauma center. Patient meeting Mechanism of Injury and/or Special Patient/System Considerations shall be a TRUAMA CONSULT and contact the County of San Luis Obispo (SLO) Trauma Center for patient destination.

C. Closest Trauma Center

1. The closest Trauma Center for patients being transported within San Luis Obispo County shall be defined as follows:

a. A unit on scene of a call that is located within San Luis Obispo County south of El Campo Rd should proceed to Marian Regional Medical Center.

b. A unit on scene of a call that is located within San Luis Obispo County north of El Campo Rd should proceed to Sierra Vista Regional Medical Center.

c. In any other area west or east of El Campo Rd, crews should use discretion in determining which trauma center is closest or fastest for patient transport.

1. **STEP 1 (Physiologic Criteria)**
   a. ***Adult*** injured patients meeting any one of the following criteria:
      1. Glasgow Coma Scale ≤13 (based on patient history and attributed to injury)
      2. Systolic blood pressure <90 mmHg
      3. Respiratory rate <10 or >29 breaths per minute
   b. ***Pediatric*** injured patients (≤ 34 Kg) meeting any one of the following criteria:
      1. Glasgow Coma Scale ≤13 (based on patient history and attributed to injury)
      2. Evidence of poor perfusion – color, temperature, etc.
      3. Respiratory rate
         - >60 breaths per minute or respiratory distress
         - <20 breaths per minute in infants <1year
      4. Heart rate
         - ≤5 years (<22Kg) heart rate <80 beats per minute or >180 beats per minute
         - ≥6 years (23-34Kg) heart rate <60 beats per minute or >160 beats per minute
      5. Blood pressure
         - Newborn (<1 month) systolic blood pressure <60mmHg
         - Infant (1 month -1 year) systolic blood pressure <70mmHg
         - Child (1 year-10 years) systolic blood pressure <70mmHg + 2X age in years
         - Child (11-14 years) systolic blood pressure <90mmHg

2. **STEP 2 (Anatomic Criteria)**

   Injured patients meeting any one of the following criteria:

   a. All significant penetrating injuries to head, neck, torso and extremities proximal to knee or elbow

   b. Chest wall instability or deformity (e.g. flail chest)

c. Two proximal long bone fractures (above the elbows and or knees)

d. Mangled, degloved or pulseless extremity

e. Open or depressed skull fracture

f. Paralysis

g. Pelvic injury with high-risk mechanism of injury (motor vehicle collisions, auto vs. pedestrian accidents, motorcycle collisions, falls from heights)

3. **STEP 3 (Mechanism of Injury Criteria)**

Injured patients meeting any one of the following criteria:

a. Falls

1. Adults: >20 feet (one story is equal to 10 feet)
2. Pediatric (≤ 34kg) : >10 feet or ≥ two times the height of the child

b. High-risk auto crash:

1. Passenger Space Intrusion (PSI) of space: >12 inches occupant patient site; or >18 inches anywhere within the passenger space
2. Ejection (partial or complete) from automobile
3. Death in same passenger compartment

c. Auto vs. pedestrian/bicyclist thrown, run over, or with significant impact (>20 mph)

d. Motorcycle or unenclosed transport vehicle crash (>20 mph)

4. **STEP 4 (Special Patient or System Considerations)**

Age and co-morbid considerations.

a. EMS provider judgment

b. Age greater than 65

1. SBP <110 mmHg may represent shock

c. Pediatric (≤ 34kg)

d. Pregnancy > 20 weeks

e. Anticoagulation therapy (excluding aspirin) or other bleeding disorders with head injury (excluding minor injuries)

f. Burns with trauma mechanism

Note:

A TRAUMA CONSULT is not required for ground level/low impact falls with GCS ≥ 14 or when the GCS is normal for patient

C. Contact the Trauma Center

Contact the receiving trauma center early and immediately upon determining the patient meets trauma patient triage criteria with a **"TRAUMA ALERT" or "TRAUMA CONSULTATION"**

1. **"TRAUMA ALERT"**

   A "TRAUMA ALERT" is initiated when an injured patient meets any one of the Step 1 (Physiologic) or Step 2 (Anatomic) Criteria. Consider early notification to the intended receiving Trauma Center, from the scene when possible

   a. EMS personnel should provide a "TRAUMA ALERT" early and from the scene when possible to assist in early activation of the trauma team and determination of patient destination.

   b. ALS personnel must contact the trauma center with the TRAUMA ALERT.

   c. A "TRAUMA ALERT" report should include the following:

      1. "TRAUMA ALERT" meeting trauma triage step criteria "x"
      2. Unit and medic #
      3. ETA to trauma center
      4. Report on individual patient (MIVT format):

         - Age and sex
         - **M**echanism of injury
         - **I**njury and complaints
         - **V**ital signs including GCS
         - **T**reatment
         - Include <u>specific</u> triage findings or considerations that identify the patient as meeting TRAUMA ALERT criteria.

2. **"TRAUMA CONSULTATION"**

   "TRAUMA CONSULTATION" with a SLO trauma center should be obtained to determine trauma patient destination when Step 3 (mechanism(s) of injury) criteria or Step 4 (special considerations) are present and Step 1 (physiologic) and Step 2 (anatomic) criteria are NOT met.

   a. Only ALS personnel may request a "TRAUMA CONSULTATION" for patient destination

   b. A "TRAUMA CONSULTATION" report should include the following:

      1. "TRAUMA CONSULTATION" meeting trauma triage step criteria "x"
      2. Unit and medic #
      3. ETA to trauma center and ETA to closest ED (When the trauma center is the closest facility include in the radio contact information notifying them they are the closest receiving facility)
      4. Report on the individual patient: (MIVT format)

- Patient age and sex
- Mechanism of injury and scene
- Injury and complaints
- Vital signs including GCS
- Treatment and response
- Include specific findings or considerations that identify the patient as meeting TRAUMA CONSULTATION criteria

c. Paramedic Concerns

3. The Trauma center, when not receiving the patient, shall notify the receiving hospital of the incoming patient and provide that hospital with the prehospital care patient information.
4. When practical, a brief updated report should be given to the trauma center Hospital and include any significant changes in route in vital signs, GCS, physical findings, symptoms or treatments.

D. Exceptions to Direct Transport to a Trauma Center

Trauma patients will be transported to the closest ED in the following situations:

1. Patient condition necessitates transport to the closest ED, such as the following:

   a. Unmanageable airway (intubation attempts are unsuccessful and an adequate airway cannot be maintained with BVM or other device)

   b. Uncontrollable bleeding with rapidly deteriorating vital signs

   c. Traumatic cardiac arrest – see EMS Agency Prehospital Determination of Death/Do Not Resuscitate (DNR) End of Life Care Policy #125.

2. SLO Trauma Center destination order
3. Patient refusal - see EMS Agency Patient Refusal of Treatment and/or Transport Policy #203.
4. Trauma center is on complete diversion – see EMS Agency Hospital Diversion Policy #154: Hospital Diversion.

E. The utilization of EMS helicopter for the response and transport of trauma patients must be in accordance with EMS Agency EMS Helicopter Operations. EMS Helicopter Policy #155 transport should be considered when ground transport is greater than 30 minutes from the trauma center and air transport would be more expeditious than ground transport.

IV. AUTHORITY

- California Health and Safety Code, Division 2.5.
- California Code of Regulations, Title 22, Chapter 7

V. ATTACHMENTS

A. Trauma Triage Matrix