Operations Subcommittee
of the Emergency Medical Care Committee

Meeting Agenda:
9 A.M., Thursday June 6th, 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*
Doug Weeda, *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*

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

AGENDA	ITEM	LEAD
Call to Order	Introductions Public Comment	Jay Wells
Summary Notes	Review of Summary Notes April 4th, 2024	
Discussion	**Protocol and Procedure Revisions:** • Protocol #602 Airway Management • Protocol #661 Traumatic Cardiac Arrest • Procedure #705 Needle Thoracostomy • Procedure #710 Vascular Access and Monitoring • Procedure #711 Use of Restraints **Policy Revisions:** • Policy #200 Scene Management **Policy Additions:** • Policy #217 Physician on Scene • Policy #217 Physician on Scene Attachment A (Note to physicians on involvement with EMS personnel card)	Ryan Rosander

Adjourn	Declaration of Future Agenda Items: - Upgrade/Downgrade Policy - Roundtable Next Meeting Date: August 1st, 2024, 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

Meeting Minutes
Thursday, April 4th, 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 Coordinator
☒	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**	
☐	Deputy Chief Sammy Fox, Fire Service	☒	Jayson Dumas, CHP
☐	Roger Colombo, Field Provider, Paramedics		
☒	Chief Dan McCrain, Fire Service	☒	Pete Gavitte, CHP
☐	Chief Casey Bryson, Fire Service	☒	John MacDonald, SLO City Fire
☐	Vacant, Law Enforcement		
☐			
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AGENDA ITEM / DISCUSSION	ACTION / FOLLOW-UP
CALL TO ORDER—9:04 am	
Introductions	
Public Comment – None	
APPROVAL OF MINUTES – D. McCrain motioned, T. Nurge 2nd. Approved.	
DISCUSSION ITEMS	
Review of Protocol and Procedure Revisions: After the implementation of SGA in SLO County, there were discussions with stakeholders about the confusion surrounding when to initiate a supraglottic airway (SGA), especially for cardiac arrest. After many discussions, SLOEMSA has decided to send SGA, ETI, airway management, and atraumatic/traumatic cardiac arrest management back through the committee process for further clarification. - The review of SGA will be taken to Clinical Advisory and then taken to EMCC. - Changes are mostly in the notes of Protocol 602. Adding provider discretion for which ALS airway to use. Removed language about visualizing a patient's airway before determining which ALS airway to use. - In Procedure 717, changes in the BLS airway, SGAs should be utilized instead. Removed language about BLS airway use, this is covered in BLS protocols. The provider shall proceed to SGA after the second ETI attempt. - Added respiratory compromise definition and left the door open for intubation. - Further amendments: - Added SGA as indicated in cardiac arrest. - Removed all language about first visualizing a patient's airway/vocal cords before SGA utilization. - Added PCR documentation component if ALS airway cannot be established. **Discussion** D. McCrain mentions that in Procedure 717, the wording should be added to indicate the procedure has started. D. Rowley asks if there is any data for SGA success or not success. If you put the SGA in and it is not working, can we remove it to put in an ETI? B. Mulkerin mentions that the goal is not to impede care, but to get to a working airway.	R. Rosander

AGENDA ITEM / DISCUSSION	ACTION / FOLLOW-UP
K. Strommen says that it is worth adding a note about patients who may have overdosed and if the airway needs to be pulled. He also says that it is a lot simpler to follow. D. McCrain makes a motion to move to EMCC. **Items Moving Forward** EMS Update Class moved to November.	Motion to approve: D. McCrain 2nd: K. Strommen Approved
ADJOURN – 9:30 am	
Next Meeting: June 6th, 2024, 09:00 A.M. Location: SLO EMSA - 2995 McMillan Ave, Suite 178, San Luis Obispo	

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

MEETING DATE	June 6th, 2024
STAFF CONTACT	Ryan Rosander, EMS Coordinator 805.788.2513 rrosander@co.slo.ca.us
SUBJECT	Traumatic cardiac arrest, needle thoracostomy, IO, restraints, scene management, and physician on scene.
SUMMARY	SLOEMSA and the trauma team at Sierra Vista have been working hand in hand to enhance trauma care within the county. As part of this joint effort, SLOEMSA is taking the traumatic cardiac arrest and needle thoracostomy protocol/procedure through the committee process for a recommendation for adoption. The proposed changes are designed to benefit a workable patient in cardiac arrest due to a traumatic event, where bilateral needle thoracostomy would be performed. Additionally, SLOEMSA is exploring the possibility of placing the midclavicular 4th intercostal space decompression site as a standing order. SLOEMSA is committed to empowering our paramedics working within the county with more options and discretion for patient care. In line with this, SLOEMSA proposes adding the humeral head and medial malleolus IO sites as standing orders, giving our paramedics the flexibility they need to provide the best possible care. Several stakeholders within the county have discussed handcuffs or restraints placed behind the patient's back during the last couple of months. For safety reasons, SLOEMSA wishes to add no handcuffs or restraints behind a patient's back to the restraint policy. Over the past year, several stakeholders have approached SLOEMSA with suggestions for reworking the scene management policy, particularly emphasizing the need to incorporate a communications piece. This crucial aspect of scene management would ensure all units on scene are on the same frequency, thereby enhancing the safety of all EMS crews involved. Having all crews on the same frequency will significantly improve coordination, especially in more complex and demanding scenes. SLOEMSA is also adding a separate physician-on-scene policy. This will further lay out the three options given to physicians and paramedics by California EMSA and California CMA. Following approval, revisions to protocols #602 Airway Management, #661 Traumatic Cardiac Arrest, procedures #705 Needle Thoracostomy, #710 Vascular Access and Monitoring, #711 Use of Restraints, and Policy #200 Scene Management, #217 Physician on Scene would be

	sent to the Clinical Advisory Subcommittee for approval. The potential implementation date would be after training occurs during the 2024 SLOEMSA Update Class.
REVIEWED BY	Dr. William Mulkerin, SLOEMSA Staff
RECOMMENDED ACTION(S)	Recommended revisions to protocols #602, #661, procedures #705, #710, #711, and policies #200 Scene Management, #217 Physician on Scene for adoption by Operations and move to Clinical Advisory Agenda.
ATTACHMENT(S)	Protocols: #602, #661 Procedures: #705, #710, #711 Policies: #200, #217, #217 Attachment A

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 indicated to control airway – Procedure #717
• Supraglottic Airway – as indicated to control airway– Procedure #718
• Needle thoracostomy with symptoms of tension pneumothorax or traumatic arrest with the possibility of chest trauma– Needle Thoracostomy Procedure #705 & Traumatic Cardiac Arrest Protocol #661
	• **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**	• **Symptomatic Esophageal Obstruction** ○ **Glucagon** 0.1mg/kg IV not to exceed 1mg followed by rapid flush. Give oral

○ **Glucagon** 1mg IV followed by rapid flush. Give oral fluid challenge 60 sec after admin - check a blood sugar prior • As needed	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, providers shall decide which ALS airway to utilize based on discretion.
- After placement of any advanced airway, providers shall verify placement of the advanced airway by waveform capnography and a minimum of one additional method. This additional method can be any of the following:
  - Auscultation of lung and stomach sounds.
  - Colorimetric CO2 Detector Device.
  - Esophageal Bulb Detection Device.

TRAUMATIC CARDIAC ARREST

ADULT	PEDIATRIC (≤34KG)
BLS	
• Universal Protocol #601 • Obvious Death – see Prehospital Determination of Death Policy #125 • Follow HPCPR guidelines for CPR (10:1) and minimize interruptions (< 5 seconds)	Same as Adult
BLS Optional	
Pulse Oximetry – O_2 administration per Airway Management Protocol #602	
ALS Standing Orders	
Traumatic arrest <u>with</u> signs of life on EMS arrival <u>and</u> < 20 min from trauma center or hospital • Do not delay transport • Perform ALS treatments en route • **Normal Saline** up to 500 mL – repeat x1 if no ROSC or SBP of < 90 mmHg • **<u>Do not use Epinephrine or Lidocaine</u>** unless the arrest is suspected to be of medical origin • Resuscitate and treat for reversible causes, i.e. hypoxia, hypovolemia, tension pneumothorax • ~~For suspected tension pneumothorax see Needle Thoracostomy Procedure #705~~ • Traumatic arrest with the possibility of chest trauma, bilateral needle thoracostomy shall be performed. See Needle Thoracostomy Procedure #705. **Traumatic arrest <u>with absent</u> signs of life on EMS arrival** • With absent signs of life consider non-initiation – Prehospital Determination of Death Policy #125	Same as Adult (except as noted below) • **Normal Saline** 20 mL/kg IV/IO – reassess and repeat
Base Hospital Orders Only	
• Traumatic arrest <u>with</u> signs of life on EMS arrival <u>and</u> > 20 min from trauma center or hospital ○ Contact SLO Trauma Center for treatment and/or destination • Termination of resuscitation • As needed	Same as Adult

Notes
• Absent signs of life assessment include: pulseless, apneic, lack of heart and lung sounds, fixed and dilated pupils. • Trauma Center is the preferred destination if equal or near equal distance. • Do not delay transport for advanced airway or other treatment modalities. • Consider medical origin in older patients with low probable mechanism of injury. • Unsafe scene or other circumstances may warrant transport despite low potential for survival. • Minimize disturbance of potential crime scene. • Consider Oral Intubation or Supraglottic Airways (Adults), provider discretion. • If the provider cannot accomplish an ALS airway, they should document in the PCR why an ALS airway wasn't accomplished.

NEEDLE THORACOSTOMY

ADULT	PEDIATRIC (≤34KG)

BLS

Universal Protocol #601

BLS Optional

Pulse Oximetry – O_2 administration per Airway Management Protocol #602

ALS Standing Orders

- Locate mid-clavicular 2nd intercostal space or mid-axillary 4th intercostal space on affected side
- Prep site with povidone-iodine and alcohol
- With syringe attached, insert large bore IV catheter (maximum 10 Ga.) at a 90° angle slightly superior to the rib
- Once in the pleural space diminished resistance should be noted with air and/or blood return
- Holding the needle, advance the catheter and remove the needle allowing pressure to be relieved
- Secure the catheter and provide for a one-way valve
- Assess and reassess lung sounds

Base Hospital Orders Only

- ~~For decompression location at the mid-axillary 4th intercostal space~~
- As needed

Notes

Indication: Tension pneumothorax with significant respiratory compromise

- Signs and symptoms may include:
  - Deteriorating respiratory status
  - Decreased SBP, increased pulse
  - Diminished lung sounds on affected side
  - Jugular vein distension
  - Hyper-resonance to percussion on affected side
  - Tracheal shift away from affected side (difficult to assess)
  - Increased resistance with ventilation (BVM, ET)
- Equipment
  - Large IV catheter (10-12 Ga.) with a syringe
  - One-way valve i.e. Asherman Seal
  - Antiseptic products, povidone-iodine/alcohol swabs

Indication: Traumatic arrest with signs of life on EMS arrival and < 20 min from trauma center or hospital, with the possibility of chest trauma, bilateral needle thoracostomy shall be performed.

VASCULAR ACCESS AND MONITORING

ADULT	PEDIATRIC (≤34KG)

BLS

- Universal Protocol #601
- In stable patients, providers may monitor and turn off IV lines of isotonic balanced salt solutions without medication or electrolyte additives and flowing at a maintenance rate

BLS Optional

Pulse Oximetry – O_2 administration per Airway Management Protocol #602

ALS Standing Orders

- Establish IV with drip set or saline lock as appropriate.
- Tibial plateau, humeral head, or medial malleolus Intraosseous (IO) placement may be utilized for:
  - Patients in extremis or cardiac arrest with hemodynamic instability/respiratory distress/cardiac arrest.
    AND
  - Unable to establish following attempt(s) or general suspicion of the inability to establish vascular access.
- Attempts to establish vascular access shall be continued even if IO is successful.
- If patient becomes responsive to painful stimuli following IO administration:
  - Lidocaine 0.5mg/kg (Total max dose of 40mg) slow IO push over 60 seconds.
- ALS providers can monitor and administer medications through a Pre-existing Vascular Access Device (PVAD). These pre-existing catheters are:
  - Peripheral Inserted Central Catheter (PICC Line)
  - Midline IV Catheters
- PVAD access procedure:
  - Wipe the access port with an alcohol pad to ensure aseptic technique.
  - Ensure that if your line is a dual lumen line that it is the line designated for medication administration (do not use the line utilized for blood, this can be identified by a red colored catheter or stated on the catheter).
  - Attach a 10ml syringe and draw up 5-10ml of fluid out of the line until blood is noted in the syringe. This is to ensure the line is not pre-loaded with heparin.
  - Discard the filled syringe and flush the line with an entire 10cc saline flush. This is to ensure that the line is clean and ready for medication administration.
  - Connect the syringe with the desired medication and administer according to the appropriate formulary. Follow the medication administration with an entire 10cc saline flush.
  - If any sort of cap was used to cover the port, ensure the cap is wiped down and placed back on the port following use.
  - If the patient is needing an infusion from a saline bag, ALS Providers may connect the IV line to the PVAD after the line has been aspirated per instructions listed above. After the infusion is finished, ensure the line is flushed with a 10cc saline flush, and wipe the port with an alcohol pad. If any sort of cap was used to cover the port, ensure the cap is wiped down and placed back on the port following use.

Base Hospital Orders Only

- ~~Pain management if patient becomes conscious after establishing IO access~~
- ~~Humeral IO Placement~~
- Access to tunneled/non-tunneled Central Lines for patients in extremis or cardiac arrest. Access of these central lines shall follow the PVAD access procedure listed above.
- As needed

Notes

- Peripheral IV placement is preferred to IO placement – including the external jugular.
- ~~Tibial plateau is preferred for IO placement over humeral placement. Humeral IO placement shall only be utilized if the Tibial plateau is unable to be accessed.~~
- When establishing IV/IO access in a patient in extremis or cardiac arrest, ALS Providers will take the following into consideration:
  - When assessing a patient's vasculature and determining access to be difficult, an ALS Provider may proceed straight to IO access. Further IV attempts will continue following IO placement.
  - If the first attempt at IV placement fails, an ALS provider may consider placement of an IO prior to a second attempt.
- External Jugular (EJ) access should always be considered prior to IO placement.
- If a patient becomes responsive to painful stimuli following IO placement, Lidocaine may be administered to assist with pain management during fluid/medication administration. The total amount of Lidocaine administered to the patient shall not exceed 40mg.

USE OF RESTRAINTS

ADULT	PEDIATRIC (≤34KG)

BLS

- Universal Protocol #601
- Pulse Oximetry – O_2 administration per Airway Management Protocol #602
- Application of restraints – see Notes
- Evaluate restrained extremities for pulse quality, capillary refill, color, nerve and motor function every 15 minutes

ALS Standing Orders

Severely agitated or aggressive patients that interfere with patient care, or patient/crew safety refer to Behavioral Protocol #613

Base Hospital Orders Only

As needed

Notes

- Restraints for prehospital use must be either padded leather or a soft material and allow for quick release
  - No hard plastic ties
  - No "sandwiching" the patient between backboards or like devices
  - No restraining hands and feet behind the patient ("hog-tying")
  - No methods or material applied in a manner that cause respiratory, vascular or neurological compromise
  - Patient may not be transported in the prone position
  - No handcuffs or restraints of any kind behind patient's back.
- Indications
  - For patients who are violent, or may harm themselves or others during field treatment or transport
- Documentation shall include:
  - Reasons and time restraints were applied
  - Which agency/personnel applied the restraint
  - Evaluation of restrained extremities for pulse quality, capillary refill, color, nerve and motor function every 15 minutes
  - Evaluation of respiratory status
- Method of application shall allow for monitoring of vital signs and shall not restrict the ability to protect the patient's airway, or compromise neurological or vascular status
- Restraints applied by law enforcement and not approved for use by EMS personnel:
  - Require the officer to remain available at the scene or during transport to remove or adjust restraints for patient safety
  - Must allow for straightening of the abdomen and chest to allow for full tidal volume respirations
- Aggressive or violent behavior may be a symptom of medical conditions such as head trauma, alcohol, drug related problems, metabolic disorders, stress or psychiatric disorders.

POLICY #200: SCENE MANAGEMENT

I. PURPOSE

A. To clarify the local application of Section 1798 of the Health and Safety Code as it relates to scene management and the related responsibilities of emergency medical service (EMS) first response agencies, transport services, and base hospitals in the County of San Luis Obispo.

II. POLICY

A. AUTHORITY FOR SCENE MANAGEMENT

1. Authority for the management of the scene of an emergency is vested in the appropriate public safety agency having primary investigative authority, law enforcement or fire suppression. Scene management at this highest level includes not only the safety of the EMS team and its patient(s) but other persons who may be exposed to the risks and the public. While public safety officials shall consult emergency medical services personnel in the determination of relevant risks, they retain the authority for scene management and incident command.
2. Responsibility to mitigate criminal activities and environmental hazards lies with the appropriately trained and equipped public safety agency. EMS providers without these responsibilities will not knowingly enter a crime scene or a hazardous scene until the appropriate public safety agency has arrived, secured the scene, and deemed it reasonably ‘safe to enter’.
3. The appropriate public safety agency is responsible for the non-medical aspects of scene management. In the exceptional situation when private EMS personnel have arrived first, there is no apparent hazard, and private EMS personnel are managing the non-medical aspects of the scene; the responsibility for scene management will immediately pass to public safety personnel upon their arrival.
4. The Incident Commander shall make all resource ordering and canceling decisions.

B. AUTHORITY FOR PATIENT HEALTH CARE MANAGEMENT

1. Authority for patient health care management in an emergency is vested in any paramedic or other prehospital emergency personnel at the scene of the emergency who is most medically qualified. Authority to provide EMS lies with the emergency medical technician (EMT) or paramedic (EMT-P) who initiates patient health care management. In the absence of these licensed or certified health care personnel authority shall be vested in the most appropriate medically qualified representative of public safety. All personnel will hand off authority for patient health care management to any arriving EMS provider who is authorized at a higher level, when medically appropriate.
2. Having accepted authority for patient health care management, public safety personnel authorized at the same level as transport personnel will hand off

individual patients as soon as possible and/or when medically appropriate. The authority for each patient passes with completion of the verbal handoff report and acceptance of the transfer of care.

3. If there is a disagreement regarding patient care while on scene of an incident, EMS personnel shall work professionally and collaboratively to find a solution. If EMS personnel still cannot agree on patient care, Base Hospital contact shall be made, and orders followed.

4. In the exceptional situation when transport service personnel have accepted authority for management of the multi-patient scene, they will immediately pass this authority to any arriving public safety personnel.

C. AUTHORITY FOR PATIENT DISPOSITION

1. Patient disposition, destination, and mode of transport (ground/air) are indicated by patient's preference, clinical needs, and operational requirements. In all cases, EMS personnel, and base hospitals when included, are responsible to collaboratively determine the medically appropriate patient disposition and to advise the incident commander (IC) of this conclusion. However, when there is disagreement, destination is primarily a medical decision. As such, EMS personnel will comply with medical direction regarding destination, whether by protocol or base hospital order. Similarly, when there is disagreement, mode of transport is primarily an operational decision. As such, EMS personnel will comply with operational direction from the IC regarding mode of transport.

D. COMMUNICATIONS

1. Upon dispatch, EMS transport personnel shall immediately monitor the fire command/tactical frequencies as assigned by the authority having jurisdiction (AHJ). All communication related to the incident shall be on the fire command/tactical channels assigned by the AHJ. EMS transport personnel shall respond to all AHJ radio communications if hailed while enroute, on scene of, or staging for an incident. While on scene of an incident, EMS transport personnel shall bring their fire radio to the scene and on the appropriate command/tactical channel. Clear text communication shall be utilized during radio communications with AHJ. EMS transport personnel will switch back to their dispatch frequency upon transporting a patient or becoming available.

2. All incident briefings will be attended by an EMS Transport Representative who shall pass on briefing details to all EMS Transport Personnel.

E. UNIT IDENTIFICATION

1. All EMS Transport Units shall have their radio identifier (ie M11, M31, etc) displayed on 4 sides of the ambulance in at least 4" tall numbers.

2. All EMS Transport Personnel shall have the radio identifier of their Ambulance displayed on both sides of their helmet.

F. MEDICALLY TRAINED BYSTANDERS

1. When a bystander at the scene of an emergency identifies themself as a registered nurse, off-duty EMS, or other medical professionals, emergency medical services personnel may request documentation of medical expertise (i.e., medical license or appropriate certificate) to determine the person's area of medical expertise and if appropriate, request their assistance with patient care. Emergency medical services personnel may allow correctly identified medical personnel to assist with patient care in an advisory or BLS capacity but shall maintain overall patient management. Emergency medical services personnel shall document on the patient care report the individual's name and medical qualifications if such assistance was utilized. If the bystander on scene is a physician, reference SLOEMSA Policy #217: Physician On-Scene.

III. AUTHORITY

- California Health and Safety Code, Division 2.5, Section 1797 – 1799.207
- California Code of Regulations, Title 22, Social Security, Division 9, Prehospital Emergency Medical Services

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

POLICY #217: PHYSICIAN ON-SCENE

I. POLICY

A. In accordance with established procedures, appropriate emergency medical service personnel may utilize the assistance of an “on-scene” physician in patient care within San Luis Obispo County.

II. PROCEDURE

A. When at the scene of a call, if an individual offers their assistance and introduces themselves as a licensed physician in the State of California, emergency medical services personnel shall:

1. If emergency medical services personnel do not know the physician’s identity, request identification. If the patient is in extremis, defer any procedure for identification and immediately allow the physician to assist or direct patient care to the level that the physician desires.
2. Provide the physician the opportunity to read the California Medical Association “Note to Physicians on Involvement with EMS personnel” card/ Policy #217 Attachment A and describe for the physician the three levels of possible physician involvement.
3. Advise the base hospital physician of the situation and of the on-scene physician’s level of involvement.
4. If appropriate, allow the physician to speak with the base hospital physician.
5. Follow the direction of the base hospital.
6. In cases of controversy between the on-scene physician and emergency medical services personnel regarding patient care, the base hospital physician will be the final arbitrator for medical direction of the paramedic.

B. Options for Physician Assistance Include:

1. Offers Assistance Only- A physician may offer BLS level assistance as another pair of eyes or hands or in making suggestions but allows medical direction to remain with the base hospital or standard SLOEMSA prehospital protocols. In this situation, prehospital personnel shall follow their normal operational policies and procedures.
2. Offers Medical Advice and Assistance- A physician may request to speak to the base hospital physician and offer medical advice and assistance. In this situation, prehospital personnel shall follow the direction of the base hospital physician.
3. Takes Total Responsibility- A physician may take total responsibility for the care given to the patient and, if safety allows, physically accompany the patient until the patient arrives at a hospital, and the receiving physician assumes responsibility.

C. Physician Request to Utilize ALS Drug or Equipment

If a physician at the scene of a patient in extremis requests to use the prehospital unit's drug and/or equipment inventory, the requested drugs and/or equipment should be made available immediately. If a physician at the scene of a stable patient request to use the prehospital unit's drug and/or equipment inventory, the requested drugs and/or equipment should be made available after the physician is either recognized by the prehospital personnel or provides appropriate identification.

D. Role of the Paramedic

ALS personnel shall function within their accredited scope of practice only. Initially, ALS personnel should provide care identified in the "standing orders" portion of the paramedic treatment protocols. The base hospital physician should be immediately notified and informed of the patient's progress and treatment being provided. If the on-scene physician is requesting ALS personnel to perform treatment outside the accredited scope of practice or treatment only allowed with base hospital approval, ALS personnel should inform the physician of their limitations and the need to notify the base hospital physician.

The base hospital physician may direct ALS personnel to actively assist the physician as appropriate with patient care. The on-scene physician shall sign the Prehospital Care Report for all instructions given.

III. AUTHORITY

- Health and Safety Code, Division 2.5, Sections 1798 & 1798.6
- California Code of Regulations, Title 22, Division 9, Section 100175

IV. ATTACHMENTS

A. Note to Physicians on Involvement with EMS personnel

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

NOTE TO PHYSICAINS ON INVOLVEMENT WITH EMS PERSONNEL CARD

FRONT

NOTE TO PHYSICIANS ON INVOLVEMENT WITH EMS PERSONNEL

EMS personnel operate under standard policies and procedures developed by the Local EMS Agency and approved by their Medical Director under Authority of Division 2.5 of the California Health and Safety Code. The drugs they carry and procedures they can do are restricted by law and local policy.

If you want to assist, this can only be done through one of the alternatives listed on the back of this card. These alternatives have been endorsed by CMA, State EMS Authority and CCLHO.

Assistance rendered in the endorsed fashion, without compensation, is covered by the protection of the "Good Samaritan Code" (see Business and Professional Code, Sections 2144, 2395-2298 and Health and Safety Code, Section 1799.104).

BACK

ENDORSED ALTERNATIVES FOR PHYSICIAN INVOLVEMENT

After identifying yourself by name as a physician licensed in the State of California, and, if requested, showing proof of identity, you may choose one of the following:

1. Offer your assistance with another pair of eyes, hands or suggestions, but let EMS personnel remain under base hospital control; or,
2. Request to talk to the base station physician and directly offer your medical advice and assistance; or,
3. Take total responsibility for the care given by EMS personnel and physically accompany the patient until the patient arrives at a hospital (if safety allows) and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedures.