The next meeting of PMAC is on:

Monday, June 27, 2011
9:00AM – 11:00AM
Riverside County Regional Medical Center
26520 Cactus Avenue, Moreno Valley
Rooms A1018 and A1021
951/358-5029

1. **CALL TO ORDER**
Chairman Reza Vaezazizi, MD

2. **PLEDGE OF ALLEGIANCE**
Reza Vaezazizi, MD

3. **ROUNDTABLE INTRODUCTIONS**
Reza Vaezazizi, MD

4. **APPROVAL OF MINUTES**
March 21, 2011 Minutes (Attachment A)

5. **COMMITTEE / TASK FORCE DISCUSSION (60 Minutes)**
This is the time / place in the agenda in which a brief committee report will be given. PMAC members are expected to engage in discussion for about 10 to 15 minutes per topic for the purposes of providing improved understanding and / or recommendations to the EMS Agency. PMAC will decide on an action at the end of each agenda item.

   5.1 Interfacility Transfers—Kent McCurdy (Attachment B)
   5.2 Policy Review Forum—Scott Moffatt (Attachment C)

6. **New Business (15 Minutes)**
This is the time / place in the agenda that brief reports will be given followed by a recommendation from PMAC.

   6.1 CE Policies 3100 and 4130—Karen Petrilla (Attachment D)
   6.2 PMAC Policy Workshop—Scott Moffatt
   6.3 Other
Kaiser Permanente Riverside
2.1 Jonathan Dyreyes, MD
2.4 Victoria Montiel

Loma Linda University Medical Center
3.6 Jeff Grange, MD
2.4 Brett McPherson

Menifee Valley Medical Center
2.1 Todd Hanna, MD
2.4 Judy Verner

Moreno Valley Community Hospital
2.1 Robin Fisher, DO
2.4 Judy Peterman

Parkview Community Hospital
2.1 Chad Clark, MD
2.4 Toni Culver

Palo Verde Hospital
2.1 David Sincavage, MD
2.4 Rachel Cortazar

Rancho Springs Medical Center
2.1 Russell Hatt, MD
2.4 Debi Clark

Redlands Community Hospital
2.1 Pong Nguyen, MD
2.4 Robert Tyson

Riverside Community Hospital
2.1 Steven Patterson, MD
2.4 Sabrina Yamashiro

Riverside County Fire Department
2.5 Scott Visyak (Coves)
2.5 Robert McIlroy (Indio)
2.8 Kevin Powell (Riverside Co. Fire Dept.)

Riverside County Police Association
2.7 Joe Flores (Interim)

Riverside County Regional Medical Center
2.1 Tim Nesper, MD
2.4 Kay Schulz

San Gorgonio Memorial Medical Center
2.1 Trence Clark, MD
2.4 Trish Ritarita

Ex-officio Members
3.1 Eric Frykman, MD, Public Health Officer
3.2 Humberto Ochoa, MD, EMS Agency Medical Director
3.3 Bruce Barton, EMS Agency Director
3.4 Brian MacGavin, EMS Agency Assistant Director
3.5 Christina Bivona-Tellez, Hospital Association of Southern California

Trauma Audit Committee & Trauma Program Managers
2.2 Jason Tomlin, MD
2.3 Georgi Collins

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7. **Unfinished Business (30 Minutes)**
7.1 Ambulance Permit Policy—James Lee (Attachment E)
7.2 Trauma Triage Criteria—Cindi Stoll (Attachment F)

8. **Announcements (5 Minutes)**
   This is the time / place in the agenda those committee members and non committee members can speak on items not on the agenda but within the purview of PMAC. Each announcement should be limited to 1 minute unless extended by the PMAC Chairperson
8.1 Committee Members
8.2 Non Committee Members

9. **Next Meeting / Adjournment**
   September 26, 2011

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Please come prepared to discuss the agenda items. If you have any questions, call Brian MacGavin at (951) 358-5029. PMAC Agendas with attachments are available at our website: [www.rivcoems.org](http://www.rivcoems.org).

The County of Riverside does not discriminate on the basis of disability in admission to, access to, or operations of its programs, services or activities. It is committed to ensuring that its programs, services, and activities are fully accessible to and usable by people with disabilities. If you have a disability and need assistance to attend this meeting, contact Brian MacGavin at (951) 358-5029.
<table>
<thead>
<tr>
<th>TOPIC</th>
<th>DISCUSSION/INFORMATION</th>
<th>ACTION</th>
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<tr>
<td>1. CALL TO ORDER</td>
<td>Chairman Dr. Vaezazizi called the meeting to order at 9:00 AM.</td>
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<td>2. PLEDGE OF ALLEGIANCE</td>
<td>Dr. Vaezazizi led the Pledge of Allegiance.</td>
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<td>3. ROUNDTABLE INTRODUCTIONS</td>
<td>Dr. Vaezazizi began roundtable introductions.</td>
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<td>4. APPROVAL OF MINUTES</td>
<td>Approval of January 24, 2011 PMAC meeting minutes without changes.</td>
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<td>5. COMMITTEE / TASK FORCE DISCUSSION</td>
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<td>5.1 Interfacility Transfer Task Force - Kent McCurdy</td>
<td>This draft policy is a combination of new policies and existing policies.</td>
<td>The policy will go out for 30-day written comment period before final approval at the next PMAC meeting.</td>
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<td>This policy sets standards for hospitals, ALS, BLS, Air and CCT providers to follow for interfacility transfers.</td>
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<td>Copies of Appendix A were distributed.</td>
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<td>It was suggested that new information in the draft policy be highlighted.</td>
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<td>5.2 CQI TAG - Laura Wallin</td>
<td>Fourteen performance standards have replaced appendix policies in the policy manual.</td>
<td>No action, information only.</td>
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<td>We anticipate that performance standards for all skills will be completed by 2013.</td>
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<td>September 22, 2011 will be the final date to submit the Low Frequency High Risk skills for presentation at the September 26 PMAC meeting.</td>
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<td>5.3 HEMS CQI - Steve Patterson, MD</td>
<td>Dr. Patterson reviewed 2010 HEMS CQI data. The data has been used for CQI processes. Epidemiological conclusions cannot be made from this data.</td>
<td>No action, information only.</td>
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### 5.4 Draft Updated Policies – Scott Moffatt

| Draft policy 5205 replaces policies 5201, 5210, 5215, 5220 and 5225. Draft policy 6000 introduces the new format of our treatment protocols, authorizes First Responder to operate as an EMR, describes requirements for base hospital contact and describes printing and distribution instructions of the treatment protocols. Draft policy 6200 presents standard paramedic treatment for chest discomfort with suspected acute coronary syndrome including Nitro paste, Morphine with a 5-10 mg prior to contact and the Base Hospital physician orders show the medications the AEMT is allowed to give as compared to the paramedic. Draft policy 6110 authorizes prior to contact I.M versed and saline boluses. In addition, base hospital physicians can order Versed and Bicarbonate on patients with suspected excited delirium. Draft policy 6250 follows the 2010 AHA guidelines. Draft policy 6390 covers treatment protocol functions for exposure to nerve agents. Draft policy 6850 will replace the current policy 7850 as we implement the new policy format. Policy 9013 allows EMT’s to use glucometer under direction or an AEMT or a paramedic. |
| These changes will go out for a public comment period, please review with your staff. |

### 6. NEW BUSINESS

| 6.1 Draft Ambulance Permit Policy - James Lee |
| A new Draft Ambulance Permit Policy introduces additional requirements to become a permitted Ambulance Provider. |
| This will go out for a public comment period. |

### 7. UNFINISHED BUSINESS

<p>| 7.1 Trauma Triage Criteria - Cindi Stoll |
| TAC made some recommended changes to Policy 5710: Trauma Triage Indicators and Destination. Geriatric patient person identified as 65 years of age. Pediatric is less than 15 years of age. Critical Pediatric Trauma patients will be transported to the closest trauma center |
| This will go out for a 30-day comment period. |</p>
<table>
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<tr>
<th>7.2</th>
<th>RCRMC PICU - Cindi Stoll</th>
<th>Pediatric trauma patients still go ED to ED. Not directly to PICU.</th>
<th>No action, information only.</th>
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<tr>
<td>7.3</td>
<td>Nitro Paste - Scott Moffatt</td>
<td>Nitro paste has not been a problem for prehospital use in hot environments.</td>
<td>No action, information only.</td>
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<th>8.</th>
<th>ANNOUNCEMENTS</th>
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<tr>
<td>8.1</td>
<td>Committee Member</td>
<td>Public Health and Safety Fair March 26 at RCRMC.</td>
<td>No action, information only.</td>
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<td>Loma Linda University Medical Center in Murrieta will be opening to the public in a few days.</td>
<td>No action, information only.</td>
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<td>The EMSAAC Conference will be held in Newport Beach, California on June 7-8, 2011.</td>
<td>No action, information only.</td>
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<td>Brian reminds everybody to sign in and make sure all of their contact information is current.</td>
<td>No action, information only.</td>
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<td>EMS Agency is taking design ideas for our County patch. Please contact James Lee.</td>
<td>No action, information only.</td>
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<td>Rancho Springs Medical Center’s new ED opened in February 2011.</td>
<td>No action, information only.</td>
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<td>We are entertaining ideas for next year’s PMAC meeting place. Last minute room setups and changes are problematic.</td>
<td>No action, information only.</td>
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<td>Dr. Patterson requested an update on which facilities perform sexual assault exams.</td>
<td>EMS Agency will look into this matter.</td>
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<td>8.2</td>
<td>Non Committee Member</td>
<td>No comments</td>
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<td></td>
<td>Members</td>
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| 9.   | NEXT MEETING / ADJOURNMENT | JUNE 27, 2011                                                    | Meeting adjourned by Dr. Vaezazizi at 10:56 A.M. |
DATE: June 14, 2011

TO: PMAC

FROM: James Lee, EMS Specialist

SUBJECT: PMAC presentation of Interfacility Transfer Policy 5750

In preparation for the PMAC meeting on June 27, 2011, please review the attached Interfacility Transfer Policy 5750. This policy has been created with the assistance of the Interfacility Task Force. Please note the following:

- This policy incorporates the existing REMSA policies 6020, 6030, 6040, 7030 & 7040 within the framework of the overall Interfacility Transfer policy.

Thank you for your participation in this process.

FOR CONSIDERATION BY PMAC
Purpose
To serve as the utilization standard for all patient transfers between acute care facilities within Riverside County.

Authority
Title 22, Division 2.5, Sections 1797.52, 1797.178, 1798.170 and 1798.172 of the California Health and Safety Code.

Policy
Patient transfers between acute care facilities will be completed based upon the medical needs of the patient and through the cooperation of both the sending and receiving facilities in accordance with approved procedures.

- These procedures are suggested for patient transfers from sub-acute and chronic care facilities to acute care facilities.
- These procedures are not necessary for transfers to sub-acute and chronic care facilities.

Procedures

1. Application of Policy and Procedure
This policy will be utilized for all patient transfers between acute care facilities. This procedure is not a substitute for required transfer agreements. Each facility shall have its own internal written transfer policy that clearly establishes administrative and professional responsibilities. Transfer agreements must be negotiated and signed with facilities that have specialized services not available at the transferring facility. [H&S Code 1317.3(a) and 1317.2(b)]

2. Responsibilities
Facilities licensed to provide emergency services must fulfill their obligation under California Health and Safety Code to provide emergency treatment to all patients regardless of patient’s ability to pay. Transfers made for reasons other than immediate medical necessity must be evaluated to assure that the patient can be safely transferred without hazard to the patient’s health and without decreasing the patient’s chance for or delaying a full recovery. In these cases, the involved physicians and facilities should generally take a conservative view, deciding in favor of patient safety. [H&S Code 1317.3(a) and 1317.2(b)]

If a facility does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency exists and shall direct the persons seeking emergency medical care to a nearby facility which can render the needed services, and shall assist in obtaining the services, including transportation services, in every way reasonable under the circumstances. [H&S Code1317(e)]

Notwithstanding the fact that the receiving facility or physicians at the receiving facility have consented to the patient transfer, the transferring physician and facility have responsibility for the patient that he or she transfers until that patient arrives at the receiving facility. The transferring physician determines what professional medical assistance should be provided for the patient during the transfer (if necessary, with the consultation of the appropriate EMS Base Hospital Physician). [H&S Code 1317.2(d)]

The transferring physician has a responsibility to candidly and completely inform the receiving physician of the patient’s condition so that the receiving physician can make suitable arrangements to receive the patient. [H&S Code 1317.2(e)]

It is the responsibility of the receiving facility, when accepting the patient, to provide personnel and equipment reasonably required in the exercise of good medical practice for the care for the transferred patient, in order to assure continuity of care. [H&S Code 1317.2a(e)]
3. Standards for Transfers

a. Physicians considering patient transfer should exercise conservative judgment, always deciding in favor of patient safety.

b. If the patient presents to an emergency department, the patient must be examined and evaluated to determine if the patient has an emergency medical condition or is in active labor. If an emergency exists, the emergency department must provide emergency care and emergency services when appropriate facilities and qualified personnel are available.

I. “Emergency services and care” means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of the physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. [H&S Code 1317.1(a)]

Where necessary, the examination shall include consultation with specialty physicians qualified to give an opinion or to render treatment necessary to stabilize the patient. [H&S Code 1317.1(i) and 1317.2(a)]

II. The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1. Placing the patient’s health in serious jeopardy.
2. Serious impairment to bodily function, or
3. Serious dysfunction of any bodily organ or part. [H&S Code 1317.1(b)]

III. The term “active labor” means labor at a time at which:

1. Delivery is imminent.
2. There is inadequate time to effect safe transfer to another hospital prior to delivery, or
3. A transfer may pose a threat to the health and safety of the patient or the unborn child. [H&S Code 1317.1(c)]

c. Immediate transfer of Critical Trauma Patients – Patients who meet the REMSA trauma triage criteria as outlined in REMSA Policy 5712 (Continuation of Trauma Care) may be immediately transferred to a Trauma Center (Refer to REMSA Policy 1700 for Approved Trauma Centers)

1. Immediate transfer is at the discretion of the examining physician. It is recommended to select the most appropriate, expeditious transport modality available. It may be based on patient condition, availability of surgeon and operating room, but NOT financial factors.
2. Those patients immediately transferred will be audited for both medical care and compliance with this procedure.
3. As in all transfers, prior acceptance of the transfer is required. Cases that are refused will be audited.

d. Immediate transfer of Acute STEMI Patients – Patients who meet the REMSA STEMI criteria as outlined in REMSA Policy 5730 may be immediately transferred to a STEMI Center (Refer to REMSA Policy 1700 for Approved STEMI Centers)

1. Immediate transfer is at the discretion of the examining physician. It is recommended that the most appropriate and expeditious transport modality available be selected. The mode of transportation may be based on patient condition, availability of cardiologist and cardiac cath. facility, but NOT financial considerations.
2. Those patients immediately transferred will be audited for both medical care and compliance with this procedure.
3. As in all transfers, prior acceptance of the transfer is required. Cases that are refused will be audited.

e. The transferring physician must determine whether the patient is medically fit to transfer and, when indicated, will take steps to stabilize the patient’s condition.

f. No transfer shall be made without the consent of the receiving physician and receiving facility. The receiving facility may designate a physician who may provide consent for both the physician and the facility. It is the responsibility of the receiving physician to inform the transferring physician of the need for additional administrative consent.

g. The patient or the patient’s legal representative must be advised, if possible, of the need for the transfer. Adequate information shall be provided regarding the proposed transportation plans. This process should be documented according to State and Federal requirements. [H&S Code 1317.2(i) and 1317.3(d)]

h. Facilities making transfers of Medi-Cal patients should refer to the California Medi-Cal Stable for Transport Guidelines, which contain the guidelines for transfer outlined by the State of California. Any inconsistent requirements imposed by the Medi-Cal program shall preempt SB 12 with respect to Medi-Cal beneficiaries. [H&S Code 1317.7]

i. Interfacility Transports for reasons of higher level of care which are life threatening and requiring time critical intervention (non-trauma/non-STEMI), requiring ALS or CCT services, should have a reasonable response time of one (1) hour, in the absence of previously agreed upon contractual obligations. Any response times which may exceed this performance standard shall be communicated by the responding ambulance provider to the transferring facility.
Facility will refrain from activating multiple agencies for a single response. Once the decision to transfer the patient
has been reached, every effort should be made to affect the transfer as rapidly and safely as possible. The transferring
physician must take into account the needs of the patient during transport and the ability of the transport personnel to
care for the patient. Transport personnel are not authorized to, and will not provide services beyond their scope of
practice.

“Appendix A” details the level of service for REMSA EMT’s, Paramedics, CCTRN & Air CCTRN. If the patient’s needs are
within the scope of practice of an EMT, no interaction with the base hospital is necessary. Paramedic personnel may
only deviate from existing REMSA Protocols under the direction of a Base Hospital Physician. Initial contact with the
transferring physician is approved and recommended in the interest of preserving the continuity of care of the patient.
If the patient requires Paramedic level of care, the transferring physician may potentially be contacted by the base
hospital so that the patient’s care can be coordinated during transport. If the patient’s care needs exceed the scope of
practice of the available transport personnel, the transferring physician may utilize CCT or Air transport providers.
Alternatively, the transferring physician may arrange for the patient to be accompanied by appropriate facility staff,
equipment or supplies necessary for patient care. In these cases, while assisting the M.D. or R.N. with patient care,
ambulance personnel must function in accordance with REMSA Policies 7020 (4,5), 7030, and 7040.

I. Additional Requirements for Transfer for Non-Medical Reasons:
When patients are transferred for non-medical reasons, the transferring facility must follow all of the above
requirements. In particular, the transferring physician must ensure that emergency care and emergency
services have been provided, and shall determine the transfer would not create a medical hazard to the
patient and would not decrease the patient’s chances for or delay the patient’s full recovery. [H&S Code
1317.2]

4. Transfer Procedures
The following are the basic transfer procedures for all patient transfers:

a. Transferring facility:
I. The transferring facility will first provide all diagnostic tests, procedures, and treatment (including, if
necessary, consultation) deemed appropriate by the transferring physician.
II. After determining the need for transfer, the transferring physician will notify the patient or his/her
representative, explaining the reason for transfer. This process should be documented according to State and
Federal requirements. [H&S Code 1317.3(d)]
III. The transferring physician will contact and consult the receiving physician. The receiving physician will be
advised of all information regarding the patient’s condition, test results, procedures, and current treatment. The
patient may be transferred only with the approval of the receiving facility and physician. The receiving
facility may designate physicians who may provide consent for both the physician and the facility. It is the
responsibility of the receiving physician to inform the transferring physician of the need for additional
administrative consent.

If Paramedic personnel are requested for the transfer, the transferring physician shall submit written orders designating the
precise level of care deemed necessary during the transport. These orders shall be in accordance with accepted REMSA
Paramedic protocols and policy and within the state-recognized Paramedic scope of practice. Any change in the patient’s
status that may require a deviation from the transferring physician’s orders, or jeopardize the continued safe transport of
the patient to the receiving facility, necessitate contacting the transferring physician (primarily) or base station hospital
(secondarily) in accordance with this policy’s subsections: Advanced Life Support Transfers and Paramedic transfers with
patients with IV lines. The transferring physician may then be consulted by base hospital personnel to facilitate care by
transport personnel.

IV. To request a transport:
1. Call the appropriate ambulance service directly.
2. Identify sending and receiving facilities.
3. Identify sending and receiving physicians.
4. Provide patient’s name, location, and condition.
5. Detail the level of care needed (BLS, ALS, CCT, Air, or advise if an R.N. or physician will accompany the
patient.

V. The transferring physician and nurse will complete documentation of the medical record. All test results, x-
rays, and other patient data, including an appropriate patient transfer form will be copied and sent with the
patient at the time of the transfer. If data are not available at the time of transfer, such data will be telephoned to the receiving facility and sent as soon thereafter as possible.

VI. In accordance with JCHO standards, the transferring facility shall provide any relevant patient care information to transport personnel using face-to-face communication. [Joint Commission Resources (2010). National Patient Safety Goal #2: Improving effectiveness of communication among caregivers.]

b. Receiving Facility
The receiving facility shall instruct its personnel (including physicians, who are authorized to accept patient transfers) on the appropriate procedures for completing transfers.

5. Audit of Transfer Procedures
All transfers using these guidelines are subject to review. Violations of transfer procedures can result from either clinical or procedural errors on the part of individual facilities and physicians, and/or other parties involved in the transfer process. Examples might include:

- Inadequate stabilization of the patient by the sending facility.
- Inadequately qualified transport personnel or equipment.
- Patient subject to excessive delay in transfer.
- Patient transferred without documentation or other records as requested by receiving facility.
- Serious deterioration of the patient’s condition en route.
- Inappropriate or denial of transfer of patient to another facility.
- Inappropriate utilization of facility staff to accommodate transport.

6. Procedure for Complaint Review
It is recommended that complaint reporting shall be performed in accordance with established internal policy & procedures. The receiving facility, and all physicians, other licensed emergency room health personnel, and certified pre-hospital emergency personnel at the receiving facility who know of apparent violations of EMTALA transfer procedures shall and the corresponding personnel at the transferring facility and the transferring facility may, report within one week of the actual or suspected violation to the State Department of Health Services on a form prescribed by the Department of Health Services. The report may be submitted by phone, fax or letter. [H&S Code 1317.4(c)]

State Department of Health Services Licensing and Certification.
Division Circle
464 West 4th Street, Suite 529 5th Floor
San Bernardino, CA 92401
(909) 383-4777

The Department of Health Services shall promptly send a copy of the form to the facility administrator and appropriate medical staff committee of the transferring facility and the Emergency Medical Services Division, unless the Department of Health Services concludes that the complaint does not allege facts which require further investigation, or is otherwise unmeritorious, or the Department of Health Services concludes, based upon the circumstances of the case, that its investigation of the allegations would be impeded by disclosure of the form. [H&S Code 1317.4]

When two or more persons, each otherwise mandated to report EMTALA violations, have joint knowledge of an apparent violation, a single report may be made by on behalf of the individuals if agreed to by all members. However, any individual who is otherwise required to file a report by the Health and Safety Code who disagrees with the proposed joint report has a right and duty to file a separate report. [H&S Code 1317.4(c)]
**BASIC LIFE SUPPORT TRANSFER**

**Authority**
Title 22, Division 2.5, Sections 1797.220 of the California Health and Safety Code.

**PRESCRIBED MEDICAL DEVICES**

**Purpose**
Define when it is appropriate for the EMT to assist a patient with their medications and/or medical devices.

**Policy**
1. When requested, EMTs with appropriate training may assist patients with their own personal pre-prescribed medications and medical devices, limited to:
   a. Epi-pens and epinephrine administration devices, in cases of acute allergic reactions.
   b. Glucometers and penlets.
   c. Home nebulizers and metered dose inhalers (MDIs) of bronchodilators, in cases of bronchospasm and wheezing.
   d. Nitroglycerin tablets or metered dose spray device for patients who have been both diagnosed with heart problems or who are currently experiencing suspected cardiac related pain/discomfort.
   e. Patient-controlled analgesia administration devices.
2. Any assistance given by an EMT shall be based upon the results of a physical assessment performed on the patient as well as an evaluation of the patient’s medical history. All findings and actions will be thoroughly documented.
3. EMTs are to inform patients that any treatment rendered by emergency personnel is of a temporary nature only and should be followed by/with a comprehensive medical examination by a licensed practitioner.
4. EMTs may assist patients with:
   a. Retrieval of medications from storage locations.
   b. Site preparation with alcohol or antiseptic wipes at the direction of the patient.
   c. Loading/preparation of Epi-pens, penlets, glucometer or other devices.
   d. Assisting with the placement and aiming of medication delivery systems.
   e. Application of pressure or bandage.
5. EMTs shall not draw up, measure, mix or solely administer any medications and shall not assist with the administration of medication or medical devices that are not prescribed to the patient. Any medication administered must be clearly labeled and identified as belonging to the patient.
6. In cases of assistance with nitroglycerin tablets or spray, the EMT shall monitor administration to ensure that doses are given at the prescribed times and in the prescribed amounts. If no specific directions are noted on the prescription, the EMT shall ensure that doses are given at five (5) minute intervals and that no more than a total of three (3) doses are given.
   a. Blood pressure will be taken and recorded prior to each dose.
   b. The EMT should not assist with the administration of nitroglycerin when the patient’s blood pressure is < 90 mmHg systolic OR the patient has an altered level of consciousness.

**EMT MEDICAL ADJUNCT MONITORING**

**Purpose**
Define the procedure for the transfer and monitoring of patients with invasive tubes and other medical adjuncts.

**Policy**
1. Nasogastric Tubes (NGTs)
   a. NGTs shall be clamped. No form of suction shall be allowed during transport.
   b. The tube shall be secured to the nose appropriately and shall also be secured to the patient’s clothing to prevent accidental dislodgement or patient discomfort.
   c. Any tubing shall be clamped and no feedings shall be infused during transport to prevent the possibility of aspiration.
d. Unless contraindicated by medical condition, any patient fed within the last two (2) hours shall be placed on the gurney in semi-fowler’s position to help prevent the possibility of aspiration.

2. Abdominal Tubes - (Gastrostomy tubes, ureterostomy tubes, wound drains, etc)
   a. EMTs shall check that tubes are secured in place in an appropriate fashion, the integrity of the drainage system is intact and drainage bags are emptied prior to transfer, with the time noted. Drainage amount and characteristics shall be noted.
   b. Drainage bags shall be secured to the patient in an appropriate fashion to prevent dislodgement, disconnection or backflow.
   c. Any dressing drainage shall be noted and charted.
   d. Dislodged tubes shall not be reinserted. A clean, dry dressing shall be applied to the site. Time and circumstances of dislodgement shall be noted on the PCR.

3. Foley Catheters
   a. Catheters shall be checked prior to transfer to assure that the catheter is appropriately secured to the patient, the system is intact and the drainage bag is secured to prevent dislodgement, disconnection and backflow.
   b. Amount and characteristics of urine shall be noted.
   c. If the drainage system becomes disconnected or dislodged during transport, the EMT will clamp the foley if disconnected, but in no circumstances shall the catheter be reinserted if dislodged.

4. Tracheostomy Tubes
   a. Tracheostomy tubes shall be checked to assure they are secured to the patient in an appropriate fashion.
   b. EMTs may suction at the opening only to remove secretions the patient is unable to clear. Amount and characteristic of secretions shall be noted.
   c. If the inner cannula becomes dislodged or is expelled, the EMT shall rinse it in sterile NaCl and gently reinsert it, or allow the patient to reinsert it if capable. Do not force during reinsertion.

**EMT TRANSPORT OF PATIENTS WITH IV LINES**

**Purpose**
To define the procedure for transfers by EMTs with IV lines.

**Policy**
1. During transfers, a certified EMT may monitor peripheral and long term venous access lines including, but not limited to, heplocks, Broviacs, Hickmans, Port-a-Catheters and PICC lines, provided the following conditions are met:
   a. A written order signed by the transferring physician is provided to the EMTs, stating that in the opinion of the transferring physician the patient is non-critical and deemed stable for transportation by an EMT staffed ambulance. The written order must include the rate of infusion for the IV fluids and the type of solution infusing.
   b. No medications can be added to the IV fluids prior to or during transport.
   c. The following are the only IV solutions that may be monitored by the EMT during interfacility transports:
      i. D5/Water
      ii. D5/0.2 NaCl
      iii. D5/0.45 NaCl
      iv. D5/0.9 NaCl
      v. D5/Lactated Ringers
      vi. 0.9 NaCl (Normal Saline)
      vii. 0.45 NaCl
      viii. 0.225 NaCl
      ix. Ionosol-T
      x. Lactated Ringers

2. Patients with vascular access lines through shunts or fistulas are not transportable by EMTs.

3. IV infusions in pediatric patients less than 8 years of age shall be administered with the use of Buretol, dial-a-flow, mini infuser or any other such metered infusion to safe guard against the over infusion of IV fluids.

4. IV sites shall be initially assessed and documented by the EMT. Periodic assessment for signs of infiltration or irritation shall be conducted and recorded.
5. The EMT may take no action regarding the IV infusion other than to monitor the IV flow rate and turn off the infusion if infiltration occurs.
   a. If infiltration does occur, the EMT shall document signs and symptoms, and actions taken, then notify the receiving center of such on arrival.

6. Care of lines inadvertently disconnected shall follow standard medical practice, to include site pressure and a dry sterile dressing if the cannula pulls completely out of the skin. If the IV tubing becomes disconnected, but the cannula remains in place, the disconnected tip of the line shall be cleansed with an appropriate germicide and the line reconnected at the original flow rate. Monitor IV site closely for signs of infiltration (reference #4 above). Appropriate written documentation of the incident and a verbal report on arrival will be made.

ADVANCED LIFE SUPPORT TRANSFERS

Purpose
To define the procedure for establishing medical control for transfers by Paramedics.

Authority
Title 22, Division 2.5, Sections 1797.218, 1797.220 and 1798 of the California Health and Safety Code.

ALS Transfer Policy
1. The ALS Provider must verify with the receiving facility prior to transferring the patient that the patient transfer has been approved and that the patient is accepted for admission.

2. The Paramedics shall receive patient specific transferring orders from the transferring physician prior to leaving the sending facility. These orders shall be documented in writing as directed by the transferring physician and must include a telephone number where the transferring physician can be reached during the patient transport.

3. The transferring physician, or designee, shall provide the Paramedics with verbal report and written documentation regarding the care provided to the patient. This documentation shall be reviewed by the Paramedic prior to the transfer.

4. The name of the receiving facility and the name of the receiving physician who has accepted the patient shall be provided in the transfer documents.

5. The Paramedic shall monitor the patient during transport and shall document the ongoing assessment on the Prehospital Care Report.

6. The Paramedics shall monitor the IV infusions as ordered. Refer to this policy’s subsection Paramedic Interfacility Transport of Patient with IV lines.

7. The Paramedic shall follow the directions of the transferring physician. If there are any questions or problems during transport, the Paramedic should attempt to contact the transferring physician. If unable to contact the transferring physician, the Paramedic may contact a Riverside County Base Hospital.

8. Paramedics may not transport patients who are being treated with procedures, medications and/or IV solutions which are outside of the Paramedic Scope of Practice as defined by Title 22 and the Riverside County EMS Agency; nor may any such transfer orders, either written or verbal, be initiated. Excluded procedures include, but are not limited to, monitoring arterial lines and/or pulmonary artery catheters. Such transports may be done if a Registered Nurse (RN), qualified to provide such care, is available to accompany the patient who shall monitor and provide care to the patient during the transport. The RN should function pursuant to the Nurse Practice Act and the standardized procedures approved by the employing hospital.
   a. If the patient is receiving a medication which is outside the paramedic’s scope of practice, but that medication is being delivered either by dermal patch, implant or patient controlled pump, the paramedic can accept the patient for transfer without the removal or discontinuance of the medication.

9. Procedures that may be performed include any of the Advanced Life Support skills as defined in the Riverside County EMS Agency Protocol, Policy, and Procedure Manual and any additional skills that the EMS Agency has approved for a provider’s specialty transfer program. This includes, but not limited to, monitoring chest tubes that are connected to water sealed
Paramedic transport of patients with IV lines policy

1. During transfers, an accredited Paramedic may monitor peripheral and long term venous access lines including, but not limited to, heplocks, Broviacs, Hickmans, Port-a-Catheters and PICC lines, provided the following conditions are met:
   a. A written order by the transferring physician is provided to the Paramedics, stating that, in the opinion of the transferring physician, the patient is non-critical and deemed stable for transportation by a Paramedic staffed ambulance. The written order must include the rate of infusion for the IV fluids and the type of solution infusing.
   b. The following are the only IV solutions that may be monitored by the Paramedic during interfacility transports:
      i. D5/Water
      ii. D5/0.2 NaCl
      iii. D5/0.45 NaCl
      iv. D5/0.9NaCl
      v. D5/Lactated Ringers
      vi. 0.9% NaCl (Normal Saline)
      vii. 0.45 NaCl
      viii. 0.225 NaCl
      ix. Ionosol-T
      x. Lactated Ringers
   c. The following medicated IV infusions are the only ones that may be monitored by the Paramedic during interfacility transports:
      i. Intropin (Dopamine)
      ii. Isoproterenol (Isuprel)
      iii. KCl of < 40mEq/1000cc
      iv. Morphine Sulfate
      v. Xylocaine HCL (Lidocaine)

2. IV sites shall be initially assessed and documented by the Paramedic. Periodic assessment for signs of infiltration or irritation shall be conducted and recorded.

3. Paramedic interventions will be performed under the medical direction of the transferring physician or Base Hospital physician, either directly or through pre-signed “Standing Orders”. Refer to this policy’s subsection Advanced Life Support Transfers.

Critical care transports

Purpose
To state the requirements for Critical Care Transport (CCT) units meeting all local, county, Riverside County Emergency Medical Services Agency (REMSA) and state requirements.

Authority
Title 22, Division 2.5, Section 1797.52, 1797.178, 1798.170, and 1798.172 of the California Health and Safety Code.

Policy
1. Request for program approval must be made in writing ninety (90) days prior to the anticipated starting date of service to the Executive Director of REMSA and include:
   a. Proposed identification and location of the CCT unit
   b. All procedures and protocols
   c. Documentation of qualifications for the Medical Director
   d. Documentation of qualifications for the Clinical Coordinator
   e. Quality Assurance plan
   f. Agreement to comply with all REMSA policies and procedures

2. Within twelve (12) working days of receiving the applicant’s request for approval, REMSA will notify the applicant of any further documentation requirements.
3. The applicant shall be notified in writing within thirty (30) days of receipt of complete package of the approval or denial of program.

4. Definition: A CCT unit shall be defined as minimally meeting Riverside County Ambulance Ordinance 756 CCT Transport unit staffing requirements and may include staffing such as physicians, mid-level providers (Registered Nurse Practitioner or Physician Assistant) in-lieu or in adjunct to Registered Nurse. Critical Care Transport Paramedic may be an adjunct team member.

5. Minimum requirements for Registered Nurse personnel:
   a. RN with current unrestricted licensed to practice in the State of California.
   b. At the CCT provider’s option, an RN may be employed by the CCT ambulance provider or be a contract employee.
   c. Current American Heart Association BLS, ACLS and PALS or PEPP certification. One of the following courses will be required within 6 months of hire: Trauma Nurse Core Curriculum (TNCC), Advanced Trauma Care for Nurses (ATCN) or Prehospital Trauma Life Support (PHTLS).
   d. A minimum of two (2) years full time experience as RN AND either two (2) years of full time ICU/ED experience OR two (2) years of full time experience as a CTRN with a CCT provider in the previous three (3) years prior to employment with the CCT ambulance provider.
   e. Successful completion of an in-house orientation program related to REMSA protocol and procedures and as approved by REMSA, additional training, continuing education, tailored to the CCT RN specific job description and scope including but not limited to basic and advanced airway management commensurate with Advanced Life Support (ALS) level of care.
   f. Needle Cricothyrotomy will remain an option for each agency.
   g. Certification in any of the following is desirable but not required: Certified Emergency Nurse (CEN); Certified Critical Care Registered Nurse (CCRN); Certified Transport Registered Nurse (CTRN); Mobile Intensive Care Nurse (MICN); Neonatal Resuscitation Provider (NRP).
   h. Continuing education requirement documentation:
      i. Maintain current California State RN license, BLS, ACLS and PALS or PEPP certification.
      ii. On-going training and competencies for low frequency and high risk skills will be based on the individual provider’s CCT scope of practice and standardized procedures. However, REMSA reserves the right to review.

6. Equipment
   a. In addition to the items required by California Administrative Code, Title 13, the ambulance provider shall provide, at a minimum, the following equipment:
      i. BLS equipment and supplies per REMSA Policy 5210.
      ii. Cardiac monitor with external pacemaker/defibrillator, 12 lead, SPO2, and capnography capabilities.
      iii. Infusion pump(s).
      iv. Portable ventilator.
      v. Back-up power source (Inverter).
      vi. Each CCT unit shall have equipment and supplies commensurate with the scope of practice for the medical personnel. This req. may be fulfilled through the utilization of appropriate kits (pack/cases), which must be removed if the vehicle is being utilized for BLS transport purposes.
      vii. CCT providers shall ensure that transport personnel are thoroughly trained in the safe operation of all patient care equipment utilized on board the CCT unit.
      viii. Nothing in this policy is intended to limit a CCT provider agency from utilizing or maintaining additional equipment or medications on board the CCT unit, as long as patient care personnel are fully trained on the safe and effective use of that equipment or medication.

7. Medical Director
   a. Medical Director: A full or part-time Physician licensed in the State of California and qualified by training and experience with recent, within the last five (5) years, practice in emergency or acute critical care medicine. The REMSA Medical Director must approve the candidate for medical director. The duties of the medical director shall include but not be limited to:
      i. Sign and approve, in advance, all medical protocols to be followed by the CCT personnel.
      ii. The CCT provider agency medical director shall ensure that all nursing/medical staff on a CCT collectively possesses the skills and knowledge to provide a level of care commensurate with the specific and anticipated needs of the patient. The CCT provider agency medical director shall be accountable for all medical procedures performed by provider agency staff.
iii. Ensure the quality of patient transfers being conducted by the provider agency, including familiarity with COBRA (Consolidated Omnibus Budget Reconciliation Act) and EMTALA (Emergency Medical Treatment & Active Labor Act).

iv. The medical director for the CCT provider agency shall ensure that a comprehensive, written quality assurance (QA) and quality improvement (QI) program or Performance Improvement Program (PIP) is in place to evaluate the medical/nursing care provided to all patients. This QA/QI or PIP program shall integrate with the countywide prehospital QA/QI or PIP program. Any incidents that result in a negative patient outcome shall be reported to the Riverside County EMS Medical Director according to the time line defined in REMSA policy 2200.

b. Clinical Coordinator: A provider shall have a Clinical Coordinator who minimally meets the requirements of Section 4 and has a minimum of one year full time experience in ambulance transports.
   i. The Clinical Coordinator may function as the Respiratory Care Practitioner (RCP) Coordinator in conjunction with the Transport Medical Director.
   ii. Duties of the CCT Clinical Coordinator include:
       1. Sign and approve, in advance, all nursing procedures to be followed by the RN.
       2. Oversee ongoing training for all medical personnel involved.
       3. Ensure quality of patient transfers being conducted by the provider by conducting patient care audits.

8. Procedure/Protocols
   a. Each company providing Critical Care Transport units shall develop and maintain procedures for the hiring and training of personnel and vehicle staffing
   b. Each provider must develop a manual to include the following:
       i. Malpractice insurance coverage.
       ii. Identity and accessibility of the Physician Director and Clinical Coordinator.
       iii. Vehicle inventory lists.
       iv. Copies of all related inter-facility transfer paperwork.
       v. The identity of the Transport Medical Director, the CCT Clinical Coordinator, and RCP Coordinator (if applicable). The EMS Agency shall be notified in writing of any changes of these key personnel.
       vi. A description of the procedure for contacting the Transport Medical Director, CCT Clinical Coordinator and RCP Coordinator if needed during a patient transport.
       vii. Statement of Responsibility of the sending physician for the patient during transfer in accordance with COBRA and EMTALA laws.
       viii. Narcotics:
            1. Physician Order Form for Narcotics (DEA 222)
            2. Waste procedure
            3. Turnover procedure
            4. Storage of Narcotics
            5. Usage documentation
            6. Discrepancy procedure
            7. Copy of your Medical Director’s DEA License.

9. Quality Assurance
   a. Submit to REMSA a quality improvement plan.
   b. All CCT providers shall conform to REMSA policy 2200.
   c. Periodic staff conference on audits of Patient Care Reports and outcomes are required in order to improve or revise protocols.
   d. Records of all these activities shall be kept by the provider and be made available for inspection and audit by REMSA.
   e. REMSA shall perform periodic on-site audits of records to ensure compliance with this policy.

AIR MEDICAL TRANSPORTS

Purpose
To state the requirements for air (rotor wing) medical staffed units meeting all local, county, Riverside County Emergency Medical Services Agency (REMSA) and state requirements.

Authority
Title 22, Division 2.5, Section 1797.52, 1797.178, 1798.170, and 1798.172 of the California Health and Safety Code.
Policy

1. Request for program approval must be made in writing ninety (90) days prior to the anticipated starting date of service to the Executive Director of REMSA and include:
   a. Proposed identification and location of the air medical staffed unit
   b. All procedures and protocols
   c. Documentation of qualifications for the Medical Director
   d. Documentation of qualifications for the Clinical Coordinator
   e. Quality Assurance plan
   f. Agreement to comply with all REMSA policies and procedures
   g. Provide and maintain proof of full accreditation by the Commission on Accreditation of Medical Transport Services (CAMTS) Certification

2. REMSA will notify the applicant in writing within twelve (12) working days following receipt of request for approval if any further documentation is needed.

3. The applicant shall be notified in writing within thirty (30) days of receipt of complete package of the approval or denial of program.

4. Minimum requirements for air medical personnel:
   a. RN currently unrestricted licensed to practice in the State of California.
   b. At the air medical provider’s option, an RN may be employed by the air medical provider or be a contract employee.
   c. Current American Heart Association BLS, ACLS, NRP and PALS/PEPP certification. One of the following courses will be required within 6 months of hire: Trauma Nurse Core Curriculum (TNCC), Advanced Trauma Care for Nurses (ATCN) or Prehospital Trauma Life Support (PHTLS).
   d. A minimum of four (4) years of experience in emergency department or critical care unit in the past five (5) years before working as a flight nurse in Riverside.
   e. Successful completion of an in-house orientation program related to REMSA protocol and procedures and as approved by REMSA, additional training, continuing education, tailored to the flight nurse specific job description and scope including but not limited to basic and advanced airway management commensurate with Advanced Life Support (ALS) level of care.
   f. Needle Cricothyrotomy will remain an option for each agency.
   g. Certification in any of the following is desirable but not required: Certified Emergency Nurse (CEN); Certified Critical Care Registered Nurse (CCRN); Certified Transport Registered Nurse (CTRN); Mobile Intensive Care Nurse (MICN); Certified Flight Registered Nurse (CFRN).
   h. Continuing education requirement documentation:
      i. Maintain current California State RN license, BLS, ACLS, NRP and PALS or PEPP certification.
      ii. On-going training and competencies for low frequency and high risk skills will be based on the individual provider’s air transport scope of practice and standardized procedures. However, REMSA reserves the right to review.

5. Equipment
   a. In addition to the items required by California Administrative Code, Title 13, the ambulance provider shall provide, at a minimum, the following equipment:
      i. BLS equipment and supplies per REMSA Policy 5210. (This may have to be revised – Air exemption)
      ii. Cardiac monitor with external pacemaker/defibrillator, 12 lead, SPO2, and capnography capabilities.
      iii. Infusion pump(s).
      iv. Portable ventilator.
      v. Back-up power source (Inverter).
      vi. Each air transport unit shall have equipment and supplies commensurate with the scope of practice for the medical personnel. This req. may be fulfilled through the utilization of appropriate kits (pack/cases).
      vii. Air transport providers shall ensure that transport personnel are thoroughly trained in the safe operation of all patient care equipment utilized on board the air transport unit.
      viii. Nothing in this policy is intended to limit a air transport provider agency from utilizing or maintaining additional equipment or medications on board the air transport unit, as long as patient care personnel are fully trained on the safe and effective use of that equipment or medication.
      ix. Air provider’s list.

6. Medical Director
Interfacility Transfer Policy

a. Medical Director: A full or part-time Physician licensed in the State of California and qualified by training and experience with recent, within the last five (5) years, practice in emergency or acute critical care medicine. The REMSA Medical Director must approve the candidate for medical director. The duties of the medical director shall include but not be limited to:
   i. Sign and approve, in advance, all medical protocols to be followed by the RN.
   ii. The air transport provider agency medical director shall ensure that all nursing/medical staff on a air transport unit collectively possesses the skills and knowledge to provide a level of care commensurate with the specific and anticipated needs of the patient. The air transport provider agency medical director shall be accountable for all medical procedures performed by provider agency staff.
   iii. Ensure the quality of patient transfers being conducted by the provider agency, including familiarity with COBRA (Consolidated Omnibus Budget Reconciliation Act) and EMTALA (Emergency Medical Treatment & Active Labor Act).
   iv. The medical director for the air transport provider agency shall ensure that a comprehensive, written quality assurance (QA) and quality improvement (QI) program or Performance Improvement Program (PIP) is in place to evaluate the medical/nursing care provided to all patients. This QA/QI or PIP program shall integrate with the countywide prehospital QA/QI or PIP program. Any incidents that result in a negative patient outcome shall be reported to the Riverside County EMS Medical Director according to the time line defined in REMSA policy 2200.

b. Clinical Coordinator: A provider shall have a Clinical Coordinator who meets the requirements of Section 4 and has a minimum of one year full time experience in air medical transports.
   i. Duties of the air transport Clinical Coordinator include:
      1. Sign and approve, in advance, all nursing procedures to be followed by the RN.
      2. Oversee ongoing training for all air medical personnel involved.
      3. Ensure quality of patient transfers being conducted by the provider by conducting patient care audits.

7. Procedure/Protocols
   a. Each company providing air medical staffed Critical Care units shall develop and maintain procedures for the hiring and training of nursing personnel and helicopter staffing.
   b. Each provider must develop a manual to include the following:
      i. Malpractice insurance coverage.
      ii. Identity and accessibility of the Physician Director and Clinical Coordinator.
      iii. Helicopter inventory lists.
      iv. Copies of all related inter-facility transfer paperwork.
      v. The identity of the air transport Medical Director and the air transport Clinical Coordinator. The EMS Agency shall be notified in writing of any changes in these key personnel.
      vi. A description of the procedure for contacting the air transport Medical Director or air transport Clinical Coordinator if needed during a patient transport.
      vii. Statement of Responsibility of the sending physician for the patient during transfer in accordance with COBRA and EMTALA laws.
   viii. Narcotics:
      1. Physician Order Form for Narcotics (DEA 222)
      2. Waste procedure
      3. Turnover procedure
      4. Storage of Narcotics
      5. Usage documentation
      6. Discrepancy procedure
      7. Copy of your Medical Director’s DEA License.

8. Quality Assurance
   a. Submit to REMSA a quality improvement plan.
   b. All air medical providers shall conform to REMSA policy 2200.
   c. Periodic staff conference on audits of Patient Care Reports and outcomes are required in order to improve or revise protocols.
   d. Records of all these activities shall be kept by the provider and be made available for inspection and audit by REMSA.
   e. REMSA shall perform periodic on-site audits of records to ensure compliance with this policy.
### APPENDIX A

#### IV FLUIDS/MEDICATIONS

<table>
<thead>
<tr>
<th>Medication</th>
<th>BLS</th>
<th>REMSA Ref</th>
<th>ALS</th>
<th>REMSA Ref</th>
<th>CCT</th>
<th>Air</th>
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<tbody>
<tr>
<td>Infusion Pump</td>
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<td>NaCl 0.225%</td>
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<td>D5/0.45% NS IV (no meds)</td>
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<td>Narcotic Analgesic (PCA pump)</td>
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<td>Blood/Blood Products</td>
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<td>Isoproterenol (Isuprel)</td>
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<td>KCl of &gt; 40 mEq/1000 cc</td>
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#### IV ACCESS LINES

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<th>ALS</th>
<th>REMSA Ref</th>
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<td>Arterial Lines to keep intact</td>
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<td>CVP or Central Venous Pressure Lines</td>
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<td>Dialysis Shunts with complications</td>
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#### TUBES

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* Not all Providers are capable of providing this intervention.
FOR CONSIDERATION BY PMAC

DATE:       June 13, 2011
TO:         PMAC
FROM:       Scott Moffatt, EMS Specialist
SUBJECT:    PMAC Consideration of DRAFT Policy 1700

In preparation the PMAC meeting on June 27, 2011, please review the attached DRAFT Policy.

DRAFT: 1700 EMS System Resource List

This is a new policy that replaces the policy below and functions as the resource list referred to starting with line 62 of 4500 Paramedic Receiving Center Criteria. We intend to regularly update this policy as it serves as a master list. We will appreciate your thorough review and correction of the contact information provided.

Thank you for your participation.

Replaces:
1700 SERVICE PROVIDERS
PURPOSE
The purpose of this policy is to provide a resource list for use within the EMS system.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
Riverside County Ordinance Number 756 (Ambulance Ordinance)

The EMS System
The EMS System consists of public and private sector organizations and individuals working together to provide emergency medical services to the residents and visitors of Riverside County.

Organizations providing EMS include:
- Call & Dispatch Centers
- First Response Agencies
  - BLS
  - ALS
- Transport Services
  - BLS
  - ALS
  - CCT
- Hospitals
  - Paramedic Receiving Centers
  - Base Hospitals
  - Trauma Centers
  - STEMI Receiving Centers

Individuals providing EMS include the:
- Emergency Medical Dispatcher (EMD)
- Emergency Medical Responder (EMR)
- Emergency Medical Technician (EMT)
- Advanced Emergency Medical Technician (AEMT)
- Paramedic (PM)
- Mobile Intensive Care Nurse (MICN)
- Base Hospital Physician (BHP)

Resource List
The following pages provide contact information for many of the resources within our EMS system.

The contacts and their contact information may be modified and updated without following the policy review process. A “last modified” field will be maintained in the footer of all pages containing contact information and the most recent list will be maintained in the REMSA Policy Manual online.
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<tr>
<td>American Medical Response (951) 782-5234</td>
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<tr>
<td>Banning Police Department (951) 955-3170</td>
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<td>Beaumont Police Department (951) 769-8500</td>
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<td>Blythe Police Department (760) 922-6211</td>
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<td>Cathedral City Police Dispatch (760) 770-0371</td>
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<td>California Highway Patrol – Border (858) 637-3800</td>
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<td>California Highway Patrol – Inland (909) 388-8000</td>
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<td>Corona Fire/Police Dispatch (951) 736-2394</td>
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<td>Hemet City Dispatch (951) 765-2400</td>
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<tr>
<td>Indio Police Dispatch (760) 347-8522 ext 5</td>
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<tr>
<td>Murrieta Fire/Police Dispatch (951) 696-3615</td>
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<td>Palm Springs Police Dispatch (760) 327-1441</td>
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<td>Riverside County Fire Department Emergency Communications Center (951) 940-6900</td>
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<td>River Medical (AMR – dispatch Blythe Ambulance) (928) 855-7777</td>
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<td>Riverside City Fire/Police Dispatch (951) 787-7911</td>
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<tr>
<td>Riverside County Sheriff Dispatch – Blythe (760) 921-7900</td>
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<td>Riverside County Sheriff Dispatch – Palm Desert (760) 836-1600</td>
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<td>Riverside County Sheriff Dispatch - Riverside (951) 776-1099</td>
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<td>University of California, Riverside Police Dispatch (951) 821-5212</td>
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<td>Southwest Station (951) 210-1000</td>
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### BLS First Response Agencies

**BLM Fire Department**  
1201 Bird Center Dr  
Palm Springs, CA 92262  
Phone: (760) 833-7100  
Website: [www.blm.gov](http://www.blm.gov)

**Blythe Volunteer Fire Department**  
201 N Commercial  
Blythe, CA 92225  
Phone: (760) 922-6117  
Website: [www.blythefire.com](http://www.blythefire.com)

**Hemet Fire Department**  
510 E Florida Ave  
Hemet, CA 92543  
Phone: (951) 765-2450  
Website: [www.cityofhemet.org](http://www.cityofhemet.org)

**March Air Reserve Base (MARB) Fire Department**  
6450 8 Street  
March Air Reserve Base, CA 92518  
Phone: (951) 655-2075  
Website: [www.march.afrc.af.mil](http://www.march.afrc.af.mil)

**Morongo Fire Department**  
12700 Pumarra Road  
Banning, CA 92220  
Phone: (951) 849-4697  
Website: [www.morongonation.org](http://www.morongonation.org)

**Pechanga Fire Department**  
48240 Pechanga Rd  
Temecula, CA 92592  
Phone: (951) 506-5332  
Website: [www.pechanga-nsn.gov](http://www.pechanga-nsn.gov)

**USFS Cleveland**  
10845 Rancho Bernardo Rd  
San Diego, CA 92127  
Phone: (858) 673-6180  
Website: [www.fs.fed.us/fire/](http://www.fs.fed.us/fire/)

**USFS San Bernardino**  
602 S Tippecanoe Ave  
San Bernardino, CA 92408  
Phone: (909) 382-2600  
Website: [www.fs.fed.us/fire/](http://www.fs.fed.us/fire/)

### ALS First Response Agencies

**Cathedral City Fire Department**  
32-100 Desert Vista  
Cathedral City, CA 92234  
Phone: (760) 770-8200  
Website: [http://www.cathedralcityfire.org/](http://www.cathedralcityfire.org/)

**Corona Fire Department**  
400 S Vicentia Ave  
Corona, CA 92882  
Phone: (951) 736-2220  
Website: [http://www.ci.corona.ca.us/](http://www.ci.corona.ca.us/)

**Idyllwild Fire Protection District**  
54160 Maranatha Drive  
Idyllwild, CA 92549  
Phone: (951) 659-2153  
Website: [www.idyllwildfire.org](http://www.idyllwildfire.org)

**Murrieta Fire Department**  
41825 Juniper St  
Murrieta, CA 92562  
Phone: (951) 304-3473  
Website: [http://www.murrieta.org/](http://www.murrieta.org/)

**Norco Fire Department**  
3902 Hillside Ave  
Norco, CA 92860  
Phone: (951) 737-1479  
Website: [http://www.norco.ca.us/](http://www.norco.ca.us/)

**Palm Springs Fire Department**  
300 North El Cielo Rd  
Palm Springs, CA 92262  
Phone: (760) 323-8181  
Website: [http://www.ci.palm-springs.ca.us/](http://www.ci.palm-springs.ca.us/)

**Riverside City Fire Department**  
3085 Saint Lawrence St  
Riverside, CA 92504  
Phone: (951) 826-5321  
Website: [http://www.riversideca.gov/fire/](http://www.riversideca.gov/fire/)

**Riverside County Fire Department**  
16902 Bundy Ave  
Riverside, CA 92518  
Phone: (951) 486-4625  
Website: [http://www.rvcfire.org/](http://www.rvcfire.org/)
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<td>Alpha Ambulance</td>
<td>425 South Fairfax, #205</td>
<td>Los Angeles</td>
<td>(800) 714-3989</td>
<td><a href="http://www.aambulance.com">www.aambulance.com</a></td>
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<td>Idyllwild Fire Protection District</td>
<td>54160 Maranatha Drive</td>
<td>Idyllwild</td>
<td>(951) 659-2153</td>
<td><a href="http://www.idyllwildfire.org">www.idyllwildfire.org</a></td>
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<td>American Medical Response – Hemet</td>
<td>208 E. Devonshire Avenue</td>
<td>Hemet</td>
<td>(951) 765-3900</td>
<td><a href="http://www.AMR.net">www.AMR.net</a></td>
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<td>Lynch Ambulance</td>
<td>1371 Red Gum Street</td>
<td>Anaheim</td>
<td>(800) 347-3262</td>
<td><a href="http://www.lynchambulance.com">www.lynchambulance.com</a></td>
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<tr>
<td>American Medical Response – Palm Springs</td>
<td>1111 Montalvo Way</td>
<td>Palm Springs</td>
<td>(760) 883-5010</td>
<td><a href="http://www.AMR.net">www.AMR.net</a></td>
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<td>Mission Ambulance</td>
<td>1055 E. Third Avenue</td>
<td>Corona</td>
<td>(800) 899-9100</td>
<td><a href="http://www.missionambulance.com">www.missionambulance.com</a></td>
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<tr>
<td>American Medical Response – Riverside</td>
<td>879 Marlborough Avenue</td>
<td>Riverside</td>
<td>(951) 782-5200</td>
<td><a href="http://www.AMR.net">www.AMR.net</a></td>
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<tr>
<td>Pacific Ambulance</td>
<td>23942 McWhorter Way</td>
<td>Lake Forest</td>
<td>(866) 277-2727</td>
<td><a href="http://www.pacificambulance.com">www.pacificambulance.com</a></td>
</tr>
<tr>
<td>River Medical – Blythe Ambulance</td>
<td>129 South 1st Street</td>
<td>Blythe</td>
<td>(760) 922-8460</td>
<td><a href="http://www.AMR.net">www.AMR.net</a></td>
</tr>
<tr>
<td>Premier Medical Transportation</td>
<td>575 Maple Court, Suite A</td>
<td>Colton</td>
<td>(909) 433-3939</td>
<td><a href="http://www.premiermedicaltransportation.com">www.premiermedicaltransportation.com</a></td>
</tr>
<tr>
<td>Cavalry Ambulance</td>
<td>420 McKinley Street, Suite 111 – 130</td>
<td>Corona</td>
<td>(888) 744-9900</td>
<td><a href="http://www.cavalryems.com">www.cavalryems.com</a></td>
</tr>
<tr>
<td>Primary Response</td>
<td>4050 N. Palm Street, Suite 501</td>
<td>Fullerton</td>
<td>(888) 353-9556</td>
<td><a href="http://www.premiermedicaltransport.com">www.premiermedicaltransport.com</a></td>
</tr>
<tr>
<td>Cole-Schaefer Ambulance Services</td>
<td>324 N. Towne Avenue</td>
<td>Pomona</td>
<td>(800) 966-4727</td>
<td><a href="http://www.schaeferamb.com">www.schaeferamb.com</a></td>
</tr>
<tr>
<td>Priority One Medical Transport</td>
<td>740 S. Rochester Avenue, Suite E</td>
<td>Ontario</td>
<td>(800) 600-3370</td>
<td><a href="http://www.priorityonemedical.com">www.priorityonemedical.com</a></td>
</tr>
<tr>
<td>C.R.A.</td>
<td>11690 Pacific Avenue, Suite 101</td>
<td>Fontana</td>
<td>(866) 907-3728</td>
<td><a href="http://www.countyrescue.org">www.countyrescue.org</a></td>
</tr>
<tr>
<td>Symons Ambulance</td>
<td>18592 Cajon Boulevard</td>
<td>San Bernardino</td>
<td>(866) 728-3548</td>
<td><a href="http://www.symonsambulance.com">www.symonsambulance.com</a></td>
</tr>
<tr>
<td>BLS Transport Services (continued)</td>
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<tr>
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<tr>
<td><strong>Desert CCT</strong></td>
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<td></td>
</tr>
<tr>
<td>140 North Broadway</td>
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<tr>
<td>Blythe, CA 92225</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Phone: (760) 922-5911</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Website: <a href="http://www.desertairambulance.com">www.desertairambulance.com</a></td>
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<table>
<thead>
<tr>
<th><strong>Valley Medical Transportation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>43-612 Jackson Street, Suite 4</td>
</tr>
<tr>
<td>Indio, CA 92201</td>
</tr>
<tr>
<td>Phone: (760) 578-4748</td>
</tr>
<tr>
<td>Website: <a href="http://www.valleymedtransport.com">www.valleymedtransport.com</a></td>
</tr>
</tbody>
</table>
ALS Transport Services

American Medical Response – Hemet
208 E. Devonshire Avenue
Hemet, CA 92543
Phone: (951) 765-3900
Website: www.AMR.net

American Medical Response – Palm Springs
1111 Montalvo Way
Palm Springs, CA 92262
Phone: (760) 883-5010
Website: www.REACHair.com

American Medical Response – Riverside
879 Marlborough Avenue
Riverside, CA 92507-2133
Phone: (951) 782-5200
Website: www.AMR.net

River Medical – Blythe Ambulance
129 South 1st Street
Blythe, CA 92226
Phone: (760) 922-9837
Website: www.AMR.net

Cathedral City Fire Department
32-100 Desert Vista
Cathedral City, CA 92234
(760) 770-8200
Website: www.cathedralcityfire.org

Idyllwild Fire Protection District
54160 Maranatha Drive
Idyllwild, CA 92549
Phone: (951) 659-2153
Website: www.idyllwildfire.com

Riverside County Fire Department – Coves
44400 Towncenter Way
Palm Desert, CA 92260
Phone: (760) 346-6254
Website: www.rvcfire.org

Riverside County Fire Department – Indio
46990 Jackson Street
Indio, CA 92201
Phone: (760) 347-0726
Website: www.rvcfire.org

California Highway Patrol – Air Rescue Ops.
56-850 Higgins Drive, #201
Thermal, CA 92274
(760) 399-0085
Website: www.chp.ca.gov

Mercy Air Service, Inc.
1097 Airport Road
Rialto, CA 92376
Phone: (909) 357-9006
Website: www.airmethods.com

REACH Air Medical Services
1670 Miro Way
Imperial, CA 92251
Phone: (877) 644-4045
Website: www.reachair.com

Tri State Careflight
2000 Hwy 95
Bullhead City, AZ 86442
Phone: (928) 704-7025
Website: www.tristatecareflightems.com
### Critical Care Transport Services

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Address 1</th>
<th>Address 2</th>
<th>Phone 1</th>
<th>Phone 2</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>American Medical Response – Hemet</strong></td>
<td>208 E. Devonshire Avenue</td>
<td>Hemet, CA 92543</td>
<td>(951) 765-3900</td>
<td></td>
<td><a href="http://www.AMR.net">www.AMR.net</a></td>
</tr>
<tr>
<td><strong>Priority One Medical Transport</strong></td>
<td>740 S. Rochester Avenue, Suite E</td>
<td>Ontario, CA 91761</td>
<td>(800) 600-3370</td>
<td></td>
<td><a href="http://www.priorityonemedical.com">www.priorityonemedical.com</a></td>
</tr>
<tr>
<td><strong>American Medical Response – Palm Springs</strong></td>
<td>1111 Montalvo Way</td>
<td>Palm Springs, CA 92262</td>
<td>(760) 883-5010</td>
<td></td>
<td><a href="http://www.AMR.net">www.AMR.net</a></td>
</tr>
<tr>
<td><strong>REACH Air Medical Services</strong></td>
<td>1097 Airport Road</td>
<td>Imperial, CA 92251</td>
<td>(877) 644-4045</td>
<td></td>
<td><a href="http://www.reachair.com">www.reachair.com</a></td>
</tr>
<tr>
<td><strong>American Medical Response – Riverside</strong></td>
<td>879 Marlborough Avenue</td>
<td>Riverside, CA 92507-2133</td>
<td>(951) 782-5200</td>
<td></td>
<td><a href="http://www.AMR.net">www.AMR.net</a></td>
</tr>
<tr>
<td><strong>Symons Ambulance</strong></td>
<td>18592 Cajon Boulevard</td>
<td>San Bernardino, CA 92423</td>
<td>(866) 728-3548</td>
<td></td>
<td><a href="http://www.symonsambulance.com">www.symonsambulance.com</a></td>
</tr>
<tr>
<td><strong>Cavalry Ambulance</strong></td>
<td>420 McKinley Street, Suites 111 – 130</td>
<td>Corona, CA 92879</td>
<td>(888) 744-9900</td>
<td></td>
<td><a href="http://www.cavalryems.com">www.cavalryems.com</a></td>
</tr>
<tr>
<td><strong>Mercy Air Medical Services</strong></td>
<td>1670 Miro Way</td>
<td>Rialto, CA 92376</td>
<td>(909) 357-9006</td>
<td></td>
<td><a href="http://www.airmethods.com">www.airmethods.com</a></td>
</tr>
<tr>
<td><strong>C.R.A.</strong></td>
<td>11690 Pacific Avenue, Suite 101</td>
<td>Fontana, CA 92337</td>
<td>(866) 907-3728</td>
<td></td>
<td><a href="http://www.countyrescue.org">www.countyrescue.org</a></td>
</tr>
<tr>
<td><strong>Mission Ambulance</strong></td>
<td>1055 East Third Avenue</td>
<td>Corona, CA 92879</td>
<td>(800) 899-9100</td>
<td></td>
<td><a href="http://www.missionambulance.com">www.missionambulance.com</a></td>
</tr>
<tr>
<td><strong>Desert CCT</strong></td>
<td>140 North Broadway</td>
<td>Blythe, CA 92225</td>
<td>(760) 922-5911</td>
<td></td>
<td><a href="http://www.desertairambulance.com">www.desertairambulance.com</a></td>
</tr>
<tr>
<td><strong>Pacific Ambulance</strong></td>
<td>23942 McWhorter Way</td>
<td>Lake Forest, CA 92630</td>
<td>(866) 277-2727</td>
<td></td>
<td><a href="http://www.pacificambulance.com">www.pacificambulance.com</a></td>
</tr>
<tr>
<td><strong>Tri State Careflight</strong></td>
<td>2000 Hwy 95</td>
<td>Bullhead City, AZ 86442</td>
<td>(928) 704-7025</td>
<td></td>
<td><a href="http://www.tristatecareflightems.com">www.tristatecareflightems.com</a></td>
</tr>
</tbody>
</table>
Paramedic Base Hospitals

**Desert Regional Medical Center**
1150 North Indian Canyon Drive
Palm Springs, CA 92262
Main phone: (760) 323-6511
ED phone: (760) 323-6521
Radio room phone: (760) 323-4723
Website: [www.desertmedctr.com](http://www.desertmedctr.com)

**Eisenhower Medical Center**
39000 Bob Hope Drive
Rancho Mirage, CA 92270
Main phone: (760) 340-3911
ED phone: (760) 837-8016
Radio room phone: (760) 837-8625
Website: [www.emc.org](http://www.emc.org)

**Inland Valley Medical Center**
36485 Inland Valley Drive
Wildomar, CA 92595
Main phone: (951) 677-1111
ED phone: (951) 677-9773
Radio room phone: (951) 677-0833
Website: [www.swhealthcaresystem.com](http://www.swhealthcaresystem.com)

**JFK Memorial Hospital**
47-111 Monroe Street
Indio, CA 92201
Main phone: (760) 347-6191
ED phone: (760) 775-8111
Radio room phone: (760) 342-3011
Website: [www.jfkmemorialhosp.com](http://www.jfkmemorialhosp.com)

**Palo Verde Hospital**
250 North 1st Street
Blythe, CA 92225
Main phone: (760) 922-4115
ED phone: (760) 921-5144
Radio room phone: (760) 921-5235
Website: [www.paloverdehospital.org](http://www.paloverdehospital.org)

**Riverside Community Hospital**
4445 Magnolia Avenue
Riverside, CA 92501
Main phone: (951) 788-3000
ED phone: (951) 788-3200
Radio room phone: (951) 683-8671
Website: [www.rchc.org](http://www.rchc.org)

**Riverside County Regional Medical Center**
26520 Cactus Avenue
Moreno Valley, CA 92555
Main phone: (951) 486-4111
ED phone: (951) 486-5650
Radio room phone: (951) 486-4137
Website: [www.rcrmc.org](http://www.rcrmc.org)
### Paramedic Receiving Centers

<table>
<thead>
<tr>
<th>Coronado Regional Medical Center</th>
<th>Moreno Valley Community Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>285 800 South Main Street</td>
<td>286 27300 Iris Avenue</td>
</tr>
<tr>
<td>Corona, CA 92882</td>
<td>Moreno Valley, CA 92360</td>
</tr>
<tr>
<td>Main phone: (951) 737-4343</td>
<td>Main phone: (951) 243-0811</td>
</tr>
<tr>
<td>ED phone: (951) 736-6241</td>
<td>ED phone: (951) 601-2018</td>
</tr>
<tr>
<td>Website: <a href="http://www.coronaregional.com">www.coronaregional.com</a></td>
<td>Website: <a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a></td>
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<table>
<thead>
<tr>
<th>Hemet Valley Medical Center</th>
<th>Parkview Community Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>287 1117 E. Devonshire Avenue</td>
<td>288 3805 Jackson Street</td>
</tr>
<tr>
<td>Hemet, CA 92543</td>
<td>Riverside, CA 92503</td>
</tr>
<tr>
<td>Main phone: (951) 652-2811</td>
<td>Main phone: (951) 688-2211</td>
</tr>
<tr>
<td>ED phone: (951) 766-6450</td>
<td>ED phone: (951) 352-5666</td>
</tr>
<tr>
<td>Website: <a href="http://www.valleyhealthsystem.com">www.valleyhealthsystem.com</a></td>
<td>Website: <a href="http://www.pchmc.org">www.pchmc.org</a></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Kaiser Permanente Hospital – Riverside</th>
<th>Rancho Springs Medical Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>289 10800 Magnolia Avenue</td>
<td>290 25500 Medical Center Drive</td>
</tr>
<tr>
<td>Riverside, CA 92505</td>
<td>Murrieta, CA 92562</td>
</tr>
<tr>
<td>Main phone: (866) 984-7483</td>
<td>Main phone: (951) 696-6000</td>
</tr>
<tr>
<td>ED phone: (951) 353-3790</td>
<td>ED phone: (951) 696-6089</td>
</tr>
<tr>
<td>Website: <a href="http://www.kaiserpermanente.org">www.kaiserpermanente.org</a></td>
<td>Website: <a href="http://www.swhealthcaresystem.com">www.swhealthcaresystem.com</a></td>
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<table>
<thead>
<tr>
<th>Menifee Valley Medical Center</th>
<th>San Gorgonio Memorial Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>291 28400 McCall Boulevard</td>
<td>292 600 North Highland Springs Boulevard</td>
</tr>
<tr>
<td>Sun City, CA 92585</td>
<td>San Gorgonio, CA 92220</td>
</tr>
<tr>
<td>Main phone: (951) 679-8888</td>
<td>Main phone: (951) 845-1121</td>
</tr>
<tr>
<td>ED phone: (951) 672-71910/672-7191</td>
<td>ED phone: (951) 769-2121</td>
</tr>
<tr>
<td>Website: <a href="http://www.valleyhealthsystem.com">www.valleyhealthsystem.com</a></td>
<td>Website: <a href="http://www.sgmh.org">www.sgmh.org</a></td>
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<table>
<thead>
<tr>
<th>Loma Linda University Medical Center, Murrieta</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>293 28062 Baxter Road</td>
<td></td>
</tr>
<tr>
<td>Murrieta, CA 92563</td>
<td></td>
</tr>
<tr>
<td>Main phone: (951) 704-1924</td>
<td></td>
</tr>
<tr>
<td>ED Phone: (951) 290-4000</td>
<td></td>
</tr>
<tr>
<td>Website: <a href="http://lomalindahealth.org/medical-center/murrieta">http://lomalindahealth.org/medical-center/murrieta</a></td>
<td></td>
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</tbody>
</table>
Trauma Centers

**Desert Regional Medical Center**
1150 North Indian Canyon Drive
Palm Springs, CA 92262
Main phone: (760) 323-6511
ED phone: (951) 323-6521
Radio room phone: (760) 323-4723
Website: [www.desertmedctr.com](http://www.desertmedctr.com)

**Riverside Community Hospital**
4445 Magnolia Avenue
Riverside, CA 92501
Main phone: (951) 788-3000
ED phone: (951) 788-3200
Radio room phone: (951) 683-8671
Website: [www.rchc.org](http://www.rchc.org)

**Riverside County Regional Medical Center**
26520 Cactus Avenue
Moreno Valley, CA 92555
Main phone: (951) 486-4111
ED phone: (951) 486-5648
Radio room phone: (951) 486-4137
Website: [www.rcrmc.org](http://www.rcrmc.org)

**Inland Valley Medical Center**
36485 Inland Valley Drive
Wildomar, CA 92595
Main phone: (951) 677-1111
ED phone: (951) 677-9773
Radio room phone: (951) 677-0833
Website: [www.swhealthcaresystem.com](http://www.swhealthcaresystem.com)

San Bernardino County Trauma Centers

**Arrowhead Regional Medical Center**
400 North Pepper Avenue
Colton, CA 92373
Main phone: (909) 580-1000
ED phone: (909) 580-1347
Radio room: recorded: (909) 580-1682/1683
Non-recorded: (909) 580-1473
Website: [www.arrowheadmedcenter.org](http://www.arrowheadmedcenter.org)

**Loma Linda University Medical Center**
11234 Anderson Street
Loma Linda, CA 92350
Main phone: (909) 558-4000
Adult ED phone: (909) 558-4444; Peds ED: (909) 558-8216
Website: [www.lomalindahealth.org](http://www.lomalindahealth.org)

Pediatric Trauma Centers

**Riverside County Regional Medical Center**
26520 Cactus Avenue
Moreno Valley, CA 92555
Main phone: (951) 486-4111
ED phone: (951) 486-5648
Radio room phone: (951) 486-4137
Website: [www.rcrmc.org](http://www.rcrmc.org)

**Loma Linda University Medical Center**
11234 Anderson Street
Loma Linda, CA 92350
Main phone: (909) 558-4000
Adult ED phone: (909) 558-4444; Peds ED: (909) 558-8216
Radio room phone: (909) 558-7911
Website: [www.lomalindahealth.org](http://www.lomalindahealth.org)

Burn Center

**Arrowhead Regional Medical Center**
400 North Pepper Avenue
Colton, CA 92373
Main phone: (909) 580-1000
ED phone: (909) 580-1357
Radio room phone recorded: (909) 580-1682/1683
Non-recorded: (909) 909) 580-1473
Website: [www.arrowheadmedcenter.org](http://www.arrowheadmedcenter.org)
Riverside County STEMI Receiving Centers

**Desert Regional Medical Center**
1150 North Indian Canyon Drive
Palm Springs, CA 92262
Main phone: (760) 323-6511
ED phone: (760) 323-6521
Radio room phone: (760) 323-4723
Website: [www.desertmedctr.com](http://www.desertmedctr.com)

**Eisenhower Medical Center**
39000 Bob Hope Drive
Rancho Mirage, CA 92270
Main phone: (760) 340-3911
ED phone: (760) 837-8016
Radio room phone: (760) 837-8625
Website: [www.emc.org](http://www.emc.org)

**Riverside Community Hospital**
4445 Magnolia Avenue
Riverside, CA 92501
Main phone: (951) 788-3000
ED phone: (951) 788-3200
Radio room phone: (951) 683-8671
Website: [www.rhc.org](http://www.rhc.org)

REMSA Approved Out of County STEMI Receiving Centers

**Loma Linda University Medical Center**
11234 Anderson Street
Loma Linda, CA 92350
Main phone: (909) 558-4000
Adult ED phone: (909) 558-4444; Peds ED: (909) 558-8216
Radio room phone: (909) 558-7911
Website: [www.lomalindahealth.org](http://www.lomalindahealth.org)

**Palomar Medical Center**
555 East Valley Parkway
Escondido, CA 92025
Main phone: (760) 739-3000
ED phone: (760) 739-3323
Website: [www.pph.org](http://www.pph.org)

**San Antonio Community Hospital**
999 San Bernardino Road
Upland, CA 91786
Main phone: (909) 985-2811
ED phone: (909) 920-4798
Website: (909) [www.sach.org](http://www.sach.org)

Hyperbaric Chambers

**Riverside County Regional Medical Center**
26520 Cactus Avenue
Moreno Valley, CA 92555
Main phone: (951) 486-4111
ED phone: (951) 486-5648
Radio room phone: (951) 486-4137
Website: [www.rcrmc.org](http://www.rcrmc.org)

**Loma Linda University Medical Center**
11234 Anderson Street
Loma Linda, CA 92350
Main phone: (909) 558-4000
Adult ED phone: (909) 558-4444; Peds ED: (909) 558-8216
Website: [www.lomalindahealth.org](http://www.lomalindahealth.org)

**Inland Valley Medical Center**
36485 Inland Valley Drive
Wildomar, CA 92595
Main phone: (951) 677-1111
ED phone: (951) 677-9773
Radio room phone: (951) 677-0833
Website: [www.swhealthcaresystem.com](http://www.swhealthcaresystem.com)
Obstetrical/Nurseries – Riverside County

**Corona Regional Medical Center**
Level 1 (Basic) Nursery
800 South Main Street
Corona, CA  92882
Main phone: (951) 736-6241
ED phone: (951) 737-4343
Website:  [www.coronaregional.com](http://www.coronaregional.com)

**Desert Regional Medical Center**
Level 2 (Specialty ) Nursery
1150 North Indian Canyon Drive
Palm Springs, CA  92262
Main phone: (760) 323-6511
ED phone: (760) 323-6521
Website:  [www.desertmedctr.com](http://www.desertmedctr.com)

**Hemet Valley Medical Center**
Level 1 (Basic) Nursery
1117 E. Devonshire Avenue
Hemet, CA  92543
Main phone: (951) 652-2811
ED phone: (951) 766-6450
Website:  [www.valleyhealthsystem.com](http://www.valleyhealthsystem.com)

**Inland Valley Medical Center**
Level 1 (Basic) Nursery
36485 Inland Valley Drive
Wildomar, CA  92595
Main phone: (951) 677-1111
ED phone: (951) 677-9773
Website:  [www.swhealthcaresystem.com](http://www.swhealthcaresystem.com)

**JFK Memorial Hospital**
Level 1 (Basic) Nursery
47-100 Monroe Street
Indio, CA  92201
Main phone: (760) 347-6191
ED phone: (760) 775-8111
Radio room phone: (760)
Website:  [www.jfkmemorialhosp.com](http://www.jfkmemorialhosp.com)

**Kaiser Permanente Hospital**
Level 2 (Specialty ) Nursery
10800 Magnolia Avenue
Riverside, CA  92503
Main phone: (866) 984-7483
ED phone: (951) 353-3790
Website:  [www.kaiserpermanente.org](http://www.kaiserpermanente.org)

**Moreno Valley Community Hospital**
Level 1 (Basic) Nursery
27300 Iris Avenue
Moreno Valley, CA  92360
Main phone: (951) 243-0811
ED phone: (951)601-2018
Website:  [www.kaiserpermanente.org](http://www.kaiserpermanente.org)

**Parkview Community Hospital**
Level 3 (Subspecialty) Nursery
3650 Jackson Street
Riverside, CA  92503
Main phone: (951) 688-2211
ED phone: (951) 352-5666
Website:  [www.pchmc.org](http://www.pchmc.org)

**Riverside Community Hospital**
Level 2 (Specialty ) Nursery
4445 Magnolia Avenue
Riverside, CA  92501
Main phone: (951) 788-3000
ED phone: (951) 788-3200
Radio room phone: (951) 683-8671
Website:  [www.rhc.org](http://www.rhc.org)

**Riverside County Regional Medical Center**
Level 3 (Subspecialty) Nursery
26520 Cactus Avenue
Moreno Valley, CA  92555
Main phone: (951) 486-4111
ED phone: (951) 486-5648
Radio room phone: (951) 486-4137
Website:  [www.rcrmc.org](http://www.rcrmc.org)

**San Gorgonio Memorial Hospital**
Level 1 (Basic) Nursery
600 North Highland Springs Boulevard
San Gorgonio, CA  92220
Main phone: (951)845-1121
ED phone: (951) 769-2121
Website:  [www.sgmh.org](http://www.sgmh.org)

**Rancho Springs Medical Center**
Level 1 (Basic) Nursery
25500 Medical Center Drive
Murrieta, CA  92562
Main phone: (951) 696-6000
ED phone: 696-6089
Website:  [www.swhealthcaresystem.com](http://www.swhealthcaresystem.com)
Obstetrical/Nurseries – San Bernardino County

**Loma Linda University Medical Center**
Level 3 (Subspecialty) Nursery
11234 Anderson Street
Loma Linda, CA 92350
Main phone: (909) 558-4000
Adult ED phone: (909) 558-4444; Peds ED: (909) 558-8216
Radio room phone: (909)
Website: [www.lomalindahealth.org](http://www.lomalindahealth.org)

**Redlands Community Hospital**
Level 2 (Specialty) Nursery
350 Terracina Boulevard
Redlands, CA 92373
Main phone: (909) 335-5500
ED phone: (909) 335-5600
Website: [www.redlandshospital.org](http://www.redlandshospital.org)

**Arrowhead Regional Medical Center**
Level 2 (Specialty) Nursery
400 N. Pepper Avenue
Colton, CA 92373
Main phone: (909) 580-1000
ED phone: (909) 580-1347
Radio phone recorded: (909) 580-1682/1683
Non-recorded: (909) 580-1473
Website: [www.arrowheadmedctr.org](http://www.arrowheadmedctr.org)

Neonatal Intensive Care Units

**Riverside Community Hospital**
4445 Magnolia Avenue
Riverside, CA 92501
Main phone: (951) 788-3000
ED phone: (951) 788-3200
Radio room phone: (951) 683-8671

**Parkview Community Hospital**
3650 Jackson Street
Riverside, CA 92503
Main phone: (951) 688-2211
ED phone: (951) 652-5666
Website: [www.pchmc.org](http://www.pchmc.org)

**Desert Regional Medical Center**
1150 North Indian Canyon Drive
Palm Springs, CA 92262
Main phone: (760) 323-6511
ED phone: (760) 323-6521
Radio room: (760) 323-4723
Website: [www.desertmedctr.com](http://www.desertmedctr.com)

**Arrowhead Regional Medical Center**
400 North Pepper Avenue
Colton, CA 92373
Main Phone: (909) 580-1000
ED phone: (909) 580-1347

**Inland Valley Medical Center**
36485 Inland Valley Drive
Wildomar, CA 92595
Main phone: (951) 677-1111
ED phone: (951) 677-9773
Radio room phone: (951) 677-0833
Website: [www.swhealthcaresystem.com](http://www.swhealthcaresystem.com)

Pediatric Intensive Care Units

**Riverside County Regional Medical Center**
26520 Cactus Avenue
Moreno Valley, CA 92555
Main phone: (951) 486-4111
ED phone: (951) (951) 486-5648
Radio room phone: (951) (951) 486-4137
Website: [www.rcrmc.org](http://www.rcrmc.org)

**Loma Linda University Medical Center**
11234 Anderson Street
Loma Linda, CA 92350
Main phone: (909) 558-4000
Adult ED phone: (909) 558-4444; Peds ED: (909) 558-8216
Radio room phone: (909)
Website: [www.lomalindahealth.org](http://www.lomalindahealth.org)
24 Hour Emergency Hotlines

- 24 Hour Detox Referral Line: (800) 499-3008
- 24 Hour Adult Protective Services Hotline: (800) 491-7123
- 24 Hour Child Abuse Hotline: (800) 442-4918

California Poison Control

3333 California Street
San Francisco, CA 94143
Phone: (800) 876-4766

Riverside County Department of Public Health

**Riverside EMS Agency (REMSA)**
During Business Hours: (951) 358-5029
Weekends, holidays, after business hours – Answering Service: (951) 782-2977
Duty Officer direct telephone number: (951) 712-3342
REMSA Communications Center: (951) 358-5134
REMSA Website: [www.rivcoems.org](http://www.rivcoems.org)

**Disease Control (Exposure Reporting):**
(951) 358-5107 (Riverside)
(760) 853-8448 (Indio)

**Departmental Operations Center (When DOC is Activated):**
(951) 358-5122

**Public Health Emergency Preparedness and Response (PHEPR)**
During Business Hours: (951) 358-7100
Weekends, holidays, after business hours – Answering Service: (951) 782-2977
PHEPR Website: [www.rivcophepr.org](http://www.rivcophepr.org)

Riverside County Sheriff-Coroner

**Perris Facility**
800 South Redlands
Perris, CA 92570
Phone: (951) 443-2300
Website: [www.riversidesheriff.org/coroner](http://www.riversidesheriff.org/coroner)

**Indio Facility**
47-225 Oasis Street
Indio, CA 92201
Phone: (760) 863-8311
Website: [www.riversidesheriff.org/coroner](http://www.riversidesheriff.org/coroner)

Organ Transplant/Tissue Bank

**One Legacy**
2200 W. 3rd Street, 4th Floor
Los Angeles, CA 90057
Phone: (800) 338-6112

Report all deaths to One Legacy – they will forward appropriate referrals to the tissue bank.
Sexual Assault Exams

**Corona Regional Medical Center**
800 S. Main Street
Corona, CA 92882
Main phone: (951) 736-6241
ED phone: (951) 737-4343
Website: [www.coronaregional.com](http://www.coronaregional.com)

**Riverside County Regional Medical Center**
26520 Cactus Avenue
Moreno Valley, CA 92555
Main phone: (951) 486-4111
ED phone: (951) 486-5648
Radio room phone: (951) 486-4137
Website: [www.rcrmc.org](http://www.rcrmc.org)

**Eisenhower Medical Center**
39000 Bob Hope Drive
Rancho Mirage, CA 92270
Main phone: (760) 340-3911
ED phone: (760) 837-8016
Radio room phone: (760) 837-8625
Website: [www.emc.org](http://www.emc.org)

Sexual Assault Services

**Riverside Area Rape Crisis Center**
1845 Chicago Avenue #A
Riverside, CA 92507
Phone: (951) 686-7273
Website: [www.rarcc.org](http://www.rarcc.org)

**Southwest Center Against Sexual Assault (CASA)**
640 North San Jacinto Street, #E
Hemet, CA 92543
Phone: (951) 652-8300
Website: [www.swcasa.org](http://www.swcasa.org)

**Rape Crisis Hot Line**
74333 Highway 111, #204
Palm Desert, CA 92260
Phone: (760) 568-9071
Sudden Infant Death Syndrome (SIDS) Services

**Guild for Infant Survival ~ Inland Empire**
1400 Barton Road #2415
Redlands, CA 92373
San Bernardino County
sharon_lang@redlands.edu
(909) 838-1536
Riverside County
maureen.chavez@rcc.edu
(951) 201-1772
(951) 571-6262 FAX
mcarrie1@hotmail.com

**5150 Receiving Centers**

**Children’s Evaluation Services Unit CESU)**
9990 County Farm Road, Suite 6
Riverside, CA 92503
Phone: (951) 358-4881
Website: [http://mentalhealth.rcmhd.org](http://mentalhealth.rcmhd.org)

**Emergency Treatment Services (ETS)**
9990 County Farm Road, Suite 4
Riverside, CA 92503
Phone: (951) 358-4881
Website: [http://mentalhealth.rcmhd.org](http://mentalhealth.rcmhd.org)

**Oasis Rehabilitation Center**
47-915 Oasis Street
Indio, CA 92201
Phone: (760) 863-8650
Website: [www.starsinc.com/oasis.php](http://www.starsinc.com/oasis.php)

**Mental Health Resources**

**Crisis Team Numbers:**

**Western Region** – Area served: Riverside, Moreno Valley
Area served: Corona, Norco
(951) 358-4507
(951) 738-2400

**Mid-County Region** – Area served: Hemet, Temecula, Perris,
Sun City, San Jacinto, Murrieta, Lake Elsinore
(951) 791-3300

**Desert Region** – Area served: Indio, Palm Springs, Blythe,
Rancho Mirage, Cathedral City, Palm Desert,
Desert Hot Springs
Area served: Banning, Beaumont
(760) 849-7142
Area served: Blythe
(760) 921-5000
### Local Mental Health Agency Numbers

#### Western Region
- **Blaine Street Clinic** (951) 358-4705
- **Main Street Corona** (951) 738-2400
- **Children’s’ Treatment Services:** (951) 358-4840
- **CARES Line** *(Community Access, Referral, Evaluation, And Support Line)* (800) 706-7500
- **Interagency Services for Families** (951) 358-4850
- **Jefferson Wellness Center** (951) 955-8000
- **Tyler Village for Mature Adults (Older Adult Services)** (951) 509-2400
- **FACT of Corona** (951) 273-0608

#### Mid-County Region
- **Hemet Clinic** (951) 791-3300
- **Mt. San Jacinto Children’s** (951) 487-2674
- **Perris Clinic** (951) 443-2200
- **Lake Elsinore Older Adult Services** (951) 245-7791

#### Desert Region
- **Cathedral Canyon Older Adult Services** (760) 773-6767
- **Banning Clinic** (951) 849-7142
- **Blythe Clinic** (760) 921-5000
- **Indio Children Services/Adult Services/Crisis Services/Residential Services** (760) 863-8455

#### Miscellaneous Mental Health
- **Emergency Treatment Services (ETS)** (951) 358-4881/82/83
- **Inpatient Treatment Facility (ITF)** (951) 358-4700
- **Oasis Crisis Services** (760) 863-8650
- **CARES Line** (800) 706-7500
- **Public Guardian** (951) 341-6440
- **Adult System of Care (Homeless Team)** (951) 955-8000
- **Patients’ Rights** (800) 350-0519
- **Family Advocate Program** (800) 330-4522
- **Adult Protective Services** (877) 565-2020
- **Helpline, Suicide Crisis** (951) 686-HELP (4357)
- **Child Protection Hotline** (800) 4-A-CHILD (422-4453)
- **National Suicide Prevention Lifeline** (800) 273-TALK (8255)
- **Family Service Association** (951) 686-3706
- **National Alliance for the Mentally Ill (NAMI)** (800) 950-NAMI (6264)
- **NAMI California** (916) 567-0163
- **NAMI Riverside** (951) 369-2721
- **NAMI Mt San Jacinto** (951) 765-1850
- **NAMI Temecula** (951) 672-0290
- **NAMI Coachella** (888) 881-NAMI (6264)
- **California Department of Mental Health** (800) 896-4042
- **Riverside County Mental Health Association** (951) 686-3706
## Domestic Violence Victim/Prevention Services

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Address</th>
<th>Phone Numbers</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alternatives to Domestic Violence</strong></td>
<td>Casas Shelter</td>
<td>P.O. Box 216</td>
<td>Los Alamitos, CA 90720</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone: (562) 594-6825; (714) 995-8601</td>
<td>Hotline: (800) 914-2272 (CASA)</td>
</tr>
<tr>
<td></td>
<td>I Care Shelter</td>
<td>P.O. Box 749</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Riverside, CA 92502</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone: (951) 354-2273</td>
<td><a href="http://www.caremaster@lilmonster.com">www.caremaster@lilmonster.com</a></td>
</tr>
<tr>
<td><strong>National Domestic Violence</strong></td>
<td>Settlement House</td>
<td>507 South Vicentia Avenue</td>
<td>Corona, CA 92882</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone: (951) 737-3504</td>
<td></td>
</tr>
<tr>
<td></td>
<td>National Referral Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Shelter from the Storm</strong></td>
<td>Administrative Offices and Palm Desert Outreach Center</td>
<td>73555 Alessandro Drive, Suite D</td>
<td>Palm Desert, CA 92260</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone: (760) 674-0400</td>
<td>Hotline: (760) 328-7233</td>
</tr>
<tr>
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<tr>
<td><strong>Shelter from the Storm</strong></td>
<td>Cathedral City Outreach Center</td>
<td>68-615 Perez Road, #9A</td>
<td>Cathedral City, CA 92234</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone: (760) 770-2390</td>
<td>Hotline: (760) 328-7233</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(800) 775-6055</td>
</tr>
<tr>
<td><strong>Shelter from the Storm</strong></td>
<td>Desert Hot Springs Outreach Center</td>
<td>14-201 Palm Drive, Suite 108</td>
<td>Desert Hot Springs, CA 92240</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone: (760) 288-3313</td>
<td>Hotline: (760) 328-7233</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(800) 775-6055</td>
</tr>
<tr>
<td><strong>Shelter from the Storm</strong></td>
<td>Indio Outreach Center</td>
<td>44-199 Monroe Street</td>
<td>Indio, CA 92201</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone: (760) 863-2855</td>
<td>Hotline: (760) 328-7233</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>(800) 775-6055</td>
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<tr>
<td><strong>Shelter from the Storm</strong></td>
<td>Coachella Outreach Center</td>
<td>53990 Enterprise Way, Suite 7</td>
<td>Coachella, CA 92236</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone: (760) 393-0561</td>
<td>Hotline: (760) 328-7233</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(800) 775-6055</td>
</tr>
<tr>
<td><strong>Shelter from the Storm</strong></td>
<td>Mecca Outreach Center</td>
<td>66th Avenue, Suite 101</td>
<td>Mecca, CA 92254</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone: (760) 863-7860</td>
<td>Hotline: (760) 328-7233</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>(800) 775-6055</td>
</tr>
</tbody>
</table>
Domestic Violence Victim/Prevention Services (continued)

Shelter from the Storm
Palm Springs Outreach Center
555 S. Sunrise
Palm Springs, CA 92262
Phone: (760) 318-0140
Hotline: (760) 328-7233
(800) 775-6055
Website: www.shelterfromthestorm.com

Valley Restart
P.O. Box 1715
Hemet, CA 92546
Phone: (951) 766-7476
Website: www.valleyrestart.org

Domestic Violence Shelter Services

Alternatives to Domestic Violence
P.O. Box 910
Riverside, CA 92502
Phone: (951) 320-1370
Hotline: (909) 683-0829
(800) 339-7233 (SAFE)
Website: http://alternativestodv.org

Casas Shelter
P.O. Box 216
Los Alamitos, CA 90720
Phone: (562) 594-6825; (714) 995-8601
Hotline: (800) 914-2272 (CASA)
Website: www.casayouthshelter.org

Coachella Valley Rescue Mission
47518 Van Buren Street
Indio, CA 92202
Phone: (760) 347-3512
Website: www.cvrm.org

Genesis Shelter
3772 Taft Street
Riverside, CA 92503
Phone: (951) 689-7847
Hotline: (951) 682-7299
Website: www.cvrm.org

Riverside County District Attorney

Riverside Family Justice Center
3900 Orange Street
Riverside, CA 92501
Phone: (951) 955-6100
Website: www.rivcoda.org

Southwest Family Justice Center
30045 Technology Drive, Suite 101
Murrieta, CA 92563
Phone: (951) 304-5680
Website: www.rivcoda.org

Family Justice Centers offer crime-related crisis counseling and, when necessary, emergency services including:
food, shelter, clothing, medical care, and transportation
<table>
<thead>
<tr>
<th>Substance/Alcohol Abuse Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Alcoholics Anonymous</strong></td>
</tr>
<tr>
<td>Website: <a href="http://www.aa.org">www.aa.org</a></td>
</tr>
<tr>
<td><strong>Narcotics Anonymous</strong></td>
</tr>
<tr>
<td>Website: <a href="http://www.na.org">www.na.org</a></td>
</tr>
<tr>
<td><strong>Life’s Journey Center, Inc.</strong></td>
</tr>
<tr>
<td>291 East Camino Monte Vista</td>
</tr>
<tr>
<td>Palm Springs, CA 92262</td>
</tr>
<tr>
<td>Phone: (760) 864-6363</td>
</tr>
<tr>
<td>Website: <a href="http://www.lifesjourneycenter.com">www.lifesjourneycenter.com</a></td>
</tr>
<tr>
<td><strong>The Ranch Recovery Centers, Inc (Men only)</strong></td>
</tr>
<tr>
<td>7885 Annandale Avenue</td>
</tr>
<tr>
<td>Desert Hot Springs, CA 92240</td>
</tr>
<tr>
<td>Phone: (760) 329-2924</td>
</tr>
<tr>
<td>Website: <a href="http://www.ranchrecovery.org">www.ranchrecovery.org</a></td>
</tr>
<tr>
<td><strong>Three Hills Ranch Recovery</strong></td>
</tr>
<tr>
<td>42145 Lyndie Lane Suite 108</td>
</tr>
<tr>
<td>Temecula, CA 92591</td>
</tr>
<tr>
<td>Phone: (951) 676-8241</td>
</tr>
<tr>
<td>Website: <a href="http://www.hillrecovery.com">www.hillrecovery.com</a></td>
</tr>
<tr>
<td><strong>Riverside Treatment Center</strong></td>
</tr>
<tr>
<td>1021 La Cadena Drive West</td>
</tr>
<tr>
<td>Riverside, CA 92501</td>
</tr>
<tr>
<td>Phone: (951) 784-8010</td>
</tr>
<tr>
<td>Website: <a href="http://www.crchealth.com">www.crchealth.com</a></td>
</tr>
<tr>
<td><strong>Riverside County Substance Abuse Program</strong></td>
</tr>
<tr>
<td>1827 Atlanta Avenue, #D1</td>
</tr>
<tr>
<td>Riverside, CA 92507</td>
</tr>
<tr>
<td>Phone: (951) 955-2105</td>
</tr>
<tr>
<td><strong>Gordon Recovery Services</strong></td>
</tr>
<tr>
<td>705 South Eugene Road</td>
</tr>
<tr>
<td>Palm Springs, CA 92264</td>
</tr>
<tr>
<td>Phone: (888) 321-2818</td>
</tr>
<tr>
<td>Website: <a href="http://www.gordonrecovery.com">www.gordonrecovery.com</a></td>
</tr>
<tr>
<td><strong>10 Acre Ranch Treatment Center</strong></td>
</tr>
<tr>
<td>5953 Grand Avenue</td>
</tr>
<tr>
<td>Riverside, CA 92504</td>
</tr>
<tr>
<td>Phone: (951) 784-7081</td>
</tr>
<tr>
<td>Website: <a href="http://www.10acreranch.org">www.10acreranch.org</a></td>
</tr>
<tr>
<td><strong>Michael’s House</strong></td>
</tr>
<tr>
<td>430 South Cahuilla</td>
</tr>
<tr>
<td>Palm Springs, CA 92262</td>
</tr>
<tr>
<td>Phone: (877) 345-8494</td>
</tr>
<tr>
<td>Website: <a href="http://www.michaelshouse.com">www.michaelshouse.com</a></td>
</tr>
<tr>
<td><strong>Hemet Valley Recovery Center</strong></td>
</tr>
<tr>
<td>371 North Weston Place</td>
</tr>
<tr>
<td>Hemet, CA 92543</td>
</tr>
<tr>
<td>Phone: (951) 765-4900</td>
</tr>
<tr>
<td>Website: <a href="http://www.hvrc.com">www.hvrc.com</a></td>
</tr>
<tr>
<td><strong>A Better Tomorrow</strong></td>
</tr>
<tr>
<td>41640 Corning Pl #104</td>
</tr>
<tr>
<td>Murrieta, CA 92562</td>
</tr>
<tr>
<td>Phone: (951) 837-2127</td>
</tr>
<tr>
<td>Website: <a href="http://www.abttc.net">www.abttc.net</a></td>
</tr>
<tr>
<td><strong>Soroptimist House of Hope</strong></td>
</tr>
<tr>
<td>13525 Cleo Azul Way</td>
</tr>
<tr>
<td>Desert Hot Springs, CA 92240</td>
</tr>
<tr>
<td>Phone: (760) 329-4673</td>
</tr>
<tr>
<td>Website: <a href="http://www.recoveryhouseofhope.org">www.recoveryhouseofhope.org</a></td>
</tr>
<tr>
<td><strong>MF Recovery Center</strong></td>
</tr>
<tr>
<td>2781 West Ramsey Street, #1</td>
</tr>
<tr>
<td>Banning, CA 92220</td>
</tr>
<tr>
<td>Phone: (951) 849-3896</td>
</tr>
<tr>
<td>Website: <a href="http://www.mfirecovery.com">www.mfirecovery.com</a></td>
</tr>
<tr>
<td><strong>Sun Ray Addictions Counseling</strong></td>
</tr>
<tr>
<td>960 North State Street, #B</td>
</tr>
<tr>
<td>Hemet, CA 92543</td>
</tr>
<tr>
<td>Phone: (951) 652-3560</td>
</tr>
<tr>
<td><strong>Clearview Counseling Center</strong></td>
</tr>
<tr>
<td>27393 Ynez Road, #154</td>
</tr>
<tr>
<td>Temecula, CA 92591</td>
</tr>
<tr>
<td>Phone: (951) 695-7675</td>
</tr>
<tr>
<td><strong>Whiteside Manor</strong></td>
</tr>
<tr>
<td>8605 Janet Avenue</td>
</tr>
<tr>
<td>Riverside, CA 92501</td>
</tr>
<tr>
<td>Phone: (951) 343-9564</td>
</tr>
</tbody>
</table>
Substance/Alcohol Abuse Services (continued)

**Advanced Drug Rehab**
1775 East Palm Canyon Drive #110
Palm Springs, CA 92264
Phone: (858) 775-9993
Website: [www.advanceddrugrehab.com](http://www.advanceddrugrehab.com)

**I AM New Life Ministries**
38400 San Ignacio Road
Hemet, CA 92544
Phone: (951) 767-2575

**MFI Recovery Center**
5870 Arlington Avenue, #103
Riverside, CA 92504
Phone: (951) 683-6596
Website: [www.mfirecovery.com](http://www.mfirecovery.com)

**ABC Recovery Center**
4474 Palm Street
Indio, CA 92201
Phone: (760) 342-4802
Website: [www.abcrecoverycenter.org](http://www.abcrecoverycenter.org)

**California Recovery Clinics**
710 Rimpau Avenue #102
Corona, CA 92879
Phone: (951) 549-8888
Website: [www.crc4treatment.com](http://www.crc4treatment.com)

**Our House**
41040 East Acacia Avenue
Hemet, CA 92544
Phone: (951) 766-7969

**Desert Medical Specialties**
1330 North Indian Canyon Drive
Palm Springs, CA 92262
Phone: (760) 322-9065

**Edwards House Sober Living**
3056 Edwards Place
Riverside, CA 92503
Phone: (951) 359-4272

**Hacienda Valdez (Women only)**
12890 Quinta Way
Desert Hot Springs, CA 92240
Phone: (760) 329-2959
Website: [www.ranchrecovery.org](http://www.ranchrecovery.org)

**Addiction Eliminators**
27247 Madison Avenue #104
Temecula, CA 92590
Phone: (951) 296-9019
Website: [www.addictioneliminators.com](http://www.addictioneliminators.com)

**Hart to Hart Women’s Christian Recovery Home**
301 South Harvard Street
Hemet, CA 92543
Phone: (951) 925-6655
Website: [www.harttohart.org](http://www.harttohart.org)

**Sober Shores**
42509 Carino Place
Temecula, CA 92592
Phone: (866) 660-5763
Website: [www.sobershores.com](http://www.sobershores.com)

**Teen Challenge International**
5445 Chicago Avenue
Riverside, CA 92507
Phone: (951) 683-4241
Website: [www.teenchallenge.com](http://www.teenchallenge.com)

**Addiction Recovery Center of Temecula**
28364 Vincent Moraga Drive, Suite C
Temecula, CA 92590
Phone: (951) 699-3030 / (951) 514-7763
Website: [www.addictionrecoverycenteroftemecula.com](http://www.addictionrecoverycenteroftemecula.com)

**DGW Ministries**
40260 Mayberry Avenue, #5
Hemet, CA 92544
Phone: (951) 92229-6206

**Victor Treatment Center**
19014 Mariposa Avenue
Riverside, CA 92508
Phone: (951) 780-9738

**Anew Drug Rehab Services**
So Palo Verde Avenue
Palm Springs, CA
Phone: (866) 492-1503
Website: [www.anewrehabservices.com](http://www.anewrehabservices.com)

**Casa Las Palmas Recovery Home**
83844 Hopi Avenue
Indio, CA 92203
Phone: (760) 342-9442
<table>
<thead>
<tr>
<th>Substance/Alcohol Abuse Services (continued)</th>
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<tr>
<td><strong>SoCal Health Services</strong></td>
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<tr>
<td>1485 Spruce Street</td>
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<tr>
<td>Riverside, CA  92507</td>
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<tr>
<td>Phone: (951) 682-5998</td>
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<tr>
<td><strong>Alcohol &amp; Drug Abuse Detox</strong></td>
</tr>
<tr>
<td>Moreno Valley, CA  92553</td>
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<tr>
<td>Phone: (951) 571-3852</td>
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<tr>
<td><strong>Drug Rehab Palm Springs</strong></td>
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<tr>
<td>277 E. Alejo Road</td>
</tr>
<tr>
<td>Palm Springs, CA 92262</td>
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<tr>
<td>Phone: (760) 841-1415</td>
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<td><strong>La Vista Recovery Center for Women</strong></td>
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<tr>
<td>2220 Girard Street</td>
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<tr>
<td>San Jacinto, CA  92583</td>
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<tr>
<td>Phone: (951) 925-8450</td>
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<tr>
<td>Website: <a href="http://www.lavistarecovery.com">www.lavistarecovery.com</a></td>
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<tr>
<td><strong>MFI Recovery</strong></td>
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<tr>
<td>4295 Brockton Avenue</td>
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<tr>
<td>Riverside, CA  92501</td>
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<tr>
<td>Phone: (951) 341-0252</td>
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<tr>
<td>Website: <a href="http://www.mfirecovery.com">www.mfirecovery.com</a></td>
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<tr>
<td><strong>Fellowship Hall</strong></td>
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<tr>
<td>45940 Portola Avenue</td>
</tr>
<tr>
<td>Palm Desert, CA 92260</td>
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<tr>
<td>Phone: (760) 779-8017</td>
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<tr>
<td><strong>St. Johns Tori</strong></td>
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<tr>
<td>54320 Avenida Montezuma</td>
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<tr>
<td>La Quinta, CA  92253</td>
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<tr>
<td>Phone: (760) 777-8226</td>
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<tr>
<td><strong>Omega Program</strong></td>
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<tr>
<td>2055 North Perris Boulevard, #G6</td>
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<tr>
<td>Perris, CA  92571</td>
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<tr>
<td>Phone: (951) 940-6061</td>
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FOR CONSIDERATION BY PMAC

DATE:       June 13, 2011
TO:        PMAC
FROM:    Scott Moffatt, EMS Specialist
SUBJECT: PMAC Consideration of DRAFT Policy 6010

In preparation the PMAC meeting on June 27, 2011, please review the attached DRAFT Policy.

DRAFT: 6010 Universal Patient
PMAC has seen the Universal Patient treatment Protocol before but as we have made progress through the policy manual we have also made further changes to the Universal. These include repositioning and rearranging what is on each page, adding references to inserting scene management and patient disposition treatment protocols, and changes to the following sections:

- Scene Management (page 1 regarding additional resources)
- Primary Assessment (page 2 regarding pediatric definition)
- Emergency Stabilization (page 2 regarding patient positioning, page 3 regarding SPO2 and then Magill forceps)
- Secondary Assessment (page 4 regarding LA Stroke Scale)
- Perform Documentation (page 7 regarding mandatory reports)

(The page numbers cited are in reference to the current draft.)

Thank you for your participation in this process.

Replaces:
5320 CANCELLATION REDUCTION OF AMBULANCE EQUIPMENT AT SCENE
5410 CRIME SCENE MANAGEMENT
5700 PREHOSPITAL MEDICAL DESTINATION
6050 BLS AUTOMATED EXTERNAL DEFIBRILLATION
6060 AXIAL SPINAL IMMOBILIZATION
6310 Drowning Near Drowning
6400 Abdominal Pain
6500 Altered Level of Consciousness Coma
6550 Syncope Near Syncope
6800 Respiratory Arrest
6810 Respiratory Distress
6830 Airway Obstruction
6900 Traumatic Arrest
6910 Traumatic Shock
7050 ALS UNIT REPORTING FORMAT
7060 ADVANCED LIFE SUPPORT GUIDELINES
7800 Respiratory Arrest
7830 Airway Obstruction
8800 Respiratory Arrest
8830 Airway Obstruction
Arrive Scene

Scene Size-up

- Personal, personnel, and patient safety
- Environmental hazards
- Nature of event and number of victims
- Mechanism of injury
- Additional response and resources needed
- Need for special operations

Scene Management

Ensure safety and security of all personnel
  - Practice body substance isolation (BSI) and use personal protective equipment (PPE)

Stage as necessary, avoid and/or mitigate hazards

Access and stabilize scene while maintaining exit, evacuation, and transport routes

Establish ICS as operationally indicated by nature of event and number of victims
  - May initiate MCI if 5 or more victims will require ambulance transport

Request additional response and resources as required
  - Conserve evidence and request law enforcement for any suspected criminal activity
  - Ensure that appropriate first response and special operations equipment are responding
  - Ensure that appropriate transport ambulance is responding
  - Ensure response or request air ambulance as clinically indicated and operationally required
  - Cancel, reduce, or increase priority of responding equipment as clinically indicated and operationally required

Begin special operations (triage, extrication, evacuation, fire fighting, etc.) as required

Assign health care management decisions to the most medically qualified REMSA authorized EMS provider

Insert Treatment Protocols for Scene Management

Follow operationally indicated Treatment Protocols when required for scene management

Patient Contact
**Primary Assessment**

*Identify self, then comfort, calm, reassure, restrict activity, position and cover or expose as clinically indicated*

*Formulate general initial impression*

*Perform qualitative assessment of:*
  - Need for spinal immobilization
  - Responsiveness using AVPU (Alert, Verbal, Pain, Unresponsive)
  - Airway patency
  - Breathing effort, approximate rate, equality of breath sounds, and adequacy
  - Circulation including skin signs, bleeding, approximate rate, strength, and regularity
  - Disability

*As clinically indicated, determine patient’s age, weight, and height:*
  - Age by written record, report by patient or parent, or estimate by EMS
  - Weight by measurement, written record, report by patient or parent, Broselow Tape, or estimate by EMS
  - Height by measurement, written record, report by patient or parent, or estimate by EMS

*Classify patient as pediatric if: 14 years old or less and 36 kilograms (80 pounds) or less and Broselow Tape Green or less*

*Determine the patient’s chief complaint*

*Perform a focused physical examination*

**Team Communication**
The most medically qualified REMSA authorized EMS provider must consult with the EMS team regarding:
*Findings on primary assessment*
*Intended emergency stabilization*

**Emergency Stabilization**

*Establish, maintain, and ensure the following as clinically indicated:*

*Manual spinal immobilization*
- **Airway** using manual airway maneuvers, oropharyngeal suction, OPA and/or NPA
- **Breathing** using mouth to mask or bag valve mask (BVM)
- **Circulation** using bleeding control, and CPR according to current AHA Guidelines

*Position*
- Position patient as clinically indicated for safety, comfort, and to meet physiologic requirements: Recovery position, left or right lateral recumbent, supine, low to high Fowler’s, or seated
- Never use Trendelenburg or elevate legs for shock, and never position patient prone

*Oxygen*
- Give oxygen as clinically indicated using:
  - Nasal cannula at 2-6 LPM, non-rebreather mask at 10-15 LPM, or BVM at 10-15 LPM

*Handoff*
- Handoff to arriving EMS providers as required using: Situation Background Assessment Recommendation
**Emergency Stabilization (continued)**

**Assist**
Assist more medically qualified REMSA authorized EMS providers within scope of practice as requested

**SpO₂**
Attach, interpret, continuously monitor, achieve, and maintain SpO₂ of 94% or greater when equipped

**Home Glucometry**
Assist patient with home glucometry as necessary

**Assist**
Prepare for ALS procedures under the direction of a more medically qualified REMSA authorized EMS provider

**ECG**
Attach ECG monitor when paramedic is present
Perform 12 Lead ECG as clinically indicated when paramedic is present

**Blood Glucose**
Obtain and evaluate blood glucose as clinically indicated when AEMT or paramedic is present

**Mechanical Spinal Immobilization**
Establish, maintain, and ensure mechanical spinal immobilization as clinically indicated by the possibility of a traumatic mechanism combined with any one of these criteria:
1. Neck or upper thoracic: pain or tenderness or deformity
2. New onset neurological deficits: numbness or tingling or weakness or paralysis
3. High risk mechanism of injury
4. Altered mental state, distracting pain, or influence of alcohol or drugs or medications
5. Atypical presentation, circumstance, or provider uncertainty

**Prepare for Transport**
Package and prepare for transport

**King Airway**
Establish, maintain, and ensure airway using King Airway when required for emergency stabilization
*See REMSA Calculation Chart for pediatric application on patients greater than 8 years of age*

Attach, interpret, and continuously monitor ETCO₂ by capnography or CO₂ by colorimetric detector
*Capnography or colorimetric CO₂ detector is mandatory following King Airway placement*

**Venous Access**
Establish, maintain, and ensure peripheral IV access when required for emergency stabilization

**Airway** using direct laryngoscopy and Magill forceps as clinically indicated

**Endotracheal Intubation**
Establish, maintain, and ensure airway using endotracheal intubation when required for emergency stabilization
*See REMSA Calculation Chart for pediatric application on patients greater than 8 years of age*

Attach, interpret, and continuously monitor ETCO₂ by capnography (colorimetric CO₂ detection may backup)
*Capnography is mandatory following endotracheal intubation*

Suction trachea as clinically indicated
Emergency Stabilization (continued)

Vascular Access
Establish, maintain, and ensure IV or IO access when required for emergency stabilization
*Peripheral IV access is the first-line method of vascular access*

ECG
Interpret and continuously monitor ECG
Interpret 12 Lead ECG
Transmit identified STEMI ECG to REMSA Base Hospital STEMI Receiving Center, when equipped

Insert Treatment Protocols for Emergency Stabilization
Follow clinically indicated Treatment Protocols when required for emergency stabilization

Secondary Assessment

Complete physical examination (head to toe)

Quantitative assessment of:
- Responsiveness including pupils, level of consciousness and orientation to PPTE (person, place, time and event)
- Airway including capnography to confirm airway patency and placement
- Breathing rate, breath sounds, and SPO₂
- Circulation including capillary refill time, rate, systolic/diastolic BP, and ECG/12 lead ECG
- Disability including GCS (Glasgow Coma Scale), LAP Stroke Screen, and V/CBG (venous or capillary blood glucose)

Detailed history of chief complaint

Signs and symptoms
- Allergies
- Medications (including dose, route and frequency)
- Past medical history
- Last oral intake
- Events leading to injury or illness

Formulate prehospital provider impression

Team Communication
The most medically qualified REMSA authorized EMS provider must consult with the EMS team regarding:
- Results of emergency stabilization
- Findings on secondary assessment
- Intended patient disposition and management
Patient Disposition

Determine Destination
Determine destination while balancing patient's preference with their clinical needs

Base Hospital Contact
*Base hospitals provide online medical direction (OMD) and base hospital physician orders (BHPOs) including: Concurrent quality assurance, orders, destinations, and other direction of prehospital care*

*Base hospital contact will be performed by the most medically qualified REMSA authorized EMS provider*

Contact a single REMSA authorized base hospital (BH) in all:
- Critical trauma – contact a trauma base hospital
- Pediatric critical trauma – contact RCRMC
- Critical burns – contact a base hospital
- MCI in the East (DRMC trauma catchment) – contact DRMC
- MCI in the West (IVMC, RCH, or RCRMC trauma catchments) – contact RCRMC
- STEMI – contact a STEMI base hospital
- ROSC – contact a ROSC base hospital
- Stroke – contact a stroke base hospital
- ALTE (apparent life-threatening event) – contact a base hospital
- Atypical presentation, circumstance, or provider uncertainty – contact a base hospital

Assess, clarify, monitor, treat within scope of practice, and determine or change destination as directed by BH

*Once contacted, the BH directs all further prehospital treatment*

Insert Treatment Protocols for Patient Disposition
*Follow operationally indicated Treatment Protocols when required for patient disposition*

Transport
Transport with continuous monitoring, reassessment, and treatment per applicable protocols
Patient Management

ECG
Repeat 12 Lead ECG as clinically indicated when paramedic is present

Blood Glucose
Obtain and evaluate blood glucose as clinically indicated when AEMT or paramedic is present

Notify Receiving
Confirm notification of receiving facility by Base Hospital, or notify receiving facility using:
  Unit, Age, Sex, History, Illness or injuries, Condition, ETA

Establish Venous Access
Establish peripheral IV access as clinically indicated
  Avoid the antecubital fossa unless required for emergency stabilization
  Consider the need for: additional sites, a volume control chamber, lock, small or large bore catheters

Draw Blood Samples
Draw venous blood samples as clinically indicated
Label tubes with:
  1. Patient’s name
  2. Date and time drawn
  3. Drawer’s initials
Store tubes in doubled biohazard bags and handoff to receiving staff

ECG
Interpret and continuously monitor ECG
Interpret 12 Lead ECG
  Transmit identified STEMI to REMSA Base Hospital STEMI Receiving Center when equipped

Insert Treatment Protocols for Patient Management
Follow clinically indicated Treatment Protocols when required for patient management
Re-Assessment

Focused physical examination

Qualitative and quantitative re-assessment of:
- Responsiveness including AVPU, pupils, level of consciousness and orientation to PPTE
- Airway patency, including capnography to confirm airway placement
- Breathing effort, rate, equality, adequacy, breath sounds, and SpO₂
- Circulation including skin signs, bleeding, capillary refill time, rate, strength, regularity, s/d BP, and ECG/12 lead
- Disability including GCS, Cincinnati Stroke Scale, and V/CBG

Repeat every 5 minutes or less as clinically indicated for unstable patients
Repeat every 15 minutes or less as clinically indicated for apparently stable patients during the first hour of care
Repeat every 30 minutes or less as clinically indicated for apparently stable patients following the first hour of care

Team Communication
The most medically qualified REMSA authorized EMS provider must consult with the EMS team regarding:
- Results of patient management
- Findings on re-assessment
- Intended further patient management

Re-Insert Treatment Protocol(s) for Patient Management
Follow clinically indicated Treatment Protocols when required for further patient management

Arrive Hospital

Handoff
The most medically qualified REMSA authorized EMS provider must handoff to receiving staff using:
- Situation Background Assessment Recommendation

Perform Documentation
The most medically qualified REMSA authorized EMS provider must complete the patient care report

Complete the following additional documents as required:
- Riverside County: Procedure Evaluation Form, STEMI Report, Submersion Incident Report Form, etc.
- California State: Report of Suspected Dependant Adult/Elder Abuse
- California State: Suspected Child Abuse Report

Ensure that local law enforcement has been notified of all suspected:
- Criminal activity
- Domestic violence or sexual assault
- Child / dependant adult / elder abuse

Return to Readiness
DATE:       June 13, 2011

TO:         PMAC

FROM:       Scott Moffatt, EMS Specialist

SUBJECT:    PMAC Consideration of DRAFT Policy 6015

In preparation the PMAC meeting on June 27, 2011, please review the attached DRAFT Policy.

DRAFT: 6015 Scene Management of Hazardous Materials
This new draft policy is for scene management of hazardous materials. Please review and comment.

Thank you for your participation.
Enter from the Universal Patient Treatment Protocol

*For specific Scene Management of Hazardous Materials*

### Scene Management

When you encounter a possible hazardous materials incident:
- Stage in a safe location: upwind, uphill, and upstream with a minimum 300 feet distance
- Maintain exit routes
- Deny entry
- Ensure Hazardous Materials Response Team (HMRT) response
- Mount a wind streamer to your vehicle’s antenna and monitor wind direction
- Do not enter until the On Scene Incident Commander has deemed it reasonably ‘safe to enter’

When you are exposed to hazardous materials:
- Escape to a safe location: upwind, uphill, and upstream with a minimum 300 feet distance
- Begin self-decontamination and self-treatment
- Identify yourself as a patient

As assigned by the On Scene Incident Commander, first response personnel trained at the First Responder Operations Level or higher may:
- Establish the Exclusion (hot), Contamination Reduction (warm), and Support (cold) Zones
- Establish Access Control Points
- Enter the Exclusion (hot) Zone while wearing the appropriate level of protection
- Provide time-sensitive emergency stabilization as clinically indicated and operationally feasible
- Direct and move patients to the Contamination Reduction (warm) Zone
- Fully decontaminate patients
- Direct and move patients to the Support (cold) Zone
- Provide emergency stabilization and patient management as clinically indicated

As assigned by the On Scene Incident Commander, EMS transport personnel trained at the First Responder Awareness Level or higher may:
- Enter the Support (cold) Zone while wearing the appropriate level of protection
- Enter the Access Control Point(s) to the Support (cold) Zone
- Provide emergency stabilization and patient management as clinically indicated

*Do not transport a contaminated patient!*
Return to Universal Patient Treatment Protocol
For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management

****** ****** Base Hospital Physician Orders ****** ******
Assess, clarify, monitor, treat within scope of practice, and determine or change destination As ordered

Once contacted, the BH directs all further prehospital treatment
FOR CONSIDERATION BY PMAC

DATE: June 13, 2011

TO: PMAC

FROM: Scott Moffatt, EMS Specialist

SUBJECT: PMAC Consideration of DRAFT Policy 6020

In preparation the PMAC meeting on June 27, 2011, please review the attached DRAFT Policy.

DRAFT: 6020 Patient Disposition of On Scene Physician Wishing to Assume Responsibility

This is a new policy for patient disposition with a physician on scene.

Thank you for your participation.

Replaces:
7020 PHYSICIAN ON SCENE
Treatment Protocol

Effective: April 1, 2012
Expires: March 31, 2013

Approval: REMSA Medical Director
Humberto Ochoa, MD

Approval: REMSA Director
Bruce Barton, CCEMT-P

Enter from the Universal Patient Treatment Protocol
For specific Patient Disposition of On Scene Physician Wishing to Assume Responsibility

Patient Disposition

On Scene Physician Wishing to Assume Responsibility
When an on scene physician wishes to assume responsibility forprehospital emergency care:

1. Require valid photo ID and California medical license

2. Inform the on scene physician that:
   a. He or she must request that the base hospital physician relinquish medical control
   b. If the base hospital physician agrees, the on scene physician may direct medical care
   c. The on scene physician must accompany the patient during ambulance transport

3. Contact a single REMSA authorized base hospital (BH):
   a. Provide the on scene physician’s name and license number
   b. The on scene physician must request medical control on a recorded line
   c. Establish that the base hospital physician has relinquished medical control

4. If the base hospital physician has relinquished medical control:
   a. Assist the on scene physician as directed, within scope of practice
   b. Maintain base hospital contact and transport to an appropriate receiving facility
   c. The on scene physician must sign the completed PCR

Return to Universal Patient Treatment Protocol
For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management

****** ***** Base Hospital Physician Orders ****** *****

Assess, clarify, monitor, treat within scope of practice, and determine or change destination
As ordered

Once contacted, the BH directs all furtherprehospital treatment

Applies To: EMR, EMT, AEMT, PM, EMS System

Signature: Humberto Ochoa, MD
Signature: Bruce Barton, CCEMT-P
FOR CONSIDERATION BY PMAC

DATE:       June 13, 2011
TO:         PMAC
FROM:  Scott Moffatt, EMS Specialist
SUBJECT:   PMAC Consideration of DRAFT Policy 6030

In preparation the PMAC meeting on June 27, 2011, please review the attached DRAFT Policy.

DRAFT: 6030 Patient Disposition of Refusal of Treatment and/or Transport

This is a new policy for refusals. Parts of it were previously included in drafts of the Universal Patient Treatment Protocol but it has become its own policy with the decision to insert treatment protocols into the Universal for scene management and patient disposition.

Thank you for your participation.

Replaces:
5500 CONSENT AND REFUSAL OF MEDICAL TREATMENT
# Patient Disposition of Refusal of Treatment and/or Transport (REMSA Treatment Protocol)

**Treatment Protocol:**

**Effective:** April 1, 2012  
**Expires:** March 31, 2013

**Applies To:**  
EMR, EMT, AEMT, PM, EMS System

**Approval:**  
EMS Medical Director  
Humberto Ochoa, MD

---

**Patient Disposition**

**Refusal of Treatment and/or Transport**

A patient, parent, or guardian initiating refusal of treatment and/or transport must be:

1. An apparently sober, rational, and competent legal-adult
2. Alert and oriented to person, place, time, and event
3. Fully informed of, and acknowledge, the:
   a. EMS provider’s level of training
   b. EMS provider’s findings
   c. Need for treatment, transport, and further evaluation by an emergency physician
   d. Possible consequences of refusal

Contact a single REMSA authorized base hospital for all:

1. Non-emancipated minors attempting refusal (consider the need for law enforcement involvement)
2. Refusals of transport following initiation of treatment
3. Refusals of clinically indicated treatment and/or transport

Having met the requirements above:

1. Allow the legal-adult patient, parent, or guardian initiated refusal of treatment and/or transport
2. The legal-adult patient, parent or guardian must sign appropriate releases
3. Fully document refusal on patient care report and attachments

---

**Return to Universal Patient Treatment Protocol**

*For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management*

---

**Base Hospital Physician Orders**

Assess, clarify, monitor, treat within scope of practice, and determine or change destination  
As ordered

*Once contacted, the BH directs all further prehospital treatment*
FOR CONSIDERATION BY PMAC

DATE:       June 13, 2011

TO:         PMAC

FROM:       Scott Moffatt, EMS Specialist

SUBJECT:    PMAC Consideration of DRAFT Policy 6090

In preparation the PMAC meeting on June 27, 2011, please review the attached DRAFT Policy.

DRAFT: 6090 Patient Disposition of Do Not Attempt Resuscitation - Discontinue Resuscitation

This is a new policy for patient disposition of DNAR and discontinuing resuscitation. It combines and modifies the policies it replaces. Parts of it were previously included in drafts of the Universal Patient Treatment Protocol but it has become its own policy with the decision to insert treatment protocols into the Universal for scene management and patient disposition.

Thank you for your participation.

Replaces:
5600 WITHHOLDING RESUSCITATION EFFORTS
5610 WITHDRAWAL OF RESUSCITATION EFFORTS
5620 DO NOT RESUSCITATE (DNR)
**Treatment Protocol**

**Effective:** April 1, 2012  
**Expires:** March 31, 2013

**Treatment Protocol:**
**Patient Disposition of Do Not Attempt Resuscitation / Discontinue Resuscitation**

**Applies To:**  
EMR, EMT, AEMT, PM, EMS System

**Approval:** REMSA Medical Director  
Humberto Ochoa, MD

**Signature**

---

**Enter from the Universal Patient Treatment Protocol**

*For specific Patient Disposition of Do Not Attempt Resuscitation / Discontinue Resuscitation*

---

**Patient Disposition**

**Do Not Attempt Resuscitation**

Do not attempt resuscitation when one or more of the following are present:

1. MCI patient remains apneic despite manual airway maneuvers
2. Apneic and pulseless with rigor mortis and postmortem lividity
3. Decapitation
4. Generalized decomposition or incineration
5. Separation of brain, or heart, or both lungs from body
6. Total evisceration
7. Complete transection of torso
8. A valid, signed, and dated advance directive indicating that resuscitation is not desired
9. Rigor mortis or postmortem lividity with continuous asystole or PEA at a rate less than 10
10. Blunt trauma arrest with continuous asystole or PEA at a rate less than 10

**Discontinue Resuscitation**

Discontinue resuscitation when one or more of the above items 1–10 are present

*To discontinue resuscitation in pediatrics requires a base hospital physician order (BHPO)*

Discontinue resuscitation when all of the following are present prior to transport:

1. Medical (not trauma) patient
2. Unwitnessed arrest
3. No bystander CPR
4. No shock delivered
5. A minimum of two rounds of resuscitative medications have been given without ROSC
6. Continuous asystole or PEA at a rate less than 10

*To discontinue resuscitation in pediatrics requires a base hospital physician order (BHPO)*

---

**Return to Universal Patient Treatment Protocol**

*For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management*

---

****** ***** **Base Hospital Physician Orders** ****** *****

Assess, clarify, monitor, treat within scope of practice, and determine or change destination  
As ordered

*Once contacted, the BH directs all further prehospital treatment*
FOR CONSIDERATION BY PMAC

DATE:       June 13, 2011

TO:         PMAC

FROM:       Scott Moffatt, EMS Specialist

SUBJECT:    PMAC Consideration of DRAFT Policy 6091

In preparation the PMAC meeting on June 27, 2011, please review the attached DRAFT Policy.

DRAFT: 6091 Patient Disposition of Prehospital Death

This is a new policy for patient disposition of prehospital death. It replaces and modifies the portion of Policy 5600 that deals with disposition of the body following field determination of death.

Thank you for your participation.

Replaces:
5600 WITHHOLDING RESUSCITATION EFFORTS
**Treatment Protocol**

**Patient Disposition of Prehospital Death**

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<td>March 31, 2013</td>
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**Approval:**

- REMSA Medical Director
  - Humberto Ochoa, MD
- REMSA Director
  - Bruce Barton, CCEMT-P

**Applies To:**

- EMR, EMT, AEMT, PM, EMS System

---

**Enter from the Universal Patient Treatment Protocol**

*For specific Patient Disposition of Prehospital Death*

---

**Patient Disposition**

**Prehospital Death**

When the decision not to attempt / to discontinue resuscitation has been made:

1. Comfort and care for survivors

2. Notify local law enforcement (LE) of prehospital death

3. Contact the County of Riverside Coroner’s Office, give report, and answer all applicable questions
   - if coroner’s case:
     - Leave invasive medical devices in place and remain at scene until released by LE
     - Arrange for the Coroner to receive a copy of the completed PCR
   - if released to mortuary:
     - Remove invasive medical devices, position and cover body
     - Do not release patient information to the mortuary

4. Include these details on the PCR:
   - Time of death, circumstances, description of any advanced directive, and disposition of body
   - Identification of the local law enforcement officer at scene
   - Identification of the coroner’s investigator who received report and coroner’s case number

When a death occurs during transport: Divert to the closest hospital without crossing county lines

Contact a Base Hospital and/or the Coroner’s Office as needed for guidance in unusual circumstances

---

**Return to Universal Patient Treatment Protocol**

*For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management*

---

**Base Hospital Physician Orders**

Assess, clarify, monitor, treat within scope of practice, and determine or change destination

*As ordered*

*Once contacted, the BH directs all further prehospital treatment*
FOR CONSIDERATION BY PMAC

DATE: June 13, 2011
TO: PMAC
FROM: Scott Moffatt, EMS Specialist
SUBJECT: PMAC Consideration of DRAFT Policy 6300

In preparation the PMAC meeting on June 27, 2011, please review the attached DRAFT Policy.

DRAFT: 6300 Burns

This is a new policy for emergency stabilization or patient management, and patient disposition, that combines, modifies, and simplifies the policies it replaces. It currently features:

- 20% BSA is the cutoff point between wet or dry dressings
- 2\textsuperscript{nd} degree with 10% BSA and all 3\textsuperscript{rd} degree burns require BH contact
- No mention of burn centers is made
- Destination is determined by the BH

Thank you for your participation.

Replaces:
5720 BURN PATIENT DESTINATION
6300 Burns
7300 Burns
8300 Burns
Enter from the Universal Patient Treatment Protocol

For specific Patient Disposition, Emergency Stabilization or Patient Management of Burns

**Pertinent Findings**

- **Environment**
  - Source: Chemical, Electrical, Thermal

- **History**
  - Mechanism of injury
  - Associated trauma
  - Inhalation injury
  - 1st, 2nd, or 3rd burns
  - Body surface area (BSA)
  - Time of event
  - Bystander treatment
  - SAMPLE history

- **Physical**
  - 1st: Superficial, red, sometimes painful
  - 2nd: Skin may be red, blistered, swollen. Very painful.
  - 3rd: Whirlish, charred or translucent, no pin prick sensation in burned area.
  - Use ‘Rule of Nines’ or ‘Rule of Palms’ to estimate BSA

  - **ADULT RULE OF NINES**
    - 9% (head)
    - 9% (right arm) 9% (left arm)
    - 36% (torso)
    - 1% (genitalia/perineum)
    - 18% (right leg) 18% (left leg)

  - **INFANT RULE OF NINES**
    - 18% (head)
    - 9% (right arm) 9% (left arm)
    - 36% (torso)
    - 14% (right leg) 14% (left leg)

- **Differential**
  - Critical trauma
  - Suspected inhalation injury
  - Airway compromise
  - Thermal, chemical, electrical
  - 1st, 2nd, or 3rd
  - Body surface area (BSA)
  - To: Face
  - Hands
  - Genitalia/perineum
  - Major joints

**Emergency Stabilization or Patient Management**

- Remove all of patient’s rings, bracelets, and binding clothing

- **Chemical burns**: Brush off dry chemicals, flush with water, and consult label for decontamination instructions

- **Electrical burns**: Consider possibility of spinal trauma and need for spinal stabilization, treat related injuries

- **Eye burns**: Flush copiously, check for contact lenses, patch the eye(s)

- **Tar burns**: Cool with water but do not remove tar; then apply petrolatum gauze dressing

- **Thermal burns of less than 20% BSA**: Cool with wet dressing, then follow with dry, clean, non-adherent dressing

- **Thermal burns greater than 20% BSA**: Apply dry, clean, non-adherent dressing

- 250 mL 0.9% Normal Saline IV/IO bolus
  - For significant burns
  - May repeat as clinically indicated
  - See REMSA Calculation Chart for pediatric dosage
**Emergency Stabilization or Patient Management (continued)**

Morphine Sulfate 5 mg slow IV/IO push or IM  
For pain associated with burns  
When systolic BP is greater than 90 mmHg prior to administration  
May repeat once prior to base hospital contact  
See REMSA Calculation Chart for pediatric dosage

**Patient Disposition**

Burn patients with airway compromise will be transported to the closest Paramedic Receiving Center  
Burn patients meeting Critical Trauma Criteria will be transported to the closest most appropriate Trauma Center  
Contact a single REMSA authorized base hospital (BH) in all critical burns including:  
   1. Suspected inhalation injury  
   2. Burns involving face, hands, genitalia/perineum, or major joints  
   3. High voltage electrical burns  
   4. Second degree (2°) burns greater than 10% BSA  
   5. Third degree (3°) burns  
Assess, clarify, monitor, treat within scope of practice, and determine or change destination as directed by BH

*Once contacted, the BH directs all further prehospital treatment*

---

**Return to Universal Patient Treatment Protocol**

*For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management*

---

**Base Hospital Physician Orders**

0.9% Normal Saline Bolus  
As ordered  
For burns  

Morphine  
As ordered  
For pain associated with burns
FOR CONSIDERATION BY PMAC

DATE: June 13, 2011
TO: PMAC
FROM: Scott Moffatt, EMS Specialist
SUBJECT: PMAC Consideration of DRAFT Policy 6320

In preparation the PMAC meeting on June 27, 2011, please review the attached DRAFT Policy.

DRAFT: 6320 Heat Illness and/or Hyperthermia

This is a revised policy for emergency stabilization or patient management that combines, modifies, and simplifies the policies it replaces. It currently features:

- A very similar to current prior to contact policy
- Additional medications as base hospital physician orders

Thank you for your participation.

Replaces:
6320 Heat Illness Hyperthermia
7320 Heat Illness
8320 Heat Illness
Enter from the Universal Patient Treatment Protocol

For specific Patient Disposition, Emergency Stabilization or Patient Management of Heat Illness and/or Hyperthermia (REMSA Treatment Protocol)

Pertinent Findings

<table>
<thead>
<tr>
<th>Environment</th>
<th>History</th>
<th>Physical</th>
<th>Differential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hot, Humid</td>
<td>Heat intolerance</td>
<td>Tachypnea and tachycardia</td>
<td>Sepsis</td>
</tr>
<tr>
<td>Physical exertion</td>
<td>Physical exertion</td>
<td>Skin temperature will be hot</td>
<td>Overdose</td>
</tr>
<tr>
<td>Dehydration</td>
<td>Elderly</td>
<td>Moisture may be either wet or dry</td>
<td>Thyroid storm</td>
</tr>
<tr>
<td>Medication use: Antihistamines Stimulants</td>
<td>Recent general anesthesia</td>
<td>Malaise, muscle cramps, exhaustion</td>
<td>Excited delirium</td>
</tr>
<tr>
<td></td>
<td>Environmental allergies</td>
<td>Altered mental status</td>
<td>Malignant hyperthermia</td>
</tr>
<tr>
<td></td>
<td>Prescribed MAOIs or SSRIs</td>
<td>Bizarre behavior, combative</td>
<td>Hemorrhagic CVA</td>
</tr>
<tr>
<td></td>
<td>Use of ecstasy, LSD, PCP, cocaine</td>
<td>Syncope, seizures or coma</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Core temperature 104°F or greater</td>
<td></td>
</tr>
</tbody>
</table>

Emergency Stabilization or Patient Management

Ensure safety and security of all personnel

*Patient may be altered, confrontational, abusive, and/or combative*

Obtain baseline temperature when available and note method: tympanic, temporal, axillary, or estimate

Re-assess temperature frequently

Cool aggressively to approximately 101°F:

Shade and expose

Wet, fan, and encourage evaporative cooling

Apply cold packs to neck, armpits, and groin

Move to air conditioned environment

Discontinue aggressive cooling at approximately 101°F

250 mL 0.9% Normal Saline IV/IO bolus

For heat illness and/or hyperthermia

May repeat as clinically indicated

See REMSA Calculation Chart for pediatric dosage

Assure IV patency

25 g Dextrose 50% slow IV/IO push

For blood glucose less than 80 mg / dL associated with heat illness and/or hyperthermia

May repeat in 5 minutes when indicated following reassessment

See REMSA Calculation Chart for pediatric dosage (using Dextrose 25% when applicable)
### Emergency Stabilization or Patient Management (continued)

5 mg Midazolam (Versed) slow IV/IO push or IM/IN  
For tonic-clonic seizures associated with heat illness and/or hyperthermia  
*May repeat with a base hospital physician order (BHPO)*  
See REMSA Calculation Chart for pediatric dosage

### Return to Universal Patient Treatment Protocol

*For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management*

### Base Hospital Physician Orders

<table>
<thead>
<tr>
<th>0.9% Normal Saline Bolus</th>
<th>AEMT PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>As ordered</td>
<td></td>
</tr>
<tr>
<td>For heat illness and/or hyperthermia</td>
<td></td>
</tr>
<tr>
<td>Dextrose 25% or 50%</td>
<td>AEMT PM</td>
</tr>
<tr>
<td>As ordered</td>
<td></td>
</tr>
<tr>
<td>For hypoglycemia associated with heat illness and/or hyperthermia</td>
<td></td>
</tr>
<tr>
<td>Albuterol</td>
<td>AEMT PM</td>
</tr>
<tr>
<td>As ordered</td>
<td></td>
</tr>
<tr>
<td>For suspected hyperkalemia associated with heat illness and/or hyperthermia</td>
<td></td>
</tr>
<tr>
<td>Midazolam (Versed)</td>
<td>AEMT PM</td>
</tr>
<tr>
<td>As ordered</td>
<td></td>
</tr>
<tr>
<td>For behavioral emergency, agitation, shivering, or seizures associated with heat illness and/or hyperthermia</td>
<td></td>
</tr>
<tr>
<td>Sodium Bicarbonate 8.4%</td>
<td>AEMT PM</td>
</tr>
<tr>
<td>As ordered</td>
<td></td>
</tr>
<tr>
<td>For suspected rhabdomyolysis and/or hyperkalemia associated with heat illness and/or hyperthermia</td>
<td></td>
</tr>
<tr>
<td>Calcium Chloride 10%</td>
<td>AEMT PM</td>
</tr>
<tr>
<td>As ordered</td>
<td></td>
</tr>
<tr>
<td>For suspected hyperkalemia associated with heat illness and/or hyperthermia</td>
<td></td>
</tr>
</tbody>
</table>
FOR CONSIDERATION BY PMAC

DATE: June 13, 2011
TO: PMAC
FROM: Scott Moffatt, EMS Specialist
SUBJECT: PMAC Consideration of DRAFT Policy 6400

In preparation for the PMAC meeting on June 27, 2011, please review the attached DRAFT Policy.

DRAFT: 6400 Nausea and Vomiting

This is a new policy that will authorize the paramedic use of Zofran by IV/IO/IM and ODT.

Thank you for your participation.
Enter from the Universal Patient Treatment Protocol
For specific Emergency Stabilization or Patient Management of Nausea and/or Vomiting

Pertinent Findings

**Environment**
- Antibiotics
- Chemotherapy meds
- NSAIDS
- Opiates
- Toxins and/or foods
- Traumatic MOI

**History**
- Sensitivity to 5-HT<sub>3</sub> antagonists:
  - Ondansetron (Zofran)
  - Alosetron (Lotronex)
  - Dolasetron (Anzemet)
  - Granisetron (Kytril)
  - Palonosetron (Aloxi)
  - Others
- Recent medication changes
- Recent surgery
- Ingestion
- Illness

**Physical**
- Nausea and/or vomiting
- Abdominal pain
- Flank pain
- Anorexia
- Constipation
- Fever
- Rash
- Dyspnea
- Cough
- Headache
- Neck pain
- Altered mental status

**Differential**
- Medical: acute myocardial infarction, alcoholic ketoacidosis, appendicitis, choking, diabetic ketoacidosis, infection, ingestion, gallstones, gastroenteritis, GI obstruction, kidney stones, meningitis, migraine, overdose, pancreatitis, pneumonia, pregnancy, pyelonephritis, stroke, testicular torsion
- Trauma: (occult) head trauma, pain

Emergency Stabilization or Patient Management

4 mg Ondansetron (Zofran) slow IV/IO push or IM
For nausea and/or vomiting
May repeat with a base hospital physician order (BHPO)
See REMSA Calculation Chart for pediatric dosage

4 mg Ondansetron (Zofran) Oral Disintegrating Tablet (ODT)
For nausea and/or vomiting
May repeat with a base hospital physician order (BHPO)
See REMSA Calculation Chart for pediatric dosage

Return to Universal Patient Treatment Protocol
For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management

***** ***** Base Hospital Physician Orders ***** *****

Ondansetron (Zofran)
As ordered
For nausea and/or vomiting
DATE:        June 13, 2011
TO:            PMAC
FROM:      Scott Moffatt, EMS Specialist
SUBJECT:  PMAC Consideration of DRAFT Policy 6530

In preparation the PMAC meeting on June 27, 2011, please review the attached DRAFT Policy.

DRAFT: 6530 Seizures

This is a new policy for seizures.

Thank you for your participation.

Replaces:
6530 Seizures
7530 Status Seizure
8530 Status Seizure
Treatment Protocol

**Seizures**

**Effective:** April 1, 2012  
**Expires:** March 31, 2013

**Approval:** REMSA Medical Director  
**Signature:** Humberto Ochoa, MD

**Approval:** REMSA Director  
**Signature:** Bruce Barton, CCEMT-P

**Applies To:**  
EMR, EMT, AEMT, PM, EMS System

---

**Enter from the Universal Patient Treatment Protocol**

*For specific Emergency Stabilization or Patient Management of Seizures*

---

**Pertinent Findings**

**Environment**  
Medical alert tag  
Anti-seizure medications  
Trauma

**History**  
Downtime, last meal, last meds  
History of seizures  
Noncompliant with medication  
Alcohol withdrawal  
Recent infection or fever

**Physical**  
Seizures  
Altered mental status  
Pallor, diaphoresis  
Urination, defecation  
Oral and other trauma

**Differential**  
Aura  
Absence seizure  
Febrile seizure  
ALTE (apparent life-threatening event)  
Simple partial seizure  
Complex partial seizure  
Tonic-clonic seizure  
Post-ictus  
Eclampsia  
Alcohol, Epilepsy, Insulin, Overdose, Uremia, Trauma, Infection, Psychosis, Stroke

---

**Emergency Stabilization or Patient Management**

Protect patient from injury; loosen restrictive clothing, do not forcibly restrain

Perform Cooling Measures as clinically indicated

Preserve privacy

25 g Dextrose 50% slow IV or IO push  
For seizures with blood glucose less than 80 mg / dL  
May repeat in 5 minutes when indicated following reassessment  
See REMSA Calculation Chart for pediatric dosage (using Dextrose 25% when applicable)

1 mg Glucagon IM or SQ  
For seizures with blood glucose less than 80 mg/dL and unable to administer Dextrose  
May repeat with a base hospital physician order (BHPO)  
See REMSA Calculation Chart for pediatric dosage

5 mg Midazolam (Versed) slow IV or IO push, or IM or IN  
For continuous or recurrent tonic-clonic seizures unrelated to eclampsia  
May repeat with a base hospital physician order (BHPO)  
See REMSA Calculation Chart for pediatric dosage
### Return to Universal Patient Treatment Protocol

*For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management*

### Base Hospital Physician Orders

<table>
<thead>
<tr>
<th><strong>Dextrose 25%</strong></th>
<th><strong>Dextrose 50%</strong></th>
<th><strong>Glucagon</strong></th>
<th><strong>Midazolam (Versed)</strong></th>
<th><strong>Magnesium Sulfate 50%</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>As ordered</td>
<td>As ordered</td>
<td>As ordered</td>
<td>As ordered</td>
<td>As ordered (typically 4 g in 50 mL Normal Saline IV or IO drip over 10 minutes)</td>
</tr>
<tr>
<td>For seizures with hypoglycemia</td>
<td>For seizures with hypoglycemia</td>
<td>For seizures with hypoglycemia</td>
<td>For seizures</td>
<td>For suspected pre-eclampsia (may be given prophylactically) or eclampsia</td>
</tr>
</tbody>
</table>
FOR CONSIDERATION BY PMAC

DATE: June 13, 2011

TO: PMAC

FROM: Scott Moffatt, EMS Specialist

SUBJECT: PMAC Consideration of DRAFT Policy 6600

In preparation the PMAC meeting on June 27, 2011, please review the attached DRAFT Policy.

DRAFT: 6600 Pre-Eclampsia and Eclampsia

This is a new policy for pre-eclampsia/eclampsia. It includes:

- BH contact required
- Magnesium is given by BHPO only

Thank you for your participation.

Replaces:
6600 Severe Pre-Eclampsia Eclampsia
7600 Eclamptic Seizures
Enter from the Universal Patient Treatment Protocol
For specific Emergency Stabilization, Patient Disposition or Patient Management of Pre-Eclampsia and Eclampsia

### Pertinent Findings

<table>
<thead>
<tr>
<th>Environment</th>
<th>History</th>
<th>Physical</th>
<th>Differential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low socioeconomic class</td>
<td>First or multiple pregnancies</td>
<td>Malaise</td>
<td>Normal pregnancy</td>
</tr>
<tr>
<td>Obesity</td>
<td>Conception with a new partner</td>
<td>Abdominal and/or back pain</td>
<td>Placenta abruptio</td>
</tr>
<tr>
<td>Less than 20 years of age</td>
<td>Multi-fetal pregnancy</td>
<td>Nausea and vomiting</td>
<td>Ruptured liver</td>
</tr>
<tr>
<td>Over 35 years of age</td>
<td>From 20 weeks gestation thru</td>
<td>Decreased urine output</td>
<td>Hypoglycemia</td>
</tr>
<tr>
<td></td>
<td>four weeks postpartum</td>
<td>Hypoglycemia</td>
<td>Chronic HTN</td>
</tr>
<tr>
<td></td>
<td>Diabetes, kidney disease, HTN</td>
<td>Headache, vertigo, visual disturbance</td>
<td>Stroke</td>
</tr>
<tr>
<td></td>
<td>Family history of pre-eclampsia</td>
<td>Focal neurological deficits</td>
<td>Seizure</td>
</tr>
<tr>
<td></td>
<td>Gravida (pregnancies)</td>
<td>Sudden water retention/weight gain</td>
<td>HELLP Syndrome</td>
</tr>
<tr>
<td></td>
<td>Para (viable births)</td>
<td>Peripheral and/or pitting edema</td>
<td>Hemolysis,</td>
</tr>
<tr>
<td></td>
<td>Abortus (lost pregnancies)</td>
<td>Hypertension</td>
<td>Elevated Liver</td>
</tr>
<tr>
<td></td>
<td>LMP (last menstrual period)</td>
<td>Pulmonary edema</td>
<td>Enzymes, Low</td>
</tr>
<tr>
<td></td>
<td><strong>EDC</strong> (estimated date of confinement:</td>
<td>Hyperreflexia, clonus, seizure, coma</td>
<td>Platelet Count</td>
</tr>
<tr>
<td></td>
<td>first day of LMP + 280 days)</td>
<td>Disseminated intravascular coagulation</td>
<td>DIC</td>
</tr>
<tr>
<td>Prenatal care and findings</td>
<td>Diagnosis of gestational diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis of pre-eclampsia</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Emergency Stabilization or Patient Management

- Decrease stimuli and maintain a quiet, dark environment
- Place patient in left lateral recumbent position
- **Assure IV potency**
  - 25 g Dextrose 50% slow IV or IO push
  - For suspected pre-eclampsia or eclampsia with blood glucose less than 80 mg / dl
  - May repeat in 5 minutes when indicated following reassessment
  - Pediatric administration is not indicated
**Patient Disposition**

**Base Hospital Contact**
Contact a single REMSA authorized base hospital (BH) in all cases of pre-eclampsia or eclampsia

Assess, clarify, monitor, treat within scope of practice, and determine or change destination as directed by BH

*Once contacted, the BH directs all further prehospital treatment*

---

**Return to Universal Patient Treatment Protocol**
For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management

---

**Base Hospital Physician Orders**

Dextrose 50%
As ordered
For suspected pre-eclampsia or eclampsia with hypoglycemia

Magnesium Sulfate 50%
As ordered (typically 4 g in 50 mL Normal Saline IV or IO drip over 10 minutes)
For suspected pre-eclampsia (may be given prophylactically) or eclampsia

Midazolam (Versed)
As ordered
For eclampsia unresponsive to magnesium
DATE:        June 13, 2011
TO:            PMAC
FROM:      Scott Moffatt, EMS Specialist
SUBJECT:  PMAC Consideration of DRAFT Policy 6700

In preparation the PMAC meeting on June 27, 2011, please review the attached DRAFT Policy.

DRAFT: 6700 Overdose

This policy combines, modifies and replaces the several policies for overdose. It works in conjunction with the next policy on the agenda, 6710 Toxic Exposure, Inhalation, or Ingestion, and a policy previously seen by PMAC, 6720 Carbamate, Organophosphate, and Nerve Agent Exposure. This should meet our need for policies related to overdoses and poisons.

Thank you for your participation.

Replaces:
7710 Beta Blockers - Calcium Channel Blockers
7740 Cyclic Antidepressants
7750 Narcotics - Sedatives
7770 Dystonic Reactions to Phenothiazine Drugs
8740 Cyclic Antidepressants
8750 Narcotics - Sedatives
8770 Dystonic Reactions to Phenothiazine Drugs
**Treatment Protocol**

**Treatment Protocol:**

**Effective:** April 1, 2012  
**Expires:** March 31, 2013

**Applies To:**  
EMR, EMT, AEMT, PM, EMS System

---

**Enter from the Universal Patient Treatment Protocol**

For specific Emergency Stabilization or Patient Management of Overdose

---

**Pertinent Findings**

<table>
<thead>
<tr>
<th>Environment</th>
<th>History</th>
<th>Physical</th>
<th>Differential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of:</td>
<td>Substance:</td>
<td>Altered mental status</td>
<td>Alcohol, Epilepsy, Insulin, Overdose, Uremia, Trauma, Infection, Psychosis, Stroke, Insecticides, Other toxins</td>
</tr>
<tr>
<td>Accident</td>
<td>Acetaminophen or aspirin</td>
<td>Seizures</td>
<td>Other toxins</td>
</tr>
<tr>
<td>Suicide</td>
<td>Cardiac medications</td>
<td>Altered respiratory rate and rhythm</td>
<td></td>
</tr>
<tr>
<td>Crime</td>
<td>Depressants or stimulants</td>
<td>Bradycardia, tachycardia, dysrhythmia</td>
<td></td>
</tr>
<tr>
<td>Evidence of:</td>
<td>Cyclic antidepressants</td>
<td>Hypotension or hypertension</td>
<td></td>
</tr>
<tr>
<td>Substance</td>
<td>Other medications</td>
<td>Hypothermia or hyperthermia</td>
<td></td>
</tr>
<tr>
<td>Route</td>
<td>Route, quantity, and time</td>
<td>Sluggish, dilated or pinpoint pupils</td>
<td></td>
</tr>
<tr>
<td>Quantity</td>
<td>SAMPLE history</td>
<td>Skin signs and secretions</td>
<td></td>
</tr>
<tr>
<td>Conserve evidence</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Emergency Stabilization or Patient Management**

2 mg Naloxone (Narcan) IN/IM  
For respiratory depression with suspected narcotic overdose  
During nasal administration: divide the dose between nostrils as needed not to exceed 1 mL per nostril  
May repeat as clinically indicated  
See REMSA Calculation Chart for pediatric dosage

2 mg Naloxone (Narcan) IV/IO push  
For respiratory depression with suspected narcotic overdose  
May repeat as clinically indicated  
See REMSA Calculation Chart for pediatric dosage

50 mg Diphenhydramine (Benadryl) IM or slow IV/IO push  
For suspected dystonic reactions and the extrapyramidal effects of phenothiazine overdose  
May repeat with a base hospital physician order (BHPO)  
See REMSA Calculation Chart for pediatric dosage
**Base Hospital Physician Orders**

<table>
<thead>
<tr>
<th>Item</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activated Charcoal PO</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As ordered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For suspected overdose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naloxone (Narcan) IN or IM</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>As ordered</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For respiratory depression with suspected narcotic overdose</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calcium Chloride 10%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>As ordered</td>
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<tr>
<td>For suspected beta blocker or calcium channel blocker overdose</td>
<td></td>
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<tr>
<td>Diphenhydramine (Benadryl)</td>
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<tr>
<td>As ordered</td>
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<tr>
<td>For suspected dystonic reactions and the extrapyramidal effects of phenothiazine overdose</td>
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<tr>
<td>Glucagon</td>
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<tr>
<td>As ordered</td>
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<tr>
<td>For suspected beta blocker or calcium channel blocker overdose</td>
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<tr>
<td>Naloxone (Narcan)</td>
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<tr>
<td>As ordered</td>
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<tr>
<td>For respiratory depression with suspected narcotic overdose</td>
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<tr>
<td>Sodium Bicarbonate 8.4%</td>
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<tr>
<td>As ordered</td>
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<tr>
<td>For altered mental status and/or dysrhythmia with suspected cyclic antidepressant overdose</td>
<td></td>
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</tbody>
</table>
DATE: June 13, 2011

TO: PMAC

FROM: Scott Moffatt, EMS Specialist

SUBJECT: PMAC Consideration of DRAFT Policy 6710

In preparation for the PMAC meeting on June 27, 2011, please review the attached DRAFT Policy.

DRAFT: 6710 Toxic Exposure, Inhalation, or Ingestion

This is a new policy to replace the policies mentioned below.

Thank you for your participation.

Replaces:

- 6700 Poisons Drugs
- 7730 Caustics - Corrosives
- 8730 Caustics - Corrosives
Treatment Protocol

Effective April 1, 2012
Expires March 31, 2013

Treatment Protocol:
Toxic Exposure, Inhalation, or Ingestion

Approval: REMSA Medical Director
Humberto Ochoa, MD

Applies To:
EMR, EMT, AEMT, PM, EMS System

Approval: REMSA Director
Bruce Barton, CCEMT-P

Enter from the Universal Patient Treatment Protocol
For specific Emergency Stabilization or Patient Management of Toxic Exposure, Inhalation, or Ingestion

Pertinent Findings

<table>
<thead>
<tr>
<th>Environment</th>
<th>History</th>
<th>Physical</th>
<th>Differential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of:</td>
<td>Substance: Chemicals (both liquids and powders), Chlorine, Cyanide, Hydrogen Sulfide, Hydrofluoric Acid, Phosgene</td>
<td>Altered mental status, agitation, seizures</td>
<td>Alcohol, Epilepsy, Insulin, Overdose, Uremia, Trauma, Infection, Psychosis, Stroke</td>
</tr>
<tr>
<td>Accident</td>
<td>Other toxins</td>
<td>Altered respirations, dyspnea, apnea</td>
<td>Carbamates</td>
</tr>
<tr>
<td>Suicide</td>
<td>Route, quantity, and time</td>
<td>Bradycardia, tachycardia, dysrhythmia</td>
<td>Organophosphates</td>
</tr>
<tr>
<td>Crime</td>
<td>SAMPLE history</td>
<td>Hypotension or hypertension</td>
<td>Other toxic exposure</td>
</tr>
<tr>
<td>Evidence of:</td>
<td></td>
<td>Hypothermia or hyperthermia</td>
<td>Other toxic inhalation</td>
</tr>
<tr>
<td>Substance</td>
<td></td>
<td>Sluggish, dilated or pinpoint pupils</td>
<td>Other toxic ingestion</td>
</tr>
<tr>
<td>Route</td>
<td></td>
<td>Skin signs and secretions</td>
<td></td>
</tr>
<tr>
<td>Quantity</td>
<td></td>
<td>Abdominal pain, nausea, and vomiting</td>
<td></td>
</tr>
<tr>
<td>Conserve evidence</td>
<td></td>
<td>SLUDGEM</td>
<td></td>
</tr>
</tbody>
</table>

Emergency Stabilization or Patient Management

Follow the Scene Management of Hazardous Materials Treatment Protocol when applicable

Decontaminate:
- Remove and bag patient’s clothing, jewelry, etc.
- Brush off dry chemicals and blot excess liquid chemicals
- Wash patient with mild soap and water
- Rinse and flush with large amounts of water
  - Flush contaminated eyes with saline for 15 minutes or until pain and irritation subside
  - Cover with warm dry clothing and/or blankets
- Consult container label or onsite MSDS for decontamination instructions
  - Remove label or copy page from MSDS, conserve in sealed plastic bag, and transport

Do not induce vomiting

Antidote:
- Consult container label or onsite MSDS for antidote instructions
- Read decontamination and antidote instructions to Online Medical Direction (OMD)

2.5 mg Albuterol 0.083% (Proventil or Ventolin) HHN or in-line with a ventilatory device
For bronchospasm associated with toxic inhalation
May repeat as clinically indicated
See REMSA Calculation Chart for pediatric dosage

6710 — Toxic Exposure, Inhalation, or Ingestion (REMSA Treatment Protocol) Page 1 of 2
### Base Hospital Physician Orders

<table>
<thead>
<tr>
<th>Medication</th>
<th>Order</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assist with site supplied antidote</td>
<td></td>
<td></td>
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<tr>
<td>As ordered</td>
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<tr>
<td>For suspected toxic exposure, inhalation, or ingestion</td>
<td></td>
<td></td>
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<tr>
<td>Potable Water PO</td>
<td></td>
<td></td>
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<tr>
<td>As ordered</td>
<td></td>
<td></td>
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<tr>
<td>For suspected toxic ingestion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Milk PO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>As ordered</td>
<td></td>
<td></td>
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<tr>
<td>For suspected toxic ingestion</td>
<td></td>
<td></td>
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<tr>
<td>Activated Charcoal PO</td>
<td></td>
<td></td>
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<tr>
<td>As ordered</td>
<td></td>
<td></td>
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<tr>
<td>For suspected toxic ingestion</td>
<td></td>
<td></td>
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<tr>
<td>Calcium Chloride 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>As ordered</td>
<td></td>
<td></td>
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<tr>
<td>For cardiac dysrhythmias associated with toxic exposure, inhalation, or ingestion</td>
<td></td>
<td></td>
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<tr>
<td>Magnesium Sulfate 50%</td>
<td></td>
<td></td>
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<tr>
<td>As ordered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For cardiac dysrhythmias associated with toxic exposure, inhalation, or ingestion</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FOR CONSIDERATION BY PMAC

DATE: June 14, 2011
TO: PMAC
FROM: Karen Petrilla, EMS Specialist
SUBJECT: Policies 3100 – CE for EMS Personnel
          4130 – EMT SCV

In preparation for the PMAC meeting on June 27, 2011, please review the attached REVISIONS of the above named policies. These two policies needed to have clarifications/specifications placed in them to better explain/define current practice and to correlate with practices of surrounding counties.

Thank you for your participation.
Note that this revised policy has additions shown in green, and deletions lined out.

PURPOSE
To delineate those continuing education (CE) credits deemed acceptable for renewal by the Riverside County EMS Agency.

AUTHORITY
California Code of Regulations (CCR), Title 22, Social Security, Division 9., Chapter 11., Article 1., Sections 100390-100395

Riverside County EMS Agency (REMS) recognizes the importance of uniformity on a statewide level for the process of continuing education and will abide by the most recent versions of Title 22 of the California Code of Regulations (CCR), regulations and State EMS Authority documents related to this issue. Riverside County policy is intended to specify and clarify the regulations and in all cases supersedes them.

Definition
Continuing education (CE) is defined by state regulations as: “... a course, activity, or experience designed to be educational in nature, with learning objectives and performance evaluations for the purpose of providing EMS personnel with reinforcement of basic EMS training as well as knowledge to enhance individual and system proficiency in the practice of prehospital emergency medical care.”

Acceptable Continuing Education
1. Riverside County EMS Agency will accept as valid only those CE classes/events sponsored by approved EMS CE providers, including those approved by other California EMS agencies or the State EMS Authority.
   a. The EMS Agency will not pre-authorize or authorize after-the-fact individual course outlines presented by EMS personnel for consideration as CE. Individuals desiring CE are expected to contact the course sponsor(s) with regards to that organization's status as an approved prehospital CE provider.
   b. The EMS Agency cannot give approval for courses sponsored by providers based outside of Riverside County. Individuals wishing to receive credit for such activities should contact the EMS agency of that jurisdiction for approval information or the State EMS Authority if the provider/location is out-of-state.
2. CE credits will only be issued to a participant upon successful passing of a written and/or skills competency based evaluation specific to the material covered by the course, class, or activity objectives.
3. Activities/courses accepted from approved providers as valid CE must have been taken within two (2) years preceding the individual's certification/authorization/licensure expiration date or the submission date of a completed application, if expired.
4. Acceptable CE must be related to prehospital emergency medical care activities and can include such didactic and non-traditional experiences as traditional (instructor-based) classroom activities, and the following non-instructor based activities:
   - media-based education (take-home, on-line, correspondence, etc),
   - precepting time (for paramedics only),
   - structured clinical or ride-out time,
   - structured teaching time,
46. a. At least ½ of the required CE hours must be received in an instructor-based format. This includes any additional CE requirements placed on an applicant due to an expired certificate or license.

47. b. At least 2/3 of the required CE hours must be received from courses whose topics involve the medical management of patients within the scope of practice of the individual submitting the EMS CE credits. This includes any additional CE requirements placed on an applicant due to an expired certificate or license.

50. i. Certain advanced topics outside the individual’s scope of practice, but directly relevant to prehospital medical care, may account for 1/3 of the required CE hours.

52. ii. Courses that do not meet the criteria of medical management but are relevant to prehospital care, may account for 1/3 of the required CE hours. This includes such topics as ICS, vehicle extrication, hazmat, low-angle rescue, defensive driving, etc.

59. c. Individuals should reference the recertification / reauthorization / (State) relicensure policies for more detailed information on the specific requirements for their practice level.

66. 5. College level courses in the biological sciences (anatomy, pathophysiology, psychology, et al) completed with a grade of "C" or better will be accepted as follows, up to the maximum levels defined in item #4.

69. a. One academic semester unit shall be equivalent to fifteen (15) CE hours.

70. b. One academic quarter unit shall be equivalent to ten (10) CE hours.

78. 6. Activities not acceptable as valid CE include:

79. • research activities

82. • committee work

86. • the writing of position papers, journal articles, or other published materials

90. • any course that is not prehospital-based in its content (except those approved advanced topics)

92. • any course not offered by an approved prehospital CE provider

95. • workplace orientation programs that deal with the employer’s policies and/or procedures

98. • personal improvement courses (self-awareness, time mgmt, wt loss, yoga, etc.)

101. • courses for the lay public (Lamaze, parenting, first aid, etc.)

104. 7. Standard courses which are nationally recognized (e.g. - CPR, ACLS, PHTLS, BBP) and offered by an approved CE provider may be repeated once within the same license/certification/authorization period with CE credit being accepted for both programs up to the maximum levels defined in item #4 above.

112. 8. CE credit for structured clinical or ride-out, structured teaching, precepting, and field care audits will be issued on a 1:1 (hours:credit) basis.

119. a. Credit can only be issued by an approved CE provider.

128. i. Teaching credits may only be issued by the provider employing the individual

131. ii. Credit may be received only once during a certification/licensure/authorization cycle for instructing a particular class or topic.

136. iii. Precepting credit may only be issued by the approved training program of the preceptor’s student.

141. iv. Structured clinical and ride-out credits can only be issued by the agency which provides and reviews the structure (outline) that the individual must complete as part of his clinical/ride-out time. (In most cases this will be a hospital.)

149. 9. Partial credit for a course may be received at the discretion of the CE provider agency provided that:

157. a. The credit issued is not less than one (1) CE credit (one hour)

162. b. Credit is not issued in less than one-half (½) hour increments (e.g. - 1, 1½, 2, 2½ are acceptable partial credits), AND

167. c. All evaluations have been completed and returned by the participant.
10. EMS personnel are responsible for maintaining CE certificates for a minimum of four (4) years after receipt and must make them available for review at the request of the Riverside County EMS Agency, the State EMS Authority, or other EMS certifying entity.
Operational Policy

Effective April 1, 2012
Expires March 31, 2013

Operational Policy: EMT Skills Competency Verification

| Applies To: EMT, EMS System | Approval: REMSA Director
|                           | Humberto Ochoa, MD |
|                           | Signature         |
|                           | Approval: REMSA Director
|                           | Bruce Barton, CCEMT-P | Signature

Note that this revised policy has additions shown in green, and deletions lined out.

PURPOSE
The purpose of this policy is to outline those steps required by any prehospital care provider, approved continuing education (CE) provider, or EMS training program within Riverside County that chooses to perform skills competency verification (SCV) for EMTs.

AUTHORITY
California Code of Regulations (CCR), Title 22, Social Security, Division 9, Chapter 2, Article 5, Section 100080

Qualifications/Responsibilities of the Skills Verifier and Verifying Agency
1. Any person authorized as a skills competency verifier (SCVr) must:
   a. Be a currently certified or licensed as EMT, EMT-P, registered nurse (RN), physician’s assistant (PA), or physician (MD/DO) employed by a qualifying agency.
   b. Receive approved training from the agency designating them as a SCVr.
2. Skills competency verification shall be done by direct observation only.
3. Skills competency verification shall be performed only by authorized providers in a setting (time/place) pre-approved by their designating agency.
4. Designated skills competency verifiers will only sign-off those skills directly observed by them, and that meet the standards as set down by their designated agency’s pre-approved skills sheets.
   a. SCV forms should be signed in colored ink, preferably blue.
   b. All five areas corresponding to each skill on the form must be completed by the skills evaluator/SCVr — signature, printed name, state license/certification number, affiliation, and date.
      i. Signature and date MUST be hand written.
   c. It is not acceptable for SCVrs to complete item 4.b (above) if sections 1a. and 1b. 1c. on the form have not been completed by the EMT seeking skills verification.
5. Qualifying agencies who wish to perform EMT skills competency verification shall:
   a. Have an approved skills sheet for each of the REMS-accepted skills in the ten (10) skills categories defined by the State.
   b. Use the skills sheets of the National Registry (NR) as the standard for skills competency verification. If no NR skill sheet exists for a particular skill, or if a variation of the NR skill sheet is desired, the skill sheet(s) used for verification shall be approved by the EMS Agency prior to implementation.
   c. Review skills sheets annually and update as appropriate for changes in the standard of care.
   d. Submit a limited list of names of persons in their agency who have met the qualifications and training for SCV and who they wish to designate as skills competency verifiers (SCVrs).
      i. Provide and document initial training to designated persons on use of the approved skills sheets.
      ii. Provide annual update/review training to their designated SCVrs.
         a. Attendees shall sign a roster verifying attendance.
   e. Immediately notify the EMS Agency of any change — addition or deletion — in their cadre of qualified, trained, and approved SCVrs, supplying the name and effective date of change.
f. Submit verification of 5a. - e to the EMS Agency as requested.

Responsibilities of the Individual Seeking Skills Competency Verification

1. EMTs requesting skills competency verification shall have the authorized person sign the State-approved skills competency verification form (EMSA-SCV (08/10)) at the time that the skill is observed and verified.
   a. EMTs shall complete items 1.a. and 1.b at the top of the state SCV form prior to having approved skills verifier (SCVr) sign for skills completion.
   b. It is not required to perform all skills for competency in a singular setting. However, only one skills form shall be utilized by the EMT for obtaining signatures verifying skills competency.
   c. Skill 5. "AED and CPR" on the state skills form, may be verified by an approved skills verifier or the CPR instructor who observed skills performance at the time of CPR renewal.
      i. The signature of an approved CPR instructor on an applicant’s SCV form does not negate the requirement to present an approved BLS/CPR card at the time of recertification.

2. The EMT is required to submit the completed original SCV form at time of certification renewal.
FOR CONSIDERATION BY PMAC

DATE:       June 14, 2011
TO:         PMAC
FROM:       James Lee, EMS Specialist
SUBJECT:    PMAC presentation of Ambulance Permit Policy 4600

In preparation for the PMAC meeting on June 14, 2011, please review the attached Ambulance Permit Policy 4600. This policy has been created by the Riverside County EMS Agency. Please note the following:

- This new policy describes the initial, continuous & renewal of ambulance permitting process.

Thank you for your participation in this process.
PURPOSE
To establish policies for ambulance operations, equipment, and personnel responding to incidents/service requests within Riverside County.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797.200 & 1797.222]
Riverside County Ordinance Number 756 (Ambulance Ordinance)

Initial Permit Application
1. To receive a ambulance service permit application, the applicant shall:
   a. Submit a letter of interest on a company letterhead stating at minimum:
      i. Your company’s interest in providing service in Riverside County
      ii. Type of service your company is seeking to provide (BLS, ALS, CCT, AIR)
      iii. Brief statement of your company’s service history and background
   b. Complete Riverside County Emergency Medical Services Agency (REMSA) ambulance permit application.
   c. Provide and maintain proof of full accreditation by the Commission on Accreditation of Medical Transport Systems (CAMTS) OR Commission on Accreditation of Ambulance Services (CAAS).*
   d. Establish EMT AED Program which meets at a minimum all the requirements of REMS Policy 4110.**
   e. Each ambulance shall utilize two-way communications equipment, as specified by the EMS Agency, capable of direct two-way voice communications with Public Safety & ALS providers in the County’s EMS system and with the EMS Agency within first year of permit.
   f. Pass REMSA inspection of ambulance equipment and supplies.
   g. Pay ambulance permit and unit fees as directed by Riverside County Ambulance Ordinance 756.
   h. Meet all requirements identified in the ambulance permit application.
   i. Comply with all rules and regulations.

* Public Safety Agencies are exempt from this requirement.
** Mandatory for BLS ambulance providers only.

Conditions of Permit
1. An ambulance service permit is valid from the date of issue and all permits shall expire on the date of June 30 of each year.
2. That all applicable provisions of Ambulance Ordinance 756 and regulations policies and protocols established to carry out its provisions are complied with.
3. That all permitted providers shall meet such operating standards as may be established by the EMS Agency.
4. Maintain proof of full accreditation by the Commission on Accreditation of Medical Transport Systems (CAMTS) OR Commission on Accreditation of Ambulance Services (CAAS).
5. Maintain EMT AED Program which meets at a minimum all the requirements of REMS Policy 4110.
6. Maintain fully operational two-way communication equipment in each ambulance as specified by the EMS Agency.
7. That all conditions set forth by ambulance ordinance 756 section H be complied with.
8. The permit officer, after conducting an investigation or upon such facts or circumstances as may be known to him, may deny the renewal of, suspend or revoke a provider permit issued under the provisions of Ambulance Ordinance 756 when it has been found that the permit holder has violated one or more of the conditions set forth in Section M of the Ordinance.
9. During mass casualty incidents (MCI), the capability of the 911 ambulance providers to provide necessary prehospital emergency care and transportation may be insufficient for the number of casualties. Therefore, it is necessary that all non 911 ambulances permitted in Riverside County be available to assist MCI needs. For this reason, each permitted provider shall make available, and place into service, all available permitted units at the request of the EMS Agency. All permitted ambulance providers, in the event of an MCI, shall:
   a. Provide immediate ambulance resource availability within Riverside County when requested by the EMS Agency.
   b. Have an emergency response plan which includes a personnel call-back plan.
   c. Have all management and field personnel of the permitted provider be trained and be compliant with Riverside County’s Mass Casualty Incident (MCI) Plan\(^3\) during an MCI.
   d. Provide, within reason, immediate response to any polls/surveys from the EMS Agency.
   e. Provide, within reason, equipment, facilities, and personnel as requested by the EMS Agency.
   f. When funding is available, the COUNTY may assist the participating providers in seeking reimbursement for its costs from any disaster relief funding. The COUNTY shall have no financial responsibility for these costs or charges.

10. When requested by the EMS Agency, the permitted provider shall participate in a Riverside County organized disaster exercise by assigning at minimum one (1) fully staffed ambulance. The EMS Agency will request participation from permitted providers with a minimum thirty (30) day written notice. All costs associated with their participation in the disaster exercise shall be the sole responsibility of the permitted provider.

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\(^1\) Currently approved providers shall have 2 years from the implementation of this policy to obtain CAMTS or CAAS accreditation excluding Public Safety Agencies.*

\(^2\) Currently approved providers shall have 1 year from the implementation of this policy to establish EMT AED Program.

\(^3\) Pending implementation of Riverside County approved Mass Casualty Incident Plan.

**Permit Renewal**

1. An application for renewal of a provider permit shall be submitted to the EMS Agency at least sixty (60) days prior to the expiration of the provider permit to be renewed.

2. If a permit holder makes application for the renewal of a provider permit in less than sixty (60) days prior to the expiration of the permit holder’s provider permit for which renewal application is made, the permit holder shall pay an additional twenty percent (20%) of the fee due.
DATE: June 14, 2011

TO: PMAC

FROM: Cindi Stoll, RN, Trauma/HEMS/EMS-C System Manager

SUBJECT: PMAC Consideration of Trauma Triage Criteria-FINAL

In preparation for the PMAC meeting on June 27, 2011, please review the attached Final Policy.

This document has been presented to PMAC and TAC for comment. TAC made final recommendations on May 25, 2011. This document represents the conclusion of all stakeholders.

Recommendation: Approval for implementation by September 2011

Thank you for your participation.
PURPOSE
The purpose of this policy is to establish criteria consistent with the American College of Surgeons and Centers for Disease Control standards and the distinctions of Riverside County to ensure that patients requiring the sophisticated and specialized care of a Trauma Center are appropriately triaged and transported in the most effective and expeditious manner by the appropriate level of pre-hospital personnel to the appropriate Trauma Center.

AUTHORITY
Health and Safety Code, Division 2.5
California Code of Regulations, Title 22, Division 9, Chapter 7, Trauma Care Systems

Definitions
1. **Adult patient**: a person appearing to be 15 years of age or more.
2. **Anatomic criteria**: severe bodily injury/injuries that require the high level care of a trauma center but may not meet physiologic criteria.
3. **Critical Trauma Patient** (CTP): is a patient who meets Riverside County EMS Agency’s trauma triage criteria.
4. **Geriatric patient**: a person 65 years of age and older.
5. **Helicopter Emergency Medical System** (HEMS): air transport.
6. **Mechanism of Injury**: the kinetic force that caused the injury.
7. **Pediatric patient**: a person appearing to be 14 years of age or less.
8. **Pediatric Trauma Center** (PTC): is a hospital that has received designation from Riverside County EMS Agency as a Pediatric Trauma Center. Riverside County designated PTC’s are Riverside County Regional Medical Center and Loma Linda University Medical Center.
9. **Physiologic criteria**: a shock state, or inadequate tissue perfusion.
10. **Trauma Center**: is a hospital that has received designation from Riverside County EMS agency as a Trauma Center.

Policy

Destination:
1. Adult patients identified as CTP’s will be transported to the closest Trauma Center.
2. Pediatric patients identified as CTP’s will preferably be transported to a PTC.
   a. If the PTC is unavailable go to the closest Trauma Center.
3. If patient destination is questionable, contact the Trauma Base for destination.

Transport:
1. Ground ambulance transport shall be utilized when estimated time to the TC/PTC is 30 minutes or less.
2. HEMS transport should be considered if the TC/PTC is greater than 30 minutes ground transport time.

Exceptions
1. Trauma Center Diversion-refer to policy 5310 Ambulance Diversion
2. The patient is identified as a CTP or potential CTP and presents with the following:
   a. Unmanageable airway: If the CTP’s airway and/or breathing is compromised and the paramedic is unable to effectively manage these using BLS or ALS measures, the patient will be transported to the closest Emergency Department.
b. Blunt traumatic arrest that does not meet the Determination of Death Criteria, refer to Policies 5600 Withholding Resuscitation Efforts and 5610 Withdrawal of Resuscitation Efforts, transport to the closest Emergency Department.

c. Penetrating traumatic arrest
CTP’s with penetrating injuries in traumatic arrest must have Base Hospital physician consult prior to termination of efforts, 5610 Withdrawal of Resuscitation Efforts.
   i. with greater than 10-minute difference in ETA transport to the closest Emergency Department
   ii. with less than 10-minute difference in ETA to transport to the Trauma Center.

d. Pediatric traumatic arrest:
   Pediatric CTP’s must have Base Hospital physician consult prior to termination of efforts, 5610 Withdrawal of Resuscitation Efforts.

e. CTP’s with burn
   a. CTP’s with burns will be transported to the Trauma Center.
   b. Patients not meeting Critical Trauma Criteria will be transported according to Policy 5720 Burn Patient Destination.

Considerations
Scene time should be limited to 10 minutes under normal circumstances.

With multiple critical patients, consider Trauma/Base Hospital consultation for destination determination. Refer to Policy 5800 Multiple Casualty Incident (MCI) Scene Management.

If not contacted from the scene, the receiving Trauma Center must be advised of incoming CTP(s) as soon as possible in order to allow for timely trauma team activation. Refer to Policy 7050 ALS Unit Reporting Format.

Trauma Triage Criteria are on the following page:
Transport patients to the Trauma Center or Pediatric Trauma Center as required by any one of these criteria:

**Physiologic Criteria**
- GCS LESS THAN or EQUAL TO 13
- SYSTOLIC BP LESS THAN 90
- RESPIRATORY RATE LESS THAN 10 or GREATER THAN 30
- GERIATRIC SYSTOLIC BP LESS THAN 100
- INFANT RESPIRATORY RATE LESS THAN 20

**Anatomic Criteria**
- OPEN or DEPRESSED SKULL FRACTURE
- PENETRATION of HEAD / NECK / TORSO/PROXIMAL to ELBOW/KNEE
- FLAIL CHEST
- ABDOMINAL TENDERNESS
- SUSPECTED PELVIC FRACTURE
- NEW ONSET PARALYSIS
- TWO or MORE PROXIMAL LONG BONE FRACTURES
- AMPUTATION/ CRUSHED / MANGLED / DEGLOVED PROXIMAL TO WRIST/ANKLE
- TRAUMA with BURNS
- NEURO/VASCULAR DEFICIT OF EXTREMITY

**Mechanism of Injury Criteria**
- FALL - ADULT 15 FEET OR GREATER
- FALL - PEDIATRIC GREATER THAN 10 FEET / 3 TIMES HEIGHT
- AUTO VS PED or BICYCLE GREATER THAN 20 MPH
- MOTORCYCLE CRASH GREATER THAN 20 MPH
- EJECTION FROM VEHICLE
- DEATH IN SAME VEHICLE
- INTRUSION GREATER THAN 12" AT OCCUPANT SITE
- INTRUSION GREATER THAN 18" ANY SITE

**Evaluate for co-morbid & other mechanisms**
- GERIATRIC
- PEDIATRIC
- ANTI-COAGULATION / ANTI-PLATLET THERAPY
- PREGNANCY GREATER THAN 20 WEEKS
- MVC GREATER THAN 40 MPH
- LOSS OF CONSCIOUSNESS REPORTED
- EMS PROVIDER JUDGEMENT

**Additional Instructions**
- CONTACT A TRAUMA BASE FOR DESTINATION
- WITH Trauma Base Contact as early as possible

References: ACS-COT Green Book, 2006; CDC, Guidelines for Field Triage of Injured Patients, Jan. 2009