PREHOSPITAL MEDICAL ADVISORY COMMITTEE MEETING AGENDA (PMAC)

PMAC MEMBERS PER POLICY 1630:

Air Transport Provider Representative
2.11 Kent McCurdy

American Medical Response
2.5 Wayne Ennis
2.5 Sam Chua, MD
2.5 Jim Price

BLS Ambulance Service Representative
2.12 Kelly Martinez

Blythe Ambulance Service
2.5 Michael Wallace

Cathedral City Fire Department
2.5 Robert Williams

Corona Regional Medical Center
2.1 Robbie Dunn, MD
2.4 Stephanie Jones

County Fire Chiefs’ Non-Transport ALS Providers
2.10 Art Durbin

County Fire Chiefs’ Non-Transport BLS Providers
2.9 Phil Rawlings (Vice Chair)

Desert Regional Medical Center
2.1 Brian Anderson, MD
2.4 Heidi Anderson

Eisenhower Medical Center
2.1 Dan Olesnicky, MD
2.4 Shellee Fetters

EMT-I / EMT-P Training Programs
2.5 Maggie Robles

EMT-I-at-Large
2.13 Mike Markert-Green

EMT-P-at-Large
2.13 Paul Duenas

Hemet Valley Medical Center
2.1 Robert Nakamura, MD
2.4 Kathy Racela

Idyllwild Fire Protection District
2.5 Mike Mulhall

Inland Valley Regional Medical Center
2.1 Reza Vaezazizi, MD (Chair)
2.4 Lia Genn

JFK Memorial Hospital
2.1 Frank Curry, MD
2.4 Katherine Heichel-Casas

A special meeting of PMAC is on:

Tuesday, August 23, 2011
9:00AM – 12:00PM
Riverside County Regional Medical Center
26520 Cactus Avenue, Moreno Valley
Rooms A1018 and A1020
951/358-5029

1. CALL TO ORDER
   Vice-Chair Phil Rawlings

2. PLEDGE OF ALLEGIANCE
   Phil Rawlings

3. ROUNDTABLE INTRODUCTIONS
   Phil Rawlings

4. Draft Policy Review and Discussion (90 Minutes)
   4.1 6400 Nausea and/or Vomiting
   4.2 6530 Seizures
   4.3 6600 Pre-Eclampsia and Eclampsia
   4.4 6700 Overdose
   4.5 6710 Toxic Exposure, Inhalation or Ingestion
   4.6 6320 Heat Illness and/or Hyperthermia
   4.7 6330 Frostbite/Hypothermia

5. Break (10 Minutes)

   6.1 6010 Universal Patient
   6.2 6011 Calculation Chart

7. Draft Policy Review and Discussion (45 Minutes)
   7.1 6720 Carbamate, Organophosphate and Nerve Agent Exposure
   7.2 5520 Physical Restraint and Transport
   7.3 5250 Data Collection

8. Good of the Order / Announcements (10 Minutes)
Kaiser Permanente Riverside  
2.1 Jonathan Dyreyes, MD  
2.4 Carrie Cobos

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

Loma Linda University Murrieta  
2.1 Robert Steal, MD  
2.4 John McGowan

Menifee Valley Medical Center  
2.1 Todd Hanna, MD  
2.4 Janny Nelsen

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

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 Hat, 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

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 Subbu Nagappan, MD  
2.3 Georgi Collins

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.

9. **Next Meeting / Adjournment (5 Minutes)**  
   September 26, 2011
### TOPIC | DISCUSSION/INFORMATION | ACTION
--- | --- | ---
1. **CALL TO ORDER** | Chair Dr. Vaezazizi called the meeting to order at 9:00 AM. |  
2. **PLEDGE OF ALLEGIANCE** | Dr. Vaezazizi led the Pledge of Allegiance. |  
3. **ROUNDTABLE INTRODUCTIONS** | Dr. Vaezazizi began roundtable introductions. |  
4. **DRAFT POLICY REVIEW AND DISCUSSION** |  
4.1 **Policy 6000 - Introduction to Protocols** | Discussions from the written comment period were reviewed. Policy 6000 - Introduction to Treatment Protocols is the basis of all treatment protocols. | PMAC unanimously approved of Policy 6000.  
4.2 **Policy 6010 - Universal Patient** | This policy applies to all EMRs, EMTs, AEMTs and PMs. | Approved with amendments.  
4.3 **Policy 6011 - Calculation Chart** | This policy uses a calculation chart to help prevent medication errors in conjunction with the Broselow Tape. | Approved with amendments.  
4.4 **Policy 6020 - Physician on Scene Assuming Responsibility** | This policy provides direction for EMS personnel when a physician arrives on scene wishing to assume patient care responsibility. | Approved.  
4.5 **Policy 6030 - Refusal of Treatment and or Transportation** | This policy defines who can refuse treatment and or transport. Refusal of transport is only made by the patient, parent or designee. | Approved with recommended changes.  
4.6 **Policy 6090 - Do not Attempt Resuscitation / Discontinue Resuscitation** | This policy provides direction on when not to attempt resuscitation or when to discontinue resuscitation. | Approved with recommended changes.  
4.7 **Policy 6091 - Prehospital Death** | This policy gives direction on what to do when the decision has been made to discontinue or not attempt resuscitation. | A recommendation was approved to send back to committee for more work.  
4.8 **Policy 6300 – Burns** | Concerns were expressed that burn patients should be treated at local EDs before being transferred to the burn center | Approved with recommended changes. 
5. **BREAK**

Scheduled break was declined by PMAC.

6. **DRAFT POLICY REVIEW AND DISCUSSION**

| 6.1 Policy 6320 – Heat Illness and/or Hyperthermia | This policy is based on heat illness and hyperthermia. | Approved. |

7. **THE FOLLOWING AGENDA ITEMS HAVE BEEN DEFERRED UNTIL THE NEXT MEETING:**

- Policy 6400 - Nausea/ Vomiting
- Policy 6530 - Seizures
- Policy 6600 - Pre-Eclampsia
- Policy 6700 - Overdose
- Policy 6710 - Toxic Exposure, Inhalation or Ingestion

|  | Scheduled for review at the next scheduled PMAC meeting. |

8. **NEXT MEETING / ADJOURNMENT**

| AUGUST 23, 2011 | Meeting adjourned by Dr. Vaezazizi at 12:00 P.M. |
FOR CONSIDERATION BY PMAC

DATE: August 15, 2011
TO: PMAC
FROM: Scott Moffatt, EMS Specialist
SUBJECT: PMAC Consideration of DRAFT Policies
ACTION: Review, discuss, and make recommendations to the EMS Agency

In preparation for the PMAC meeting on August 23, 2011, please review the attached DRAFT policies which are new to PMAC:

6400 Nausea and-or Vomiting
6530 Seizures
6600 Pre-Eclampsia and Eclampsia
6700 Overdose
6710 Toxic Exposure, Inhalation, or Ingestion
6320 Heat Illness and/or Hyperthermia
6330 Frostbite/Hypothermia

Also, please review the changes that have been made to the following DRAFT policies based on your recommendations:

6010 Universal Patient
6011 Calculation Chart

Also, please review the following DRAFT policy that was previously reviewed by PMAC, now we will be considering the cost of stocking the medications:

6720 Carbamate, Organophosphate, and Nerve Agent Exposure

Also, please review the following DRAFT revisions of current Operational Policies:
5520 Physical Restraint and Transport
   Combines and revises 5510 5150 TRANSPORT and 5520 RESTRAINTS
5250 Data Collection
   Revises 5250 PATIENT CARE DOCUMENTATION STANDARDS

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
Allergy to 5-HT₃ 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

Ondansetron (Zofran) slow IV/IO push or IM or ODT (Oral Disintegrating Tablet)
For nausea and/or vomiting, may prophylax when giving opioids and/or anticipating motion sickness
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
Repetition requires a base hospital order (BHO)

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

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

Ondansetron (Zofran)
As ordered
For nausea and/or vomiting
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
Febrile, absence, simple partial, complex partial, myoclonic, atonic, tonic, clonic, tonic-clonic, or eclamptic seizure
Aura and/or post-ictus
ALTE (apparent life-threatening event)
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, preserve privacy
Perform cooling measures as clinically indicated for febrile seizures
Obtain and evaluate blood glucose when AEMT or paramedic is present
Midazolam (Versed) slow IV/IO push or IM/IN
For continuous or recurrent tonic-clonic seizures unrelated to eclampsia
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
Repetition requires a base hospital order (BHO)

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

****** ***** Base Hospital Orders ****** *****
Midazolam (Versed)
As ordered
For seizures
**Effective**
April 1, 2012

**Expires**
March 31, 2013

**Policy:**
Pre-Eclampsia and Eclampsia

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

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**Enter from the Universal Patient Treatment Protocol**

*For specific Emergency Stabilization, Patient Disposition or Patient Management of Pre-Eclampsia and Eclampsia*

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**Pertinent Findings**

**Environment**
Low socioeconomic class
Obesity
Less than 20 years of age
Over 35 years of age

**History**
First or multiple pregnancies
Conception with a new partner
Multi-fetal pregnancy
From 20 weeks gestation thru four weeks postpartum
Diabetes, kidney disease, HTN
Family history of pre-eclampsia
Gravida (pregnancies)
Para (viable births)
Abortus (lost pregnancies)
LMP (last menstrual period)
**EDC** (estimated date of confinement: first day of LMP + 280 days)
Prenatal care and findings
Diagnosis of gestational diabetes
Diagnosis of pre-eclampsia

**Physical**
Malaise
Abdominal and/or back pain
Nausea and vomiting
Decreased urine output
Hypoglycemia
Headache, vertigo, visual disturbance
Focal neurological deficits
Sudden water retention/weight gain
Peripheral and/or pitting edema
Hypertension
Pulmonary edema
Hyperreflexia, clonus, seizure, coma
Disseminated intravascular coagulation

**Differential**
Normal pregnancy
Placenta abruptio
Ruptured liver
Hypoglycemia
Chronic HTN
Stroke
Seizure
HELLP Syndrome
Hemolysis,
Elevated Liver Enzymes,
Low Platelet Count

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**Emergency Stabilization or Patient Management**

Decrease stimuli and maintain a quiet, dark environment

Place patient in left lateral recumbent position

Obtain and evaluate blood glucose when AEMT or paramedic is present

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

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

Midazolam (Versed)
As ordered
For eclampsia unresponsive to Magnesium Sulfate 50%
# Treatment Protocol

**Policy:** Overdose

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

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

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

---

## Enter from the Universal Patient Treatment Protocol

For specific Emergency Stabilization or Patient Management of **Overdose**

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### 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>
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<tr>
<td>Suicide</td>
<td>Cardiac medications</td>
<td>Altered respiratory rate and rhythm</td>
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<tr>
<td>Crime</td>
<td>Depressants or stimulants</td>
<td>Bradycardia, tachycardia, dysrhythmia</td>
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<tr>
<td>Evidence of:</td>
<td>Cyclic antidepressants</td>
<td>Hypotension or hypertension</td>
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<tr>
<td>Substance</td>
<td>Other medications</td>
<td>Hypothermia or hyperthermia</td>
<td></td>
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<tr>
<td>Route</td>
<td>Route, quantity, and time</td>
<td>Sluggish, dilated or pinpoint pupils</td>
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<tr>
<td>Quantity</td>
<td>SAMPLE history</td>
<td>Skin signs and secretions</td>
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<tr>
<td>Conserve evidence</td>
<td></td>
<td>Abdominal pain, nausea, and vomiting</td>
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</tr>
</tbody>
</table>

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## Emergency Stabilization or Patient Management

Obtain and evaluate blood glucose when AEMT or paramedic is present

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 the REMSA Calculation Chart for concentration, and patient specific dosage and volume

Naloxone (Narcan) IV/IO push  
For respiratory depression with suspected narcotic overdose  
May repeat as clinically indicated  
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume

Diphenhydramine (Benadryl) IM or slow IV/IO push  
For suspected dystonic reactions and the extrapyramidal effects of phenothiazine overdose  
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume

**Repetition requires a base hospital order (BHO)**
Return to Universal Patient Treatment Protocol
For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management

<table>
<thead>
<tr>
<th>Base Hospital Orders</th>
<th>E</th>
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<th>A</th>
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</thead>
<tbody>
<tr>
<td><strong>Activated Charcoal PO</strong></td>
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<tr>
<td>As ordered</td>
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<tr>
<td>For suspected overdose</td>
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<tr>
<td><strong>Naloxone (Narcan) IN/IM</strong></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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<td><strong>Calcium Chloride 10%</strong></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><strong>Diphenhydramine (Benadryl)</strong></td>
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<tr>
<td>As ordered</td>
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<td><strong>Glucagon</strong></td>
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<td>As ordered</td>
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<tr>
<td>For respiratory depression with suspected narcotic overdose</td>
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<tr>
<td><strong>Sodium Bicarbonate 8.4%</strong></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>
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</table>
Effective April 1, 2012
Expires March 31, 2013

Policy:
Toxic Exposure, Inhalation, or Ingestion

Approval: REMSA Director
Humberto Ochoa, MD

Appplies 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

| Environment Evidence of: | History Substance: Chemicals (both liquids and powders), Chlorine, Cyanide, Hydrogen Sulfide, Hydrofluoric Acid, Phosgene Other toxics Route, quantity, and time SAMPLE history | Physical Altered mental status, agitation, seizures Altered respirations, dyspnea, apnea Bradycardia, tachycardia, dysrhythmia Hypotension or hypertension Hypothermia or hyperthermia Sluggish, dilated or pinpoint pupils Skin signs and secretions Abdominal pain, nausea, and vomiting | Differential Alcohol, Epilepsy, Insulin, Overdose, Uremia, Trauma, Infection, Psychosis, Stroke Carbamates Organophosphates Other toxic exposure Other toxic inhalation Other toxic ingestion |

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 and relate decontamination and antidote instructions to Online Medical Direction (OMD)

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 the REMSA Calculation Chart for concentration, and patient specific dosage and volume
**Return to Universal Patient Treatment Protocol**
*For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management*

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

<table>
<thead>
<tr>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PM</th>
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</thead>
</table>

Assist with the administration of physician prescribed, site supplied antidote
As ordered
For suspected toxic exposure, inhalation, or ingestion

**Potable Water PO**
As ordered
For suspected toxic ingestion

**Milk PO**
As ordered
For suspected toxic ingestion

**Activated Charcoal PO**
As ordered
For suspected toxic ingestion

**Calcium Chloride 10%**
As ordered
For cardiac dysrhythmias associated with toxic exposure, inhalation, or ingestion

**Magnesium Sulfate 50%**
As ordered
For cardiac dysrhythmias associated with toxic exposure, inhalation, or ingestion
Effective April 1, 2012 Expires March 31, 2013

Policy: Heat Illness / Hyperthermia

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

Approval: REMSA Medical Director Humberto Ochoa, MD
Signature

Approval: REMSA Director Bruce Barton, CCEMT-P
Signature

Enter from the Universal Patient Treatment Protocol

For specific Patient Disposition, Emergency Stabilization or Patient Management of Heat Illness / Hyperthermia

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Pertinent Findings

**Environment**
- Hot
- Humid
- Physical exertion
- Dehydration
- Electrolyte depletion
- Medication use:
  - Anticholinergics
  - Antihistamines
  - Neuroleptics
  - Stimulants

**History**
- Heat intolerance
- Lack of acclimatization
- Physical exertion / physically unfit
- Allergies, illness, infection
- Sickle cell trait/disease
- Elderly
- Thyroid disorder
- Medication use
- Prescribed MAOIs or SSRIs
- Use of ecstasy, LSD, PCP, cocaine
- Recent general anesthesia

**Physical**
- Normal mental status
- Headache, nausea and vomiting
- Malaise, muscle cramps, exhaustion
- Tachypnea, tachycardia, normotension
- Skin signs may vary
- Shivering
- Hypotension
- Altered mental status
- Bizarre behavior, combative
- Syncope, seizures or coma
- May exceed core temperature of 106°F

**Differential**
- Heat cramps
- Heat exhaustion
- Heat stroke
- Thyroid storm
- Excited delirium
- Malignant hyperthermia
- Alcohol, Epilepsy, Insulin
- Overdose, Uremia
- Trauma, Temperature, Infection, Psychosis, Stroke

---

**Emergency Stabilization or Patient Management**

Remove from heat:
- Shade and expose
- Wet constantly with tepid water, fan, and encourage evaporative cooling but avoid causing shivering
- Move to air conditioned environment

Obtain baseline temperature and note method: tympanic, temporal, axillary, or touch

Obtain and evaluate blood glucose when AEMT or paramedic is present

Cool 0.9% Normal Saline IV/IO bolus
For heat illness / hyperthermia
May repeat as clinically indicated
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume

Apply cold packs to anterior neck, armpits, and groin
For hyperthermia with an approximated core temperature greater than 106°F
Re-assess temperature frequently
Discontinue cooling at an approximated core temperature of 102°F
Application with an approximated core temperature less than 106°F requires a base hospital order (BHO)
### Return to Universal Patient Treatment Protocol

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

<table>
<thead>
<tr>
<th>Step</th>
<th>EMR</th>
<th>EMT</th>
<th>AEMT</th>
<th>PM</th>
</tr>
</thead>
</table>

#### Base Hospital Orders

- **Cool 0.9% Normal Saline**
  - As ordered
  - For hyperthermia

- **Midazolam (Versed)**
  - As ordered
  - For shivering associated with heat illness / hyperthermia

- **Sodium Bicarbonate 8.4%**
  - As ordered
  - For suspected rhabdomyolysis and/or hyperkalemia associated with heat illness / hyperthermia

- **Albuterol HHN or in-line with a ventilatory device**
  - As ordered
  - For suspected hyperkalemia associated with heat illness / hyperthermia

- **Calcium Chloride 10%**
  - As ordered
  - For suspected hyperkalemia associated with heat illness / hyperthermia
Enter from the Universal Patient Treatment Protocol
For specific Emergency Stabilization or Patient Management of Frostbite / Hypothermia

**Pertinent Findings**

**Environment**
- Heat loss through:
  - Evaporation
  - Conduction
  - Convection
  - Radiation
  - Water immersion

**Heat Source**
- Cold
- Inadequate:
  - Clothing
  - Shelter

**History**
- Environmental exposure
- Neonate, pediatric, geriatric
- Severe malnutrition, hypoglycemia
- Alcoholism, mental illness, homelessness
- Trauma, stroke, or overdose
- Hypothyroid, hypopituitary, or sepsis

**Use of:**
- Alcohol, analgesics, anesthetics, antihistamines, sedatives, etc.
- Over cooling of:
  - Burns, heat illness, hyperthermia

**Physical**
- Shivering and chills
- Tachypnea
- Altered mental status:
  - Irritability, poor judgment, slurred speech, impaired coordination, apathy, removing clothing, stupor, coma
- Frostbite
- Arrhythmia
- Hypoventilation and bradycardia
- Pupils dilated and sluggish to fixed
- Cardiac arrest

**Differential**
- Alcohol
- Epilepsy
- Insulin
- Overdose
- Uremia
- Trauma
- Temperature
- Infection
- Psychosis
- Stroke

**Emergency Stabilization or Patient Management**

*Rough handling may precipitate cardiac arrhythmia in the severely hypothermic patient*

Remove from cold:
- Remove wet clothing and dry
- Wrap and cover with warm, dry blankets
- Move to heated environment
- Individually wrap, cover, and protect areas of cold injured tissue; do not rub

Obtain baseline temperature and note method: tympanic, temporal, axillary, or touch

Obtain and evaluate blood glucose when AEMT or paramedic is present

Apply hot packs to anterior neck, armpits, and groin
For hypothermia with an approximated core temperature between 92°F and 95°F
Re-assess temperature frequently
Discontinue warming at an approximated core temperature of 98°F

*Application with an approximated core temperature less than 92°F requires a base hospital order (BHO)*
Warm 0.9% Normal Saline IV/IO bolus
For hypothermia
May repeat as clinically indicated
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume

Morphine Sulfate slow IV/IO push
For pain associated with frostbite
While systolic BP remains greater than 90 mmHg
May repeat once
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
Further repetition requires a base hospital order (BHO)

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

Apply hot packs
As ordered
For hypothermia

Warm 0.9% Normal Saline
As ordered
For hypothermia

Morphine Sulfate
As ordered
For pain associated with frostbite
Policy: Universal Patient

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

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

Approval: REMSA Medical Director
Humberto Ochoa, MD

Approval: REMSA Director
Bruce Barton, CCEMT-P

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, or as operationally required

Request additional response and resources as required
Preserve 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 as required

Assign patient health care management decisions to a REMSA authorized provider with the highest credential:
EMR, EMT, AEMT, or PM

Insert Treatment Protocols for Scene Management

Follow operationally indicated Treatment Protocols when required for scene management
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 appearing to be 14 years of age or less

- Determine the patient’s chief complaint

- Perform a focused physical examination

Team Communication

The assigned REMSA authorized provider with the highest credential 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) with manometer and colorimetric CO₂ detector
  - Circulation using direct pressure, pressure dressing, tourniquet, and/or hemostatic dressing to control bleeding; 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 REMSA authorized EMS providers with higher credentials as requested, within scope of practice

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<th>M</th>
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<th>M</th>
</tr>
</thead>
</table>

**SpO₂**  
Attach, interpret, titrate oxygen/ventilation, continuously monitor, and maintain SpO₂ of 94% 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, appropriately covering patient for heat regulation, privacy and dignity

**King Airway**  
Establish, maintain, and ensure airway using King Airway when required for emergency stabilization

See REMSA Calculation Chart for pediatric application in patients greater than 8 years of age

Attach, interpret, and continuously monitor ETCO₂ by capnography (colorimetric CO₂ detector for AEMT/backup)  
Capnography is mandatory following King Airway placement

**Venous Access**  
Establish, maintain, and ensure peripheral IV access when required for emergency stabilization  
Establish IV access during transport of the non-entrapped, transport ready critical trauma patient  
Restrict fluid administration in the critical trauma patient by using saline lock extension sets

**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 in patients greater than 8 years of age

Attach, interpret, and continuously monitor ETCO₂ by capnography (colorimetric CO₂ detector may backup)  
Capnography is mandatory following endotracheal intubation
Emergency Stabilization (continued)

- Suction trachea as clinically indicated
  - Introduce 3 mL Normal Saline as needed to loosen thick secretions

Vascular Access
- Establish, maintain, and ensure IV or IO access when required for emergency stabilization
  - Establish IV or IO access during transport of the non-entrapped, transport ready critical trauma patient
  - Restrict fluid administration in the critical trauma patient by using saline lock extension sets
  - Peripheral IV access is the first-line method of vascular access

ECG
- Interpret and continuously monitor ECG
- Interpret 12 lead ECG
- Transmit 12 lead ECG to a REMSA authorized STEMI BH when equipped, including:
  - Machine identified STEMI, PM identified STEMI, any PM or BH requested transmission

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 monitor/12 lead ECG
  - Disability including GCS (Glasgow Coma Scale), LAPSS (Los Angeles Prehospital 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
- Lost oral intake
- Events leading to injury or illness

- Formulate prehospital provider impression

Team Communication

- The assigned REMSA authorized provider with the highest credential 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 considering patient’s preference and their clinical needs

Base Hospital Contact
Contact a single REMSA authorized base hospital (BH) as required by REMSA Policy, and in all:
- Critical trauma – contact a REMSA authorized Trauma BH
- Critical burns
- MCI
- STEMI – contact a REMSA authorized STEMI BH
- Stroke
- ALTE (apparent life-threatening event)
- Atypical presentation, circumstance, or provider uncertainty

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

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

Receiving Notification
Confirm receiving notification by BH, or notify receiving using:
- Age, Sex, History, Illness or injuries, Condition, ETA

Include:
- Call sign/identifier, for “receiving notification”, and ETA
- Age, sex, weight and Broselow color
- Chief complaint and mechanism of injury / history of present illness
- Pertinent findings upon assessment of responsiveness, airway, breathing, circulation, and disability
- Pertinent past medical history, medications, and allergies
- Interventions
**Patient Management (continued)**

**Establish Venous Access**  
Establish peripheral IV access as clinically indicated  
- Restrict fluid administration in the critical trauma patient by using saline lock extension sets  
  - *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 a biohazard bag and handoff to receiving staff

**ECG**  
Interpret and continuously monitor ECG  
Interpret 12 lead ECG  
Transmit 12 lead ECG to a REMSA authorized STEMI BH when equipped, including:  
  - Machine identified STEMI, PM identified STEMI, any PM or BH requested transmission

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**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 PPTT
- 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, LAPSS, 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 assigned REMSA provider with the highest credential 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 assigned REMSA provider with the highest credential must handoff to receiving staff using:
Situation Background Assessment Recommendation

Perform Documentation
A REMSA authorized provider with the highest credential (EMT, AEMT, or PM) from each agency at scene/seeing the patient must complete the patient care report (PCR/ePCR)

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
<table>
<thead>
<tr>
<th>Medication</th>
<th>Grey 3–5 kg</th>
<th>Pink 6–7 kg</th>
<th>Red 8–9 kg</th>
<th>Purple 10–11 kg</th>
<th>Yellow 12–14 kg</th>
<th>White 15–18 kg</th>
<th>Blue 19–23 kg</th>
<th>Orange 24–29 kg</th>
<th>Green 30–36 kg</th>
<th>Adult</th>
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<td>BHO</td>
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<td>BHO</td>
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<td>BHO 50 g</td>
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<td>50 g</td>
<td>4.2 g</td>
<td>6.3 g</td>
<td>8.3 g</td>
<td>10.4 g</td>
<td>12.5 g</td>
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<td>BHO 6 mg</td>
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<td>0.9 mg</td>
<td>0.9 mg</td>
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<td>1.5 mg</td>
<td>2.1 mg</td>
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<td><strong>Repeat Dose</strong></td>
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<td>BHO</td>
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<td>BHO 2.5 mg</td>
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<td>2.5 mg</td>
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<td>0.6 mL</td>
<td>0.8 mL</td>
<td>1 mL</td>
<td>1.4 mL</td>
<td>1.8 mL</td>
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<td>0.9 mL</td>
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<td>1.3 mL</td>
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<td>2.1 mL</td>
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<td><strong>Repeat Dose</strong></td>
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<tr>
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<td>3.3 mL</td>
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<td>1 Autoinjector (kit)</td>
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<td>REMSA 2012 Policy 6011 — Calculation Chart</td>
<td>[8/1/11 - 14:40] 3 of 6</td>
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</tbody>
</table>
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, heart, or lungs from body
6. Total abdominal evisceration
7. Complete transection of torso
8. A valid, signed, and dated advance directive (POLST/DNR) 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)**

#### Following Prehospital Determination of 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 determination of 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 ePCR/PCR
**Patient Disposition (continued)**

If released to mortuary:
- Remove invasive medical devices, position and cover body
- If contacted, release only name, location, and time of death to the mortuary

4. Include these details on the ePCR/PCR:
   - History, medications, time of death, circumstances, and description of any advanced directive:
   - DNR, POLST or medallion
   - Identification of the local law enforcement officer at scene
   - Identification of the coroner’s investigator who received report and coroner’s case number
   - Disposition of the body

When the decision not to attempt / to discontinue resuscitation has been made during transport:
- Do not cross county lines
- Divert to the closest, most appropriate hospital; or other prearranged secure location
- Contact the County of Riverside Coroner’s Office, give report and follow their directions

*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 Orders ***** *****

Discontinue resuscitation in pediatrics
- As ordered
- Requires a base hospital physician order (BHPO)
**NEW** Sign up at and request a quote ONLINE! **NEW**

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<tr>
<th>Reference #:</th>
<th>Our Quote #:</th>
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<tbody>
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<td>Quote Date :</td>
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<tr>
<td>Reply To :</td>
<td>Quote Expiration :</td>
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<tr>
<td>Phone #:</td>
<td>Customer #:</td>
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<table>
<thead>
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Ship : U.P.S. GROUND
F.O.S Point : DESTINATION
# of Days for Deliv : 2
Prepared By : 
Title : 
Signature : 

* A Prescription Drug Authorization Form must be filled out prior to placing your first order of pharmaceuticals.

If you have any questions, please give me a call.
Have a nice day.

Your Regional Manager is:
### Treatment Protocol 6720

**Effective**
April 1, 2012

**Expires**
March 31, 2013

<table>
<thead>
<tr>
<th>Policy:</th>
<th>Carbamate, Organophosphate, or Nerve</th>
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<tbody>
<tr>
<td>Approval:</td>
<td>REMSA Medical Director Humberto Ochoa, MD</td>
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<tr>
<td>Applies To:</td>
<td>EMR, EMT, AEMT, PM, EMS System</td>
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<tr>
<td>Approval:</td>
<td>REMSA Director Bruce Barton, CCEMT-P</td>
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**Enter from the Universal Patient Treatment Protocol**

*For specific Emergency Stabilization or Patient Management of Carbamate, Organophosphate, or Nerve*

---

**Pertinent Findings**

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<thead>
<tr>
<th>Environment</th>
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<tbody>
<tr>
<td>Agriculture</td>
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<td>Mass gathering</td>
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<td>Terrorist Attack</td>
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<td>Combat</td>
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<tr>
<th>History</th>
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<tr>
<td>Release of: Pesticides or nerve agents</td>
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<tr>
<td>Use Atropine &amp; 2-PAM with caution in:</td>
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<tr>
<td>Pediatrics and geriatrics</td>
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<tr>
<td>The medically compromised</td>
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<tr>
<td>Hypertension and renal failure</td>
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<table>
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<tr>
<th>Physical</th>
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<tbody>
<tr>
<td>Agitation, diaphoresis, rhinorhoea, dyspnea</td>
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<tr>
<td>Muscle twitching, seizures, muscle weakness</td>
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<tr>
<td>Headache, unconscious, flaccid, apneic</td>
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<tr>
<td>Salivation, Laximation, Urination,</td>
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<tr>
<td>Defecation, Gastric effects, Emesis, Miosis</td>
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<tr>
<th>Differential Diagnosis</th>
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<td>Mass hysteria</td>
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<tr>
<td>Other exposure</td>
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<tr>
<td>Cholinergic Drug OD</td>
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</tbody>
</table>

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**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**

*The appropriately authorized EMR, EMT or AEMT, or PM may self-administer the Mark I or DuoDate*

Atropine / Pralidoxime (2-PAM) Chloride IM auto-injection(s)

For self-administration in symptomatic carbamate, organophosphate, or nerve agent exposure

May repeat twice as clinically indicated

See the REMSA Calculation Chart for concentration, and adult dosage and volume

*When using the Mark I or DuoDate*

Atropine / Pralidoxime (2-PAM) Chloride IM auto-injection(s)

For symptomatic carbamate, organophosphate, or nerve agent exposure

May repeat twice prior to base hospital contact

See the REMSA Calculation Chart for concentration, and patient specific dosage and volume

**Further repetition requires a base hospital order (BHO)**
**Emergency Stabilization or Patient Management (continued)**

<table>
<thead>
<tr>
<th>EMT</th>
<th>AEMT</th>
<th>PM</th>
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</table>

**When the 0.5 mg AtroPen or 1 mg AtroPen is made available by deployment of a CDC CHEMPACK**
Atropine IM auto-injection
For symptomatic carbamate, organophosphate, or nerve agent exposure
May repeat as clinically indicated
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume

**When the 8 mg / 20 mL Vial of Atropine is made available by deployment of a CDC CHEMPACK**
Atropine IM
For symptomatic carbamate, organophosphate, or nerve agent exposure
May repeat as clinically indicated
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume

Further repetition requires a base hospital order (BHO)

**When the Diazepam 10 mg / 2 mL Autoinjector is made available by deployment of a CDC CHEMPACK**
Diazepam (Valium) IM auto-injection
For seizures associated with carbamate, organophosphate, or nerve agent exposure
May repeat twice at 15 minute intervals prior to base hospital contact
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
Further repetition requires a base hospital order (BHO)

**When the Diazepam 50 mg / 10 mL Vial is made available by deployment of a CDC CHEMPACK**
Diazepam (Valium) IM
For seizures associated with carbamate, organophosphate, or nerve agent exposure
May repeat twice at 15 minute intervals prior to base hospital contact
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
Further repetition requires a base hospital order (BHO)

**When the Pralidoxime Chloride 1000 mg / 20 mL Vial is made available by deployment of a CDC CHEMPACK**
Reconstitute the 1000 mg / 20 mL vial of Pralidoxime Chloride with 5 mL of Sterile Water to 1000 mg / 5 mL
Pralidoxime (2-PAM) Chloride IM
For symptomatic carbamate, organophosphate, or nerve agent exposure
May repeat twice prior to base hospital contact
See the REMSA Calculation Chart for concentration, and patient specific dosage and volume
Further repetition requires a base hospital order (BHO)
Do not give this concentration by IV/IQ
Return to Universal Patient Treatment Protocol
For continuing Scene Management, Emergency Stabilization, Patient Disposition, or Patient Management

<table>
<thead>
<tr>
<th>Base Hospital Orders</th>
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<tbody>
<tr>
<td><strong>When using the Mark I or DuoDate</strong></td>
</tr>
<tr>
<td>Atropine / Pralidoxime (2-PAM) Chloride</td>
</tr>
<tr>
<td>As ordered IM auto-injection(s)</td>
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<tr>
<td>For symptomatic carbamate, organophosphate, or nerve agent exposure</td>
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</table>

| **When the 0.5 mg AtroPen or 1 mg AtroPen is made available by deployment of a CDC CHEMPACK** |
| Atropine |
| As ordered IM auto-injection(s) |
| For symptomatic carbamate, organophosphate, or nerve agent exposure |

| **When the 8 mg / 20 mL Vial of Atropine is made available by deployment of a CDC CHEMPACK** |
| Atropine |
| As ordered |
| For symptomatic carbamate, organophosphate, or nerve agent exposure |

| **When the Diazepam 10 mg / 2 mL Autoinjector is made available by deployment of a CDC CHEMPACK** |
| Diazepam (Valium) |
| As ordered |
| For seizures associated with carbamate, organophosphate, or nerve agent exposure |

| **When the Diazepam 50 mg / 10 mL Vial is made available by deployment of a CDC CHEMPACK** |
| Diazepam (Valium) |
| As ordered |
| For seizures associated with carbamate, organophosphate, or nerve agent exposure |

| **When the Pralidoxime Chloride 1000 mg / 20 mL Vial is made available by deployment of a CDC CHEMPACK** |
| Pralidoxime (2-PAM) Chloride |
| As ordered |
| For symptomatic carbamate, organophosphate, or nerve agent exposure |
PURPOSE
The purpose of this policy is to set parameters for the use of physical restraint and transport of the restrained.

AUTHORITY
California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Welfare and Institutions Code - Division 5: Community Mental Health Services [5150]

Physical Restraint and Transport
Physical restraint is to be used only when necessary:

1. When a patient is a danger to others, or to him or herself.
   a. Use the minimum restraint necessary to ensure safety.

2. When the patient is transported under California Code Section 5150.
   a. Use four point wrist and ankle restraints.
   b. Take the original, complete, signed, and apparently valid 5150 form with the patient.
   c. Transport the medical patient as clinically indicated by REMSA Policy.
      i. Law enforcement may elect to meet the ambulance, follow in tandem, or ride in the patient compartment.
      ii. Law enforcement remains legally responsible for the patient during transport.
   d. Transport the non-medical patient as contracted to the most appropriate facility.

3. When the patient is transported under arrest.
   a. If restrained, but not handcuffed, law enforcement may follow the ambulance in tandem.
   b. If handcuffed, law enforcement must ride in the patient compartment of the ambulance.
      i. Do not allow handcuffing to the ambulance cot.

When wrist and/or ankle restraints are used:

1. Use only REMSA approved nylon/neoprene/Velcro wrist and/or ankle restraints.

2. Distal circulation must be assessed at least every 15 minutes.

3. Restraint may not interfere with assessment or care of the patient.
   a. Transport the retrained patient on the ambulance cot in low to high Fowler’s position.
   b. Never restrain supine or prone.
      i. Clinically indicated mechanical spinal immobilization is an exception for supine restraint.
   c. Never restrain a patient on a spine board or lifting appliance to the ambulance cot.
      i. Restrain to the spine board or lifting appliance only.
   d. Never “hog-tie” or “backboard sandwich” a patient.

OPERATIONS: General Policy (BLS/ALS Policy: 5250)

Date: 7/1/10

PATIENT CARE DOCUMENTATION STANDARDS

1. This policy sets forth the minimum requirements for such documentation with the intent that provider agencies may add to these minimums to meet the needs of their individual operations.

PURPOSE

This policy describes the minimum requirements for record keeping, data collection, the handwritten patient care report (PCR) or electronic patient care report (ePCR), and distribution of these records. Each first response agency, or combined first response and transport agency, or EMS transport service may adopt additional internal requirements in order to meet their administrative and operational needs.

AUTHORITY

California Health and Safety Code - Division 2.5: Emergency Medical Services [1797. - 1799.207.]
California Code of Regulations, Title 22, Social Security, Division 9. Prehospital Emergency Medical Services
California EMS Authority - California EMS Information System (CEMSIS)

9. PCRs must be retained by the EMS service provider agency for a minimum of seven (7) years, or, for minors, twenty (20) years of age (age of majority + 2 years), whichever is longer.

Record Keeping

Each first response agency, or combined first response and transport agency, or EMS transport service must securely create and retain EMS response records and patient care reports. These records must be retained for at least seven years, or for two years after the patient reaches the age of majority, whichever is longer. HIPAA compliance is required.

10. When requested for purposes of quality review, PCRs will be provided by an EMS service provider to the EMS Agency or the involved base hospital.
11. Timely retrospective review of PCRs is a key component of EMS system improvement.

Data Collection

EMS response records and patient care reports will be provided to the EMS Agency upon request. These records will also be provided to the base hospital giving online medical direction for a specific patient or incident upon the base hospital’s request to the first response agency, or combined first response and transport agency, or EMS transport service.

Each first response agency, or combined first response and transport agency, or EMS transport service is encouraged to use Sansio’s HealthEMS software; the EMS Agency’s contracted ePCR system. Other CEMSIS compliant ePCR systems are also compliant with the California Emergency Medical Services Information System (CEMSIS) and whose data can be integrated into the Riverside EMS data system.
require approval. The paper PCR, patient information worksheet (PIW), and any other form used for data collection must also be approved by the EMS Agency.

12. All PCRs generated by EMS personnel contain protected healthcare information. Therefore, all EMS providers shall include a HIPAA compliance program as part of their QI plan. Included in the plan will be policies for the custody and security of PCRs. The paper PCR or PIW that is transcribed into the ePCR must be handled according to each agency or service’s internal HIPAA policy.

Patient Care Reports

2. A patient care report (PCR) shall be completed for all patient contacts, except those involved in multi-casualty incidents (as defined in policy #5800, MCI Scene Management) and to which an approved triage tag is assigned. Each service provider rendering patient care shall complete their own PCR.

3. BLS providers arriving simultaneously with ALS providers of the same agency are not required to complete their own PCR if ALS personnel assume immediate care. BLS providers arriving on scene after ALS personnel do not need to complete a PCR unless they are given specific and unique responsibility for patient care in multiple patient circumstances.

4. PCRs shall be legible, accurate, and complete.

6. PCRs should be completed by the highest medically authorized person(s) directly involved with that patient’s care.

7. EMS providers will use only a Riverside County approved PCR for all patient documentation.

7.1 ePCRs will be compliant with the EMS Agency’s data system and include all mandatory data points.

A REMSA approved, legible PCR or ePCR will be completed for each patient. The person with the highest level of REMSA authorized credential, EMT, AEMT, or PM, from each first response agency, or combined first response and transport agency, or EMS transport service seeing a patient will complete a separate PCR or ePCR. Students may not participate in completing the patient care report.

2.1 A patient is defined as

2.1.1 Any person who is encountered by an authorized EMS provider functioning as part of the organized EMS system, and who meets any of the following criteria:

2.1.1.1 Has a chief complaint.

2.1.1.2 Makes a request for examination or treatment.

2.1.1.3 Has signs or symptoms of injury or illness.

2.1.1.4 Has experienced an event or is in a circumstance or situation that could reasonably lead to illness or injury.

2.1.1.5 Is disoriented or impaired and meets one of the above criteria.

2.1.1.6 Has evidenced suicidal intent.

2.1.1.7 Is dead.

2.1.1.8 Any person for whom a prehospital care provider has a medically-based index of suspicion for illness or injury.

2.2 A patient contact has occurred once EMS personnel arrive on scene and have performed any level of assessment on a patient. This includes a visual assessment.

For the purposes of this policy, a patient is defined as any person seen by an EMR, EMT, AEMT, or paramedic, during the performance of their first response or EMS transport duties, that:

1. Has experienced an event that could cause illness or injury; or

2. Is in a circumstance or situation that creates a suspicion of illness or injury; or
3. Makes a request for examination or treatment; or
4. Has a chief complaint; or
5. Has signs or symptoms of illness or injury; or
6. Has spoken of or acted toward suicide; or
7. Is dead

This definition does not apply to casualties treated under the REMSA Operational Policy for Multiple Casualty Incident (MCI) Scene Management.

2.3 A patient care report (PCR) is the legal healthcare record of any patient contact. It is the document, written or electronically generated (ePCR), that describes the assessment and treatment/response of a patient by EMS personnel.

3. A patient care report (PCR / ePCR) shall accurately and completely describe pertinent scene conditions, chief complaint or health problems of the patient, patient assessment(s), any treatment(s) given, response to treatment(s), any changes in the patient’s condition, any advisements given to the patient/family/legal guardian, and his/her disposition.

The PCR or ePCR must accurately and completely document the scene size-up, any scene management performed, the primary assessment, any emergency stabilization performed, the secondary assessment, the patient disposition, any patient management performed, and all re-assessments.

3.1 PCRs must contain the following information as mandated by the California Code of Regulations (CCR), Title 22, and the Riverside County EMS Agency:

- The date and estimated time of incident.
- The time of receipt of the call (available through dispatch records).
- The time of dispatch to the scene.
- The time of arrival at the scene.
- The time of patient contact.
- The location of the incident.
- The patient’s name; age; gender; weight, height, and address.
- Chief complaint.
- Mechanism of injury (MOI), if applicable.
- Vital signs, to include pulse, respirations, blood pressure, skin signs, capillary refill, and, if applicable, temperature.
- Pain rating (on appropriate pain scale), if applicable.
- Appropriate physical assessment.
- Pertinent medical history and medications taken.
- Allergies.
- The emergency care rendered and the patient’s response to such treatment.
- Patient disposition.
- The time of departure from scene.
- The time of arrival at receiving facility (if transported).
- The name of receiving facility (if transported).
- The name(s) and any unique EMS identifying number(s) of personnel directly involved in patient care will be included on their service provider’s PCR.
- Signature(s) of the primary care person, and, if used/applicable, the scribe.
- Entries noting procedures/treatments administered or attempted shall include time of attempt and initials of person rendering care. If the person rendering care is from a different provider, the service provider’s name may be used in place of initials.
- Entries noting any response or lack of response or any change in patient condition must be timed.
- The individual component scores for GCS and APGAR, when utilized.
- If recommended treatments or transport was/were declined, a statement to
document the explanation of possible consequences, the patient’s understanding of these consequences, and continued declination after explanation.

- The provider’s unique incident number.
- Name of base hospital contacted and time of contact, if applicable.

3.3 Documentation of assessments reported and treatments done prior to the arrival of the specific EMS unit completing the PCR may be listed as “prior to arrival” (PTA) if specific times are unknown.

5. A PCR will give a clear and chronological description of events from first contact to transfer of care.

The completed PCR or ePCR must contain the following minimal information:

1. The service date
2. The unique incident number assigned by the first response agency or EMS transport service
3. Call times including:
   a. Call received
   b. Dispatched
   c. Enroute
   d. On scene
   e. Patient contact
   f. Left scene (when transported)
   g. At destination (when transported)
   h. In service
4. Run disposition including:
   a. Name of base hospital (when applicable)
   b. Name of receiving facility (when transported)
   c. Refusals as required by protocol (when patient refuses)
   d. Other explanation of disposition as indicated
5. The incident address
6. The patient’s:
   a. Name, address, and contact information
   b. Age, gender, and weight
7. The chief complaint and history including:
   a. Signs and symptoms
   b. Allergies
   c. Medications
   d. Past medical history
   e. Last oral intake
   f. Events leading to injury or illness
8. Physical assessments and vital signs including:
   a. The time or, if performed prior to arrival, a notation of “PTA”
   b. Primary assessment and qualitative vital signs as required by protocol
   c. Secondary assessment and quantitative vital signs as required by protocol
   d. All re-assessments
   e. Other assessments as clinically indicated
9. All emergency stabilization and patient management performed including:
   a. The time or, if performed PTA, a notation of “PTA”
   b. The staff identity or, if performed PTA, the agency
   c. The treatment or medication with necessary details
   d. The number of attempts and results
10. The name and REMSA authorization number of each EMR, EMT, AEMT, or paramedic
11. The signature, or electronic identification, of the person completing the PCR or ePCR

3.2 There are rare circumstances wherein all of the above information cannot be obtained. Those circumstances include patient refusal of a hands-on assessment.
and a patient in police custody where attempting a complete assessment would create a safety hazard for personnel. In such instances, documentation of a visual assessment and whatever additional assessment parameters can be completed will be sufficient, provided an explanation of the situational restrictions is also included.

In the rare circumstances when any of the above information cannot be obtained, the PCR or ePCR must contain an explanation of the circumstances.

Addendums and revisions to the completed PCR or ePCR must clearly indicate when, what, and by whom the addition or revision was made.

8. Patient care reports are both verbal and written. Patient Care Report forms are legal healthcare documents of patient assessment, treatment, and response to treatment. PCRs shall be as complete as possible before handing a copy to the next care provider. However, when two or more providers are at the scene and patient transport must be expedited, it is expected that if care is transferred, a full verbal report will be given by the non-transporting care provider(s) and a written report will be consigned that is as complete as possible.

8.1 Information added after-the-fact, whether immediately after transferring patient care responsibilities or completing the PCR away from the scene, must be indicated as having been added after leaving the care of the patient.

8.2 Once a copy of a handwritten paper report is handed-off, any new PCR created shall be attached to the original, and both filed as part of the patient’s healthcare record by the provider.

8.2.1 Rewriting restrictions do not apply to the transference of information to an electronic PCR (ePCR).

8.3 PCRs obtained from first response units shall be taken by the transporting agency and handed off to the receiving hospital along with a copy of the transporting agency’s PCR.

Record Distribution

The PIW, PCR, and ePCR will be distributed in this manner:

1. If provided to the combined first response and transport agency, or EMS transport service, a copy of the first response agency’s PCR or PIW will be passed on to the receiving facility’s staff. HIPAA compliance is required.

2. If not using ePCR, a copy of the combined first response and transport agency or EMS transport service’s completed PCR will be provided to the receiving facility’s staff.

3. Each Sansio ePCR will be available to the applicable receiving facility by internet login.

4. First response agencies, or combined first response and transport agencies, or EMS transport services using other approved ePCR systems must make ePCR distribution arrangements that are satisfactory to each receiving facility.