The Next Meeting of PMAC is on:
Monday, September 26, 2011
9:00AM – 11:00PM
Riverside County Regional Medical Center
26520 Cactus Avenue, Moreno Valley
Rooms A1018 and A1020

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

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

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

4. **Approval of Minutes (5 Minutes)**
   4.1 June 27, 2011(Attachment A)
   4.2 July 26, 2011 Special PMAC Meeting (Attachment B)

5. **COMMITTEE / TASK FORCE DISCUSSION (45 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 Transfer TF—James Lee
   5.2 Data Collection System—Scott Moffatt
   5.3 CQI TAG—Laura Wallin (Attachment C)
   5.4 HEMS CQI—Steve Patterson, MD
   5.5 Policy Review Forum—Scott Moffatt (Handout)

6. **New Business (30 Minutes)**
   6.1 Proposal for an October PMAC meeting for discussion of Draft Policies—Scott Moffatt
   6.2 Draft 2012 PMAC Meeting Schedule—Brian MacGavin (Attachment D)
   6.3 Ventricular Assist Devices Draft Policy—Laura Wallin (Handout)
7. **Good of the Order / Announcements (10 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
   7.1 Committee Members
   7.2 Non Committee Members

8. **Next Regular Meeting / Adjournment (5 Minutes)**
   November 21, 2011
<table>
<thead>
<tr>
<th>TOPIC</th>
<th>DISCUSSION/INFORMATION</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CALL TO ORDER</td>
<td>Chair, Dr. Vaezazizi called the meeting to order at 9:00 AM.</td>
<td></td>
</tr>
<tr>
<td>2. PLEDGE OF ALLEGIANCE</td>
<td>Dr. Vaezazizi led the Pledge of Allegiance.</td>
<td></td>
</tr>
<tr>
<td>3. ROUNDTABLE INTRODUCTIONS</td>
<td>Dr. Vaezazizi began roundtable introductions.</td>
<td></td>
</tr>
<tr>
<td>4. APPROVAL OF MINUTES</td>
<td>Approval of March 21, 2011 PMAC minutes with amendment of the mentioned agenda item.</td>
<td></td>
</tr>
<tr>
<td>5. COMMITTEE / TASK FORCE DISCUSSION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.1 Prehospital Thermometer Use – Tony Ricci</td>
<td>Discussion on whether thermometers should be added for use by prehospital providers. No action.</td>
<td></td>
</tr>
<tr>
<td>5.2 Interfacility Transfer – Kent McCurdy</td>
<td>Policy 5750 - went through written comment and Dr. Ochoa’s approval. This is a new policy that combines five new policies. These new policies will require more discussion when the new regulations for critical care paramedic and advanced care paramedic are approved. No action.</td>
<td></td>
</tr>
<tr>
<td>5.3 Policy Review Forum – Scott Moffatt</td>
<td>Policy 1700 - List of Resources. Everyone was instructed to review it carefully and let REMSA know if there are any typos or changes. Policy 6010 - Universal Patient. This policy is being reviewed by the policy review forum and it will be going out for public comment following this PMAC. Policy 6015 - Scene Management of Hazardous Materials. REMSA requests that fire personnel give written comment on this policy. It was suggested to change the title of this policy to make it more reflective of an EMS policy. No action.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policy 6030 - Patient Disposition of Refusal of Treatment /Transport. Comments need to be reported to PMAC.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policy 6090 - Patient Disposition of Do Not Attempt Resuscitation – Discontinue Resuscitation. Bring back to next PMAC meeting for discussion on time frames specific to discontinuing resuscitation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policy 6091 - Patient Disposition of Prehospital Death. Policy has been edited for clarity; send any comments to Scott Moffatt via e-mail.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policy 6330 - Burns. TAC has suggested wording on patient disposition to state: That burn patients meeting critical trauma criteria will be transported to the closest trauma centers.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policy 6320 - Heat Illness and / or Hyperthermia. Subsequent to discussion on agenda item 5.1, It was suggested to have further review of the sections that refer to Emergency Stabilization or Patient Management using temperature readings of 101°F.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policy 6400 - Nausea and Vomiting. Dr. Ochoa wants Zofran IV/IM/IO and ODT to be a base hospital physician order.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Policy 6530 - Seizures. Base Hospital Physician orders are required for administering Dextrose and Glucagon by the AEMT or Paramedic on seizure patients with hypoglycemia unrelated to eclampsia.</td>
<td>No action.</td>
</tr>
</tbody>
</table>
| 5.3 Policy Review Forum – Scott Moffatt continued | **Policy 6600 - Pre-Eclampsia and Eclampsia.**  
Dextrose administration requires base hospital orders for pre-eclampsia and eclampsia. |  |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6. New Business</td>
<td>There was discussion about having additional meetings to review and discuss policies.</td>
<td></td>
</tr>
<tr>
<td>6.1 CE Policies 3100 and 4130 – Karen Petrilla</td>
<td>Changes in these policies require that all CEs be EMS related.</td>
<td>Approval for the change in recertification policy.</td>
</tr>
<tr>
<td>6.2 PMAC Policy Workshop – Scott Moffatt</td>
<td>Dr. Vaezazizi suggested better development or redesign in the presentation of policies submitted by REMSA.</td>
<td>REMSA will send out notification of additional meetings via e-mail.</td>
</tr>
<tr>
<td>6.3 Other</td>
<td>No other discussion.</td>
<td></td>
</tr>
<tr>
<td>7. Unfinished Business</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.1 Ambulance Permit Policy – James Lee</td>
<td>This policy received comments during written comment period and will be finalized by July 1, 2011.</td>
<td>Approval of Policy.</td>
</tr>
<tr>
<td>7.2 Trauma Triage Criteria – Cindi Stoll</td>
<td>There were concerns regarding the language used to determine the destination of pediatric trauma patients.</td>
<td>Referred back to REMSA for further review by TAC.</td>
</tr>
<tr>
<td>8. Announcements</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.1 Committee Members</td>
<td>Laura announced that there will be a STEMI meeting at Riverside Community Hospital on July 21, 2011. Please contact Laura Wallin if you are interested in being on the STEMI committee. Also, when you have a STEMI patient contact a STEMI Base Hospital. There will also be a PLN meeting today.</td>
<td></td>
</tr>
<tr>
<td>8.2 Non Committee Members – Britta Barton</td>
<td>There will be a disaster drill tomorrow on June 28, 2011.</td>
<td></td>
</tr>
<tr>
<td>9. Next Meeting / Adjournment</td>
<td>Next regular PMAC meeting will be on September 26, 2011.</td>
<td></td>
</tr>
<tr>
<td>TOPIC</td>
<td>DISCUSSION/INFORMATION</td>
<td>ACTION</td>
</tr>
<tr>
<td>-------</td>
<td>------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>1. CALL TO ORDER</td>
<td>Chair Dr. Vaezazizi called the meeting to order at 9:00 AM.</td>
<td></td>
</tr>
<tr>
<td>2. PLEDGE OF ALLEGIANCE</td>
<td>Dr. Vaezazizi led the Pledge of Allegiance.</td>
<td></td>
</tr>
<tr>
<td>3. ROUNDTABLE INTRODUCTIONS</td>
<td>Dr. Vaezazizi began roundtable introductions.</td>
<td></td>
</tr>
<tr>
<td>4. DRAFT POLICY REVIEW AND DISCUSSION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.1 Policy 6000 - Introduction to Protocols</td>
<td>Discussions from the written comment period were reviewed. Policy 6000 - Introduction to Treatment Protocols is the basis of all treatment protocols.</td>
<td>PMAC unanimously approved of Policy 6000.</td>
</tr>
<tr>
<td>4.2 Policy 6010 - Universal Patient</td>
<td>This policy applies to all EMRs, EMTs, AEMTs and PMs.</td>
<td>Approved with amendments.</td>
</tr>
<tr>
<td>4.3 Policy 6011 - Calculation Chart</td>
<td>This policy uses a calculation chart to help prevent medication errors in conjunction with the Broselow Tape.</td>
<td>Approved with amendments.</td>
</tr>
<tr>
<td>4.4 Policy 6020 - Physician on Scene Assuming Responsibility</td>
<td>This policy provides direction for EMS personnel when a physician arrives on scene wishing to assume patient care responsibility.</td>
<td>Approved.</td>
</tr>
<tr>
<td>4.5 Policy 6030 - Refusal of Treatment and or Transportation</td>
<td>This policy defines who can refuse treatment and/or transport. Refusal of transport is only made by the patient, parent or designee.</td>
<td>Approved with recommended changes.</td>
</tr>
<tr>
<td>4.6 Policy 6090 - Do not Attempt Resuscitation / Discontinue Resuscitation</td>
<td>This policy provides direction on when not to attempt resuscitation or when to discontinue resuscitation.</td>
<td>Approved with recommended changes.</td>
</tr>
<tr>
<td>4.7 Policy 6091 - Prehospital Death</td>
<td>This policy gives direction on what to do when the decision has been made to discontinue or not attempt resuscitation.</td>
<td>A recommendation was approved to send back to committee for more work.</td>
</tr>
<tr>
<td>4.8 Policy 6300 – Burns</td>
<td>Concerns were expressed that burn patients should be treated at local EDs before being transferred to the burn center.</td>
<td>Approved with recommended changes.</td>
</tr>
<tr>
<td>5. BREAK</td>
<td>Scheduled break was declined by PMAC.</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>--------------------------------------</td>
<td></td>
</tr>
<tr>
<td>6. DRAFT POLICY REVIEW AND DISCUSSION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1 Policy 6320 – Heat Illness and / or Hyperthermia</td>
<td>This policy is based on heat illness and hyperthermia.</td>
<td>Approved.</td>
</tr>
<tr>
<td>7. THE FOLLOWING AGENDA ITEMS HAVE BEEN DEFERRED UNTIL THE NEXT MEETING:</td>
<td>Scheduled for review at the next scheduled PMAC meeting.</td>
<td></td>
</tr>
<tr>
<td>Policy 6400-Nausea/ Vomiting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy 6530-Seizures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy 6600-Pre-Eclampsia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy 6700-Overdose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy 6710-Toxic Exposure, Inhalation or Ingestion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. NEXT MEETING / ADJOURNMENT</td>
<td>AUGUST 23, 2011</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meeting adjourned by Dr. Vaezazizi at 12:00 P.M.</td>
<td></td>
</tr>
</tbody>
</table>
Performance Standard 9013

<table>
<thead>
<tr>
<th>Date</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2009</td>
<td>October 2011</td>
</tr>
</tbody>
</table>

12-Lead Electrocardiogram (ECG)  
Approval: EMS Medical Director  
Humberto Ochoa MD  
Signature  
Applies To: ALS Provider Agencies  
Approval: EMS Agency Director  
Bruce Barton, CCEMT-P  
Signature

Purpose
To identify guidelines for the acquisition, interpretation and transmission of a 12 Lead ECG in the prehospital setting.

12 Lead Inclusion Criteria
1. A 12 Lead ECG shall be performed when a patient presents with signs or symptoms suggestive of Acute Coronary Syndrome, including but not limited to:
   a. Chest Pain  
   b. Discomfort or tightness radiating to the jaw, shoulders, or arms  
   c. New onset cardiac dysrhythmias (including adult cardiac arrest, if return of spontaneous circulation)  
   d. Complaints of palpitations  
   e. Diaphoresis inconsistent with environment  
   f. Dyspnea  
   g. Syncope, near syncope, or dizziness  
   h. Known treatment for Acute Coronary Syndrome (ACS)  
   i. Epigastric pain  
   j. General weakness  
   k. Congenital heart problems  
   l. Any patient the paramedic feels would benefit from a 12 Lead ECG assessment

Before performing a 12 Lead ECG on a patient, paramedics must: ¹, ²:
1. Explain the procedure to the patient.  
2. Properly clean and prepare the patient’s skin.  
   a. Care must be taken in patients with sensitive skin.  
3. Properly apply electrodes to the prepared skin of the patient.  
   a. Attach the lead wire to each electrode before applying the electrode for patient comfort.

---

¹ ECG Interpretation: How to obtain a good quality ECG, Lancashire and South Cumbria Cardiac Network  
² Improving ECG Quality, Philips Healthcare
b. Place electrodes on flat, fleshy parts of the arms and legs, avoiding bony areas and major muscles if possible to minimize muscle and motion-related artifact and maximize the ECG signal strength.

c. Apply the electrode by pressing around the entire edge of the electrode. Avoid pressing directly on the electrode center since it spreads the gel out and may create air pockets that contribute to artifact.
   i. Note: If you are using multifunction electrode defibrillator pads, you may need to reposition ECG electrodes to allow for correct pad placement to facilitate pacing or defibrillation therapy.

d. ECG precordial leads shall be placed as indicated below:
   i. V1: right 4\textsuperscript{th} intercostal space, immediately adjacent to sternum
   ii. V2: left 4\textsuperscript{th} intercostal space, immediately adjacent to sternum
   iii. V4: left 5\textsuperscript{th} intercostal space, mid-clavicular line
   iv. V3: halfway between V2 and V4
   v. V6: horizontal to V4, mid-axillary line
   vi. V5: horizontal to V4, anterior axillary line

e. Limb leads should be placed as per manufacturer’s directions.

While performing a 12 Lead ECG on a patient, paramedics must:

1. 12-lead ECG should be done early in the call, and early transport should be considered when a STEMI is identified.\(^3\)
   a. If possible, ECG should be obtained prior to administration of medications.
   b. Note on ECG if patient has received medications prior to ECG.

\(^3\) Implementation and Integration of Prehospital ECGs into Systems of Care for Acute Coronary Syndrome, AHA Scientific Statement, August 13, 2008, Ting, HH; Krumholz, HM; Bradley, EH; Cone, DC; Curtis, JP; Drew, BJ; French, WJ; Gibler, WB; Goff, DC; Jacobs, AK; Nallmothu, BK; O’Connor, RE; Schuur, JD
2. In suspected cardiac patients, paramedics should acquire ECG prior to beginning transport.
3. In order to record a good quality ECG the patient must be as relaxed and comfortable as possible.
   a. Ensure privacy for the patient.
   b. Cover the patient with a sheet or blanket once leads have been placed to reduce shivering and ensure privacy.
4. Instruct the patient to breathe normally and not speak during the acquisition of the ECG. Note patient’s position on ECG recording strip.
5. Acquire ECG tracing as per manufacturer’s directions.
6. If the ECG tracing quality precludes a good interpretation, the tracing should be repeated.

12 Lead ECG Transmission Criteria
1. Transmit all 12 lead ECGs where the machine reads, **Acute MI Suspected** or equivalent
   a. “Infarct suspected, age indeterminate” usually indicates an MI in the patient’s past, and is usually not considered to be an Acute MI.
2. Transmit ECGs interpreted by paramedics as acute MI, even if the machine does not read **Acute MI Suspected** or equivalent
3. Transmit any ECGs that the paramedic has questions or concerns about.
4. Transmit any ECGs requested by the Base Hospital.
5. STEMI Base Hospital contact is mandatory for all patients identified as possible STEMI patients.
   a. In addition to standard ALS reporting format, include:
      i. Interpretation of the 12 Lead ECG:
         1. Machine interpretation
            a. If the paramedic disagrees with machine interpretation, include that information in the report.
         2. Tell the STEMI Base Hospital exactly what you are seeing on the ECG.
         3. Include the underlying rhythm and width of the QRS complex in the report.
      ii. If a standard treatment, such as aspirin, oxygen, or nitroglycerine was withheld, include this information along with an explanation why it was withheld.
      iii. Family history of heart disease
      iv. Patient’s local cardiologist/local PMD
      v. Any request for orders.
vi. ETA to closest Paramedic Receiving Center and to closest STEMI Receiving Center.

   b. Once a patient is identified as a STEMI patient, the focus must be on rapid transport to the nearest STEMI Receiving Center, as directed by the STEMI Base Hospital, while still ensuring optimal patient care en route.

   c. Once the STEMI Receiving Center has assumed care of the patient, complete the first section of the Suspected ST Elevation MI (STEMI) Report form and hand it to the MICN or accepting nurse at the STEMI Receiving Center.

      i. The Suspected STEMI Report form shall be completed for all patients transported to a STEMI Receiving Center with a suspected STEMI.

Once the hospital has assumed care of the patient, the paramedic must:

   1. Give one copy of the PCR to the MICN or accepting nurse.
   2. Give all 12-Lead ECG printouts to the MICN or accepting nurse. Ensure that each printout is identified with the patient’s name, and that the date/time stamps are correct.
      a. The paramedic should make copies of the 12 Lead ECG and attach to his/her copy of the PCR.

Critical Success Targets for 12-Lead ECG

   1. Appropriately identify patients meeting criteria for obtaining a 12-Lead ECG.
   2. A diagnostic quality ECG will be obtained on above patients.
   3. Results of ECG will be communicated to an appropriate hospital.

System Benchmark

% of patients meeting specific criteria have a diagnostic quality ECG performed.

Applicable Protocols

   6010 Universal Patient
   7200 Cardiac Chest Discomfort
Core Competency Requirements to be covered during education/training:

1. Explain the placement and view of the heart provided by bipolar, unipolar (augmented) and precordial ECG leads.
2. Discuss QRS axis deviation and the effects of body position on the axis.
3. Explain the evolution and localization of acute myocardial infarction.
4. Discuss/define five STEMI “mimics” or imposters.
5. Explain prehospital 12-Lead ECG monitoring procedure.
6. Describe the importance of skin preparation prior to the application of the electrodes.
7. Describe the proper placement of precordial and limb leads for a 12-Lead ECG.
8. Discuss trouble shooting the ECG machine.
9. Describe methods to decrease artifact on the 12-Lead ECG.
10. Discuss the importance of providing privacy for the patient while performing a 12-Lead ECG.
11. Describe the criteria for interpreting a 12-Lead ECG as a STEMI.
12. Describe the step-by-step process of interpreting ECGs.

Adjunctive Performance Standards
Patient Assessment

Equipment Requirements

1. PPE
2. Single-use razor
3. Sharps container
4. 12-Lead ECG machine
5. Electrodes
6. Sheet or blanket

---

4 “Paramedic Care Principles & Practice”, Volume 3, Third Edition, Bledsoe, Porter, Cherry
## Performance Standard 9013

<table>
<thead>
<tr>
<th>Date</th>
<th>Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2009</td>
<td>October 2011</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12-Lead Electrocardiogram (ECG)</th>
<th>Approval: EMS Medical Director Humberto Ochoa MD</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applies To: ALS Provider Agencies</td>
<td>Approval: EMS Agency Director Bruce Barton, CCEMT-P</td>
<td>Signature</td>
</tr>
</tbody>
</table>

**Instructor Resource Materials**

3. Rapid Interpretation of EKG’s, 6th Edition, Dale Dubin, MD
Draft PMAC Meeting Schedule 2012

Wednesday, January 25 from 9:00 AM to 12:00 PM

Monday, March 19 from 9:00 AM to 12:00 PM

Monday, June 18 from 9:00 AM to 12:00 PM

Monday, September 24 from 9:00 AM to 12:00 PM

Monday, November 5 or Monday, November 26 from 9:00 AM to 12:00 PM

All meetings will be held at the Riverside County Regional Medical Center
26520 Cactus Avenue, Moreno Valley
Rooms A1018