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INLAND COUNTIES EMERGECY MEDICAL AGENCY

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February 18, 2003

Nancy Steiner
EMSA
1930 9th Street, Suite 100
Sacramento, CA 95814-7043

Dear Ms. Steiner:

Please accept this letter as a formal request for an EMT-I Advanced Scope of Practice Trial Study by Inland Counties Emergency Medical Agency and San Bernardino County Sheriff's West Valley Search and Rescue. This Trial Study is much like previous advance scope trial studies approved by EMDAC with minor modifications.

This study will involve certain advanced scope procedures in which EMT-Is will be trained and tested to perform during the rescue of individuals in rural areas where there is minimal or no radio contact. Enclosed you will find the complete proposal and a request for approval of these procedures.

If you have any questions, please contact Sarah Momsen RN, at (909) 388-5814 or via e-mail at Smomsen@dph.sbcounty.gov.

Sincerely,

Conrad Salinas, MD
ICEMA Medical Director

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INTRODUCTION:

The population base for the County of San Bernardino is approximately 2 million. The geographic area covers 20,106 square miles, of which 90% is desert, with 75% of the population living in non-desert urban areas. Within this geographic area is the San Bernardino National Forest, Joshua Tree National Monument, Death Valley National Monument and several state parks and recreational areas.

With the vast amount of rural and wilderness areas in the county, a need has been recognized for a higher level of prehospital care than is currently available in these remote areas.

The County of San Bernardino draws large numbers of visitors and users of the recreational areas. With elevations ranging from below sea level (Death Valley) to mountain peaks rising to nearly 13,000 feet (San Gorgonio Peak), this results in the propensity of some of these individuals to become lost and or injured. Current trends in the county indicate that the number of people that will require rescue will rise from nearly 200 to well over 300 per year.

By state constitution, the sheriffs department is tasked with the responsibility of providing Search and Rescue for the unincorporated areas of the county. In San Bernardino County, the actual Search and Rescue operations are provided by a handful of well-trained and certified search and rescue teams.

Statistics show that most call outs of rescue teams occur in the late afternoon and evening hours or when adverse weather conditions exist. The actual injuries are often incurred hours prior to the request for a Search and Rescue team. This delay or environmental conditions may limit or preclude the use of rescue helicopter resources.

The typical search and rescue operation may last longer than twelve hours. This may include several hours to hike into the wilderness area, provide the necessary rescue procedures (high angle rope, ice climbing etc), and hand carry the injured individual several miles to a location that can be reached by a ground ambulance or other ALS provider.

In summation, the nature of Search and Rescue predisposes to long response times to patient access and prolonged extrications. Coupled with a lack of qualified wilderness ALS providers, the need for advanced skills is noted and desired to reduce the morbidity and mortality of individuals utilizing the recreational areas of San Bernardino County.

NAME OF PROPOSED PRODEDURE OR MEDICATION:

EMT-I advanced scope of practice would include:

1. Endotracheal intubation
2. Injections (subcutaneous, intramuscular, intravenous)
3. Oral medication administration
4. Determination of blood glucose level via fingerstick
5. Peripheral intravenous access
6. Determination of Death
7. Clearance of Spine/Transport without Immobilization
8. Medications
    - Albuterol nebulized (Proventil)
    - Aspirin
    - Dextrose 50%
    - Diphenhydramine (Benadryl)
    - Epinephrine via EpiPen or similar device
    - Glucagon
    - Naloxone (Narcan)
    - Nitroglycerin (NTG) spray
    - Oxygen
    - Prednisone

MEDICAL CONDITIONS:

The advanced EMT-I scope of practice will be used in the clinical conditions that warrant treatment under the following treatment protocols:

TS01 Allergic Reaction and/or Anaphylaxis
TS02 Altered Mental Status
TS03 Cardiopulmonary Arrest
TS04 Chest Pain (suspected cardiac origin)
TS05 Dehydration
TS06 Near Drowning/Drowning
TS07 Respiratory Distress
TS08 Trauma

PATIENT POPULATION:

Individuals who meet the parameters of the Treatment Protocols and with whom West Valley Search and Rescue have contact with during rescue operations.

RELEVANT STUDIES:

There is a growing recognition that advanced skills may be performed, at least to a limited extent, by basic personnel. The use of the automated external defibrillator (AED) was recently determined to be included within the EMT-I's basic scope of practice. The Inland Counties Emergency Medical Agency (ICEMA) has also included the use of an Esophageal -Tracheal Airway Device (ETAD) as an optional skill for EMT-I's. West Valley Search and Rescue is both an AED and ETAD provider.

Recent trial studies by Northern California EMS, Napa County EMS and Imperial County EMS Agencies have shown the benefit of having EMT-I's with advanced skills in the rural setting. These studies indicate that the advanced EMT-I's are able to accurately assess patients and successfully provide advanced procedures well before ALS would otherwise be available. The patients' conditions were improved by advanced EMT treatments. Quality improvement programs in conjunction with continuing education have modified and improved provider performance in these studies.

The ability of EMT's to successfully perform endotracheal intubations has been demonstrated by the Hayward Fire Department in Alameda County. The Hayward Fire Department has developed an extensive training program for endotracheal intubations by EMT's, including frequent educational updates and skills tests, and a detailed CQI program. As a result, the Hayward Fire Department has an 87% success rate of EMT intubations since the program was established in 1996.

Previous studies have also shown the success and benefit of peripheral intravenous access by EMT-I's. An 18-month trial study on the use of peripheral intravenous access by EMT-I's was conducted by ICEMA beginning in September 1996. Success rate for establishment of peripheral intravenous access by advanced EMT-I's was 89% (25/28). A similar trial study in Sierra County from October 1995 to August 2000 also demonstrated a high success rate of intravenous access by advanced EMT-I's.

A recent study defining the ability of prehospital care providers to correctly identify those patients requiring cervical spine immobilization after blunt trauma was published in the New England Journal of Medicine. This study demonstrated that prehospital care providers, utilizing a specific set of clinical criteria, were 99% accurate in identifying which patients required cervical spine immobilization. (Hoffman JR, et al: Validity of a set of clinical criteria to rule out injury to the cervical spine in patients with blunt trauma. National Emergency X-Radiography Utilization Study Group. New England Journal of Medicine, July 2000).

A recent paper in Academic Emergency Medicine reported that EMT's using AED's were able to successfully follow a termination-of-resuscitation guideline for out-of-hospital cardiac arrests. (Verbeek, et al: Derivation of a termination-of-resuscitation guideline for emergency medical technicians using automated external defibrillators. Academic Emergency Medicine, July 2002).

PROPOSED STUDY DESIGN:

All individuals selected will be certified EMT-I's and members of West Valley Search and Rescue. They must also have completed the optional skill training and be certified in the use of the esophageal-tracheal airway device. It is anticipated that the initial class will include approximately 15 EMT's.

Didactic education will total 60 hours, followed by a clinical requirement of sixteen (16) hours (two – 8 hour shifts) in a hospital emergency department and additional time in a hospital operating room with a minimum of four (4) live intubations. There will also be a field requirement of sixteen (16) hours (two – 8 hour shifts) with an ALS unit and paramedic preceptor. The EMT must successfully complete five ALS field contacts. A summary of the lesson plans is attached.

We anticipate that the EMT-I's trained in the advanced scope of practice will respond to the majority of search and rescue calls in the county of San Bernardino. The advanced EMT-I's will initiate the trial study's ALS procedures using standing order protocols. After rescue of the patient, if arrangements have not been made for ALS transport to the hospital, then the EMT's may arrange for a rendezvous with an ALS ground ambulance or EMS aircraft. A smooth and orderly transfer of patient care shall be made to the transporting ALS unit. Patients generally will be transported to San Antonio Community Hospital in

Upland or to either nearby trauma center, Arrowhead Regional Medical Center (Colton) and Loma Linda University Medical Center (Loma Linda).

Continuing education oversight will be provided by the West Valley Search and Rescue medical director and QI coordinator (see Continuing Education requirements). The trial study will continue for 18 months and then be evaluated for extension. All required reports will be reviewed by the Quality Improvement Committee, ICEMA Regional Quality Improvement Committee and the EMS Agency Medical Director prior to submission to the State EMS Authority.

The program effectiveness will be evaluated in several ways:

1. The participating EMT-I's retention of knowledge, assessment of skills and skill performance will be evaluated by mid-term and final exams as well as post-tests after initial and continuing education. Exams and post-tests must be submitted for approval by the EMS Agency Medical Director prior to testing.
2. All patient contacts will be reviewed to evaluate EMT performance. There will be an evaluation of patient assessment, including congruence with subsequent paramedic and hospital diagnosis, documentation, appropriateness and performance of field interventions, including whether interventions were actually performed when indicated.
3. Patient response, measured by change in vital signs, patient assessment and outcome.
4. For all cases, the estimated time interval will be recorded that ALS would have been provided without the availability of the EMT with advanced skills to care for the patient.

MEDICAL CONTROL:

Medical control will be through the specific EMT-I advanced scope of practice Treatment Protocols (attached). All patient contacts will be reviewed by the medical director/QI Committee within seven days of occurrence. West Valley Search and Rescue Trial Study Reviews will be forwarded within fourteen days of occurrence for further review by the EMS Agency Medical Director and the EMS Agency staff.

ICEMA will establish policies and procedures regarding certification, continuing education, data collection and other operational procedures.

TRAINING AND COMPETENCY TESTING:

Training will follow the attached lesson plan objectives. Qualified physicians, nurses (RN's), and paramedics will conduct the training sessions. Competency testing, both written and skills examinations, will be included in the training program. There will be both hospital clinical time and field preceptorship time, as outlined above. Training curriculum is available on request.

MEDICAL ADVISORY COMMITTEE:

It is anticipated that the trial study will be submitted, reviewed, and endorsed by the Medical Advisory Committee appointed by the local EMS Agency Medical Director.

TRIAL STUDY
EMT-I ADVANCED SCOPE OF PRACTICE
INLAND COUNTIES EMERGENCY MEDICAL AGENCY
WEST VALLEY SEARCH AND RESCUE

TREATMENT PROTOCOLS

I. EMT-I's using the advanced scope of practice will be utilizing standing order protocols. Due to the nature of the response areas (mountainous terrain, etc) and the rescue situation, radio or telephone communications will be impractical if not impossible.

II. EMT-I's using the advanced scope of practice will document on the patient care report form any treatment initiated on standing orders and will complete the Advanced Skill Documentation Form (see Appendix A).

III. Definitions:
Pediatric patient = any patient 8 years of age or younger, or the appearance of.

IV. Pediatric weights will be determined by use of the Broselow Tape.

ALLERGIC REACTION/ANAPHYLAXIS

CRITERIA

Apparent allergic reaction with wheezing, threatened airway, hypotension or shock.

PROTOCOL

1. Personal Protective Equipment.
2. Institute and/or maintain BLS procedures.
3. Epinephrine (1:1000) 0.3 mg SQ via EpiPen. Use caution for patients over age 40, and/or heart disease, hypertension.
4. May repeat Epinephrine (1:1000) 0.3 mg SQ in 5 minutes if condition worsens or in 15 minutes if condition does not improve.
5. Albuterol 5.0 mg via hand-held nebulizer for wheezing. May repeat albuterol nebulizer treatments as needed.
6. Benadryl 50 mg po. May repeat in 1 hour if not improved.
7. Establish peripheral intravenous access. If patient's systolic blood pressure < 90mm Hg, then give a bolus of 500 cc normal saline. May repeat the fluid bolus as needed to sustain a BP of >90 mm Hg systolic. Monitor lung sounds and decrease flow rate as needed.
8. Prednisone 40 mg po.

PEDIATRIC DOSE (use Broselow Tape)

1. If pediatric patient is >15 kg, then give epinephrine (1:2000) 0.15 mg SQ via EpiPen Jr.
2. Albuterol 2.5 mg via hand-held nebulizer or blow-by mask nebulizer.
3. If pediatric patient is 12.5 - 24 kg, then give Benadryl 12.5 mg po.
   If pediatric patient is > 25 kg, then give Benadryl 25 mg po.
4. Prednisone 20 mg po.

ALTERED MENTAL STATUS

CRITERIA

Unresponsive (comatose), slow to respond (obtunded), responds with unintelligible sounds, inappropriate words, confusion and/or agitation.

PROTOCOL

1. Personal Protective Equipment
2. Institute and/or maintain BLS procedures.
3. Obtain blood by fingerstick and analyze blood sample via glucose stick.

FOR SUSPECTED HYPOGLYCEMIA

1. Establish peripheral intravenous access.
2. Dextrose 50% 25 gm IV if blood sugar < 80 or unobtainable (if patient presents with altered mental status and unable to swallow).
3. Glucagon 1 mg IM if blood sugar < 80 or unobtainable and peripheral intravenous access cannot be established.
4. If patient has blood sugar < 80 but is alert and can swallow, give oral glucose 15 gm in gel solution (prepackaged, single dose).

FOR SUSPECTED NARCOTIC OVERDOSE

1. Naloxone (Narcan) 2 mg IV in patients with depressed respirations (<12/min), pinpoint pupils and/or circumstantial evidence of drug use.
2. If no peripheral intravenous access, then Naloxone 2 mg IM. May repeat as needed.

PEDIATRIC DOSE

1. Dextrose 0.5 – 1.0 gm/kg IV
2. Glucagon 0.5 mg IM < 1 year of age
   Glucagon 1.0 mg IM > 1 year of age
3. Naloxone 0.1 mg/kg IM or IV (maximum of 2 mg). May repeat as needed.

CARDIOPULMONARY ARREST (NON-TRAUMATIC)

CRITERIA

Confirmed unconscious, non-breathing and pulseless.

PROTOCOL

1. Personal Protective Equipment
2. Refer to Determination of Death on Scene policy – if appropriate.
3. Institute and/or maintain BLS procedures.
4. Apply AED and perform defibrillation as indicated.
5. Establish and maintain airway patency with basic airway adjuncts as per protocol.
6. Intubate with endotracheal tube.
7. If intubation unsuccessful after 3 attempts, insert esophageal-tracheal airway device.
8. Establish peripheral intravenous access.

CHEST PAIN (SUSPECTED CARDIAC ORIGIN)

CRITERIA

Typical symptoms of cardiac pain: "pressure" or "squeezing" pain, with or without radiation to arms or jaw. Patient may or may not have associated signs and symptoms of shortness of breath, nausea/vomiting, diaphoresis, or dizziness.

PROTOCOL

1. Personal Protective Equipment
2. Institute and/or maintain BLS protocols.
3. Establish peripheral intravenous access.
4. Nitroglycerine 0.4 mg metered dose oral spray for pain. May repeat every 5 minutes as long as blood pressure remains >90 mm Hg systolic.
5. Two chewable, non-enteric coated, baby aspirin (81 mg each tab X 2 tabs = 162 mg total dose).

DEHYDRATION

CRITERIA

Typical symptoms of dehydration: thirst, dry mucous membranes, poor skin turgor, sunken eyes and/or history of prolonged environmental exposure without sufficient intake of fluids.

PROTOCOL

1. Personal Protective Equipment
2. Institute and/or maintain BLS procedures.
3. Establish peripheral intravenous access.
4. If patient's systolic BP < 90 mm Hg, then give bolus of 500 cc normal saline. May repeat the fluid bolus as needed to sustain a BP of >90 mm Hg systolic. Monitor lung sounds and decrease flow rate as needed.
5. If patient's systolic BP > 90 mm Hg, then give bolus of 250 cc of normal saline. May repeat the fluid bolus as needed for continued clinical appearance of dehydration. Monitor lung sounds and decrease flow rate as needed.

PEDIATRIC DOSE (use Broselow Tape)

In pediatric patient, give 20 cc/kg fluid bolus for change in central/peripheral pulses, limb temperature transition, altered level of consciousness and/or systolic BP < 80 mm Hg. May repeat fluid bolus as needed.

NEAR DROWNING / DROWNING

CRITERIA

Obvious

PROTOCOL

1. Personal Protective Equipment
2. Institute and/or maintain BLS procedures, with spinal immobilization if appropriate.
3. If full arrest, begin CPR per protocol. If respiratory arrest with pulse, begin ventilation.
4. Establish and maintain airway patency with basic airway adjuncts per protocol.
5. Intubate with endotracheal tube with inline spinal immobilization.
6. If intubation unsuccessful after 3 attempts, insert esophageal-tracheal airway device.
7. Establish peripheral intravenous access.
8. If patient has spontaneous respiration and is conscious:
   Albuterol 5.0 mg via nebulizer for wheezing.

PEDIATRIC DOSE

Albuterol 2.5 mg via hand-held nebulizer or blow-by mask nebulizer

RESPIRATORY DISTRESS

CRITERIA

Shortness of breath or difficulty breathing

PROTOCOL

1. Personal Protective Equipment
2. Institute and/or maintain BLS procedures.

UNCONSCIOUS WITH APNEA / INEFFECTIVE RESPIRATIONS

1. Personal Protective Equipment
2. Institute and/or maintain BLS procedures.
3. Intubate with endotracheal tube if unconscious.
4. If intubation unsuccessful after 3 attempts, insert esophageal-tracheal airway device.
5. Establish peripheral intravenous access.

RESPIRATORY DISTRESS SUSPECTED CARDIAC (CHF) ETIOLOGY

1. Personal Protective Equipment
2. Institute and/or maintain BLS procedures.
3. Establish peripheral intravenous access.
4. Nitroglycerin 0.4 mg metered dose oral spray for relief every 5 minutes as long as BP remains > 90 mm Hg systolic.

RESPIRATORY DISTRESS WITH BRONCHOSPASM (SUSPECT ASTHMA, COPD, TOXIC SUBSTANCE [SMOKE, GAS] INHALATION

1. Personal Protective Equipment.
2. Institute and/or maintain BLS procedures.
3. Albuterol 5.0 mg via hand-held nebulizer. May continue treatment for distress as needed.
4. Epinephrine (1:1000) 0.3 mg SQ via EpiPen if patient < 40 years old.
5. Prednisone 40 mg po.
6. Establish peripheral intravenous access.

PEDIATRIC DOSE (use Broselow Tape)

1. Albuterol 2.5 mg via blow-by mask nebulizer or hand-held nebulizer. May continue nebulizer treatment for severe distress as needed.
2. If pediatric patient is >15 kg, then give epinephrine (1:2000) 0.15 mg SQ via EpiPen Jr. if the child is unable to cooperate with inhaled albuterol nebulizer treatment or child's respiratory status deteriorates.
3. Prednisone 20 mg po.

TRAUMA

CRITERIA

Patient who has sustained any physical trauma.

PROTOCOL

1. Personal Protective Equipment
2. Institute and/or maintain BLS procedures.
3. Establish peripheral intravenous access.
4. If patient's systolic BP < 90 mm Hg, then give a bolus of 500 cc of normal saline. May repeat the fluid bolus as needed to sustain a BP of >90 mm Hg systolic. Monitor lung sounds and decrease flow rate as needed.

PEDIATRIC DOSE (use Broselow Tape)

In pediatric patient, give 20 cc/kg fluid bolus for systolic BP < 80 mm Hg. May repeat fluid bolus as needed.

ORAL ENDOTRACHEAL INTUBATION – ADULT

PRIORITIES:

1. ABC's
2. Monitor changes in cardiac status.
3. Periodic reassessment of airway.

FIELD ASSESSMENT/TREATMENT INDICATORS:

1. Non-responsive and apneic
2. Cardiac arrest (including traumatic full arrest)
3. Agonal or failing respirations, no gag reflex and non-responsive
4. When prolonged ventilation is required and adequate ventilation cannot otherwise be achieved.

RELATIVE CONTRAINDICATIONS:

1. This method of intubation is to be used cautiously on patients with obvious or suspected cervical spine injury.
2. Intubation may be initially contraindicated on patients that are known diabetics or heroin overdose cases prior to administration of dextrose or naloxone.

PROCEDURE:

1. Assure and maintain airway patency. Use in-line cervical immobilization as needed for suspected head or neck injury.
2. Support ventilations with appropriate basic airway adjuncts. Cricoid pressure should be applied prior to intubation to protect against regurgitation of gastric contents.
3. Place on cardiac monitor and pulse oximeter.
4. Patient must be pre-oxygenated prior to intubation attempt.
5. Position the patient by placing the head in the "sniffing position" and stop CPR if in progress. Contraindicated in suspected cervical spine injury. In the trauma patient, the neck should be maintained in a neutral position to facilitate in-line axial stabilization.
6. Visualize the epiglottis and vocal cords with the laryngoscope. Insert the endotracheal tube until the entire balloon is 2 cm past the vocal cords. Inflate the balloon with air to the point where no air leak can be heard, and resume ventilation with 100% oxygen. Attach end-tidal CO_2 device.
7. Assure correct tube position by observing chest expansion with ventilation and by noting adequate breath sounds and absence of gastric sounds. Also note end-tidal CO_2 and pulse oximeter readings.
8. Placement efforts must stop after twenty (20) seconds. Immediately re-oxygenate the patient before another attempt.
9. Reinsert an oral airway to prevent the patient's biting the endotracheal tube. Secure the endotracheal tube in place.
10. Suction the trachea if necessary observing appropriate aseptic techniques.

11. Manually ventilate with sufficient pressure to expand chest. Auscultate to assure complete expiration and constantly monitor for correct tube placement by end-tidal CO_2 and pulse oximetry.
12. If intubation unsuccessful after 3 attempts, insert esophageal-tracheal airway device.

DOCUMENTATION:

1. The Advanced Skills Documentation Form will be initiated by the EMT-I providing the advanced skill. The form must be signed by the ALS provider accepting responsibility for continued care of the patient. The form will be reviewed by the medical director/QI coordinator for any necessary follow-up. The form will be then forwarded to ICEMA and the EMS Medical Director.
2. In the event the receiving clinician discovers the device was improperly placed, an Incident Report must be filed and forwarded to ICEMA within forty-eight (48) hours by the medical director/QI coordinator.

ESOPHAGEAL-TRACHEAL AIRWAY DEVICE (COMBITUBE / COMBITUBE SA)

PRIORITIES:

1. ABC'S
2. Monitor changes in cardiac status.
3. Periodic reassessment of airway.

FIELD ASSESSMENT/TREATMENT INDICATORS:

1. Non-responsive and apneic
2. Cardiac arrest (including traumatic full arrest)
3. Agonal or failing respirations, no gag reflex and non-responsive
4. When prolonged ventilation is required and adequate ventilation cannot otherwise be achieved.
5. Over 15 years of age *AND* at least 5 feet tall **(for Combitube SA height range is 4 feet to 5 feet 6 inches)**.

ADDITIONAL CONSIDERATIONS:

1. Use when BVM management is not adequate or effective.
2. Endotracheal intubation has been attempted and is unsuccessful.
3. The ETAD should not be removed unless there is a malfunction.

CONTRAINDICATIONS:

1. Known ingestion of caustic substances
2. Suspect foreign body airway obstruction
3. Facial and/or esophageal trauma
4. Patients with known esophageal disease (cancer, varices, surgery, etc.)

RELATIVE CONTRAINDICATIONS:

1. This method of intubation is to be used cautiously on patients with obvious or suspected cervical spine injury.
2. Intubation may be initially contraindicated on patients that are known diabetics or heroin overdose cases prior to administration of dextrose or naloxone.

PROCEDURE:

1. Pre-oxygenate patient prior to insertion, then lubricate distal end of device with water-soluble lubricant.
2. Attach right angle emesis deflector to lumen #2.
3. Perform tongue/jaw lift and gently insert device in mid-line until teeth are between the double black rings.

4. Inflate pharyngeal cuff (#1) with 100 cc's of air (85cc for SA) and remove syringe.
5. Inflate distal cuff (#2) with 15 cc's of air (12cc for SA) and remove syringe.
6. Attach bag valve device to lumen #1 (esophageal) and ventilate. Verify placement by:
   a. Rise and fall of the chest
   b. Bilateral breath sounds
   c. Absent epigastric sounds.
   d. Colormetric end-tidal CO2 detector

   If the above criteria are met, you may continue to ventilate through lumen #1. If breath sounds are absent and epigastric sounds are present, remove bag valve and ventilate through lumen #2 (tracheal). Additional tube placement verification may be done with pulse oximetry. If unable to confirm placement with absent breath sounds from either lumen, reposition tube slightly and try again. If still unsuccessful, remove ETAD and continue to use a bag valve mask with either an OPA or NPA.
7. ETAD placement may be attempted two times.
8. If resistance is met when advancing the tube, then the attempt should be discontinued.

DOCUMENTATION:

1. The Advanced Skills Documentation Form will be initiated by the EMT-I providing the advanced skill. The form must be signed by the ALS provider accepting responsibility for continued care of the patient. The form will be reviewed by the medical director/QI coordinator for any necessary follow-up. The form will be then forwarded to ICEMA and the EMS Medical Director.
2. In the event the receiving clinician discovers the device was improperly placed, an Incident Report must be filed and forwarded to ICEMA within forty-eight (48) hours by the medical director/QI coordinator.

ORAL ENDOTRACHEAL INTUBATION – PEDIATRIC

PRIORITIES:

1. ABC's
2. Cardiac status
3. Constant reassessment of airway

FIELD ASSESSMENT/TREATMENT INDICATORS:

1. Cardiac arrest (including traumatic full arrest)
2. Non-responsive and apneic
3. Agonal or failing respirations, no gag reflex and non-responsive

RELATIVE CONTRAINDICATIONS:

1. This method of intubation is to be used cautiously on patients with obvious or suspected cervical spine injury.
2. Intubation may be initially contraindicated on patients that are known diabetic or heroin overdose prior to administration of dextrose or naloxone.

PROCEDURE:

1. Assure and maintain airway patency. Use in-line cervical immobilization as needed for suspected head or neck injury.
2. Support ventilations with appropriate basic airway adjuncts.
3. Place on cardiac monitor and pulse oximeter.
4. Patient must be pre-oxygenated prior to intubation attempt.
5. Select proper tube size. Use Broselow tape for determination of appropriate tube size. Uncuffed tubes should be used in patients less than 8 years of age.
6. Position the patient by placing the head in the "sniffing position" and stop CPR if in progress. Contraindicated in suspected cervical spine injury. In the trauma patient, the neck should be maintained in a neutral position, which facilitates in-line axial stabilization.
7. Visualize the epiglottis and vocal cords with the laryngoscope. Insert the endotracheal tube until the black line or mark (which is the 2 cm mark) is at the glottic opening. Remove the stylet, ventilate with 100% oxygen and verify placement, attach end-tidal CO_2 device.
8. Assure correct tube position by observing chest expansion with ventilation and by auscultating for adequate breath sounds and absence of gastric sounds. Also note end-tidal CO_2 and pulse oximeter readings.
9. Placement efforts must stop after twenty (20) seconds or when heart rate drops. Immediately re-oxygenate the patient before another attempt.
10. Reinsert an oral airway to prevent the patient's biting the endotracheal tube. Secure the endotracheal tube in place.
11. Suction the trachea if necessary, observing appropriate aseptic techniques.

12. Full cervical spine immobilization should be used as a precaution to prevent possible extubation.
13. Manually ventilate with sufficient pressure to expand chest. Auscultate to assure complete expiration and constantly monitor for correct tube placement by end-tidal CO_2 and pulse oximetry.
14. If intubation unsuccessful after 3 attempts, then support ventilations with appropriate basic airway adjuncts.

DOCUMENTATION:

1. The Advanced Skills Documentation Form will be initiated by the EMT-I providing the advanced skill. The form must be signed by the ALS provider accepting responsibility for continued care of the patient. The form will be reviewed by the medical director/QI coordinator for any necessary follow-up. The form will be then forwarded to ICEMA and the EMS Medical Director.
2. In the event the receiving physician discovers the device is improperly placed, an Incident Report must be filed and forwarded to ICEMA within forty-eight (48) hours by the medical director/QI coordinator.

DETERMINATION OF BLOOD GLUCOSE VIA FINGERSTICK

PRIORITIES:

1. ABC's
2. Monitor changes in mental status
3. Periodic reassessment of airway

FIELD ASSESSMENT/TREATMENT INDICATORS:

1. Cardiac or Respiratory arrest (including traumatic full arrest)
2. Altered level of consciousness for any reason (medical or trauma)

ADDITIONAL CONSIDERATIONS:

If possible, should be performed prior to advanced airway procedures in the patient with altered level of consciousness that have an intact airway.

CONTRAINDICATIONS:

None

PROCEDURE:

1. Select and cleanse tip of finger with antiseptic wipe.
2. Perform fingerstick with approved lancet device. NOTE: Avoid the middle of the finger pad for the stick to prevent unnecessary discomfort.
3. Transfer sufficient quantity of blood to monitoring strip.
4. Wait 1 minute then wipe blood off strip with cotton wipe.
5. Wait an additional minute and read value, comparing the strip visually to the indicators on the bottle.
6. Document the value on the patient care report form.
7. Continue with appropriate care according to protocol.

DOCUMENTATION:

The Advanced Skills Documentation Form will be initiated by the EMT-I providing the advanced skill. The form must be signed by the ALS provider accepting responsibility for continued care of the patient. The form will be reviewed by the medical director/QI coordinator for any necessary follow-up. The form will be then forwarded to ICEMA and the EMS Medical Director.

PERIPHERAL INTRAVENOUS ACCESS

PRIORITIES:

1. ABC's
2. Determine degree of physiological distress.
3. Treat shock with resuscitation.

FIELD ASSESSMENT/TREATMENT INDICATORS:

All patients experiencing:
1. Hypotension
2. Symptomatology related to inadequate tissue perfusion
3. Multi-system trauma
4. Non-traumatic victim of shock
5. Dehydration

PROCEDURE:

1. Select catheter and prepare for insertion.
2. Identify an appropriate vein for cannulation.
3. Prep site.
4. Stabilize vein while piercing skin, adjusting angle of insertion and entering the vein.
5. Aspirate or watch for flashback of blood.
6. Advance cannula and needle to ensure cannulation.
7. Advance catheter while stabilizing needle.
8. Tamponade over tip of catheter to obstruct blood flow and release constricting band.
9. Withdraw needle.
10. If saline lock, attach plug and flush with 3 cc of normal saline.
11. If IV, attach intravenous tubing.
12. Open IV flow and assure patency.
13. Secure catheter and apply dressing to IV site.
14. Secure IV tubing.
15. Adjust IV flow to appropriate rate per treatment protocol.
16. Continually recheck puncture site and manage as needed.

DOCUMENTATION:

1. The Advanced Skills Documentation Form will be initiated by the EMT-I providing the advanced skill. The form must be signed by the ALS provider accepting responsibility for continued care of the patient. The form will be reviewed by the medical director/QI coordinator for any necessary follow-up. The form will be then forwarded to ICEMA and the EMS Medical Director.
2. In the event the receiving clinician discovers the device is improperly placed, an Incident Report must be filed and forwarded to ICEMA within forty-eight (48) hours by the medical director/QI coordinator.

DETERMINATION OF DEATH

Frequently Search and Rescue EMS personnel are dispatched to a scene where the victim(s) may appear to be deceased. There may be situations where the EMS personnel are called upon to determine death on scene. The prehospital care personnel may determine death on scene if any of the following conditions are present along with pulselessness and apnea:

CONDITIONS:

1. Decomposition.
2. Obvious signs of rigor mortis such as rigidity or stiffening of muscular tissues and joints in the body which occurs anytime after death and usually appears in the head, face and neck muscles first.
3. Obvious signs of venous pooling in dependent body parts, lividity such as mottled bluish-tinged discoloration of the skin, often accompanied by cold extremities.
   NOTE: Coldness of the extremities should be evaluated based upon environmental exposures, altitude and aging, and should not be utilized to presume death without other signs of death present.
4. Patient wearing an approved DNR band.
5. Decapitation.
6. Incineration of the torso and/or head.
7. Massive crush injury and/or penetrating injury with evisceration or total destruction of the heart, lung and/or brain.
8. Gross dismemberment of the trunk.
9. Blunt Trauma.

If death is determined, according to the above stated criteria, basic life support or advanced life support should not be initiated or continued. The EMT-I with advanced skills is authorized to discontinue CPR initiated at the scene if the patient falls into the category of obvious death. It is at this point the County Coroner must be notified along with the appropriate law enforcement agency. In any other situation where there may be doubt as to the clinical findings of the patient, BLS/CPR must be initiated.

CLINICAL FINDINGS:

If the patient does not meet the above criteria for obvious death, then death may be determined on scene if:

1. Cardiac arrest persists continuously for over 20 minutes of sustained chest compressions, assisted ventilations and AED application, and the patient's ECG shows an agonal rhythm or asystole in two (2) different leads.
2. Cardiac arrest persists continuously for over 30 minutes with sustained basic and advanced EMT interventions, then all treatment may be stopped if:
   a. The patient's ECG continues to show a non-perfusing rhythm and
   b. The availability of ALS personnel is over 30 minutes.

DOCUMENTATION:

1. The EMT-I with advanced skills shall describe the patient's condition on the patient care report, clearly stating the circumstances under which resuscitative efforts were terminated.
2. All terminated resuscitation efforts must have an ECG attached to the patient care report.
3. The Advanced Skills Documentation Form must be filled out by the EMT-I performing the advanced skill.

PRECAUTIONS:

1. Most victims of electrocution, lightning and drowning should have resuscitative efforts begun and transported to the appropriate Hospital/Trauma Center.
2. Hypothermic patients should be treated per the hypothermia protocol.

CLEARANCE OF SPINE

1. Determine whether mechanism of injury is positive, negative or uncertain.
   a. If positive mechanism, do full spinal immobilization.
   b. If negative mechanism, spinal immobilization is not indicated.
   c. If uncertain mechanism, must complete assessment of clinical criteria for spinal injury.
2. Assessment of spinal injury – Answer "yes" or "no" to each clinical criteria:
   a. Is patient reliable (calm, cooperative, awake, fully alert, oriented)?
   b. Is there suspicion of ingestion or use of alcohol or drugs?
   c. Is there a language or communications barrier?
   d. Is the patient < 4 years of age?
   e. Does the patient have an abnormal mental status?
   f. Does the patient have any distracting injuries?
   g. Does the patient have spine pain? Spine tenderness?
   h. Is the motor exam abnormal?
   i. Is the sensory exam abnormal?
3. If the patient is reliable (2a is answered "yes") and all other assessments (2b-i) have been answered "no", the spine may be cleared and the patient transported without spinal immobilization.

DOCUMENTATION:

The Advanced Skills Documentation Form will be initiated by the EMT-I providing the advanced skill. The form must be signed by the ALS provider accepting responsibility for continued care of the patient. The form will be reviewed by the medical director/QI coordinator for any necessary follow-up. The form will be then forwarded to ICEMA and the EMS Medical Director.

TRIAL STUDY
EMT-I ADVANCED SCOPE OF PRACTICE
INLAND COUNTIES EMERGENCY MEDICAL AGENCY
WEST VALLEY SEARCH AND RESCUE

LESSON PLANS

LESSON PLAN

SECTION 1
INTRODUCTION
(allow approximately 1 hour)

INTRODUCTION TO COURSE

Roles and responsibilities of the West Valley Search and Rescue EMT-I with advanced scope of practice.

LESSON PLAN

SECTION 2
PROTOCOLS
(allow approximately 2 hours)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. State the importance of using protocols in algorithm form for patient care.
2. Identify the eight (8) treatment protocols included in this program.
3. Given a list of patient scenarios, identify the correct protocol to be used for each scenario.
4. State the importance of continuous quality improvement in EMS to evaluate the effectiveness and compliance with these protocols.
5. Define standing orders and scope of practice.

LESSON PLAN

SECTION 3
PATIENT ASSESSMENT
(allow approximately 4 hours)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. Identify the components of a field "medical team."
2. Identify the six parts of a run.
3. Identify the components of the PQRST for evaluating a chief complaint of pain.
4. Explain the modified PQRST for a chief complaint of dyspnea.
5. Identify the special questions for a chief complaint of narcotic overdose.
6. Identify the special assessment for the altered neurological function.
7. Identify the components of the physical examination.
8. Identify the criteria for establishing priorities of care.
9. Identify the modified physical exam for a chief complaint of chest pain.
10. Identify the modified physical exam for a chief complaint of dyspnea.

LESSON PLAN

SECTION 4
PHARMACOLOGY
(allow approximately 4 hours)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. Explain the importance of developing expertise in the administration of drugs.
2. List the four reasons for giving drugs.
3. Differentiate between the generic and trade names of various drugs.
4. Understand the basic drug terminology of the following terms:
   a. antagonism
   b. cumulative
   c. synergism
   d. hypersensitivity
5. Identify the general characteristics for drugs to be administered to include:
   a. indications
   b. actions
   c. dose/route
   d. contraindications
   e. side effects
   f. classification
6. Identify the 6 "Rights" to ensure safe administration of drugs:
   a. right drug
   b. right patient
   c. right dose
   d. right route
   e. right time
   f. right documentation
7. Identify general characteristics for drugs (outlined in 5 above) for each of following medications:
   a. epinephrine 1:1000
   b. albuterol
   c. naloxone (Narcan)
   d. nitroglycerin
   e. glucagon
   f. dextrose
   g. aspirin
   h. diphenhydramine (Benadryl)
   i. prednisone
8. Identify the onset of actions and what information should be obtained in order to assess the effectiveness of administration for each of the above listed medications.

LESSON PLAN

SECTION 5
SKILLS OF PHARMACOLOGY
(allow approximately 6 hours)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. Identify the routes by which medications can be delivered and explain the possible complications and absorption rates of each.
2. Calculate drug dosages for administration via the oral, sublingual, subcutaneous, intramuscular and intravenous routes.
3. Prepare medications for administration from the following:
   a. vials
   b. ampules
   c. pre-loaded syringes
4. Explain the importance of evaluating a patient for response to medications.
5. Explain and demonstrate the proper procedure for administering medications via the following routes:
   a. orally (PO)
   b. nebulizer
   c. sublingual
   d. subcutaneous (SQ)
   e. intramuscular (IM)
   f. intravenous (IV)

LESSON PLAN

SECTION 6
CHEST PAIN
Suspected Cardiac Origin
(allow approximately 2 hours)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. Identify the pathophysiology of angina pectoris and acute myocardial infarction.
2. List the signs and symptoms for angina and acute MI.
3. Differentiate angina from an MI in the onset, duration, and relief of pain.
4. List the pertinent special questions (PQRST) and physical exam for a chief complaint of chest pain.
5. List the field treatment for a patient with chest pain.

LESSON PLAN

SECTION 7
CHEST PAIN: DIFFERENTIAL DIAGNOSIS
(allow approximately 4 hours)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. List the signs and symptoms of the following non-cardiac causes of chest pain:
    a. respiratory
    b. gastrointestinal
    c. musculoskeletal
    d. vascular
2. Identify the general field treatment for patients complaining of chest pain.
3. Identify treatment priorities for patients suspected of having dissecting aortic aneurysm, pneumothorax, pulmonary embolism.

LESSON PLAN

SECTION 8
CONGESTIVE HEART FAILURE / PULMONARY EDEMA
(allow approximately 2 hours)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. Give the pathophysiology of congestive heart failure/pulmonary edema (CHF/PE) to include left and right heart failure.

2. List the signs and symptoms of acute CHF/PE and explain how to differentiate between the other causes of respiratory distress.

3. List the pertinent special questions and physical exam to be elicited from a patient with respiratory distress.

4. List the field treatment for CHF/PE.

LESSON PLAN

SECTION 9
RESPIRATORY DISTRESS
(allow approximately 3 hours)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. List the pertinent special questions to be elicited from a patient with respiratory distress.

2. Explain the physical exam to be performed on a patient with respiratory distress.

3. List the causes, pathophysiology, signs and symptoms, and field treatment of:

   a. hyperventilation syndrome

   b. asthma

   c. COPD
      emphysema
      chronic bronchitis

   d. smoke, gas, toxic substance inhalation

LESSON PLAN

SECTION 10
ALTERED MENTAL STATUS
(allow approximately 2 hours)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. Identify causes of altered mental status to include coma and decreased level of consciousness.
2. Identify how to use "BRIM" as an assessment tool.
3. Identify the various levels of consciousness.
4. Identify the pertinent special questions and physical exam to be elicited from a patient with an altered level of consciousness.
5. Identify the field treatment of a patient with altered mental status.
6. Explain the use of glucagon, dextrose, and naloxone as diagnostic tools for altered mental status.
7. List the characteristic signs and symptoms of a narcotic overdose.
8. List the field treatment for suspected narcotic overdose.

LESSON PLAN

SECTION 11
ALLERGY AND ANAPHYLAXIS
(allow approximately 2 hours)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. Identify the pathophysiology of allergy/anaphylaxis.

2. List the signs and symptoms for an allergic reaction to include:

   a. localized, non-acute
   b. systemic, acute

3. List the signs and symptoms for anaphylaxis to include:

   a. less severe
   b. more severe

4. List the pertinent special questions and physical exam to be elicited from a patient with allergic reaction/anaphylaxis.

5. Explain the importance of prompt treatment in anaphylaxis.

6. List the field treatment for allergic reaction and anaphylaxis.

LESSON PLAN

SECTION 12
NEAR DROWNING
(allow approximately 1 hour)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. Identify the pathophysiology of near drowning.
2. Identify post-immersion syndrome (parking lot drowning).
3. List the signs and symptoms of near drowning.
4. Identify the special questions and pertinent physical exam to be elicited from a patient who has an episode of near drowning.
5. List the field treatment for near drowning.

LESSON PLAN

SECTION 13
ENDOTRACHEAL INTUBATION
(allow approximately 14 hours)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. Describe and recognize pertinent anatomy and physiology of the airway and respiratory system.
2. Describe the importance of ventilation and oxygenation in the healthy and impaired adult/pediatric patient.
3. List common causes of respiratory arrest in the adult/pediatric patient.
4. Describe methods of recognizing and stabilizing impending respiratory arrest.
5. Describe, discuss, and demonstrate methods of airway maintenance in the conscious and unconscious adult/pediatric patient.
6. Describe, discuss, and demonstrate methods of recognizing and correcting airway obstruction in the conscious and unconscious adult/pediatric patient.
7. List the indications, contraindications, and complications for endotracheal intubation in the adult/pediatric patient.
8. Discuss the importance of pre-oxygenation prior to endotracheal intubation.
9. Describe, discuss, and demonstrate the use of the laryngoscope and blades, suction devices, bag-valve-mask, adjunct airways, endotracheal tubes and other related devices.
10. Describe and demonstrate at least 3 methods of assuring and maintaining correct placement of endotracheal tube in the adult/pediatric patient.
11. Identify the appropriate method for securing the endotracheal tube in place.
12. Explain the use of the Broselow Tape for determining the correct endotracheal tube size in the pediatric patient.
13. Explain the use of the endotracheal tube in conjunction with the automatic external defibrillator (AED) in accordance with local policy – procedure- protocol.

LESSON PLAN

SECTION 14
PERIPHERAL INTRAVENOUS ACCESS
(allow approximately 8 hours)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. Discuss the importance of fluid and electrolyte balance.
2. Describe the medical conditions that may necessitate peripheral intravenous access.
3. List the contraindications to establishing peripheral intravenous access.
4. Identify the appropriate peripheral sites for intravenous access.
5. Demonstrate the procedure of IV and saline lock placement.
6. Describe the medical conditions that may require IV fluid boluses and how to monitor the patient's status.
7. List potential complications: local, systemic, and environmental.

LESSON PLAN

SECTION 15
DETERMINATION OF DEATH
(allow approximately 1 hour)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. List the conditions for Determination of Death on Scene as stated in local protocol.

2. Identify the clinical findings and ECG rhythm necessary for determination of death if the criteria for obvious death have not been met.

3. Demonstrate the documentation required on the patient care report, including the patient's condition, circumstances under which resuscitative efforts were terminated, and attached ECG.

LESSON PLAN

SECTION 16
CLEARANCE OF SPINE
(allow approximately 3 hours)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. Describe the mechanisms of spinal injury.

2. Describe the thorough patient evaluation, including a history and physical examination, to rule out spinal injury.

3. List criteria in the protocol which must be met in order to rule out spinal injury.

4. Demonstrate the procedure of full spinal immobilization if spinal injury has not been ruled out by the above criteria.

LESSON PLAN

SECTION 17
PATIENT CARE REPORTS
(allow approximately 1 hour)

LESSON OBJECTIVES

At the end of this session, the student will be able to:

1. Explain the components of the written report.
2. Describe what information is required in each section of the patient care report form.
3. Define the special considerations concerning patient refusal.
4. Describe the legal implications associated with the written report
5. Discuss state and/or local record and reporting requirements.
6. Discuss the importance and proper completion of the Advanced Skills Documentation Form.

TRIAL STUDY
EMT-I ADVANCED SCOPE OF PRACTICE
INLAND COUNTIES EMERGENCY MEDICAL AGENCY
WEST VALLEY SEARCH AND RESCUE

CONTINUING EDUCATION

Approved EMT-I's with advanced scope of practice will receive mandatory monthly continuing education (CE) with post-test evaluations designed to test their knowledge of protocols, assessment skills, and ability to perform technical skills.

The local EMS Agency shall approve all EMT-I advanced scope of practice continuing education courses and monitor attendance records.

In order to maintain certification, an EMT-I with advanced scope of practice shall participate in continuing education, which shall include:

a. An organized field care audit of recorded or written patient care records no less than six (6) times a year.

b. Monthly training sessions or structured clinical experience or a combination thereof in EMT-I basic and EMT-I advanced knowledge and skills, including CPR and required field care audits, totaling no less than forty-eight (48) hours every two years.

c. A monthly demonstration of selected skills proficiency documented by the QI coordinator/medical director. The following skills shall be demonstrated on a regular basis:

   i. Patient assessment, communications, and reporting techniques

   ii. Endotracheal intubation and use of esophageal-tracheal airway device

   iii. Preparation and administration of the drugs in the advanced EMT-I formulary

   iv. Review of selected basic life support procedures

   v. Use of the automated external defibrillator

   vi. Intravenous infusion

d. Monthly demonstration of skills may be reduced to quarterly demonstration of skills after six (6) months based on program evaluation.

SAN BERNARDINO COUNTY SHERIFF
WEST VALLEY SEARCH AND RESCUE
ADVANCED EMT – I SKILL DOCUMENTATION FORM

Date:_____ **ICEMA Run #:**_____

INTUBATION: Intubation completed by: _____ Time: _____

Successful: ☐ Yes ☐ No No. of attempts: _____ Size tube: _____ Placement at: _____ cm at lips
☐ Adult ☐ Peds
age: _____ Broselow wt: _____

Indications: ☐ Cardiac Arrest (including trauma) ☐ Agonal or failing Respirations ☐ Non-responsive and apneic
☐ Prolonged ventilation is required and adequate ventilation cannot otherwise be achieved

Placement checked after intubation by: ☐ Bilat. breath sounds ☐ absent gastric sounds ☐ ETCO2: FEF (color_____)
☐ mist in tube ☐ pulse ox:_____% ☐ direct visualization

Tube secured by: ☐ tape ☐ twill ☐ Commercial Tube Holder - Brand: _____

Placement rechecked after securing in litter by means of: _____

after transfer to ALS (medic / ED) by means of: _____

If unsuccessful was it due to: ☐ excessive secretions (type:_____) ☐ unable to visualize cords due to: _____
☐ unable to pass tube through vocal cords ☐ Trismus ☐ Other: _____

If successful, airway managed by: ☐ BVM ☐ Combi-tube/ SA Port: ☐ blue ☐ white

Comments: _____

VASCULAR ACCESS: Completed by:_____ Time: _____

☐ IV NS ☐ Saline lock
Indications: ☐ Hypothension ☐ Symptomatology related to inadequate tissue perfusion ☐ Multi-system trauma
☐ Non-traumatic victims of shock ☐ Dehydration

Location: ☐ Hand ☐ Forearm ☐ Antecubital ☐ Other: _____
☐ right ☐ left Gauge needle:_____ No. of attempts:_____

Successful: ☐ yes: blood return ☐ no due to: ☐ unable to get blood return ☐ unable to thread catheter ☐ Infiltrated

Total amount of fluid infused: _____

☐ Vascular access intact after transfer to ALS (medic / ED) If not, why: ☐ Infiltrated ☐ Clotted ☐ Other: _____

Comments:_____

FINGERSTICK BLOOD SUGAR DETERMINATION: Completed by:_____

Time:_____ Result: _____

Indication: ☐ Altered Mental Status ☐ Other: _____

Treatment:
☐ None ☐ D/50
If administered: Repeat Fingerstick: _____ Time: _____

Comments: _____

CLEARANCE OF SPINE / TRANSPORT WITHOUT IMMOBILIZATION: Completed by: _____

Time: _____

☐ Mechanism positive for immobilization ☐ Mechanism negative (immobilization not indicated) ☐ Mechanism uncertain
(Complete assessment)

	Yes	No
Patient is reliable	☐	☐
Is there suspicion of ingestion or use of alcohol or drugs	☐	☐
Is there a language or communications barrier	☐	☐
Is the patient < 4 years of age	☐	☐
Does the patient have an abnormal mental status	☐	☐
Does the patient have distracting injuries	☐	☐
Does the patient have spine pain / tenderness	☐	☐
Is the motor exam abnormal	☐	☐
Is the sensory exam abnormal	☐	☐

Comments:_____

DETERMINATION OF DEATH: Completed by:_____ Time:_____

☐ Patient pulseness and apneic and:

Indications: ☐ Decomposition ☐ Obvious Rigor Mortis ☐ Obvious lividity ☐ Wearing approved DNR Band
☐ Decapitation ☐ Incineration of head or torso
☐ Massive crush / penetrating injury with evisceration or total destruction of heart, lung and / or brain
☐ Gross dismemberment ☐ Blunt trauma

☐ Cardiac arrest persists continuously for over 20 minutes of sustained chest compressions, assisted ventilations, and AED shows asystole or agonal in 2 leads

☐ Cardiac arrest persists continuously for over 30 minutes with sustained basic and advanced EMT interventions and:
- ☐ the patients rhythm continues to show a nonperfusing rthythm AND
- ☐ the availability of ALS personnel is over 30 minutes

Comments:_____

MEDICATION ADMINISTRATION:

Time	Medication	Dose / Route	Administered by	Indications

Comments / Effect of Medication: _____

EMT #1: _____ EMT #2: _____

Receiving ALS Signature: _____ Agency: _____