

# Operations Subcommittee

of the Emergency Medical Care Committee



## Meeting Agenda:

9 A.M., Thursday April 3rd, 2025

Location: SLOEMSA Conference Room

2995 McMillan Ave, STE #178, San Luis Obispo

### Members

Jay Wells, *Sheriff's Department, CHAIR*  
Tim Nurge, *Ambulance Providers*  
Scotty Jalbert, *Office of Emergency Services*  
Jennifer Mebane, *Med-Com*  
Adam Forrest, M.D., *Hospitals*  
Kris Strommen, *Ambulance Providers*  
Rob Jenkins, *Fire Service*  
Lisa Epps, *Air Ambulance Providers*  
Dennis Rowley, *Air Ambulance Providers*  
Jon Ontiveros, *CHP*  
Deputy Chief Sammy Fox, *Fire Service*  
*Vacant, Law Enforcement*  
Chief Casey Bryson, *Fire Service*  
Chief Dan McCrain, *Fire Service*  
Roger Colombo, *Field Provider-Paramedic*  
Heidi Hutchison, M.D., *Hospitals*

### Staff

STAFF LIAISON, Ryan Rosander, *EMS Director*  
Bill Mulkerin, M.D., *Medical Director*  
Rachel Oakley, *EMS Coordinator*  
Kaitlyn Blanton, *EMS Coordinator*  
Eric Boyd, *EMS Coordinator*  
Alyssa Vardas, *Administrative Assistant*

AGENDA	ITEM	LEAD
Call to Order	Introductions Public Comment	Jay Wells
Summary Notes	Review of Summary Notes February 6th, 2024	
Discussion	<b>Policy Revisions:</b> <ul style="list-style-type: none"><li>158 Ambulance Offload Time (APOT)</li><li>203 Patient Refusal</li><li>341 Emergency Medical Technician Paramedic Accreditation</li><li>342 Emergency Medical Technician Paramedic Reaccreditation</li><li>125 Determination of Death</li></ul>	Eric Boyd Ryan Rosander Rachel Oakley
Discussion	<b>Protocol and Formulary Revisions:</b> <ul style="list-style-type: none"><li>704 Needle Cricothyrotomy</li><li>XXX Opioid Withdrawal</li><li>Suboxone Formulary</li></ul>	Kaitlyn Blanton

Adjourn	Declaration of Future Agenda Items: - Roundtable	Jay Wells
	Next Meeting Date: June 5th, 2025, 9:00 A.M. Location: SLOEMSA Conference Room 2995 McMillan Ave, STE #178, San Luis Obispo	

# Operations Subcommittee

Meeting February 6, 2025  
2995 McMillan Way, Suite 178  
San Luis Obispo, CA 93401



## MINUTES

### MEMBERS PRESENT:

Chair Jay Wells, Sheriff's Department  
Rob Jenkins, Fire Service  
Kris Strommen, Ambulance Providers  
Lisa Epps, Air Ambulance Providers  
Jon Ontiveros, CHP  
Sammy Fox, Fire Service  
Dan McCrain, Fire Service  
Casey Bryson, Fire Service  
Heidi Hutchison, Hospitals

### MEMBERS ABSENT:

Tim Nurge, Ambulance Providers  
Scotty Jalbert, OES  
Jennifer Mebane, Med-Com  
Adam Forrest, Hospitals  
Dennis Rowley, Air Ambulance providers  
Roger Columbo, Field Providers

### EMS AGENCY STAFF PRESENT:

Alyssa Vardas, EMS Administrative Assistant  
Rachel Oakley, EMSA  
Kaitlyn Blanton, EMSA  
Eric Boyd, EMSA  
Ryan Rosander, EMSA  
Bill Mulkerin, EMS Medical Director

### PUBLIC COMMENTORS:

Scott Hallet, FCFA  
Anthony Simonian, CHP

### 1. CALL TO ORDER

Chair Jay Wells called the meeting to order at 9:07 a.m. He led the reviewing of the meeting protocols and meeting agenda.

### 2. REVIEW AND APPROVAL OF December 5th, 2024, MINUTES

**Action: Rob Jenkins moved approval of December 5th, 2024, Operations Subcommittee Meeting Minutes. Jay Wells seconded. The motion carried unanimously with no abstentions.**

### **3. Protocols/Policies**

Policy 100 and 101 Continuous Quality Improvement and Quality Assurance: Policy #100: Continuous Quality Improvement (CQI) and Policy #101: Quality Assurance (QA) were developed to align with modern healthcare standards and enhance system-wide evaluation and improvement processes. This transition reflects a shift from a punitive disciplinary approach to a proactive, quality-driven model to identify systemic issues and improve performance.

#### Discussion:

Rob Jenkins asks if the form will be electronic, with a drop-down option for selecting the recipient. A form that sends a receipt.

Rob Jenkins asks who determines the level of care.

Bill Mulkerin says we should have visibility on all these as they come through.

Rob Jenkins notes that 24 hours may be challenging, as not everyone is on duty when these notifications arrive. If we issue a receipt, then we can eliminate the 24-hour waiting period.

Heidi Hutchison says that the phrase “Just Culture” should be present, and if the LEMSA is not utilizing a just culture model, why not?

Bill Mulkerin says it is something we should be looking at.

Ryan Rosander says he only removed it because he wasn’t sure if our county utilized Just Culture.

Rob Jenkins asked if we could add the address to the form.

Eric Boyd says that would create PHI.

Dan McCrain says if we have the run number, then we should be able to find it.

Lisa Epps asks if we want the personnel involved all typed together or in separate boxes.

#### Protocol 616 Respiratory Distress:

The Respiratory Distress Bronchospasm Protocol #616 currently operates with standing orders for Albuterol and Epinephrine 1;1000. Based on feedback from field paramedics, a revision and broadening of the standing orders within Protocol #616 is requested for committee review. The option to include Ipratropium Bromide and Magnesium Sulfate as possible treatments for moderate and severe distress patients was added for review based on consultation with Dr. Mulkerin

#### Discussion:

Heidi Hutchison says this is great and also asks if there is a reason the duration is over five minutes, as she is used to 20 minutes.

Katy Blanton says CCEMSA is 2 minutes.

Rob Jenkins says that he thinks the medication comes in vials and that they will have to mix it.

Ryan Rosander mentions that we can always change it once we start looking into it.

Dan McCrain says this is a significant addition.

Katy Blanton says we can adjust the duration for mag.

#### Protocol 613 Behavioral Emergencies and 620 Seizure:

Increased dosing of midazolam (Versed) is proposed for adults and pediatric patients under Active Seizure Protocol #620, and Behavioral Emergencies Protocol #613 only. Dosing remains the same for sedation pre-cardioversion.

#### Discussion:

Rob Jenkins says he has a 5 and 1, and if we need a “not to exceed” on the IN?

Katy Blanton suggests adding something after “may repeat after 5 Minutes.”

Dan McCrain says that those clarifications are good.

#### Protocol 618 Respiratory Distress:

Increasing the dose to align with the current standard of practice involves revising Naloxone dosing from 1mg IV for adults to 2mg IV, as well as expanding pediatric dosing under protocol #618.

#### Discussion:

Rob Jenkins says that this is so the medics can give the same as the others.

Bill Mulkerin mentions we should change from opiate overdose.

Dan McCrain mentions that some of the other protocols still include sublingual.

Ryan Rosander says we will pull sublingual from the others.

## **4. FUTURE AGENDA ITEMS**

Pre-hospital determination of death, AMA, Suboxone for withdrawals, EMT/Medic and optional scope and skills sheets, IGEL for BLS, Procedures for 5150 patients, Lukas Device, OB, Gestational and neonatal viability

## **5. ADJOURNMENT**

**Action: Dan McCrain moved to approve 100, 101, 616, 613, 620, 618. Rob Jenkins seconded. The motion carried unanimously.**

Jay Wells adjourned the meeting at 10:18 a.m.



**COUNTY OF SAN LUIS OBISPO HEALTH AGENCY**  
**PUBLIC HEALTH DEPARTMENT**

**Nicholas Drews** *Health Agency Director*

**Penny Borenstein, MD, MPH** *Health Officer/Public Health Director*

MEETING DATE	April 3 <sup>rd</sup> , 2025
STAFF CONTACT	Ryan Rosander, EMS Director 805.788.2512 rrosander@co.slo.ca.us
SUBJECT	Policy #158: Ambulance Patient Offload Time (APOT) Monitoring
SUMMARY	<p>Ambulance Patient Offload Time (APOT) is the interval from when an ambulance arrives at an emergency department (ED) to when the patient is transferred to hospital staff and the ambulance is available for the next call. Excessive APOT negatively impacts EMS system efficiency, delays emergency responses, and contributes to ambulance shortages.</p> <p>California Health and Safety Code Section 1797.225 mandates that LEMSAs monitor and report APOT data. The California EMS Authority (EMSA) has established standardized reporting requirements and defined "excessive offload delay" as patient transfer times exceeding <b>30 minutes</b> after arrival at the ED.</p> <p>LEMSAs are responsible for collaborating with hospitals, ambulance providers, and other stakeholders to mitigate delays and ensure timely patient transfer. Furthermore, LEMSAs are responsible for lowering the statutory time of 30 minutes, if it would benefit the LEMSAs EMS system. In the County of San Luis Obispo, all prolonged APOT times negatively impact the system due to the amount of ambulances available, for this reason SLOEMSA is seeking stakeholder feedback for a 20 minute standard.</p>
REVIEWED BY	Dr. William Mulkerin, SLOEMSA Staff
RECOMMENDED ACTION(S)	Policy #158 recommended for approval by Operations and moved to the Clinical Advisory agenda.
ATTACHMENT(S)	Policy #158: Ambulance Patient Offload Time (APOT) Monitoring

**Emergency Medical Services**

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## **POLICY #158 AMBULANCE OFFLOAD TIME (APOT) MONITORING:**

### **I. PURPOSE**

- A. To establish standardized methodologies for collecting and reporting Ambulance Patient Offload Time (APOT) data to the County of San Luis Obispo Emergency Medical Services Agency (SLOEMSA). APOT functions as a crucial metric for evaluating the efficiency of patient care transitions from pre-hospital to hospital settings, ensuring that pre-hospital resources can transfer care effectively and allowing them to return to service.

### **II. DEFINITIONS**

- Ambulance Arrival at ED: The time the ambulance wheels stop at the designated hospital ED offload location.
- Ambulance Patient Offload Time (APOT): The interval between the arrival of an ambulance patient at an emergency department (ED) and the time when the patient is transferred to an ED gurney, bed, chair, or other suitable location, at which point the ED assumes responsibility for the patient's care.
- Ambulance Patient Offload Delay (APOD): Any delay in ambulance patient offload time that exceeds the local standard for ambulance patient offload time, which is 20 minutes. This is synonymous with "non-standard patient offload time" in the Health and Safety Code.

### **III. POLICY**

- A. EMS field personnel are obligated to continue delivering and documenting patient care until the patient is transferred to the designated base hospital's Emergency Department (ED) medical personnel. The medical control and management of the EMS system, including EMS field personnel, remain under the jurisdiction of the EMS agency medical director. All patient care provided must adhere strictly to the treatment protocols and policies outlined by SLOEMSA.
- B. Ambulance Patient Offload Times should be kept to a minimum to ensure the efficient transfer of patient care from pre-hospital to hospital settings. APOTs exceeding 20-minutes will be considered an Ambulance Patient Off Delay (APOD).
- C. Designated base hospitals and EMS field personnel shall follow the APOD Mitigation Procedures detailed in Section IV of this policy when an APOD event occurs.

### **IV. PROCEDURE**

#### **A. Direction of EMS Field Personnel**

##### **1. Ambulance Patient Offload Time (APOT) Monitoring**

- a. If the transfer of care and patient offloading from the ambulance gurney exceeds the 20-minute standard, it will be documented and tracked as an APOD.



- b. The transporting EMS field personnel are not responsible for continuing to monitor the patient or provide care within the hospital setting after the patient's care has been transferred to ED medical personnel.

## 2. APOD Mitigation Procedures

- a. Designated base hospitals are responsible for ensuring policies and processes facilitate the rapid and appropriate transfer of patient care from EMS field personnel to ED medical personnel.

- b. If APOD does occur, the hospital should make every attempt to:

- i. Provide a safe area in the ED within direct sight of ED medical personnel where the ambulance crew can temporarily wait while the hospital's patient remains on the ambulance gurney.
- ii. Inform the attending paramedic or EMT of the anticipated time for the offload of the patient.
- iii. Provide information to the EMS Field Supervisor regarding the steps the hospital is taking to resolve APOD.

- c. If requested, hospitals will provide written details to SLOEMSA of policies and procedures that have been implemented to mitigate APOD and assure effective communication with affected partners:

- i. Processes for the immediate notification of the following hospital staff through their internal escalation process of the occurrence of APOD, including but not limited to:

- ED Attending Physician
- ED Nurse Manager/Director or Designee (i.e. Charge Nurse) House Supervisor
- Administrator on-call

- ii. Processes for ED medical personnel to immediately respond to and provide care for the patient if the attending EMS field personnel alert the ED medical personnel of a decline in the condition of a patient being temporarily held on the ambulance gurney.

- iii. EMS field personnel are directed to do the following to prevent APOD:

- Notify the base hospital ED as soon as possible (call-in) that a patient is being transported to their facility.
- Contact the EMS Field Supervisor for direction if the ED medical personnel do not offload the patient within the 20-minute ambulance patient offload time standard.
- Work cooperatively with the base hospital staff to transition patient care within the timeframes established in this policy.

V. AUTHORITY

- California Health and Safety Code, Division 2.5
- California Code of Regulations, Title 22, Division 9

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	



**COUNTY OF SAN LUIS OBISPO HEALTH AGENCY**  
**PUBLIC HEALTH DEPARTMENT**

**Nicholas Drews** *Health Agency Director*

**Penny Borenstein, MD, MPH** *Health Officer/Public Health Director*

MEETING DATE	April 3, 2025
STAFF CONTACT	Rachel Oakley
SUBJECT	Patient Refusal Policy 203 Revision
SUMMARY	<p>Policy 203, Patient Refusal of Treatment and/or Transport was last revised on April 15<sup>th</sup>, 2017. The main reason for the recent revision was to change language regarding patient “competency” to “mental capacity”.</p> <p><b><u>Edits Include:</u></b></p> <ul style="list-style-type: none"><li>• The Policy name was changed as a result of adding EMS assessment to the list of patient refusals and not just treatment and/or transportation.</li><li>• The purpose was changed to reflect patient refusals of assessment and to address when a refusal cannot be accepted due to the patient’s mental capacity.</li><li>• Some definitions were thought to be unnecessary, while some were lengthy and better addressed in policy or procedure sections.</li><li>• Designated decision maker, patient, full mental capacity, and implied consent were added to definitions.</li><li>• The policy and procedure sections were revised to include terminology established in the definitions section.</li><li>• The procedure section has a few steps added to AMA and documentation guidelines.</li></ul>
REVIEWED BY	EMSA Staff.
RECOMMENDED ACTION(S)	Approve and move to Clinical Advisory Subcommittee.
ATTACHMENT(S)	Draft policy of: <ul style="list-style-type: none"><li>• 203 Patient Refusal</li></ul>

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## **POLICY #203: PATIENT REFUSAL**

### **I. PURPOSE**

- A. To establish policy and procedure for the County of San Luis Obispo (SLO) Emergency Medical Services (EMS) personnel to utilize for a refusal of EMS assessment, treatment, and/or transportation, or to recognize and initiate treatment and/or transportation without explicit consent.

### **II. DEFINITIONS**

- Against Medical Advice (AMA) Refusal: The refusal of assessment, treatment, and/or transport by a patient or his/her designated decision maker against the advice of the EMS personnel on scene or of the Base Hospital. This includes patient refusal to be transported to the closest or designated base station.
- Designated Decision Maker (DDM): An individual whom a patient has legally given or implied the authority to make medical decisions concerning the patient's health care.
  - Parent, legal guardian, and "attorney-in-fact" through a Durable Power of Attorney for Health Care, or an "agent" through an Advance Health Care Directive.
- Patient: Any person for whom the EMS system has been activated and who meets any of the following criteria:
  - Has a chief complaint or suspected illness or injury.
  - Requires or requests assessment, treatment, or transportation.
  - Is a minor who is not accompanied by a DDM and is or appears to be ill or injured.
  - Is not oriented to person, place, time, or event.
- Mental Capacity: An individual's ability to understand, retain, and use information to make informed decisions about their own life. It encompasses the cognitive abilities necessary to understand the situation and relevant information, appreciate the consequences of potential decisions, and communicate their choice effectively.
- Implied Consent: When a patient is not able to make medical decisions for themselves due to mental capacity, the agreement of EMS treatment and/or transportation can be inferred rather than explicitly obtained.
- Welfare and Institutions (W&I) 5150 Hold: Holding a patient against his/her will for evaluation under the authority of Welfare and Institutions Code, Section 5150, because the patient is a danger to him/herself, a danger to others, and/or is gravely disabled, e.g., unable to care for self. A law enforcement officer or County Mental Health worker may place a written order.

### **III. POLICY**

- A. All patients will be offered treatment and/or transportation following a complete EMS assessment.
- B. Adult Patients who can make decisions for themselves have the right to refuse medical assessment, treatment, and/or transportation.
- C. An unaccompanied minor who has an illness/injury requiring immediate EMS treatment and/or transportation may not refuse and shall be treated and/or transported by EMS personnel without DDM consent.
- D. Decisions made by a DDM shall be treated as though the patient was making the decisions for him/herself.

#### IV. PROCEDURE

- A. When an AMA refusal exists, complete the following steps:
  - 1. If the patient has a medical condition requiring medical attention, ensure the patient has or is making personal arrangements to seek medical care at a hospital, urgent care, or private physician's office.
  - 2. EMS personnel shall advise the patient of the risks and consequences that may result from refusal of treatment and or transportation including the possible risk of death or disability from any undiagnosed condition being untreated.
  - 3. If the patient still refuses, EMS personnel must attempt to obtain the patient's signature on the EMS provider's refusal of treatment and/or transport form.
  - 4. The signature should be witnessed, preferably by a family member.
  - 5. If the patient refuses to sign the EMS provider's refusal of assessment, treatment, and/or transport form, prehospital personnel must note and initial that the patient refused to sign. EMS personnel or other witnesses present should sign the form.
  - 6. The patient and caregivers shall be advised to seek medical care immediately or call 911 if the patient develops adverse symptoms at any time.
- B. Consultation with the Base Hospital or Specialty Care Base physician or MICN will be made for:
  - 1. AMA refusal cases where EMS interventions are performed or indicated, and the patient is refusing assessment, treatment, and/or transport, which includes transport to the appropriate receiving hospital.
  - 2. Unstable patients, as defined in Universal Protocol # 601, who refuse transport to the nearest appropriate receiving hospital.
- C. When Base Hospital physician consultation is indicated, EMS personnel shall advise the physician of all the circumstances while on scene, including indicated care or transportation, reasons for refusal, mental capacity, and the patient's plan for follow-up care with his/her own private physician or provider.

- D. Consultation with the Base Hospital physician or MICN is not required for isolated injury without potential for significant airway, hemodynamic, orthopedic, or neurological compromise.
- E. If EMS or Base Hospital personnel determine that a patient with an emergency condition lacks mental capacity to refuse assessment, treatment, and/or transportation, the following alternatives exist:
  - 1. The patient should be transported to a hospital under implied consent.
  - 2. A Base Hospital physician may determine that it is necessary to transport the patient against his/her will. If the patient resists, or if EMS personnel believe the patient will resist, assistance from law enforcement or County Mental Health shall be requested to assist in the transportation of the patient.
  - 3. Law enforcement or County Mental Health may consider the placement of a W&I 5150 hold on the patient, but this is not required for transport.
  - 4. If EMS personnel believe a DDM of the patient may not be acting in the best interest of the patient in refusing indicated immediate treatment and/or transportation, assistance from law enforcement personnel shall be requested.
  - 5. EMS personnel should never put themselves in danger by attempting to treat and/or transport a patient who refuses. EMS personnel should use good judgment and request appropriate assistance, as needed.
- F. Documentation Guidelines:
  - 1. A PCR shall be completed for individuals meeting the definition of patient.
  - 2. Patient information is not required for individuals that did not present with any complaint or illness/injury and advised EMS personnel upon initial contact that he/she did not want further assessment or evaluation.
  - 3. A PCR and an EMS provider's AMA refusal form shall be completed for each incident of refusal of EMS assessment, treatment, and/or transportation, including transport to the appropriate receiving hospital.
  - 4. AMA refusal forms shall include:
    - a. Who activated 9-1-1 and the reason for the call, if known.
    - b. A complete patient history and assessment.
    - c. All circumstances pertaining to consent issues during the patient encounter.
    - d. A mental status examination of the patient that clearly indicates his/her decision making capacity.
    - e. The presence or absence of any impairment, such as by alcohol or drugs.
    - f. The reason that the patient is refusing care, evaluation, treatment, and/or transportation.
    - g. A statement that the patient understands the risks and consequences of refusing medical treatment and/or transportation to the appropriate receiving hospital that was offered.
    - h. All alternatives presented to the patient.

- i. The patient has been informed that they may re-access 9-1-1 as necessary.
- j. Base Hospital and/or Base physician contacted if applicable.
- k. Signature of patient and EMS personnel on the refusal of treatment and/or transport form.

V. AUTHORITY

- California Health and Safety Code, Division 2.5
- California Welfare and Institutions Code 5150
- Title 22, California Code of Regulations, Division 9

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	



**COUNTY OF SAN LUIS OBISPO HEALTH AGENCY**  
**PUBLIC HEALTH DEPARTMENT**

**Nicholas Drews** *Health Agency Director*

**Penny Borenstein, MD, MPH** *Health Officer/Public Health Director*

MEETING DATE	April 3, 2025
STAFF CONTACT	Rachel Oakley
SUBJECT	Paramedic Policy Revisions
SUMMARY	<p>Paramedic policies 341 and 342 for initial accreditation and reaccreditation were last revised on March 1, 2023. Since that time there have been many conversations regarding clarifying information currently in policy and also making a few changes. On December 5<sup>th</sup> of 2024, EMS personnel policy revisions were discussed with the Operations Subcommittee. The following revisions were brought to our attention and included in the draft policies attached.</p> <p><b><u>Paramedic Accreditation:</u></b></p> <ul style="list-style-type: none"><li>• Paramedic Liaison:<ul style="list-style-type: none"><li>○ To align with other EMS personnel policies, each provider agency will have a designated liaison to submit and track all accreditation and reaccreditation applications with SLOEMSA.</li></ul></li><li>• Accreditation Exam:<ul style="list-style-type: none"><li>○ State that only 2 attempts will be offered.</li><li>○ Provide the procedure if the test is not successfully completed; consult the medical director if accredittee fails both attempts.</li></ul></li><li>• Prorated Reaccreditation Requirements:<ul style="list-style-type: none"><li>○ Upon initial accreditation, and if applicable, any prorated reaccreditation requirements will be communicated.</li><li>○ Internal standardization of prorated requirements is current practice.</li></ul></li><li>• PALS:<ul style="list-style-type: none"><li>○ PALS certification was added to the list of initial application requirements, as paramedics are provided with PALS certification as part of Cuesta's EMS program and most other counties require PALS certification.</li></ul></li><li>• Rush Fee:<ul style="list-style-type: none"><li>○ The rush fee language was changed for requests to process a completed application within 10 business days.</li><li>○ A rush fee will apply to requests to approve accreditation start dates within 5 business days.</li></ul></li></ul> <p><b><u>Paramedic Accreditation:</u></b></p> <ul style="list-style-type: none"><li>• Paramedic Liaison:</li></ul>

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	<ul style="list-style-type: none"> <li>○ To align with other EMS personnel policies, each provider agency will have a designated liaison to submit and track all accreditation and reaccreditation applications with SLOEMSA.</li> <li>• Lapse: <ul style="list-style-type: none"> <li>○ Remove the 90 day leave of absence from lapse criteria.</li> <li>○ All leaves and reinstatements under a year will require the provider agency to submit a plan to the SLOEMSA Medical Director for approval.</li> </ul> </li> <li>• Prorated Reaccreditation Requirements: <ul style="list-style-type: none"> <li>○ Upon initial accreditation, and if applicable, any prorated reaccreditation requirements will be communicated (skills and base station meetings).</li> <li>○ Internal standardization of prorated requirements is current practice.</li> </ul> </li> <li>• Skills: <ul style="list-style-type: none"> <li>○ Remove the advanced airway maneuver form from skills requirements.</li> <li>○ Clearly state that one "Paramedic Skills Annual Verification Tracking Sheet-Attachment B" is required to be completed within every 12 months.</li> <li>○ Change the frequency of required intubations and cardiac arrest management so that they are not completed all at once and are spread throughout the 12 months (per sheet).</li> <li>○ Eliminate requirement for provider agencies to retain "Skills Verification Checklist-Attachment D" for 4 years. Use only for skills verification, and now is attachment C.</li> </ul> </li> <li>• Rush Fee: <ul style="list-style-type: none"> <li>○ The rush fee language was changed for requests to process a completed application within 10 business days.</li> </ul> </li> </ul> <p><b><u>Attachments:</u></b></p> <ul style="list-style-type: none"> <li>• All attachments will be revised to match policy changes.</li> </ul>
<b>REVIEWED BY</b>	EMSA Staff.
<b>RECOMMENDED ACTION(S)</b>	Approve and move to Clinical Advisory Subcommittee.
<b>ATTACHMENT(S)</b>	Draft policies of: <ul style="list-style-type: none"> <li>• 341 Emergency Medical Technician Paramedic Accreditation</li> <li>• 342 Emergency Medical Technician Paramedic Reaccreditation</li> </ul>

## **POLICY #341: EMERGENCY MEDICAL TECHNICIAN PARAMEDIC ACCREDITATION**

### **I. PURPOSE**

- A. To establish criteria as defined by Title 22 of the California Code of Regulations (CCR), for the local accreditation of emergency medical technician paramedics (paramedics) in the County of San Luis Obispo (SLO).

### **II. SCOPE**

- A. This policy applies to all current California state licensed paramedics employed by approved County of SLO advanced life support (ALS) providers, wishing to provide ALS patient care in SLO.

### **III. POLICY**

- A. Changes in State paramedic regulations will supersede information in this policy upon codification.
- B. A current and valid California paramedic license and local accreditation are required to practice as a paramedic in SLO.
- C. A paramedic with an expired license may not provide ALS or basic life support (BLS), patient care in the State of California.
- D. A paramedic with an expired accreditation may not provide ALS patient care in SLO.
- E. Only paramedics with a current license in the State of California may represent themselves as a paramedic. Individuals not currently licensed as a paramedic who represent themselves as such may be subject to disciplinary action and criminal penalties.
- F. An individual with an expired paramedic license will be required to apply for license renewal through the State Emergency Medical Services (EMS) Authority prior to applying for local accreditation.
- G. Candidates for initial accreditation must apply to SLO Emergency Medical Services Agency (SLOEMSA) and pay the non-refundable accreditation application fee.
- H. Candidates whose checks return for insufficient funds may be subject to disciplinary action as outlined in EMS Agency Policy #101: Fee Collection.
- I. Each ALS provider shall have a Paramedic Liaison that will be responsible for the coordination of the application and accreditation process for each of the ALS provider's employees.

- J. All information on the SLOEMSA accreditation application is subject to verification. Candidates who supply information found to be fraudulent may be subject to disciplinary action for fraudulent procurement of accreditation per Title 22 1798.200 (c)(1).
- K. The SLOEMSA Medical Director will evaluate any candidate who fails to complete the field evaluation. The SLOEMSA Medical Director may recommend further evaluation or training as required or take other license review action deemed necessary.
- L. If the individual fails to complete remediation recommended by the SLOEMSA Medical Director, the accreditation may be denied for a minimum of one (1) year and up to two (2) years.
- M. As a condition of continued accreditation, individuals must attend and pass all mandated training as required by SLOEMSA.
- N. Candidates must have sufficient time to accredit. SLOEMSA may require up to thirty (30) calendar days to process a complete application. If a request is made to expedite a completed application within ten (10) business days of the request, a rush fee will apply.
  - 1. Candidates need to allow five (5) business days to be approved to begin the accreditation field evaluation. If the anticipated field evaluation start date is within five (5) business days, a rush fee will apply.
- O. It is the responsibility of the accredited paramedic to notify SLOEMSA within seven (7) days of any arrest or change in their eligibility status. Failure to report such actions may result in disciplinary action.
- P. The SLOEMSA Medical Director must approve exceptions to any accreditation requirement.

#### IV. PROCEDURE

- A. Candidates must complete the SLOEMSA Paramedic Application for County Accreditation – Attachment A and supply documentation establishing eligibility for accreditation as follows:
  - 1. Current government-issued photo identification.
  - 2. Current and valid paramedic license issued by the California EMS Authority.
  - 3. Possess current certification as a Cardiopulmonary Resuscitation (CPR) Provider according to the American Heart Association guidelines for BLS Healthcare Providers or other course approved by the SLOEMSA Medical Director.
  - 4. Proof of current ACLS provider certification issued by the American Heart Association or other course approved by the SLOEMSA Medical Director.
  - 5. Proof of current PALS provider certification issued by the American Heart Association or other course approved by the SLOEMSA Medical Director.

6. Paramedic Field Evaluation Completion Form – Attachment B, is due upon completion of accreditation process and includes:
  - a. Orientation to SLO EMS system policies, procedures, and protocols that emphasize the local optional scope of practice.
  - b. Ten (10) ALS patient care contacts if the paramedic has been licensed for less than one year, or
  - c. Between five (5) and ten (10) ALS patient contacts if the paramedic has a current license and has been licensed for more than one year.
  - d. Successfully pass the Accreditation Test with a score of at least 80 percent. Two (2) attempts will be offered. Consult the Medical Director for next steps if accredee fails both attempts.
  - e. The field evaluation will be waived if the candidate successfully completed a paramedic training program internship with SLOEMSA within the previous six (6) months (refer to Policy #340, Paramedic Student Internships, for more information).
7. Provide a letter of employment from a SLO ALS provider indicating employment as a paramedic.
8. Provide the name of the FTO assigned to lead the accreditation process, and the tentative field evaluation start date.
9. Pay the established local non-refundable accreditation fee.

B. Confirmation of application receipt and approval for an accreditation start date will be communicated by email to the applicant and the Paramedic Liaison.

C. Accreditation will be for a maximum of two (2) years, or such time as specified in the current state regulations.

1. The effective date of accreditation will be the date the candidate meets all local requirements and will be communicated by letter of approval.
2. The accreditation will expire on the same date as:
  - a. The paramedic license issued by the California EMS Authority, or
  - b. The paramedic is no longer employed as a paramedic by a SLO ALS provider, or
  - c. The paramedic does not meet accreditation requirements.

D. If the expiration date of the paramedic license is less than two years, the prorated reaccreditation requirements outlined in Policy #342, Emergency Medical Technician Paramedic Reaccreditation, will be communicated upon initial accreditation approval.

## V. AUTHORITY

- State of California Code of Regulations, Title 22

- California Health and Safety code, Division 2.5

VI. ATTACHMENTS

- A. Paramedic Application for County Accreditation
- B. Paramedic Field Evaluation Completion Form

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

## **POLICY #342: EMERGENCY MEDICAL TECHNICIAN PARAMEDIC REACCREDITATION**

### **I. PURPOSE**

- A. To establish criteria as defined by Title 22 of the California Code of Regulations (CCR), for the local reaccreditation of emergency medical technician paramedics (paramedics) in the County of San Luis Obispo (SLO).

### **II. SCOPE**

- A. This policy applies to all current California state licensed paramedics employed by approved County of SLO advanced life support (ALS) providers, wishing to provide ALS patient care in SLO.

### **III. DEFINITIONS**

- **Lapse in Accreditation:** A period of time that a paramedic's accreditation is expired.
- **Reinstatement:** The process whereby a paramedic is restored to active accreditation following a **lapse in accreditation**.
- **Return to Work:** The process whereby a paramedic is approved to return to work following a leave of absence (LOA).

### **IV. POLICY**

- A. Changes in State paramedic regulations will supersede information in this policy upon codification.
- B. A current and valid California paramedic license and local accreditation are required to practice as a paramedic in SLO.
- C. A paramedic with an expired license may not provide ALS or basic life support (BLS) patient care in the State of California.
- D. A paramedic with an expired accreditation may not provide ALS patient care in SLO.
- E. Only paramedics with a current license in the State of California may represent themselves as a paramedic. Individuals not currently licensed as a paramedic and represent themselves as such may be subject to **disciplinary action and** criminal penalties.
- F. An individual with an expired paramedic license will be required to apply for license renewal through the State Emergency Medical Services (EMS) Authority prior to applying for local accreditation.
- G. Candidates for reaccreditation must apply to SLO Emergency Medical Services Agency (SLOEMSA) and if applicable, pay the non-refundable reaccreditation application fee.

- H. Candidates whose checks return for insufficient funds may be subject to disciplinary action as outlined in EMS Agency Policy #101: Fee Collection.
- I. Each ALS provider shall have a Paramedic Liaison that will be responsible for the coordination of the application and accreditation process for each of the ALS provider's paramedic employees.
- J. All information on the SLOEMSA accreditation application is subject to verification. Candidates who supply information found to be fraudulent may be subject to disciplinary action for fraudulent procurement of accreditation per Title 22 1798.200 (c)(1).
- K. If there is a change in employment status for any reason, resulting in an employee no longer acting in the capacity of paramedic including employees on a LOA, medical leave, workers comp leave, or leave for disciplinary reasons, the employer must send SLOEMSA a written notification of the LOA and expected return date as soon as practical.
- L. If a paramedic is no longer employed, the employer must send a written notification to SLOEMSA within three (3) business days after separation of the employee.
- M. A paramedic's accreditation is considered expired or lapsed when:
  - 1. They are not currently employed by an ALS provider in SLO.
  - 2. Failure to maintain a California paramedic license.
  - 3. Failure to meet SLO reaccreditation requirements.
- N. Once accreditation has lapsed, or in the situation of an employee returning to work after a LOA, the employer must submit to SLOEMSA a written request for employee reinstatement of accreditation or return to work. The written request shall include a plan for any training, skills evaluations, or field training officer (FTO) led observations that the employer deems necessary. The plan will be reviewed and approved by the SLOEMSA Medical Director. This section applies to all LOAs and lapses in accreditation up to one (1) year.
- O. All reaccreditation candidates returning to SLO following a lapse or LOA of one year or more must comply with the requirements for initial accreditation as outlined in SLOEMSA Policy #341: Emergency Medical Technician Paramedic Accreditation.
- P. Lapsed reaccreditation requirements due to LOAs may be prorated for a period not to exceed six (6) months. The prorated relief may include a reduction in the number of required advanced skills verifications and base station meetings and will be communicated with the Paramedic Liaison as part of the reinstatement and return to work plan with the employer. All remaining requirements of reaccreditation outlined in the reaccreditation procedures will remain in effect.
- Q. If advanced skills verifications and base station meeting reaccreditation requirements are prorated upon initial or reaccreditation approval, the requirements that were communicated by SLOEMSA at the time of initial or reaccreditation approval will be

due when applying for reaccreditation. All remaining requirements of reaccreditation outlined in the reaccreditation procedures will remain in effect.

- R. The SLOEMSA Medical Director will evaluate any candidate who fails to meet reaccreditation requirements. The SLOEMSA Medical Director will recommend further evaluation or training as required or take other license review action deemed necessary.
- S. Accreditation lapses for failure to meet reaccreditation requirements, for reasons other than a change in employment, will result in suspension of accreditation until such time as the requirements have been met.
  - a. This includes but is not limited to failure to successfully complete any of the advanced skill verifications and failure to maintain required certifications during the two (2) year accreditation cycle.
- T. Based on the continuous quality improvement and assurance process, the employer or SLOEMSA Medical Director may determine that a paramedic needs additional training, observation, or testing. The employer, the SLOEMSA Medical Director or his/her designee, may create a specific and targeted program of remediation based upon the identified need of the paramedic. If there is disagreement between the paramedic, the employer, and/or the SLOEMSA Medical Director, the decision of the SLOEMSA Medical Director will prevail.
- U. If the individual fails to complete this targeted program of remediation the SLOEMSA Medical Director may suspend or revoke the accreditation for a minimum of one (1) year and up to two (2) years.
- V. As a condition of continued accreditation, individuals must attend and pass all mandated training as required by SLOEMSA and meet all requirements listed under reaccreditation procedures.
- W. Candidates must have sufficient time to reaccredit. SLOEMSA may require up to thirty (30) calendar days to process a complete application. If a request is made to expedite a completed application within ten (10) business days of the request, a rush fee will apply.
- X. It is the responsibility of the accredited paramedic to notify SLOEMSA within seven (7) days of any arrest or change in their eligibility status. Failure to report such actions may result in disciplinary action.
- Y. The SLOEMSA Medical Director must approve exceptions to any reaccreditation requirement.

## V. PROCEDURE

- A. Candidates for paramedic reaccreditation must complete the SLOEMSA Paramedic Application for County Accreditation – Attachment A and supply documentation establishing eligibility for reaccreditation as follows:

- 1. Current government-issued photo identification.



2. Current and valid paramedic license issued by the California EMS Authority.
  3. Possess current certification as a Cardiopulmonary Resuscitation (CPR) Provider according to the American Heart Association guidelines for BLS Healthcare Providers or other course approved by the SLOEMSA Medical Director.
  4. Proof of completion of the SLOEMSA EMS Update course from each year of the preceding two (2) year accreditation period.
  5. Completion of two (2) Paramedic Skills Annual Verification Tracking Sheet- Attachment B. One (1) sheet of low use / high risk skills shall be completed every 12 months of accreditation either in the field during patient care or under the observation of a FTO or other EMS Agency approved evaluator, using the Skills Verification Checklists- Attachment C.
    - a. One (1) adult and one (1) pediatric cardiac arrest management skill shall be verified every six (6) months for a total of four (4) each during the two (2) year accreditation period.
    - b. One (1) intubation skill shall be verified every three (3) months for a total of eight (8) during the two (2) year accreditation period. Intubation requirements exclude supraglottic airway adjunct (SGA) use.
  6. A letter of employment from a SLO ALS provider indicating employment as a paramedic.
  7. Proof of attendance at four (4) base station meetings in the preceding two (2) year accreditation period.
- B. Reaccreditation will be for a maximum of two (2) years.
1. The effective date of reaccreditation will be the date the candidate meets all local requirements.
  2. The reaccreditation will expire on the same date as:
    - a. The paramedic license issued by the California EMS Authority, or
    - b. The paramedic is no longer employed as a paramedic by a SLO ALS provider, or
    - c. The paramedic does not meet accreditation requirements.

## VI. AUTHORITY

- State of California Code of Regulations, Title 22
- California Health and Safety code, Division 2.5

## VII. ATTACHMENTS

- A. Paramedic Application for County Accreditation
- B. Paramedic Skills Annual Verification Tracking Sheet
- C. Skills Verification Checklists

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

## **POLICY #125: PREHOSPITAL DETERMINATION OF DEATH / DO NOT RESUSCITATE (DNR) / END OF LIFE CARE**

### I. PURPOSE

- A. To establish criteria for the determination of death and/or the termination of resuscitative measures and outline the procedure to be followed by EMS personnel in the County of San Luis Obispo (SLO).

### II. DEFINITIONS

- Resuscitation: medical interventions whose purpose is to restore cardiac or respiratory activity at the scene of an emergency, which includes chest compressions (CPR), assisted ventilation (breathing), endotracheal intubation, defibrillation, and cardiotoxic drugs (heart stimulating drugs).
  - Such measures do **not** affect the provision of life sustaining measures of artificial nutrition or hydration or the provisions of other emergency medical care, including treatment for pain, difficulty breathing, major bleeding, or other medical conditions.

### III. POLICY

- A. EMS Personnel may withhold or terminate resuscitation, determine that a patient is dead, and leave the body in custody of medical or law enforcement personnel, according to the procedures outlined in this policy.
- B. The following Do Not Resuscitate (DNR) orders are considered operative to withhold resuscitative measures from patients in accordance with their wishes and the procedures outlined in this policy:
  1. California Durable Power of Attorney for Health Care (DPAHC): As defined in California Civil Code, Sections 2410-2444 and a health care agent designated therein is present, and that agent requests that resuscitation not be done.
  2. Physician Order for Life-Sustaining Treatment (POLST) – Section A “Do not attempt resuscitation/DNR (Allow Natural Death)”
  3. A fully executed Natural Death Act Declaration
  4. DNR Medallion: A metal or permanently imprinted insignia, worn by a patient, that has been manufactured and distributed by an organization approved by the California State Emergency Medical Services Authority. The insignia must be imprinted with the words “Do Not Resuscitate, EMS,” “Do Not Resuscitate, or “POLST”.
  5. A written document in the patient’s permanent medical record for patients who are in a licensed health care facility, or who are being transferred between licensed health care facilities containing the statement “Do Not Resuscitate”, “No Code”, or “No CPR” **has been read and reviewed** on scene by EMS personnel,

**and** whose authenticity has been verbally documented by a witness from the health care facility.

- C. Nothing in this policy will prevent peace officers from acting within the scope and course of their official duties and pronouncing death as permitted by the policies of their agencies.

#### IV. PROCEDURE

##### A. General Guidelines

1. All patients require rapid and immediate medical evaluation.
2. The highest medical authority on scene shall determine death in the field.
  - a. If BLS responders have any questions or uncertainty regarding determination of death, then BLS measures shall be instituted until arrival of ALS personnel.
  - b. If ALS responders have questions or uncertainty regarding determination of death, ALS measures shall be instituted until base hospital contact is made and orders are received.
3. EMS Personnel who arrive on scene after the patient is determined to be dead shall not re-evaluate the patient.
4. The Coroner must be contacted when resuscitation has been withheld or terminated:
  - a. Deceased patients should not be moved unless directed by the Coroner, to access other patients requiring medical care or assessment, for the safety of First Responders, or for other extraordinary circumstances.
  - b. All IV lines, airways, etc., must be left in place whenever resuscitation is terminated in the field.
5. Pre-term deliveries or spontaneous abortions with a gestation  $\leq 20$  weeks without signs of life (pulseless, not breathing) are considered non-viable. A first responder may withhold resuscitation on scene.
  - c. If uncertain as to gestational age begin resuscitation and establish base hospital contact.
  - d. Initiation of resuscitation efforts may be also made based on provider judgement of scene itself.
6. References to "signs of life" in the following sections are based on results from assessment procedures described in Table 1.

**Table 1. Assessment procedures for determining absence of signs of life.**

CATEGORY	ASSESSMENT PROCEDURES	ABSENT SIGNS OF LIFE
Respiratory	Open the patient's airway. Auscultate lungs or feel for breaths while observing the chest for movement for a minimum of 30 seconds	No spontaneous breathing. No breath sounds on auscultation
Cardiac	Palpate the carotid artery (brachial for infant) for a minimum of 20 seconds. Auscultate for heart sounds for minimum of 20 seconds. OR ALS ONLY- Monitor the patient's cardiac rhythm for minimum of 1 minute. Obtain a 6-second strip to be retained with the EMS provider's documentation.	No Pulse  No heart sounds.  Asystole in 2 leads
Neurological	Check for pupil response to light.  Check for response to painful stimuli.	No pupillary response  No response to painful stimuli

B. Upon assessment, if the patient is found to be **obviously dead**, based on any of the following conditions, then no further assessment or treatment shall be started, and base hospital contact is not required:

- Decapitation
- Incineration
- Evisceration of heart or brain
- Decomposition

C. Upon assessment, resuscitation may be withheld without the need for base hospital contact if the patient is absent signs of life **AND** any of the following criteria are met:

1. Rigor mortis and/or dependent lividity is present
  - a. Rigor is determined to be present when found in the jaw **and** at one more joint(s)
  - b. Dependent lividity is determined by checking dependent areas of the body for purplish-red discoloration
2. Traumatic arrest and absent signs of life upon EMS arrival
3. Reliable history of cardiac arrest with no CPR rendered for more than 20 minutes
4. Severe or multiple injuries clearly incompatible with life
5. EMS personnel are presented with an operative Do Not Resuscitate (DNR) order

D. Consultation with Base Hospital is required prior for withholding or terminating resuscitation efforts under the following circumstances:

1. Consultation with the STEMI Base Hospital (French Hospital) physician or MICN:
    - a. Termination of resuscitative measures for medical arrest of cardiac origin > 34 kg unresponsive to ALS procedures after 20 min of resuscitation (include a capnography reading if available)
    - b. Mechanical ventricular device is present
  2. Consultation with the SLO Trauma Center (SVRMC) physician or MICN:
    - a. Traumatic Arrest **with** signs of life upon EMS arrival, unresponsive to ALS procedures and more than 20 minutes estimated time for transport to Trauma Center or closest hospital (refer to protocol #661)
  3. Consultation with the closest SLO base hospital physician or MICN:
    - a. All other termination orders: e.g. medical arrest of pediatrics <34kg, atraumatic arrests due to non-cardiac origin (refer to protocol #641)
- E. An operative **DNR is presented for patient with a pulse and or respiratory effort**:
1. Provide care and treatment within paramedic scope of practice, unless clearly excluded by the documents
  2. POLST - follow the directions noted in Section A - cardiopulmonary resuscitation (CPR) and Section B - medical intervention
  3. Other advanced directives - follow any supportive care and interventions as noted
  4. Consult the Base Hospital if situation or legitimacy of the DNR is unclear
- F. During a **Mass Casualty Incident (MCI)**, determination of death procedures are modified as follows:
1. Utilize START Adult Triage Algorithm and JumpSTART Pediatric Triage Algorithm for the assessment of patients.
  2. Base contact is **NOT** necessary for withholding resuscitation efforts or determination of death during an MCI.
  3. A triage tag denoting "black" with the time of the initial evaluation and findings must be applied to the patient.

## V. DOCUMENTATION

- A. The circumstances under which resuscitation was not initiated or was terminated, including results of physical exam, and/or any additional findings such as a lack of heart and lung sounds, fixed and dilated pupils, skin color, ECG tracing and capnography if available
- B. The resuscitation measures performed, if any, and the results thereof.
- C. The name of the EMS personnel terminating resuscitative measures or the name of the Base Hospital physician who pronounced the patient
- D. The time of termination or non-initiation of resuscitation

E. When DNR is present:

1. Name of physician on the DNR
2. Date the DNR order was signed
3. Type of DNR - attach copy when possible
4. Name of the person that confirmed patient identity
5. Name and certification # of the person and the agency name if determination or resuscitative measures were made by other than the transporting agency

VI. AUTHORITY

- A. Health and Safety Code, Division 2.5, Sections 1797.200, 1797.220, 1798, 1798.6. and Division 7, Section 7180.
- California Code of Regulations, Title 22, Division 9, Sections 100015, 100144, 100147, and 100169.
- California Probate Code Sections 4780-4785.
- California Code of Regulations, Title 22, Sections 70707(6), 72527(a) (4).
- AB19 California POLST eRegistry

VII. REFERENCES

- [POLST California](#)
- [START Adult Triage Algorithm - CHEMM](#)
- [JumpSTART Pediatric Triage Algorithm - CHEMM](#)



**COUNTY OF SAN LUIS OBISPO HEALTH AGENCY**  
**PUBLIC HEALTH DEPARTMENT**

**Nicholas Drews** *Health Agency Director*

**Penny Borenstein, MD, MPH** *Health Officer/Public Health Director*

MEETING DATE	April 3 <sup>rd</sup> , 2025
STAFF CONTACT	Kaitlyn Blanton, EMS Coordinator 805.788.2513 kblanton@co.slo.ca.us
SUBJECT	Procedure #704 Opioid Withdrawal – implementation of Suboxone and County Plan
SUMMARY	<p>In conjunction with the County's Strategic Plan for 2025, the introduction of Protocol #XXX (no currently assigned numeric) for Opioid Withdrawal has been drafted. This new protocol will include the addition of Suboxone to our County as an ALS pre-hospital medication with Base Orders. Aligned with the California Bridge Program ideals, this draft protocol has been created with the intention of benefiting patients experiencing Opioid withdrawal symptoms with the intent of seeking resources for treatment.</p> <p>Procedure #704 Needle Cricothyrotomy has been updated with language approving ALS providers to follow manufacture guidelines for brand specific instructions on their equipment.</p>
REVIEWED BY	Dr. William Mulkerin, SLOEMSA Staff
RECOMMENDED ACTION(S)	Listed attachments are recommended for OPS approval to move to CAC agenda
ATTACHMENT(S)	Protocol # xxx – Opioid Withdrawal Suboxone Formulary Procedure #704

**Emergency Medical Services**

2995 McMillan Ave Ste 178 | San Luis Obispo, CA 93401 | (P) 805-781-2519

[www.slocounty.gov/emsa](http://www.slocounty.gov/emsa)



NEEDLE CRICOTHYROTOMY	
ADULT	PEDIATRIC (≤34KG)
BLS	
<ul style="list-style-type: none"> <li>• Universal Protocol #601</li> <li>• Attempt BLS maneuvers for airway obstruction</li> <li>• Pulse Oximetry – O<sub>2</sub> administration per Airway Management Protocol #602</li> </ul>	
ALS Standing Orders	
<ul style="list-style-type: none"> <li>• Position patient supine</li> <li>• Identify and clean cricothyroid membrane between thyroid cartilage and cricoid cartilage with povidone-iodine and alcohol</li> <li>• With finger marking cricothyroid membrane, stabilize the trachea</li> <li>• Insert large bore IV catheter (maximum 10 Ga.) with a syringe attached at a 45° angle towards the patients feet through the membrane while aspirating. Aspiration of air indicates entry into the trachea</li> <li>• Withdraw the needle, attach a cut 3 mm endotracheal tub and ventilate with BVM               <ul style="list-style-type: none"> <li>○ Refer to manufacturer guidelines and follow specific directions if indicated</li> </ul> </li> <li>• Secure tube and manually stabilize through transport</li> <li>• Assess and reassess lung sounds</li> </ul>	
Base Hospital Orders Only	
As needed	
Notes	
<ul style="list-style-type: none"> <li>• Indications - upper airway obstruction resulting in severe respiratory distress not relieved by conventional airway maneuvers in accordance to Airway Management Protocol #602               <ul style="list-style-type: none"> <li>○ Epiglottitis</li> <li>○ Fractured larynx</li> <li>○ Facial burns with upper airway involvement</li> <li>○ Laryngeal edema or spasm</li> <li>○ Massive facial trauma</li> </ul> </li> <li>• Equipment               <ul style="list-style-type: none"> <li>○ Large IV catheter (10-12 Ga.) with a syringe</li> <li>○ 3mm ET tube – cut distal end to make tube approx. 2"</li> <li>○ Antiseptic products, povidone-iodine/alcohol swabs</li> </ul> </li> <li>• Rapid transport with early notification</li> <li>• In the event of complications – remove and repeat procedure</li> </ul>	

OPIOID WITHDRAWAL	
ADULT	PEDIATRIC (≤34 KG)
BLS Procedures	
<ul style="list-style-type: none"> <li>• <b>Universal Algorithm #601</b></li> <li>• <b>Pulse Oximetry</b> <ul style="list-style-type: none"> <li>○ <b>O<sub>2</sub> Administration per Airway Management Protocol #602</b></li> </ul> </li> <li>• <b>May assist with administration of patient's prescribed medications</b></li> </ul>	<ul style="list-style-type: none"> <li>• <b>Universal Algorithm</b></li> </ul>
ALS Procedures	
<ul style="list-style-type: none"> <li>• If suspected opioid withdrawals, use "COWS" score to determine if patient meets criteria to receive Suboxone <ul style="list-style-type: none"> <li>○ "COWS" ≥ 7 to qualify</li> <li>○ Patient must be agreeable to treatment with goal of seeking resources and counseling</li> </ul> </li> <li>• If believed that patient will benefit from Suboxone with no contraindications – contact nearest Base Hospital for orders</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Suboxone is contraindicated in pediatric patients under 18</b></li> </ul>
Base Hospital Orders Only	
<ul style="list-style-type: none"> <li>• <b>Suboxone</b> 16mg SL tablet– reassess after 10 minutes <ul style="list-style-type: none"> <li>○ Call for secondary 8mg SL dose for persistent or worsening symptoms after 10 minutes</li> <li>○ Give water to moisten mucus membranes prior to SL tablet administration</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• As needed</li> </ul>
Notes	
<ul style="list-style-type: none"> <li>• <b>SEE PAGE 2 FOR COWS SCORE ASSESSMENT TOOL</b></li> <li>• If Suboxone is administered repeat "COWS" score assessment 10 minutes after initial dose and secondary dose if applicable</li> <li>• Patients should have history of any one of the following: <ul style="list-style-type: none"> <li>○ Recent opioid use</li> <li>○ Chronic opioid use</li> <li>○ Evidence of illicit drug use (paraphernalia, needles etc)</li> <li>○ Prescription narcotics in household or on patient</li> </ul> </li> <li>• Naloxone in Suboxone has a negligible SL absorption and should not be factored into dosing totals. Should a patient present in respiratory distress with suspicion of opioid overdose refer to Protocol #618</li> </ul>	

### Clinical Opioid Withdrawal Scale (COWS)

<b><u>ANXIETY OR IRRATIBILITY</u></b> <i>Visually observed during assessment</i> <b>0</b> None <b>1</b> Reports increasing irritability or anxiousness <b>2</b> Visually irritable or anxious <b>4</b> Too irritable to participate or affecting participation	<b><u>RESTING HEART RATE</u></b> <i>Measured after sitting for one (1) minute</i> <b>0</b> ≤80 bpm <b>1</b> 81 to 100 bpm <b>2</b> 101 to 120 bpm <b>4</b> >120 bpm
<b><u>BONE OR JOINT ACHES</u></b> <i>Only new pain attributed to withdrawal is scored</i> <b>0</b> Not present <b>1</b> Mild, diffuse discomfort <b>2</b> Reports severe, diffuse aching of joints/muscles <b>4</b> Patient rubbing joints/muscles and unable to be still	<b><u>RESTLESSNESS</u></b> <i>Visually observed during assessment</i> <b>0</b> Able to be still <b>1</b> Report difficulty being still, but able to do so <b>3</b> Frequent shifting or extraneous movement of legs/arms <b>5</b> Unable to be still for more than a few seconds
<b><u>SKIN SIGNS</u></b> <i>Visually or physically observed during assessment</i> <b>0</b> Skin is smooth <b>3</b> Piloerection of skin – can be felt or visible arm hairs standing up <b>5</b> Prominent piloerection – “Gooseflesh Skin”	<b><u>TREMOR</u></b> <i>Observation of outstretched hands</i> <b>0</b> No tremors <b>1</b> Tremor can be felt but not observed <b>2</b> Slight tremor observed <b>4</b> Gross tremor or muscle twitching
<b><u>GASTROINTESTINAL UPSET</u></b> <i>Within past 30 minutes</i> <b>0</b> No GI symptoms <b>1</b> Stomach cramps <b>2</b> Nausea or loose stool <b>3</b> Vomiting or diarrhea <b>5</b> Multiple episodes of diarrhea or vomiting	<b><u>SWEATING</u></b> <i>Over past 30 – <b>not</b> from environment or activity</i> <b>0</b> No reports of chills or flushing <b>1</b> Subjective report of chills or flushing <b>2</b> Flushed or observable moistness to face <b>3</b> Beads of sweat on brow or face <b>4</b> Sweat streaming off of face
<b><u>PUPIL SIZE</u></b> <i>Visually observed during assessment</i> <b>0</b> Pupil pinned or normal size for ambient light <b>1</b> Pupils possibly larger than normal for ambient light <b>2</b> Pupils moderately dilated <b>5</b> Pupils very dilated	<b><u>YAWNING</u></b> <i>Visually observed during assessment</i> <b>0</b> No Yawning <b>1</b> Yawning once or twice during assessment <b>2</b> Yawning three or more times during assessment <b>4</b> Yawning several times per minute
<b><u>RUNNY NOSE OR TEARING</u></b> <i>Not accounted for by cold symptoms or allergies</i> <b>0</b> Not present <b>1</b> Nasal stuffiness or unusually moist eyes <b>2</b> Runny nose or tearing <b>4</b> Nose constantly running or tears streaming down face	<b>TOTAL COWS SCORING</b> <b>5 - 12</b> Mild Withdrawal <b>13 - 24</b> Moderate Withdrawal <b>25 - 36</b> Moderately Severe Withdrawal <b>&gt;36</b> Severe Withdrawal

**Buprenorphine/Naloxone (Suboxone®)**  
**(Base Hospital Order Only)**

**Classification:** Narcotic analgesic combination (Class III)

**Actions:**

1. Buprenorphine; partial mu-receptor opioid agonist
2. Naloxone; opioid antagonist

**Indications:**

1. Management of opioid withdrawal in adults with moderate to severe opioid drug dependence

**Contraindications:**

1. **Patients under 18 years of age**
2. **Recent methadone use (within 10 days)**
3. **Pregnancy**
4. **No signs of Opioid withdrawal or COWS <7**
5. **Altered mental status – unable to give consent**
6. **Severe medical illness – sepsis, respiratory distress, hypoglycemia etc**

**Adverse Effects (Precautions, Side Effects and Notes)**

1. Headache
2. Nausea/Vomiting
3. Respiratory Depression

**Administration:**

**ADULT DOSE – Base Hospital Order Only**

1. **Suboxone – 16 mg SL tablet, reassess after 10 minutes**
  - a. 8 mg SL tablet secondary dose if ordered by Base Hospital after 10 minute reassessment

**PEDIATRIC DOSE**

2. **None - Contraindicated in patients under 18 years of age**

**Onset:** 20 – 40 minutes  
Peak effect 3-4 hours\*

**Duration:** 24+ hours

**Notes:** Naloxone has a negligible SL absorption and should not be factored into dosing totals. Should a patient present in respiratory distress with suspicion of opioid overdose refer to Protocol #618