Operations Subcommittee
of the Emergency Medical Care Committee

Meeting Agenda:
9 A.M., April 2, 2026
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, *Hospitals*
Kris Strommen, *Ambulance Providers*
Rob Jenkins (John Pearl)*, Fire Service*
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*
Anthony Gutierrez, *Field Provider-Paramedic*
Chief Scott Hallett, Fire Service

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 December 4, 2025	
Discussion	**Policy Revisions:** • 154 Hospital Diversion • 158 APOT Monitoring • 222 Mechanical CPR • 124 Documentation of Prehospital Care	Ryan Rosander
Discussion	**Policy Revisions:** • 153 Trauma Patient Triage and Destination	Kaitlyn Blanton

Discussion	**Policy Attachment Revision:** • 153 Attachment A	Kaitlyn Blanton
Discussion	**Policy Attachment Revision:** • 205 Attachment A	Bill Mulkerin
Adjourn	Declaration of Future Agenda Items: - Roundtable Next Meeting Date: June 4, 2026 Location: SLOEMSA Conference Room 2995 McMillan Ave, STE #178, San Luis Obispo	Jay Wells

Operations Subcommittee

Meeting December 4, 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
Anthony Gutierrez, Fire Service
Casey Bryson, Fire Service

MEMBERS ABSENT:
Tim Nurge, Ambulance Providers
Scotty Jalbert, OES
Jon Ontiveros, CHP
Dan McCrain, Fire Service
Jennifer Mebane, Med-Com
Adam Forrest, Hospitals
Dennis Rowley, Air Ambulance providers
Scott Hallett, Fire Service

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

PUBLIC COMMENTORS:
Dusty Renner, SLOCITY

1. CALL TO ORDER

Chair Jay Wells called the meeting to order at 8:56 a.m. He led the review of the meeting protocols and the meeting agenda.

2. REVIEW AND APPROVAL OF October 2, 2025, MINUTES

Action: Rob Jenkins moved approval of the October 2, 2025, Operations Subcommittee Meeting Minutes. Dusty Renner seconded. The motion carried unanimously with no abstentions.

3. Protocols/Policies

The meeting focused on reviewing and updating several EMS policies and protocols. Key discussions included revisions to EMT certification policies, with changes to background check processes and rush fee timeframes, and updates to the EMT basic scope of practice to align with regulations by separating additional skills from optional skills. The committee reviewed new policies for EMT and public safety AED service provider approvals, with EMT providers requiring attestation that personnel are oriented to specific equipment. Two new clinical protocols were presented: an updated burns protocol incorporating best practices from other agencies, and a new scuba diving emergencies protocol requested by Avila Canyon due to their regular diving operations. The burns protocol generated significant discussion about adding a 20-minute cool water treatment for burns under 30% body surface area, removing references to hospital helipad requirements, and clarifying burn center referral criteria language. The diving protocol was refined to emphasize obtaining the patient's dive computer and contacting the Divers Alert Network. The meeting also addressed EMS committee membership renewal processes and provided updates on the upcoming BLS division launch and EMD software implementation, with quotes being obtained from vendors and CAD system compatibility being evaluated with the sheriff's department.

Investigation Purposes and Background Checks:

- Discussed the challenges of contacting people for investigation purposes and mentioned the process of analyzing live scans for background checks without applications.
- The rush fee for applications is currently $93, and it will be updated on July 1.
- Explained the changes in the application form, including the submission information at the bottom.
- Additional skills are being separated from optional skills and will be utilized in the county with minimal additional training.

Implementation Plans for Additional Skills:

- mentions that Dr. Mulkerin will work with agencies interested in implementing additional skills safely.
- Two skills, monitoring intravenous lines and delivering glucose solutions, might need an implementation plan.
- Mentioned that these skills are not currently an issue and can be monitored as the system changes.

Training and Competency Verifications:

- mentions the removal of Section E for continued competency verifications, as it is now part of basic scope.
- Employers may need their own verification or EMS quality improvement programs for certain skills.

- Agencies can opt out of maintaining training on certain skills, such as auto-injectors.

Optional Skills and Accreditation:

- Discussed the addition of language on when skills can be used and the intent to provide standardized training.
- A program fee will be charged for reviewing optional skills, typically costing $180 per hour.
- The next step for optional skills is accreditation, which will be covered in the next policy.

EMT AED Service Provider Approval:

- Introduced a new policy for EMT AED service provider approval, treating it as an attestation.
- The policy requires that all employee EMTs are oriented to specific AED equipment and maintain their equipment.

Public Safety AED Service Provider Approval:

- Discusses the revised public safety AED service provider approval policy, which is simplified to reflect the regulation.
- The policy requires reporting to pre-hospital personnel for documentation.
- Mentions the challenges of tracking AEDs in private businesses and the need for a better structure.

Burn Policy Updates and Burn Center Referral Criteria:

- Presents the updated burn policy, which includes thermal, chemical, and electrical burns, and references burn center referral criteria.
- The policy includes the addition of wheezing and treatments from the respiratory protocol.
- The policy will be revised to emphasize the importance of not delaying transport and to include specific criteria for burns.
- The protocol will be revised to include only the most relevant criteria and to ensure clear communication of destination decisions.
- Explains that the criteria are included to inform destination decisions and to ensure major burn patients are transported appropriately.

Diving Emergencies Protocol:

- Introduced the diving emergencies protocol, which includes best practices for diving emergencies and the importance of obtaining a dive computer.
- The protocol emphasizes not delaying transport and includes specific criteria for different types of diving emergencies.
- The protocol will be revised to focus on the dive computer and include specific criteria for different types of diving emergencies.

4. ADJOURNMENT

5. Action: Rob Jenkins moved to approve. Anthony Gutierrez seconded. The motion carried unanimously.

Adjourned the meeting at 10:04 a.m.

MEETING DATE	April 2, 2026
STAFF CONTACT	Ryan Rosander, EMS Director 805.788.2512 rrosander@co.slo.ca.us
SUBJECT	Hospital Diversion, Documentation, APOT Monitoring, Mechanical CPR Devices
SUMMARY	Policy 154 was updated to modernize the County of San Luis Obispo Emergency Medical Services Agency's hospital diversion standards by replacing the 2018 policy with clearer definitions, stronger EMS Agency oversight authority, improved accountability measures, and more specific criteria for when diversion may be requested. The revised policy clarifies diversion categories, strengthens requirements for hospital internal mitigation prior to diversion, reinforces expectations for continuous availability at specialty care centers, and establishes clearer communication and quality improvement reporting requirements. These updates were necessary to align diversion practices with current EMS system performance expectations, improve consistency across hospitals, reduce inappropriate diversion use stemming from operational throughput issues, and ensure the EMS Agency maintains appropriate regulatory oversight to protect patient access and system reliability. Policy 124 was revised to strengthen documentation standards within the County of San Luis Obispo EMS system by replacing the 2023 policy with clearer minimum documentation expectations, improved legal protections for medical records, defined documentation timelines, and stronger EMS Agency oversight authority. The updated policy improves upon the prior version by simplifying definitions, removing outdated technology references, clarifying documentation as a condition of EMS system participation, strengthening amendment and audit trail requirements, and better aligning documentation practices with current CEMSIS and NEMSIS data standards. These revisions were necessary to modernize documentation expectations, improve data integrity, reduce ambiguity for EMS providers, and ensure documentation supports quality improvement, regulatory compliance, and EMS system performance monitoring consistent with current statewide EMS data management practices. Policy #158 was revised to clarify EMS Agency oversight, strengthen the link between ambulance patient offload times and overall EMS system performance, and emphasize a collaborative quality-improvement approach with system partners. The APOT standard was also updated from 20 minutes to 30 minutes to better align with surrounding California LEMSAs of similar size and ensure a realistic and regionally consistent performance benchmark.

	Policy #222 was previously reviewed by Operations and approved. During the Clinical Advisory Committee meeting, the policy was temporarily deferred to allow discussion of potential Quality Improvement (QI) software options and associated costs. The policy is being brought to the Operations Committee to review any operational or fiscal impacts before returning to CAC and onward to EMCC.
REVIEWED BY	Dr. William Mulkerin, SLOEMSA Staff
RECOMMENDED ACTION(S)	Recommended the following for approval by Operations and moved to the Clinical Advisory agenda: Policy #154: Hospital Diversion, Policy #124: Documentation of Prehospital Care, Policy #158: APOT Monitoring, Policy #222: Mechanical CPR Devices
ATTACHMENT(S)	Policy #154, Policy #124, Policy #158, Policy 222

POLICY #154 HOSPITAL DIVERSION:

I. PURPOSE

A. To establish standardized criteria and procedures for hospital ambulance diversion within the County of San Luis Obispo to ensure patient safety, preserve uninterrupted access to emergency and specialty care, and maintain EMS system stability.

II. POLICY

A. Ambulance diversion is a temporary measure used when a hospital's ability to safely receive additional ambulance patients is significantly compromised.

B. Diversion shall be limited in scope and duration and used only after internal mitigation efforts have been implemented.

C. Specialty Care Center cannot go on diversion for patients in their area of designation.

D. Specialty care destination policies (trauma, STEMI) remain in effect at all times unless conditions described in Section V are met.

E. The EMS Agency retains authority to, at any time, approve, deny, modify, place on, suspend, or terminate diversion status to preserve patient safety and system access.

III. DIVERSION CATEGORIES

A. INTERNAL DISASTER (COMPLETE DIVERSION)

A hospital may request diversion when a declared internal disaster prevents safe patient reception.

Examples include, but are not limited to:

- Fire
- Structural damage
- Power outage affecting patient care
- Hazardous materials contamination
- Active security threat
- Critical system failure impacting patient safety

Staffing shortages, boarding, or inpatient bed unavailability alone do not qualify.

B. EMERGENCY DEPARTMENT SATURATION

A hospital may request ED Saturation diversion when:

1. All ED treatment spaces appropriate for unstable patients are occupied; AND

2. Additional ambulance arrivals would compromise safe monitoring or treatment; AND
3. The hospital has implemented internal surge and mitigation measures; AND
4. The on-call hospital administrator and ED physician concur.

ED Saturation Diversion:

1. Requires consultation with and approval by the EMS Agency Duty Officer;
2. May be approved for up to two (2) hours;
3. After two (2) hours, must be reassessed and reapproved by the EMS Agency Duty Officer prior to continuation;
4. Shall be terminated once safe receiving capacity is restored.

ED Saturation diversion shall not be declared solely for inpatient bed unavailability unless it directly results in unsafe ED conditions.

C. CAPABILITY-SPECIFIC (PARTIAL) DIVERSION

A hospital may request diversion for a defined patient category when critical emergency, diagnostic, or treatment capabilities are temporarily unavailable.

Examples include, but are not limited to:

- CT scanner unavailable, affecting acute stroke or significant head injury evaluation;
- Required specialty physician coverage unavailable for emergency intervention.

Partial diversion applies only to patients requiring the unavailable capability.

Scheduled maintenance affecting key services shall be communicated to the EMS Agency Duty Officer in advance, or as soon as possible thereafter.

IV. CLINICAL EXCEPTIONS

EMS shall transport to the closest appropriate facility regardless of diversion status when, in the paramedic's judgment or base hospital direction, bypass would increase patient risk.

Examples include, but are not limited to:

- Cardiac arrest
- Unstable airway
- Uncontrollable bleeding with rapidly deterioration of vital signs
- Extremis

Units already on hospital property or enroute after base hospital contact shall not be diverted.

V. SPECIALTY CARE CENTERS

A. Designated Specialty Care Centers, including the Trauma Centers, and the STEMI Receiving Center, shall maintain continuous capability consistent with designation requirements.

B. Specialty Care Centers may declare diversion for patients under their area of designation only under one of the following circumstances:

1. A declared Internal Disaster; OR
2. Complete and temporary loss of the designated specialty capability such that the hospital is unable to provide required emergency stabilization and specialty intervention for patients meeting designation criteria.

C. Diversion under subsection (C)(2) requires direct consultation with and approval by the EMS Agency Duty Officer prior to activation.

D. Partial limitation that does not eliminate the hospital's ability to provide emergency stabilization and specialty care shall not constitute grounds for diversion.

E. If a designated Specialty Care Center declares diversion due to Internal Disaster, the facility shall immediately notify the nearest like specialty care center(s) and the EMS Agency.

VI. ACTIVATION AND COMMUNICATION

A hospital requesting diversion shall:

1. Contact the EMS Agency Duty Officer, MEDCOM, and all County of San Luis Obispo Hospitals;
2. Enter diversion status via ReddiNet;
3. Identify diversion category;
4. Provide estimated duration;
5. Identify the approving hospital authority.

Diversion status shall automatically expire after two (2) hours unless renewed with EMS Agency approval.

No two hospitals may simultaneously declare diversion without notifying and coordinating with the EMS Agency Duty Officer.

If ReddiNet is not properly updated, a hospital will not be considered on diversion.

VII. OVERSIGHT AND QUALITY IMPROVEMENT

The EMS Agency shall monitor diversion frequency and duration and may:

1. Audit diversion events in person or remotely;
2. Require corrective action;
3. Modify or suspend diversion privileges when use is excessive or inconsistent with policy.

Hospitals must email a detailed synopsis of any diversion and the actions taken to resolve it. For ED saturation, this includes a comprehensive account of internal surge responses. This should cover timelines, critical decisions, and any staffing or protocol adjustments made. The email should be sent to PH_EMSA@co.slo.ca.us within 24 hours of the diversion.

VIII. 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	

POLICY #158 AMBULANCE PATIENT 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) and to support continuous monitoring of EMS system performance, hospital patient flow, ambulance availability, and support data-driven EMS system improvements. APOT monitoring also supports EMS system reliability and emergency response readiness within San Luis Obispo County

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 30 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 (off EMS gurney and transfer signature obtained) to the 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 the EMS Agency.

B. Ambulance Patient Offload Times should be minimized to ensure efficient transfer of patient care and timely return of EMS resources to service. APOT exceeding 30 minutes shall be classified as an Ambulance Patient Offload Delay (APOD).

C. Hospitals and EMS field personnel shall follow the APOD Mitigation Procedures detailed in Section IV of this policy when an APOD event occurs.

D. The EMS Agency may review APOT and APOD events as part of its EMS system quality improvement responsibilities and may request data or information from hospitals or EMS providers necessary to evaluate system performance and patient care transitions.

E. The EMS Agency maintains oversight of APOT as a system performance indicator and may review delays to identify opportunities to improve EMS system efficiency and patient care transitions. System factors impacting APOT may be considered when evaluating overall EMS system performance.

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 30-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. 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 the EMS Agency 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 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 30-minute ambulance patient offload time standard.
- Work cooperatively with the hospital staff to transition patient care within the timeframes established in this policy.

d. System Performance Monitoring

i. The EMS Agency may evaluate APOD trends to identify opportunities for system improvement. Hospitals experiencing ongoing APOD events may be asked to participate in collaborative improvement discussions or submit mitigation strategies to improve patient offload efficiency.

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	

Local EMS Agency	APOT Standard (Hours:Minutes:Seconds)
Alameda County EMS Agency	0:30:00
Central California EMS Agency	0:30:00
Coastal Valleys EMS Agency	0:20:00
Contra Costa County EMS Agency	0:20:00
El Dorado County EMS Agency	0:30:00
Inland Counties EMS Agency	0:25:00
Imperial County EMS Agency	0:20:00
Kern County EMS Agency	0:30:00
Los Angeles County EMS Agency	0:30:00
Marin County EMS Agency	0:20:00
Merced County EMS Agency	0:30:00
Monterey County EMS Agency	0:30:00
Mountain Counties EMS Agency	0:30:00
Napa County EMS Agency	0:20:00
North Coast EMS Agency	0:30:00
Northern California EMS Agency	0:20:00
Orange County EMS Agency	0:30:00
Riverside County EMS Agency	0:30:00
Sacramento County EMS Agency	0:25:00
San Benito County EMS Agency	0:30:00
San Diego County EMS Agency	0:30:00
San Francisco County EMS Agency	0:30:00
San Joaquin County EMS Agency	0:20:00
San Luis Obispo County EMS Agency	0:20:00
San Mateo County EMS Agency	0:20:00
Santa Barbara County EMS Agency	0:30:00
Santa Clara County EMS Agency	0:20:00
Santa Cruz County EMS Agency	0:30:00
Sierra-Sacramento Valley EMS Agency	0:30:00
Solano County EMS Agency	0:30:00
Stanislaus County EMS Agency	0:30:00
Tuolumne County EMS Agency	0:20:00
Ventura County EMS Agency	0:30:00
Yolo County EMS Agency	0:20:00

POLICY #222 MECHANICAL CPR DEVICES:

I. PURPOSE

II. To establish standard procedures and clinical criteria for the deployment, operation, training, and documentation of all mechanical cardiopulmonary resuscitation (CPR) devices (e.g., LUCAS, AutoPulse) by EMS personnel in San Luis Obispo County.

III. POLICY

Manual chest compressions are the standard of care for patients in cardiopulmonary arrest. Studies have shown no mortality benefit to support the use of mechanical CPR devices over high-quality manual chest compressions. However, there are situations where manual CPR is challenging or dangerous for the prehospital provider, and mechanical chest compressions are preferred.

A. Mechanical CPR devices may be used in adult, non-traumatic cardiac arrest patients when continuous, high-quality manual chest compressions are not feasible, or when fatigue is a concern.

B. Mechanical CPR devices are not mandatory and should be used at the provider's discretion.

C. Agencies must inform SLOEMSA in writing prior to deploying mechanical CPR devices in the field.

IV. PROCEDURE

A. Training & Competency

1. All personnel operating mechanical CPR devices must complete manufacturer-approved initial training and participate in annual refreshers. Training must include indications (listed herein), contraindications (listed herein), device application, troubleshooting, safety, and patient assessment during use.

B. Clinical Indications

1. Prolonged cardiac arrest with ongoing CPR
2. Unsafe environments for manual CPR
3. Limited staffing or when fatigue is a concern
4. If not already placed, prophylactic application prior to transport in patients with ROSC in case of rearrest. The device should only be activated in the event of rearrest
5. Provider discretion

C. Contraindications

1. Pediatric patients
2. Traumatic cardiac arrest
3. Presence of ventricular assist device (VAD)
4. Incompatible patient body size or anatomy
5. Patients who meet SLOEMSA Policy #125: Prehospital Determination of Death / Do Not Resuscitate (DNR) / End of Life Care

D. Device Application

1. Manual CPR should be performed immediately on patient arrival. Do not delay the initiation of chest compressions to place the mechanical CPR device.
2. Apply the device using deployment to minimize interruptions. Please note that the principles of High-Performance CPR (HPCPR) remain the top priority, 10 sec. Confirm proper positioning and secure attachment. Monitor for movement, malfunctions, and signs of ROSC.

The EMS crew shall use an objective timing method (e.g., monitor/defibrillator event marker and/or a CPR quality data monitoring program) to verify that all pauses in chest compressions are less than 10 seconds. The expectation is that an EMS agency using a mechanical CPR device would be able to provide documented verification of pause length during its application (and ongoing use during management of a patient in cardiac arrest).

4. Follow device-specific manufacturer instructions for application and operation.

E. Documentation

1. Time of device application and removal.
2. Type of device used.
3. Any complications or malfunctions.
4. Electronic record for CQI that verifies that the longest pause was < 10 seconds, unless there was a clinical reason to explain a longer pause, such as but not limited to a hazardous scene requiring emergent patient movement, or other unexpected event that would justify a longer pause in compressions.

V. AUTHORITY

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

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

MEETING DATE	April 2, 2026
STAFF CONTACT	Kaitlyn Blanton, EMS Coordinator kblanton@co.slo.ca.us
SUBJECT	Documentation, Trauma Triage Steps
SUMMARY	Policy #124 was revised to strengthen documentation standards within the County of San Luis Obispo EMS system by replacing the 2023 policy with clearer minimum documentation expectations, improved legal protections for medical records, defined documentation timelines, and stronger EMS Agency oversight authority. The updated policy improves upon the prior version by simplifying definitions, removing outdated technology references, clarifying documentation as a condition of EMS system participation, strengthening amendment and audit trail requirements, and better aligning documentation practices with current CEMSIS and NEMSIS data standards. These revisions were necessary to modernize documentation expectations, improve data integrity, reduce ambiguity for EMS providers, and ensure documentation supports quality improvement, regulatory compliance, and EMS system performance monitoring consistent with current statewide EMS data management practices. Policy #153 and #153 - Attachment A, have been updated from the 2017 version in partnership with The American College of Surgeons (ACS) Committee on Trauma (COT) guidelines and San Luis Obispo County's Trauma Center, receiving guidance from their Trauma Medical Director and Trauma Program Manager. Additions to the current Trauma Triage Steps are intended to expand San Luis Obispo County's current field activation criteria as well as better align itself with the Trauma Tiers utilized in-house at the San Luis Obispo County Trauma Center. Implementation is intended to ensure optimal patient outcomes across the continuum of care. Definitions have been simplified to reduce confusion among EMS providers regarding transportation expectations. All Medical Direction remains within San Luis Obispo County.
REVIEWED BY	Dr. William Mulkerin, SLOEMSA Staff
RECOMMENDED ACTION(S)	Recommended the following for approval by Operations and moved to the Clinical Advisory agenda: Policy #124: Documentation of Prehospital Care, Policy#153 Trauma Patient Triage and Destination, Policy #153 Attachment A
ATTACHMENT(S)	Policy#124, Policy #153, Policy #153 Attachment A

POLICY #124: DOCUMENTATION OF PREHOSPITAL CARE

I. PURPOSE

A. To establish minimum standards for EMS patient care documentation within the County of San Luis Obispo to ensure accurate documentation, regulatory compliance, quality improvement, and EMS system oversight.

II. DEFINITIONS

- Documentation: The recording of patient assessment, treatment, clinical decision-making, and patient disposition in the approved EMS documentation system.
- Electronic Patient Care Report (ePCR): The official electronic medical record documenting prehospital patient care.
- EMS Provider: Any EMR, EMT, paramedic, or authorized responder operating within the EMS system under the EMS Agency authority.
- Patient: A person who has an actual or suspected injury or illness or who requests or requires medical evaluation, treatment, or transport by EMS personnel.
- Patient Contact: Any encounter in which EMS personnel initiate patient assessment or care.
- Transfer of Care: When an EMS provider relinquishes their responsibility of providing medical treatment to a patient after giving a full report to medical staff at a receiving hospital or facility. Transfer of care is only complete once a patient has been transferred off of an EMS gurney, signatures obtained by receiving medical providers, and verbal report has been given. Refer to EMS Agency Policy #158: Ambulance Patient Offload Time (APOT)
- CEMSIS: The California EMS Information System, the statewide EMS data repository managed by the California EMS Authority.
- NEMSIS: The National Emergency Medical Services Information System (NEMSIS) is the national system used to collect, store and share EMS data from the U.S. and Territories.
- EMS Agency Data Repository: The EMS data system designated by the EMS Agency for submission, validation, and management of EMS documentation.

III. POLICY.

A. All EMS providers shall complete electronic patient care documentation for all patient contacts using an EMS Agency-approved documentation system.

B. The electronic patient care report (ePCR) shall serve as the official legal medical record of prehospital care and shall accurately reflect patient assessment, treatment, clinical decision-making, and disposition.

C. Compliance with documentation requirements is a condition of participation in the EMS system.

D. Documentation shall be accurate, complete, objective, timely, and capable of supporting clinical care, quality improvement, EMS system evaluation, and regulatory review.

IV. REQUIRED DOCUMENTATION

A. An electronic patient care report shall be completed for all patient transports, patient contacts, refusals of care, treatment without transport, ALS assessments, cardiac arrest incidents, trauma activations, STEMI alerts, stroke alerts, and any incident in which patient care is provided.

B. Documentation is not required for responses canceled prior to patient contact; however, sufficient incident information shall be recorded to document the response and reason for cancellation.

V. DOCUMENTATION REQUIREMENTS

A. Documentation shall accurately describe the patient encounter and support clinical decision-making.

B. Required documentation elements include incident information, responding unit identification, personnel involved in patient care, response times, patient demographics when obtainable, chief complaint, assessment findings, vital signs, treatments performed, medications administered, procedures performed, patient response to treatment, disposition, and destination facility.

C. Documentation should reflect only care provided. Providers should document care rendered by other responders when known and clinically relevant.

D. All ePCR documentation for patients that are transported to a hospital or receiving facility shall have a minimum of two sets of vitals obtained and documented.

E. All ePCR’s involving specialty care systems (Stroke, STEMI, Trauma, and Cardiac Arrest) shall have vitals obtained and documented every 5 minutes for the duration of the call.

F. If cardiac monitoring is performed, significant ECG findings shall be included in the record.

VI. NARRATIVE REQUIREMENTS

A. The documenting provider shall complete a narrative accurately describing the patient encounter, including patient presentation, chief complaint, relevant history, assessment findings, clinical impression, treatments provided, patient response, and disposition.

B. Documentation shall clearly support clinical decision-making and be written in a manner understandable to other healthcare providers. Common clinical abbreviations or acronyms may be used when documentation remains clear and interpretable.

C. Artificial Intelligence and automatically generated narratives are not permitted.

VII. DOCUMENTATION TIME REQUIREMENTS

A. Documentation for critical patients, including trauma alerts, cardiac arrest patients, STEMI alerts, stroke alerts, and Code 3 transports, shall be completed as soon as practical but no later than 12 hours following transfer of care.

B. Documentation for all other transports and non-transport patient contacts shall be completed no later than twenty-four hours following the incident or by the end of shift, whichever occurs first.

VIII. DOCUMENTATION OF REFUSALS

A. Documentation of patient refusals shall be completed by the EMS provider who has authority for patient health care management, consistent with EMS Agency Policy #200: Scene Management. This provider is responsible for completion of the ePCR, documentation of the patient assessment, and obtaining all required refusal signatures.

B. When BLS and ALS providers are present, BLS personnel shall complete documentation of care provided until authority for patient health care management has been transferred to the ALS provider. The ALS provider assuming authority shall be responsible for completion of the refusal documentation and required signatures.

C. For additional refusal documentation requirements and definitions see EMS Agency Policy #203 Patient Refusal of Treatment and/or Transport.

IX. DOCUMENTATION CORRECTIONS AND AMENDMENTS

A. The ePCR is a legal medical record and shall not be altered in a manner that removes or obscures original documentation.

B. Errors shall be corrected using approved amendment or addendum functions that maintain the original entry and audit trail.

C. Amendments shall include the date, time, person making the correction, and reason for the change.

D. Late entries shall be identified as such and include the reason for delayed documentation.

E. Documentation shall not be altered to misrepresent patient care, conceal errors, or avoid quality improvement or assurance review.

F. Documentation shall not be modified after notification of a complaint, investigation, or legal request except through proper amendment procedures.

G. All documentation shall be completed by the individual who wrote the original ePCR,.

H. Agencies shall ensure documentation integrity through internal review processes.

I. The EMS Agency may require documentation corrections when deficiencies are identified. Patterns of documentation deficiencies may result in a quality improvement or assurance review, a system compliance action, or a participation review.

X. DATA STANDARDS

A. Documentation shall comply with current CEMSIS requirements, NEMSIS standards, and the EMS Agency data repository required data elements.

B. The EMS Agency may establish or modify documentation requirements as necessary to maintain regulatory compliance, improve data quality, support EMS system oversight, or support quality improvement activities.

C. Documentation may be used for EMS system performance evaluation, regulatory reporting, and state audit review.

XI. TRANSFER OF CARE

A. Documentation shall reflect transfer of patient care, including receiving facility or provider, patient condition at transfer, treatments provided, and significant clinical findings.

B. EMS units shall not return to service prior to appropriate transfer of care unless operational necessity exists.

A. Ambulance patient offload times (APOT) shall be documented per the local standard, as well as any delays in patient turnover of care (APOD) – see EMS Agency Policy #158 Ambulance Patient Offload Time (APOT) Monitoring

XII. SYSTEM PARTICIPATION

A. Participation in the EMS system requires compliance with all documentation standards.

B. EMS providers and agencies shall submit required documentation, maintain documentation accuracy, meet submission timelines, and participate in documentation review and quality improvement processes.

C. The EMS Agency may review documentation for quality improvement, protocol compliance, system performance monitoring, public health reporting, and regulatory compliance.

D. The EMS Agency may conduct documentation audits to ensure compliance with documentation standards, regulatory requirements, and EMS system participation requirements.

E. The EMS Agency may require corrective action when documentation deficiencies are identified.

F. EMS providers and agencies shall submit required documentation within timelines established by the EMS Agency.

XIII. RECORD RETENTION

A. EMS providers shall comply with applicable medical record retention requirements in accordance with California Code of Regulations Title 22 and applicable law.

XIV. CONFIDENTIALITY

A. All patient documentation shall comply with HIPAA, the California Confidentiality of Medical Information Act, applicable state regulations, and County privacy policies. Access shall be limited to authorized individuals.

XV. COMPLIANCE

A. Failure to meet documentation requirements may result in quality improvement review, corrective action, or system compliance action.

B. Intentionally falsifying documentation or failing to meet documentation requirements, such as not submitting an ePCR, may lead to an investigation in accordance with the California Health and Safety Code and related regulations.

C. The EMS Agency may request amendments and documentation correction when improper documentation is found, following the quality improvement or assurance review.

D. Any EMS personnel involved in patient assessment, treatment, or patient contact who fail to complete required documentation may be subject to quality improvement review, quality assurance investigation, or EMS system compliance action.

XVI. AUTHORITY

- California Health and Safety Code Division 2.5
- California Code of Regulations Title 22 Division 9
- California Code of Regulations Title 22 Division 5

Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

POLICY #153: TRAUMA PATIENT TRIAGE AND DESTINATION

I. PURPOSE

A. To establish guidelines for EMS personnel to identify and transport "significantly injured" patients who could benefit from the rapid response and specialized services of a trauma center.

II. ~~SCOPE~~

~~A. This policy applies to both adult and pediatric injured patients, unless stated otherwise.~~

III. PROCEDURE

A. Trauma Activation Criteria

1. "STEP 1, STEP 2, or STEP 3 TRAUMA ALERT" - Patient meeting any one of the Physiologic (Step 1) and/or Anatomic criteria (Step 2) and/or Mechanism of Injury (Step 3) following a traumatic event shall be designated a "TRAUMA ALERT" and shall be transported to the closest trauma center. The target off-scene time should be 10 minutes or less for transport personnel.

2. ~~"STEP 3 TRAUMA CONSULTATION" - Patient meeting (Step 3) Mechanism of Injury - contact with the County of San Luis Obispo (SLO) Trauma Center for patient destination. The target off-scene time should be 10 minutes or less for transport personnel.~~

3. "STEP 4 TRAUMA CONSULTATION" - A trauma consultation with the County of San Luis Obispo Trauma Center shall be made to determine patient destination when a paramedic identifies a significantly injured patient who does **not** meet Step 1 (Physiologic), Step 2 (Anatomic), or Step 3 (Mechanism of Injury) criteria, but meets one or more Step 4 (Special Patient or System Considerations) criteria, unless the intended destination is already the closest trauma center.

B. Trauma Patient Criteria

1. ~~Patients meeting any one of the Physiologic and/or Anatomic and/or Mechanism of Injury criteria following a traumatic event shall be a "TRAUMA ALERT" and transported to the closest trauma center. Patient meeting Mechanism of Injury and/or Special Patient/System Considerations shall be a "TRAUMA CONSULT" and contact the County of SLOTrauma Center for patient destination, unless the patient's intended destination is already a Trauma Center.~~

C. Medical Direction

1. All Base Hospital requests and/or orders, regardless of Trauma Center destination, shall be made to the County of ~~SLO~~ San Luis Obispo Trauma Center.

D. Closest Trauma Center

The closest Trauma Center for patients being transported within San Luis Obispo County will be defined as follows:

a. A unit on scene of a call that is located within San Luis Obispo County south of El Campo Rd should proceed to Marian Regional Medical Center.

b. A unit on scene of a call that is located within San Luis Obispo County north of El Campo Rd should proceed to ~~Sierra Vista Regional Medical Center~~ the County of San Luis Obispo Trauma Center.

c. In any other area west or east of El Campo Rd, crews should exercise discretion in determining which trauma center is closest or fastest for patient transport.

d. Discretion in all cases should include abnormal traffic patterns, congestion, or other travel factors affecting transport to the closest and fastest Trauma Center

1. **STEP 1 (Physiologic Criteria)**

The target off-scene time should be 10 minutes or less for transport personnel

Adult Injured patients meeting any one of the following criteria:

a. Pre-hospital advanced airway

b. Glasgow Coma Scale ≤13 (based on patient history attributed to injury)

c. Systolic blood pressure <90mmHg

d. Respiratory rate <10 or >29 breaths per minute

Pediatric injured patients (≤34 Kg) meeting any one of the following:

a. Pre-hospital advanced airway

b. Glasgow Coma Scale ≤ 13 (based on patient history ~~and~~ attributed to injury)

c. Evidence of poor perfusion – color, temperature, etc.

d. Respiratory rate

   1. >60 breaths per minute or respiratory distress
   2. <20 breaths per minute in infants <1year

e. Heart rate

   1. ≤5 years (<22Kg) heart rate <60 beats per minute or >180 beats per minute
   2. ≥6 years (23-34Kg) heart rate <60 beats per minute or >160 beats per minute

f. Blood pressure

   1. Newborn (<1 month) systolic blood pressure <60mmHG
   2. Infant (1 month – 1 year) systolic blood pressure <70mmHg
   3. Child (1 year to 10 years) systolic blood pressure <70mmHg + 2X age in years
   4. Child (11-14 years) systolic blood pressure <90mmHg

2. **STEP 2 (Anatomic Criteria)**

The target off-scene time should be 10 minutes or less for transport personnel

Injured patients meeting any one of the following criteria:

a. All significant penetrating injuries to head, neck, torso and extremities proximal to knee or elbow
b. Chest wall instability or deformity (e.g. flail chest)
c. Two proximal long bone fractures (above the elbows and knees)
d. Mangled, degloved, crushed, or pulseless extremity
e. Open or depressed skull fracture
f. Paralysis or suspected spinal cord injury with new onset motor or sensory deficits
g. Pelvic injury with high-risk mechanism of injury (motor vehicle collisions, auto vs. pedestrian accidents, motorcycle collisions, falls from heights)
h. Any extremity amputation excluding digits or phalanges
i. Abdominal seat belt sign
j. Strangulation w/ hard signs (voice changes, bruising, discoloration, subcutaneous emphysema, crepitus)

3. **STEP 3 (Mechanism of Injury Criteria)**

The target off-scene time should be 10 minutes or less for transport personnel

Injured patients meeting any one of the following criteria:

a. Falls
   1. Adults: ~~>20 feet~~ >10 feet (one story is equal to 10 feet)
   2. Pediatric: (≤34 Kg) >10 feet (one story is equal to 10 feet)
b. High-risk auto crash
   1. Passenger Space Intrusion (PSI) of space: >12 inches occupant patient site; or >18 inches anywhere within the passenger space
   2. Ejection (partial or incomplete) from automobile
c. Auto vs. pedestrian/bicyclist thrown, run over, or with significant impact (>20 mph)
d. Motorcycle or unenclosed transport vehicle crash (>20 mph)
e. Blunt abdominal injury with significant impact
f. Judicial near hanging (fall or jump associated)
g. Pediatric ages 0-9 unrestrained or improperly restrained (MVC)

4. **STEP 4 (Special Patient or System Considerations)**

Age and co-morbid considerations

Injured patients meeting any one of the following criteria:

a. EMS provider judgement
b. Age greater than 65 (SBP <110 mmHg may represent shock)
c. Pediatric (≤34Kg)
d. Pregnancy > 20 weeks

e. Burns with mechanism

f. Vehicle accident with prolonged extrication

g. Submersion event/Drowning with high suspicion or confirmed trauma

h. Anticoagulation therapy (excluding aspirin) or other bleeding disorders with head injury (excluding minor injuries)

NOTE: a "TRAUMA CONSULT" is not required for ground/low level impact falls with GCS ≥ 14 or when GCS is normal for patient

E. Contact the Trauma Center

Contact the receiving trauma center early and immediately upon determining the patient meets trauma patient triage criteria with a "TRAUMA ALERT" or "TRAUMA CONSULTATION"

1. "TRAUMA ALERT"

   a. A "TRAUMA ALERT" is initiated by ALS personnel when an injured patient meets any one of the Step 1 (Physiologic) or Step 2 (Anatomic) or Step 3 (Mechanism of Injury) Criteria. Consider early notification to the intended receiving Trauma Center~~,~~ Notify from the scene when possible.

   b. ~~EMS personnel should provide a "TRAUMA ALERT" early and from the scene when possible to assist in early activation of the trauma team and determination of patient~~ destination.

   ~~c. ALS personnel must contact the trauma center with the TRAUMA ALERT.~~

   d. A "TRAUMA ALERT" report should include the following:

      1. "TRAUMA ALERT" meeting trauma triage step criteria "x"
      2. Unit and paramedic #
      3. ETA to trauma center
      4. Report on individual patient (MIVT format):

      - Age and sex
      - Mechanism of injury and scene
      - Injury and complaint
      - Vital signs including GCS
      - Treatment and response
      - Include specific triage findings or considerations that identify the patient as meeting TRAUMA ALERT criteria.

2. "TRAUMA CONSULTATION"

   a. "TRAUMA CONSULTATION" with the ~~SLO County~~ County of San Luis Obispo Trauma Center should be obtained to determine trauma patient destination when ~~Step 3 (mechanism(s) of injury) criteria or~~ Step 4 (special considerations) are present and Step 1 (physiologic), Step 2 (anatomic), and Step 3 (Mechanism of injury) criteria are NOT met AND the intended patient destination is NOT already a designated Trauma Center

   b. Only ALS personnel may request a "TRAUMA CONSULTATION" for patient destination

c. A “TRAUMA CONSULTATION” report should include the following:

1. “TRAUMA CONSULTATION” meeting trauma triage step criteria ~~“x”~~ 4
2. Unit and paramedic #
3. ETA to Trauma Center and ETA to closest ED if applicable (When a Trauma center is the closest facility, include that information in radio report)
4. Report on the individual patient: (MIVT format)
   - Patient age and sex
   - Mechanism of injury and scene
   - Injury and complaints
   - Vital signs including GCS
   - Treatment and response
   - Include specific findings or considerations that identify the patient as meeting TRAUMA CONSULTAION criteria
5. Paramedic concerns

d. The Trauma center, when not receiving the patient, shall notify the receiving hospital of the incoming patient and provide that hospital with the prehospital care ~~patient~~ information including any Base Hospital orders given.

e. When practical, a brief updated report should be given to the ~~trauma center~~ receiving Hospital by ALS personnel and include any significant changes in route in vital signs, GCS, physical findings, symptoms or treatments.

f. All Base Hospital orders or requests shall be made to the ~~SLO County~~ County of SLO Trauma Center, regardless of destination.

F. Exceptions to Direct Transport to a Trauma Center

Trauma patients will be transported to the closest ED in the following situations:

1. Patient condition deteriorates and ~~necessitates transport to the closest ED, such~~ presents as the following:

   a. Unmanageable airway (Intubation and/or SGA attempts are unsuccessful and an adequate airway cannot be maintained with BVM or other BLS devices)

   b. Uncontrollable bleeding with rapidly deteriorating vital signs

   c. Traumatic cardiac arrest – see ~~EMS Agency Prehospital Determination of Death/Do Not Resuscitate (DNR) End of Life Care Policy #125~~ EMS Agency Policy #125: Prehospital Determination of Death/Do Not Resuscitate (DNR) End of Life Care

2. SLO Trauma Center destination order

3. When a transport unit is directed to an alternate hospital regardless of patient presentation per Incident Command/ Designee (Transportation Unit Leader) during an MCI – see EMS Agency Policy #210: Multi-Casualty Incident Response Plan

4. Patient refusal - see ~~EMS Agency~~ EMS Agency ~~Patient Refusal of Treatment and/or Transport~~ Policy #203: Patient Refusal of Treatment and/or Transport

5. Trauma center is on complete diversion – see ~~EMS Agency Hospital Diversion Policy #154: Hospital Diversion.~~ EMS Agency Policy #154: Hospital Diversion

6. If the County of SLO Trauma Center is on partial diversion, patients meeting Trauma Triage Criteria shall still be accepted by the County of SLO Trauma Center and shall be transported accordingly – see EMS Agency Policy #154: Hospital Diversion

7. Utilization of EMS helicopters for the response/transport of trauma patients ~~must be in accordance with~~ – see EMS Agency Policy #155: EMS Helicopter Operations

IV. AUTHORITY

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

V. ATTACHMENTS

A. Trauma Triage Matrix

IV. Approvals:

EMS Agency, Administrator	
EMS Agency, Medical Director	

TRAUMA ALERT CRITERIA – transport to nearest TC

STEP 1 - Physiologic

TARGET DEPART SCENE ≤ 10 Min

Adult Criteria

- Pre-hospital advanced airway
- Glasgow Coma Scale ≤ 13
- Systolic blood pressure <90 mmHg
- Respiratory rate <10 or > 29 breathe per minute

Pediatric Criteria

- Pre-hospital advanced airway
- Glasgow Coma Scale≤ 13
- Evidence of poor perfusion – color, temperature, etc.
- Respiratory Rate
  - > 60/min or respiratory distress/apnea
  - < 20/min in infants < 1 yr
- Heart Rate
  - ≤ 5 yrs (<22 kg) < 80 or > 180/min
  - ≥ 6 yrs (23-34 kg) < 60 or > 160/min
- Blood Pressure
  - Newborn (<1 month) SBP < 60mmHg
  - Infant (1mo to 1 yr) SBP <70 mmHg
  - Child (1yr to 10 yrs) SBP < 70mmHg + 2X age in yrs
  - Child (11 to 14 yrs) SBP < 90 mmHg

STEP 2 – Anatomic

TARGET DEPART SCENE ≤ 10 MIN

- All penetrating injuries to head, neck, torso, and extremities proximal to the elbow or knee
- Chest wall instability or deformity (i.e. flail chest)
- Two long bone fractures – proximal to elbow or knee
- Mangled, degloved, crushed or pulseless extremity
- Open or depressed skull fracture
- Paralysis or suspected spinal cord injury with new onset motor or sensory deficits
- Pelvic injury with high-risk mechanism of injury
- Any extremity amputation excluding digits or phalanges
- Abdominal seat belt sign
- Strangulation with hard signs (voice changes, bruising, discoloration, subcutaneous emphysema, crepitus)

STEP 3 – Mechanism

TARGET DEPART SCENE ≤ 10 MIN

- Falls
  - Adults - > ~~20~~ 10 feet (one story equals 10 feet)
  - Children (≤34Kg) - > 10 feet ~~or two times their height~~
- High risk auto crash
  - Intrusion of passenger compartment space > 12 inches occupant site or > 18 inches any site including the roof/floor
  - Ejection (partial or complete) from automobile
  - Death in the same vehicle
- Auto vs pedestrian/bicycle thrown, run over, or with significant impact (> 20 mph)
- Motorcycle or unenclosed transport vehicle crash > 20 mph
- Blunt abdominal injury with significant impact
- Judicial near hanging (associated jump or fall)
- Pediatric ages 0-9 unrestrained or improperly restrained (MVC)

If STEPS 1, 2 & 3 not applicable – continue to STEP 4

TRAUMA CONSULT CRITERIA –

Call for destination UNLESS already transporting to TC

STEP 4 – Special Patient and System Considerations

- EMS provider judgement
- Age > 65 yrs or < 14 yrs
- Pregnancy > 20 weeks
- Burns with traumatic mechanism
- Vehicle accident with prolonged extrication
- Submersion event/Drowning with high suspicion or confirmed trauma
- Anticoagulants therapy * (excluding ASA) or other bleeding disorders with head injury (excluding minor injuries)

(*) Trauma Consult is not required for ground level/low impact falls with a GCS ≥ 14 (or GCS is normal for patient) – follow EMS Agency Policy # 151 Destination

Contact TC and Transport to nearest ED with:
-Unmanageable airway
-Uncontrolled bleeding
-Traumatic Arrest

If ALL STEPS not applicable – follow EMS Agency Policy #151 Destination

MEETING DATE	April 2, 2026
STAFF CONTACT	Bill Mulkerin, MD; EMS Medical Director 805.788.2515, wmulkerin@co.slo.ca.us
SUBJECT	Policy 205, Attachment A: EMS Equipment and Supply List; Policy 221: Mechanical CPR Device Policy
SUMMARY	Policy 205, Attachment A: Adjusted minimum stock quantities for various medications. Key changes: Ketamine: quantity 1 for ALS transport units (from prior of qty 2). This is based upon infrequent use, waste of unused medications. Nitroglycerine paste: qty 2 for ALS transport units (from prior of qty 3) Adenosine: increased ALS qty to allow for full treatment of 1 patient Burn sheets: made these optional, except for ALS Wildland Long boards: Expectation is 2 for ALS Transport, but still in service with 1 (to allow for some flexibility if they need to have a quick turnaround from ED after a trauma call).
REVIEWED BY	Dr. Bill Mulkerin, SLOEMSA Staff
RECOMMENDED ACTION(S)	Recommend the following for approval by Operations and moved to the Clinical Advisory agenda: Policy 205, Attachment A, Policy 221
ATTACHMENT(S)	Policy 205, Attachment A: EMS Equipment and Supply List; Policy 221: Mechanical CPR Device Policy

EMS Equipment and Supply List

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum † *Add'l and optional skills as approved*
MEDICATIONS						
Activated charcoal	50 gm bottle (aqueous solution)	1	1	0	0	0
Adenosine	6 mg/2 mL	5	5	5	5	0
Albuterol unit dose	2.5 mg/3 mL solution	4	2	2	2	0
Amiodarone	450mg/9mL (9mL vials)	1	1	1	1	0
	OR					
Amiodarone	150mg/3ml (3ml vials)	3	3	3	3	0
Amiodarone	**Optional** 150mg/100mL NS drip	1	1	1	1	0
†Aspirin	81 mg nonenteric coated chewable	1 bottle	1 bottle	4 tablets	4 tablets	†1 bottle
Atropine	1 mg/10 mL	2	2	2	2	0
Atropine	8 mg multi-dose vial	1	1	0	0	0
Calcium Chloride 10%	1 gm/10 mL	1	1	0	0	0
Dextrose 10%	25 gm/250 mL bag	2	2	1	1	0
*Dextrose 50%	25 gm/50 mL	0	0	0	0	0
Diphenhydramine	50 mg/1 mL	2	2	2	2	0
†Epinephrine	1:1,000 1 mg/1 mL	4	2	2	2	†2
†Epinephrine Auto-Injector	Pediatric and Adult	0	0	0	0	†1 each
Epinephrine	1:10,000 1 mg/10 mL (10 mL preload)	8	6	3	6	0
Fentanyl	100 mcg/2 mL	2	2	2	2	0
Glucagon	1 mg/1 mL	1	1	0	0	0
Glucose gel	15 gm	2 tubes	2 tubes	2 tubes	2 tubes	2 tubes
Lidocaine 2%	100 mg/ 5 mL	1	1	1	1	0
Ketamine	500 mg/ 5mL	1	1	1	1	0
Midazolam	10 mg/ 2 mL	2	1	1	1	0
Naloxone	2 mg (vial or pre-load)	2	2	2	2	0
†Naloxone IN Kit	§2 mg pre-load and Atomizer	0	0	0	0	†2
Nitroglycerine	SL tablets or spray	1 bottle	1 bottle	1 bottle	1 bottle	0
Nitro Paste 2%	1 gm single dose packet	2	2	0	0	0
Ondansetron	4 mg /2 mL injectable	3	3	0	0	0
	4 mg dissolvable tablets	3	3	1	1	0
Sodium Bicarbonate	50 mEq/50 mL	2	2	0	0	0
Magnesium Sulfate	1Gm/2mL	4	4	2	2	0
Ipratropium Bromide	500mcg/3mLsolution	2	2	2	2	0
Buprenorphine	8 mg SL tablet/film	6	3	0	0	0
Tranexamic Acid (TXA)	100 mg/1 mL 10 mL vial	2	1	0	1	0
Variations in the concentration of medications being stocked, due to medication supply shortages, must be approved by Medical Director						
†BLS Basic Scope Add'l Skills equipment required for participating agencies						
Alternate Medications to be Stocked ONLY with Medical Director Approval and Waiver						

EMS Equipment and Supply List

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum † *Add'l and optional skills as approved*
§Other pre-packaged single dose intranasal naloxone delivery devices that may be used with Medical Director Approval		0	0	0	0	†2
Diazepam (alternate to be stocked by order of Med Dir **ONLY**)	10 mg	2	1	1	1	0
Morphine (alternate to be stocked by order of Med Dir **ONLY**)	10 mg	3	2	2	2	0
Lidocaine 2% (alternate to be stocked during Amiodarone shortage by order of Med Dir ONLY)	100mg / 5ml	6	4	3	3	0
IV SOLUTIONS/EQUIPMENT						
0.9% Normal Saline	1,000 mL bag (or equivalent total volume)	6	4	2	4	0
100 mL Saline Delivery Equipment	0.9% NS 100 mL bag	4	2	2	2	0
0.9% Normal Saline	10 mL Vials/Flush	5	5	2	2	0
IV Tubing	10-20gtt/mL	6	3	2	2	0
IV Catheters	Sizes 14, 16, 18, 20, 22, 24 gauge	2 each	2 each	2 each	2 each	0
Syringes	Assorted - 1mL, 3mL, 6mL-20mL	2 each	2 each	1 each	1 each	0
†Syringes BLS only	1mL (draw up epi)	N/A	N/A	N/A	N/A	†2 each
Needles Assorted	½ , 1 , 1 ½ 18-30 gauge	2 each	2 each	2 each	2 each	0
†Needles Assorted BLS only	23 & 25 gauge (draw up epi)	N/A	N/A	N/A	N/A	†2 each
Intraosseous (IO) single needle device	(FDA approved) adult and pediatric	1 each	1 each	1 each	1 each	0
Tourniquets (for IV start)		2	2	2	2	0
Saline locks		4	2	2	2	0
Luer-Lock adaptors	(Not required but recommended for use with STEMI patients)	2	2	0	0	0
†Alcohol and betadine swabs		10 each	10 each	10 each	10 each	†10 each
TRAUMA						
Bandages and bandaging supplies:						
Bandaids	Assorted	10	10	5	5	10
Sterile bandage compresses or equivalent	4"x4"	12	10	10	10	10
Trauma dressing	10"x30" or larger universal dressing	2	2	2	2	2
Roller gauze	3" or 4"	8 rolls	8 rolls	2 rolls	2 rolls	8 rolls
Cloth adhesive tape	1, 2, or 3"	1 roll	1 roll	1 roll	1 roll	1 roll
Triangular bandages with safety pins		4	2	1	1	2
Tourniquet	See approved list for commercial devices	2	2	1	1	2
Vaseline gauze	3"x8", or 5"x9"	2	2	1	1	2

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum *† Add'l and optional skills as approved*
Tongue blade or bite stick		2	2	2	2	2
Burn Sheets (sterile or clean) –	may be disposable or linen (with date of sterilization indicated)	1	1	0	2	1
Cervical collars	Stiff: Sizes to fit all patients over one year old	1each	1 each	1 each	1 each	1 each
Cold packs		2	2	2	2	2
Irrigation equipment and supplies:						
Saline, sterile	250mL	4	2	1	2	2
Long spine board and light weight head immobilizer blocks	(or equivalent immobilization device)	2	1	0	0	1
Straps to secure patient to boards		2 sets	1 set	0	0	1 set
Splints, traction	Adult and pediatric (or a single device suitable for both)	1 each	1 each	0	0	1 each
Splints, cardboard or equivalent	arm and leg splint	2 each	2 each	1 each	2 each	2 each
K.E.D. or equivalent	*optional*	0	0	0	0	0
Pediatric spinal immobilization board	(or equivalent immobilization device)	1	0	0	0	0
Sheet or commercial pelvic binder		1	1	0	0	1
Infection Control						
Meet the minimum requirement per crew member as stated in the California Code of Regulations Title 8 (All Providers)						
Transportation Equipment						
Collapsible gurney cot with adjustable contour feature		1	0	0	0	0
Stair chair or equivalent device		1	0	0	0	0
Sheets, pillow, pillow case, towels, blankets (cloth or disposable)		2	0	0	0	0
Scoop stretcher with straps		1	0	0	0	0
Flat vinyl/canvas stretchers with straps		1	0	0	0	0
MISCELLANEOUS						
Blood pressure cuffs (portable):	Adult	1	1	1	1	1
	Large adult or thigh	1	1	0	0	1
	Pediatric	1	1	0	1	1
Obstetrical kit - sterile, prepackaged		1	1	0	0	1
Restraints - non-constricting wrist and ankle		1 set each	1 set each	0	0	1 set each
Stethoscope		1	1	1	1	1
Trash bags/receptacles		2	2	1	1	2

EMS Equipment and Supply List

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum † *Add'l and optional skills as approved*
Blanket	Disposable	1 each	1 each	1 each	1 each	1 each
Bandage scissors (heavy duty)		1	1	1	1	1
Emesis basins or emesis bags with containers		2	2	1	1	2
Water, potable		1 liter	1 liter	0	1 liter	1 liter
Maps, entire county		1	1	0	0	1
Penlight		1	1	1	1	1
Triage tags		20	20	20	20	20
Bed pan		1	0	0	0	0
Urinal		1	0	0	0	0
†Glucometer	with ≥10 test strips, lancets, and other appropriate supplies	1	1	1	1	†1
†Puncture proof sharps container	small	2	2	1	1	†1
Thermometer		1	1	0	0	0
Automatic External Defibrillator	With AED pads	* For EMT-D Provider Agencies (1)				
AIRWAY						
Endotracheal tubes:	sizes-3.0, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5, 9.0	1 each	1 each	1 each	1 each	0
Laryngoscope handles, with extra batteries		2	2	1	1	0
Laryngoscope blades:	Miller # 0, 1, 2, 3, 4 Macintosh # 1, 2, 3, 4	1 each	1 each	1 each	1 each	0
†i-Gel Supraglottic Airways	Size 1, 1.5, 2, 2.5	1 each	1 each	1 each	0	†1 each
†i-Gel Supraglottic Airways	Size 3 and Size 5	1 each	1 each	1 each	1 each	†1 each
†i-Gel Supraglottic Airways	Size 4	2 each	2 each	1 each	1 each	†2 each
Magill forceps (pediatric and adult)		1 each	1 each	1 each	1 each	0
Adult stylets		2 each	1 each	1 each	1 each	0
10-20 mL syringe, sterile lubricant		2 each	1 each	1 each	1 each	0
Needle Cricothyrotomy kit with:	10 or 12 ga needle, 10-20 mL syringe, alcohol and betadine wipes and oxygen supply adapter OR other FDA approved percutaneous cricothyrotomy kit with MD approval	1	1	1	1	0
Capnography Device	Qualitative or Quantitative	1	1	1	1	0
Hand held nebulizer for inhalation therapy		2	2	1	1	0
Medrafter or equivalent		1	1	0	0	0

Description	Strength/Size	ALS Transport Minimum	ALS First Responder Minimum	ALS Special Use Medic Minimum	ALS Wildland Unit Minimum	BLS First Responder Minimum † *Add'l and optional skills as approved*
Portable, battery powered, cardiac monitor-defibrillator with 12-lead ECG capability with the ability to perform computerized ECG readings and provide hard copy ECG tracings, with:		1	1	1	AED w.manal defib and w/EKG	0
	Patient ECG cable	1	1	1	0	0
	ECG recording chart paper	1	1	1	0	0
	Adult ECG electrodes	4 sets	4 sets	2 sets	2 sets	0
	Defibrillation pads or equivalent - Adult	2 set each	2 set each	1 set each	1 set each	0
	Defibrillation pads or equivalent - Pediatric	1 set each	1 set each	1 set each	1 set each	0
IV catheter for pleural decompression	10 gauge/3 inch	2	2	1	1	0
Asherman chest seal or equivalent open wound dressing		1	1	1	1	1
Pulse oximeter		1	1	1	1	1
Continuous Positive Airway Pressure (CPAP) Ventilator	portable/adjustable pressure settings, FDA Approved with an oxygen supply	1	1	0	0	1
Nasopharyngeal airways (soft rubber)	Medium and Large adult sizes	2 each	2 each	1 each	1 each	2 each
Lubricant, water-soluble jelly (K-Y)		2	2	2	2	2
Oropharyngeal airways	(sizes 5.5 – 12 or equivalent)	2 each	1 each	1 each	1 each	1 each
Adult non-rebreather masks		2	2	1	1	2
Pediatric/infant non-rebreather mask		2	2	1	1	2
Adult nasal cannula		4	2	1	1	2
Oxygen Cylinders	D or E size cylinder with regulator capable of delivering 2-15 LPM	1	1	1	1	1
	M, H, or K cylinder with wall outlet(s) and constant flow regulator(s)	1	0	0	0	0
Oxygen reserve:						
	D or E cylinders	1	1	0	0	1
Face masks for resuscitation (clear)		2	1	1	1	1
Bag-valve mask with O2 reservoir and supply tubing						
	Adult	1	1	1	1	1
	Pediatric	1	1	1	1	1
	Infant	1	1	1	0	1
Suction equipment and supplies:						
Rigid pharyngeal tonsil tip		2	2	0	0	2
Spare suction tubing		1	1	0	0	1
Suction apparatus (portable)		1	1	1	1	1
Suction catheters	at least 2 sizes suitable for adult and pediatric endotracheal suctioning	2 each	1 each	1 each	1 each	1 each