NAPA COUNTY EMS AGENCY

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System Organization & Management

Scene Management and Authority

ADMINISTRATIVE POLICY 1001

1001.1 POLICY

At the scene of a non-disaster medical emergency the following will occur:

1001.2 AUTHORITY FOR MEDICAL EMERGENCY SCENE MANAGEMENT

A. Authority for patient health care management in a non-disaster medical emergency shall be vested in the pre-hospital response personnel holding the highest level of medical certification or license.

B. Not withstanding the above, authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority. The scene of an emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition and priority shall be placed upon the interests of those persons exposed to the more serious and immediate risks to life and health. Public safety officials shall consult emergency medical services personnel or other authoritative health care professionals at the scene in the determination of relevant risks (Health and Safety Code 1798.6).

C. Medical management at the scene of a medical emergency includes:

1. Medical evaluation.
2. Medical aspects of extrication and all movement of the patient(s).
3. Medical care.
4. Patient destination.
5. Transport code.

D. Responsibility for emergency medical management is based on the following order as personnel arrive on the scene:

1. First responder (First Aid).
2. First responder Basic Life Support (BLS).
3. Transport unit BLS.
4. First responder Advanced Life Support (ALS).
5. Transport unit ALS.

E. Whenever a pre-hospital care provider transfers patient care responsibility to another pre-hospital care provider, he/she is responsible for noting that such action took place on the Patient Care Record (PCR). The responsible pre-hospital care provider is (are) required to document patient findings and treatments according to Napa County Emergency Medical Service (EMS) policy.

On-Viewing Medical Emergencies

ADMINISTRATIVE POLICY 1002

1002.1 DEFINITIONS

On-View: When a pre-hospital care provider either comes upon the scene of a medical/traumatic emergency or is flagged down by bystanders requesting assistance for a medical/traumatic emergency for which that provider has not been dispatched.

1002.2 PURPOSE

To coordinate the utilization of Emergency Medical Services (EMS) resources when responding to and coming upon the scene of medical emergencies.

1002.3 POLICY

A. When a pre-hospital care provider comes upon the scene of a medical emergency without being dispatched to that emergency, the crew of that unit shall immediately notify the EMS dispatch of the location and nature of that emergency.

B. If no pre-hospital care responders are on scene and the on-viewing unit is not en-route to another medical emergency or not transporting a patient, the crew of that unit shall stop and render aid including transport, if appropriate or wait until other EMS resources arrive.

C. When en-route to another medical emergency or transporting a patient, notify dispatch and continue current assignment unless redirected by dispatch.

EMS Response to Hazardous Materials Incidents

ADMINISTRATIVE POLICY 1004

1004.1 DEFINITIONS

Exclusion Zone (Hot Zone): The area immediately around the spill.

Contamination Reduction Zone (Warm Zone): Area between the "Exclusion Zone" and the "Support Area". A "Safe Refuge Area" and "Contamination Reduction Corridor" are set up within this area.

Safe Refuge Area: A holding area within the "Contamination Reduction Zone" where victims are placed while waiting for decontamination.

Contamination Reduction Corridor: An area within the "Contamination Reduction Zone" where the actual decontamination takes place. Once cleared, Emergency Medical Services (EMS) personnel receive patients at the end of the "Contamination Reduction Corridor" and move them to the "Support Area" for secondary treatment.

Support Area (Cold Zone): A clean area outside the "Contamination Reduction Zone" where equipment and rescue personnel are staged to receive and treat decontaminated patients.

Secondary exposure to hazardous material is not expected in this area and special clothing is not required.

1004.2 POLICY

Individuals who respond to and function within the Exclusion Zone (Hot Zone) or Contamination Reduction Zone (Warm Zone) must be members of specially trained HazMat teams, trained in the use of self contained breathing apparatus, selection of appropriate chemical protective suits and how to function in them. Other rescuers should be trained in accordance with Federal OSHA standards identified in OSHA 29 CFR 1910.120 and California OSHA as defined in the California Code of Regulations, Title 8, Section 5192.

1004.3 EMS INTERFACE WITH HAZMAT TEAMS

A. The Incident Command System (ICS) shall be used for on scene management.

B. The Medical Branch Supervisor shall make contact with the Incident Commander.

C. Pertinent information will be relayed to the Medical Branch Supervisor including, patient information (number requiring transport and injuries) and the type of exposure chemical, radiological, nuclear, biological or environmental (CRNBE). (For example: chemical name and information about the chemical).

   1. Once cleared by the Site Access Leader, EMS personnel may proceed to the end of the Contamination Reduction Corridor to receive patients. Any secondary treatment by EMS personnel (as it relates to decontamination) should be done in the Support Area.

1004.4 SCENE MANAGEMENT RESPONSIBILITIES SPECIFIC TO HAZMAT INCIDENTS

A. Law Enforcement Responsibilities

   1. Evacuations ahead of hazard area or provide direction to potential victims to shelter in place. Evacuation plans are developed under unified command.
   2. Traffic control in and around effected area(s).
   3. Incidents on State/Federal Highways joint command is with CHP.

B. Fire Department Responsibilities

   1. Incident stabilization/mitigation.
   2. Rescue and medical treatment (all paramedics may provide treatment in Cold Zone).

3. Assistance to responsible party or agency with development of appropriate clean up/disposal plan. May include the assistance of other agencies, i.e. environmental health, etc.

C. EMS Responsibilities

1. Report to the incident commander on scene.
2. Stage in safe zone.
3. Protect from contamination or threat.
4. Patient Management:
   a. Follow the Multi-Casualty Incident (MCI) Plan, if appropriate.
   b. Paramedics should make base contact early in the incident and consult with the base hospital physician regarding treatment for specific exposures.

Crime Scene Management

ADMINISTRATIVE POLICY 1005

1005.1 CRIME SCENE CLASSIFICATION

A. The Law Enforcement Agency having jurisdiction is in charge of a crime scene.

B. The officer on scene will make a determination of status of the scene (see below) and make this information available to responding police, fire and medical units. In the absence of being notified, fire and medical units should not assume that the scene is secure and shall take precautions to protect themselves.

C. It is the responsibility of all responding fire and medical units to be aware of the important evidence that can be damaged or destroyed upon entering a crime scene.

D. Fire and medical personnel shall consult with law enforcement officers on scene before disturbing items that may be evidence of a crime.

E. All involved should take precautions to not disturb crime scene evidence, (e.g., weapons, bloodstains, vehicles, skid marks, etc.) or other evidence that can be vital to investigators to reconstruct the crime or accident scene.

1005.2 CLOSED ACCESS TO UNSECURED CRIME SCENE (Hazard still exists)

A. Hostage situation.

B. Suspect(s) still on scene.

C. Environmental hazards present.

1005.3 LIMITED ACCESS CRIME SCENE

A. Critical evidence could be destroyed or compromised.

B. Hazard may still be present; environmental hazards present.

C. EMS personnel will take direction from the officer in charge who will direct entrance and arrange appropriate escort.

D. Life saving considerations will take precedence.

E. EMS to confirm death on obvious suicides/homicides.

1005.4 OPEN ACCESS CRIME SCENE

A. Evidence still has to be collected but personnel have access to entire area.

B. Consult with police officers before disturbing.

C. Critical evidence could still be destroyed or compromised.

1005.5 COLD CRIME SCENE

A. No evidential concerns or hazard present.

Report of Personal Injuries Resulting from Assaultive or Abusive Conduct

ADMINISTRATIVE POLICY 1006

1006.1 DEFINITIONS

Health Practitioner: A "health practitioner" means a physician, surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, optometrist or any other person who is currently licensed under the Division 2 of the Business and Professional Code (commencing with Section 500), a marriage, family and child counselor; any Emergency Medical Technician (EMT), paramedic or other person certified pursuant to Division 2.5 of the Health and Safety Code (commencing with Section 1797), a psychological assistant registered pursuant to Section 2913 of the Business and Professional Code; a marriage, family and child counselor trainee, as defined in subdivision of Section 4980.03 of the Business and Professional Code; an unlicensed marriage, family and child counselor intern; a state or county public health employee who treats a minor for venereal disease or any other condition; a coroner; a medical examiner or any other person who performs autopsies; or a religious practitioner who diagnoses, examines, or treats children.

Assaultive or Abusive Conduct: Means mayhem, battery, sexual battery, rape and the other types of violence or abusive conduct specified in Subsection (d) of Penal Code Section 11160.

Domestic Violence: Abuse committed against an adult or fully emancipated minor who is a spouse, former spouse, cohabitant, former cohabitant or person with whom the suspect has had a child, is having or has had a dating relationship. Ref: Penal Code 13700 (b).

Injury: For the purposes of this section, "injury" shall not include any psychological or physical condition brought about solely through the voluntary administration of a narcotic or restricted dangerous drug.

1006.2 PURPOSE

A. When a health practitioner, while providing medical treatment to an individual, reasonably suspects that the individual has been the victim of assaultive or abusive conduct, the health practitioner shall report that information to law enforcement. A telephone report shall be made immediately and written report within two (2) working days. The suspected abuse is reportable regardless of the reason the individual is currently seeking treatment.

B. Report to law enforcement any person suffering from a physical injury that has been inflicted by a firearm.

C. Reporting requirements apply not simply to a domestic violence situation but to all injuries caused by abusive or assaultive conduct as defined by law.

1006.3 POLICY

A. Napa County Emergency Medical Services Agency (NCEMSA) requires that every health practitioner who, in his or her professional capacity or within the scope of his or her employment, provides medical services for any physical condition to a patient whom he or she knows or reasonably suspects has been abused as described below, shall immediately make a report in accordance with procedures outlined in this policy:

   1. Any person suffering from any wound or other physical injury inflicted by his or her own act or inflicted by another where the injury is by means of a firearm.

   2. Any person suffering from any wound or other physical injury inflicted upon the person where the injury is the result of assaultive or abusive conduct as defined by law.

1006.4 PROCEDURE

A. The written report shall be prepared and sent even if the person who suffered the wound, other injury, or assaultive or abusive conduct has died, regardless of whether or not the wound, other injury, or

assaultive conduct was a factor contributing to the death and even if evidence of conduct of the perpetrator of the wound, other injury, or assaultive or abusive conduct was discovered during an autopsy.

B. Both the verbal and written reports should be given to the law enforcement agency having jurisdiction over the location where the wound, injury, or assaultive or abusive conduct occurred or if such location cannot be determined, to the law enforcement agency having jurisdiction over the location where the client resides. If neither of these locations can be determined, the reports shall be given to the law enforcement agency having jurisdiction over the location where the health practitioner has provided medical services to the client.

C. When two (2) or more persons who are required to report are present and jointly have knowledge of a known or suspected instance of violence that is required to be reported pursuant to this section and when there is an agreement among these persons to report as a team, the team may select by mutual agreement a member of the team to make a report by telephone and a single written report, as required in this policy. The selected member of the reporting team shall sign the written report. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make the report.

D. No supervisor or administrator shall impede or inhibit the reporting duties required under this law and no person making a report pursuant to this law shall be subject to any sanctions for making a report. However, internal procedures to facilitate reporting and to apprise supervisors and administrators of reports may be established, except that such procedures shall not be inconsistent with this policy. The internal procedures shall not require any mandated reporter to disclose his or her identity to the employer.

E. The report shall contain the following information:

1. The name of the injured person, if known.
2. The injured person’s current whereabouts or residence.
3. The character and extent of the person’s injuries.
4. The identity of any person the injured person alleges inflicted the wound, other injury, or assaultive or abusive conduct upon the injured person.

F. Any patient suffering from the above-mentioned physical injuries shall be given referrals for follow-up care. A referral list of local agencies and programs are attached to the reporting form, and should be detached and given to the client.

G. The individual’s medical record shall contain the following minimum documentation:

1. An objective assessment of the injuries or suspected abuse and a summary of care rendered.

H. A copy of the report should be filed in the patient’s medical record. Confidentiality protocols must be observed regarding filing, subsequent copying or release of this information.

I. When a health practitioner has cause to file a report pursuant to the Child Abuse and Neglect Reporting Act (Penal Code Section 1165 et seq.), reporting under this Domestic Abuse Reporting Law shall not apply.

LEMSA – Ambulance Franchise Reporting

ADMINISTRATIVE POLICY 1007

1007.1 POLICY

A. The Local Emergency Medical Services Agency (LEMSA) staff shall produce quarterly a report no more than sixty (60) days after the last day of the quarter.

1. This report shall include the ambulance franchise holders' performance for:

   a. Response Time Standards.

   b. Quarterly Assessed Penalties – including a description of their origin.

   c. Exceptions Granted.

   d. Customer Complaints.

   e. Unusual Occurrence Reports.

   f. Quarterly Correspondence/Special Meeting.

   g. Quarterly Compliance Issues.

   h. Previous Compliance Issue(s) Follow-up.

   i. Electronic Charting Performance.

   j. Total Number of Calls/Incidents – ALS, BLS, Non-Transport, IFT (including CCT, ALS, BLS).

   k. Total Number of Calls/Incidents by Response Zone.

   l. Licensure/Certification Actions/Investigations.

   m. Summary of Quarterly Vehicle Inspections.

   n. Continuing Education Classes Provided – Topic, hours, location, number attended.

   o. Personnel Changes (New Hires, Resignations, Terminations).

   p. On-Going Issues.

   q. New Issues.

B. The LEMSA staff shall produce annually a report no more than sixty (60) days after the last day of the year. This annual report will be in lieu of the normally scheduled quarterly report.

1. This report shall consist of a cumulative review and analysis of the quarterly reports and overall ambulance franchise provider performance for the year. This report shall be submitted as part of the year end Emergency Medical Services report submitted to the Emergency Medical Care Committee and County Board of Supervisors.

Use of Restraints

ADMINISTRATIVE POLICY 1008

1008.1 AUTHORITY

California Code of Regulations, Title 22, Sections 1000075 and 1000159. Welfare and Institutions Code 5150. California Administrative Code, Title 13, Section 1103.2 Health and Safety Code, Section 1798.6.

1008.2 PURPOSE

To provide guidelines on the use of restraints in the field or during transport for patients who are violent or potentially violent or who may harm self or others.

1008.3 PRINCIPLES

The Safety of the patient, community and responding personnel is of paramount concern when following this policy. Restraints are to be used only when necessary in situations where the patient is potentially violent and is exhibiting behavior that is dangerous to self or others. Pre-hospital personnel must consider that aggressive or violent behavior may be a symptom of medical conditions such as head trauma, alcohol, drug-related problems, metabolic disorders, stress and psychiatric disorders. Base contact criteria shall be strictly adhered to for those conditions that require it. The responsibility for patient health care management care rests with the highest medical authority on scene. Therefore, medical intervention and patient destination shall be determined by pre-hospital personnel. Authority for scene management shall be vested in law enforcement. The method of restraint used shall allow for adequate monitoring of vital signs and shall not restrict the ability to protect the patient's airway nor compromise neurological or vascular status. Restraints applied by law enforcement require the officer to remain available to remove or adjust the restraints for patient safety. This policy is not intended to negate the need for law enforcement personnel to use appropriate restraint equipment that is approved by their respective agency to establish scene management control.

1008.4 PROCEDURES

A. The following procedure should guide pre-hospital personnel in the application of restraints and the monitoring of a restrained patient:

   1. Restraint equipment applied by pre-hospital personnel must be either padded leather restraints or soft restraints (i.e. posey, Velcro or seatbelt type). Both methods must allow for quick release.
   2. The application of any of the following forms of restraint shall not be used by Emergency Medical Services (EMS) pre-hospital care personnel:
      a. Hard plastic ties or any restraint device requiring a key to remove.
      b. "Sandwiching patients between backboards, scoop-stretchers or flat, as a restraint.
   3. Restraining a patient's hands and feet behind the patient (i.e. "hog-tying").
   4. Methods or other materials applied in a manner that could cause respiratory, vascular or neurological compromise.
   5. Restraint equipment applied by law enforcement (handcuffs, plastic ties, or "hobble" restraints) must provide sufficient slack in the restraint device to allow the patient to straighten the abdomen and chest and to take full tidal volume breaths.
   6. Restraint devices applied by law enforcement require the officer's continued presence to ensure patient and scene management safety. The officer should, if at all possible, accompany the patient in the ambulance or follow by driving in tandem with the ambulance on a predetermined route. A method to alert the officer of any problems that may develop during transport should be discussed prior to leaving the scene.

7. Patients shall not be transported in a prone position. Pre-hospital personnel must ensure that the patient's position does not compromise the patient's respiratory/circulatory systems or does not preclude any necessary medical intervention to protect the patient's airway should vomiting occur.
8. Restrained extremities should be evaluated for pulse quality, capillary refill, color, nerve and motor function every fifteen (15) minutes. It is recognized that the evaluation of nerve and motor status requires patient cooperation and thus may be difficult or impossible to monitor.
9. Restrained patients shall be transported to the most accessible basic emergency department facility within the guidelines of EMS Agency Point of Entry policy.

1008.5 DOCUMENTATION

A. Documentation on the EMS Report Form shall include:

1. The reasons the restraint were needed.
2. Which agency applied the restraints (i.e., EMS/Law Enforcement).
3. Information and data regarding the monitoring of circulation to the restraint extremities.
4. Information and data regarding the monitoring of respiratory status while restrained.

Organ Donor Procurement

ADMINISTRATIVE POLICY 1009

1009.1 DEFINITIONS

Reasonable Search: A brief attempt by EMS field personnel to locate documentation that may identify a patient as a potential donor or one who has refused to make an anatomical gift. This search shall be limited to a wallet or purse that is on or near the individual to locate a driver's license or other identification card with donor status information. This requirement may be met by asking a family member, if one is present, about the existence of an organ donor card when conditions are conducive to such an interview. No search shall be made on the victim/possessions of a suspected crime or attempted suicide. A reasonable search shall not take precedence over patient care or treatment.

Imminent Death: A condition wherein illness or injuries are of such severity that in the opinion of EMS personnel, death is likely to occur before the patient arrives at the receiving hospital. For purposes of this policy, this definition does not include any conscious patient, regardless of the severity of illness or injury.

Adult: A person eighteen (18) years or older or who reasonably appears to be eighteen (18) years or older in the opinion of the field personnel in the absence of verifiable proof.

1009.2 PURPOSE

To establish guidelines for EMS field personnel to meet legislative requirements that they search for organ donor information on adult patients for whom death appears imminent.

1009.3 PROCEDURE

A. When EMS field personnel encounter an unconscious adult patient for whom it appears death imminent (that is, death prior to the arrival of the patient at a receiving facility), they shall attempt a "reasonable search" of the patient's belongings to determine if the individual carries information indicating the patient's status as an organ donor. This search must be done in the presence of a witness, preferably a public safety officer.

B. Treatment and transport of the patient remains the highest priority for field personnel. This search shall not interfere with patient care or transport.

C. Field personnel shall notify the receiving hospital personnel if organ donor information is discovered.

D. Any organ donor document that is discovered should be transported to the receiving hospital with the patient unless it is requested by the investigating law enforcement officer. In the event that no transport is made, any document should remain with the patient.

E. Field personnel should briefly note the results of the search, notification of hospital and witness name(s) on the EMS Run Report.

F. No search is to be made by EMS personnel after the patient has obviously expired.

G. If a member of the patient's immediate family objects to the search for an organ donor document at the scene, their response to a question about the patient's organ donation wishes may be considered to satisfy the requirement.