SAN FRANCISCO EMS AGENCY
POLICY MANUAL

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January 30, 2017

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Summary of Changes effective January 30, 2017

Summary of Policy Revisions			
Policy Number	**Title**	**Action Taken**	**Details**
1010	Advisory Committees	Revision	Updated participating organizations: • Added: UCSF Mission Bay, Falk Ambulance, and NorCal Ambulance • Removed: San Francisco Paramedic Association.
2000	Prehospital Personnel Standards & Scope of Practice	Revision	• Entire policy format revised. • Updated experience requirements for EMTs + Paramedics for independent work assignments. • New EMT Scope of Practice updates include: 1) Administration of Narcan intranasally for altered mental status and/ or suspected opiod overdose + training requirements. 2) Administration of intramuscular epinephrine by auto-injector for suspected anaphylaxis and/or severe asthma + training requirements. 3) Corresponding updates were added to Protocols 2.02 Allergic Reaction and 2.03 Altered Mental Status.
4001	Vehicle Equipment and Supply	Revision	• Line 143 – 144: Added pedi and adult epi auto injectors. Optional item for use by EMTs if ambulance provider medical director approved use of Epinephrine administration by EMTs. • Item lines re-numbered.
4050	Death in the Field	Revision	• Entire policy format revised. • Added POLST guidelines. • Coordinated procedures for Base Contact with policy 4051 DNR & POLST. • Revised to include the use of End Tidal CO2 devices to assist paramedics with decisions for cessation of resuscitation efforts. • Revised notification to Medical Examiner and SFPD by the highest medical authority at the scene per provider agency protocol
4051	Do Not Resuscitate (DNR) & Physician Orders for Life Sustaining Treatment (POLST)	Revision	• Entire policy format revised. • Added POLST guidelines. • Added sample DNR and POSLT forms. • Coordinated procedures for Base Contact with policy 4050 Death in the Field.
5000 & 5000.1	Destination & Destination Chart	Revision	• Renamed San Francisco General Hospital as Zuckerberg San Francisco General Hospital (ZSFG). • Added ZSFG as a post-sexual assault destination. • Added South Kaiser as a stroke destination. • Clarified that all patients who are incarcerated or under arrest must be taken to ZSFG for evaluation. • Clarified that St Francis only is the only Burn Center. Only patients who meet trauma triage criteria AND have burns must go ZSFG. • Added LVAD criteria and identified CPMC and UCSF as designated LVAD hospitals. • Added new destination category for critical airway patients.

5020	Diversion	Revision	• **Decreased the diversion suspension period from 6 hours to 4 hours.** • **Add NEW diversion category for "Internal Disaster"** defined as when a hospital is completely closed to ALL patients transported via 911 ambulance due to a compromised specialty center function OR when an internal disaster status with Hospital Incident Command System (HICS) is activated. ALL 911 ambulance traffic to an emergency department will stop when an Internal Disaster status is posted on Reddinet. • Added diversion does not apply to patients with a critical airway.
7010	EMS at Special Events	Revision	• Renamed the policy from "EMS Plans for Mass Gathering" to "EMS at Special Events." • Font updated and entire policy revised to improve readability and clarity. • Add requirement for MCI plan and MCI kit as a disaster requirements to address large-scale patient care incidents at mass gatherings (e.g. Boston Marathon bombing). • Add descriptors and required equipment for special event mobile (roving) teams. • Added water-based staffing, for events. • Updated and clarified staffing matrix

Section 1:
EMS System Organization and Management

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 1000
Effective Date: September 9, 2013
Supersedes: January 1, 2011

POLICY & PROTOCOL PUBLIC COMMENT PROCESS

I. PURPOSE

To define the San Francisco Emergency Medical Services (EMS) Agency public comment and approval process for policies and patient treatment protocols.

II. POLICY

A. The EMS Agency is responsible for developing and updating policies and protocols for the administration and operations of the EMS system. By state statute, the EMS Agency Medical Director retains the final decision through his/her medical authority in matters pertaining to the planning, implementation and evaluation of the EMS system including all EMS policies and protocols. The EMS Agency shall follow the procedures outlined in this policy for public comment and approval of new or revised policies or patient treatment protocols. **For brevity, the term "policy" is used to mean either policy or protocol in this policy.**

III. PUBLIC COMMENT PROCESS

A. All new or significantly revised current policies are released via email and posted on the EMS Agency website for public review and comment prior to becoming effective. Written comments are due at the EMS Agency by the date listed on the public comment notice and webpage. The EMS Agency allows a minimum of 14 days for public comment.

B. All comments received during the comment period will be reviewed by the EMS Agency Medical Director for either inclusion or exclusion in the policy. A summary of the comments received, their disposition and final policy drafts will be reviewed at the next EMS Advisory Committee meeting following the close of the public comment period.

C. The EMS Advisory Committee shall vote on a recommendation to the Medical Director to accept or reject the draft version of the policies. The Medical Director may accept or reject the EMS Advisory Committee recommendation when determining the final policy content.

D. The EMS Agency Medical Director shall forward the final policy to the Director of Health at the Department of Public - for his/her signature as the Chief Executive Officer of the Health Commission - the governing body for emergency medical services.

IV. POLICY RELEASE WITHOUT PUBLIC COMMENT

A. The Medical Director reserves the right to make minor revisions to policies without public comment for administrative continuity of the EMS System. Minor revisions include grammatical, format editing, and /or minor corrections of outdated information.

B. The Medical Director may immediately and without prior notice implement a new or significantly revised EMS Agency policy to protect public health and safety. Policies released under these circumstances shall be valid for 90 days from the initial effective date. Within 60 days of the initial effective date, the policy shall be released for the public comment following the procedures in Section IV. The Medical Director may extend a policy without public comment for one time for a total of 180 days from the initial effective date.

V. POLICY EXEMPTION PROCESS

A. Requests for a policy exemption by an EMS provider must be submitted in writing to the EMS Medical Director. All requests must identify the reasons for the requested exemption and include substantive supporting documentation justifying the request.

B. Upon request of the EMS Medical Director, the EMS Advisory Committee will review the exemption request at their next scheduled meeting to recommend either an approval or denial of the request.

C. The Medical Director will review the exemption request, supporting documentation and recommendations in making a determination to approve or deny the request. The Medical Director will notify the submitting agency of a decision within 60 days of the date of the EMS Advisory Committee review. The decision of the Medical Director is final.

VI. POLICY DISTRIBUTION

A. The EMS Agency is responsible for distribution of the final policy to EMS System stakeholders via email and EMS Agency website posting.

B. All EMS system providers are responsible for:
   1. Distributing new or revised policies to employees prior to the implementation date and providing training on all relevant policies.
   2. Making available an EMS Agency Policy Manual to employees (either paper or electronic versions).

VII. AUTHORITY

California Health and Safety Code, Section 1797 et seq.
California Code of Regulations, Title 22, Division 9
San Francisco City Charter, Section 4.110
San Francisco Health Code, Article 3, Section 112
Health Commission Rules and Regulations, January 17, 2012

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 1010
Effective Date: January 30, 2017
Supersedes: September 9, 2013

ADVISORY COMMITTEES

I. PURPOSE

To define the roles, structure, membership and procedural standards for advisory committees to the EMS Agency Medical Director.

II. POLICY

A. Advisory committees, composed of EMS system constituents, shall convene to review EMS system issues relevant to their scope of responsibility and recommend actions to the EMS Agency Medical Director concerning matters of policy, procedure, and protocol.

B. The EMS Agency Medical Director, as mandated by state statute, provides medical control and assures medical accountability throughout the planning, implementation and evaluation of the EMS System. The EMS Agency Medical Director retains the final decision through his/her medical authority for the EMS system.

III. OPEN PUBLIC MEETINGS

A. All committee and sub-committee meetings are open to members of the public. Meeting agendas, minutes, and other documents pertaining to these committees, except quality improvement documents, are public records and subject to public review. The EMS Agency shall distribute and post on its website an annual meeting schedule.

B. The quality improvement portions of the EMS Advisory Committee and its sub-committees are closed meetings because of confidential patient information reviewed during case discussions.

IV. PARLIAMENTARY AUTHORITY / QUORUM

A. Proceedings of the advisory committee and subcommittees are conducted under the "Robert's Rules of Order" when they do not conflict with this policy. This policy shall take precedence if any procedures are in conflict with "Robert's Rules of Order."

B. A quorum is required to call the meeting to order and to transact committee business. A committee must maintain a quorum to continue a meeting. Specific quorum requirements are listed in Section VII.

V. COMMITTEE MEMBERSHIP

A. Representative organizations are listed the appendices to this policy. Committee members are nominated by their representative organization and appointed by the EMS Agency Medical Director to a two year term. Members may be re-appointed to their position with concurrence of the EMS Agency Medical Director and their organization.

B. Members who do not attend three meetings within a year may be replaced in their position by the EMS Agency Medical Director.

VI. COMMITTEE OFFICERS

A. Each committee shall elect a Chair and Vice-Chair. The Chair of each committee shall call and preside over all meetings of that committee. The Chair shall develop the committee agenda in consultation with the EMS Agency Medical Director. The Vice-Chair shall assume the duties of the Chair in their absence.

B. Committee Chairs and Vice-Chairs serve a one year term from July 1 – June 30. At the last meeting of each committee before July 1st, the members shall elect a Chair and Vice-Chair. Chair and Vice Chair terms are effective at the first meeting of that committee after July 1st. The committee may vote to extend their term once (for a total of two years of consecutive service) if the current officers who wish to continue. Past officers are eligible for service again after three years from the end of their last term.

C. This provision does not apply to the Trauma System Audit Sub-Committee, which has the Trauma Medical Director at San Francisco General Hospital as the standing Chair.

D. The EMS Agency will provide professional and clerical support to the advisory committees created by this policy.

VII. STANDING ADVISORY COMMITTEE AND SUBCOMMITTEES

A. **Emergency Medical Services Committee (EMSAC):** The standing advisory committee that is a multi-disciplinary forum for reviewing and making recommendations related to the following:

- Prehospital clinical policies and treatment protocol issues involving First Responder, Basic Life Support, Advanced Life Support, interfacility transport, and/or critical care transport personnel in the San Francisco EMS system;
- General system management and operational policies including communications, system performance, destination, ambulance diversion, and development of strategies to optimize the EMS System;
- Disaster medical emergency management, including mitigation, preparedness, response and recovery, and

- Approval of prehospital pilot and research projects.

Meetings: Held five times per year in even numbered months or more frequently by request of the Committee Chair, vote of the committee, or the request of the EMS Agency Medical Director or his/her designee.

Location: As set by agenda

EMS Agency Staff: Medical Director, EMS Administrator, EMS Agency Specialists

Quorum: Consists of:

- 33% + one of the representatives from the prehospital EMS organizations listed under Appendix A.
- 33% + one of the hospital organizations listed under Appendix B.

Membership: Consists of the EMS Agency Medical Director (ex-officio) and one primary representative and one alternate representative from:

- Ambulance Provider Companies listed in Appendix A
- San Francisco Receiving Hospitals listed in Appendix B
- San Francisco Emergency Physicians' Association
- City College of San Francisco - Paramedic Training Program
- San Francisco Department of Public Health
- San Francisco General Hospital Base Hospital Medical Director
- San Francisco Fire Department EMS Medical Director
- San Francisco Emergency Communications Department Medical Director
- Paramedic field representatives currently accredited in San Francisco and working for a permitted ambulance company appointed by the EMS Agency Medical Director
- EMT field representatives currently certified in San Francisco and working on a permitted ambulance company appointed by the EMS Agency Medical Director
- Members of the public, not affiliated with a regulated provider organization, and appointed by the EMS Agency Medical Director.

B. **Trauma System Audit Subcommittee (TSAC):** A standing subcommittee of the EMS Advisory Committee that advises on trauma system policy. Its goals are the evaluation and administration of the trauma system with oversight responsibility for system vulnerabilities, the development of policy and/or approaches to related issues such as major trauma and burn-related prehospital care, injury surveillance, trauma transfers, repatriation, and long-term outcomes.

Meetings: Meets four times per year, coincident with dates of the EMS Advisory Committee, or by request of the subcommittee Chair or the EMS Agency Medical Director.

Location: As set by agenda

EMS Agency Staff: EMS Medical Director, EMS Administrator and Trauma Coordinator

Quorum: Consists of:

- 33% **+** one of the hospital organizations listed under TSAC Membership
- 33% **+** one of the prehospital EMS organizations listed under Membership
- One representative from SFGH Trauma Center
- One representative from St. Francis Bothin Burn Center

Membership: Hereby consists of:

- EMS Agency Medical Director (ex-officio)
- Zuckberg San Francisco General Hospital Trauma Medical Director (ex-officio)
- Zuckerberg San Francisco General Hospital Trauma Program Manager (ex-officio)
- St. Francis Bothin Burn Center Medical Director (ex-officio)
- St. Francis Bothin Burn Center Manager (ex-officio)
- One representative from a minimum of five of the San Francisco Receiving Hospitals listed in Appendix B (including San Francisco General Hospital and St. Francis Memorial Hospital)
- One representative from each approved ALS ambulance provider
- One member of the public not affiliated with a regulated stakeholder organization, appointed by the EMS Agency Medical Director

C. **STAR Subcommittee:** A standing subcommittee of the EMS Advisory Committee that advises on STEMI and post-cardiac arrest prehospital care. The subcommittee's goals are the evaluation of STEMI and cardiac arrest policies and protocols for the EMS system with the responsibility for addressing system vulnerabilities. It assists the EMS Medical Director by evaluating topics and data about related issues such as clinical research on prehospital STEMI and cardiac arrest care, clinical outcomes, community education, interfacility transfers, repatriation, and long-term outcomes.

Meetings: Four times per year by request of the subcommittee Chair or the EMS Agency Medical Director.

Location: As set by agenda.

EMS Agency Staff: EMS Medical Director, EMS Administrator and STAR program coordinator.

Quorum: Consists of:

- Representatives from 3/5 of the STAR designated hospitals listed in Appendix C.

Membership: Hereby consists of:

- EMS Agency Medical Director (ex-officio)
- Two representatives from each approved of the STAR designated hospitals; one from hospital administration, and one clinical expert (preferably an interventional cardiologist) who are knowledgeable about the cases reviewed at each institution's STEMI committee
- One representative from a non-STAR designated hospital
- At least one representative from a permitted ALS ambulance provider

D. **Quality Improvement (QI) Subcommittee**: A standing subcommittee of the EMS Advisory Committee that advises on system quality improvement issues. The subcommittee's goal is to report and evaluate the EMS system, and recommend any necessary changes. It assists the EMS Medical Director by evaluating topics and data about issues such as response capabilities, system structure, clinical performance, clinical outcomes, and professional training.

Meetings: Six times per year by request of the subcommittee Chair or the EMS Agency Medical Director

Location: As set by agenda

EMS Agency Staff: EMS Medical Director, EMS Quality Manager

Quorum: Consists of at least one representative from each of the following:

- Department of Emergency Communication
- Prehospital providers, and
- Emergency department supervisors.

Membership: Consists of:

- EMS Agency Medical Director (ex-officio)
- DEC Medical Director
- DEC Quality Management staff
- One representative from a designated EMS receiving hospital
- One representative from each approved ALS ambulance

VIII. AUTHORITY

California Health and Safety Code, Section 1797 et seq. and 1798 et seq;
California Government Code, Section 54950 et seq.;

California Code of Regulations, Title 22, Division 9;
City and County of San Francisco Administrative Code, Section 67.1 et seq.

APPENDIX A: SAN FRANCISCO AMBULANCE PROVIDERS

1. San Francisco Fire Department
2. American Medical Response
3. King American Ambulance
4. Pro-Transport 1
5. Bayshore Ambulance
6. St. Joseph's Ambulance
7. Falck Northern California
8. NorCal Ambulance

APPENDIX B: SAN FRANCISCO RECEIVING HOSPITALS

1. Zuckerberg San Francisco General Hospital Trauma Center &Base Hospital
2. California Pacific Medical Center – Pacific, Davies, California and St Luke's Campuses
3. Kaiser Permanente Medical Center
4. St. Mary's Medical Center
5. St. Francis Memorial Hospital
6. University of California, San Francisco Medical Center, Parnassus Campus
7. University of California, San Francisco, Mission Bay Campus
8. Veterans Administration Medical Center
9. Chinese Hospital
10. Seton Medical Center (San Mateo)
11. South Kaiser (San Mateo)

APPENDIX C: STAR DESIGNATED RECEIVING HOSPITALS

1. Zuckerberg San Francisco General Hospital
2. California Pacific Medical Center – Pacific Campus
3. Kaiser Permanente Medical Center
4. St. Mary's Medical Center
5. University of California, San Francisco Medical Center, Parnassus Campus

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference Number: 1020
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GLOSSARY

Term	Definition
800 MegaHertz (MHz)	The band of frequencies dedicated by the Federal Communications Commission for local, district, and state government agencies. In this Policy Manual, the term refers specifically to the radio system used by the City and County of San Francisco.
ABC's	Airway, Breathing, and Circulation
Abbreviated Injury Scale (AIS)	"Abbreviated Injury Scale" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purpose of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.
Acute Care Facility or Acute Care Hospital	A facility licensed by the State Department of Health Services as a general acute care hospital.
ACS	Auxiliary Communications Service
Advanced Cardiac Life Support (ACLS)	A specific protocol or methodology for cardiac patients published by a recognized panel or association of experts in the field of cardiology, such as the American Heart Association's ACLS guidelines.
Advanced Life Support (ALS)	Medical care in the treatment of prehospital or interfacility transport patients as defined in Title 22 under Paramedic Scope of Practice. Also refers to the capabilities of a crew configuration containing at least 1 EMT-P, a vehicle equipped appropriately and staffed by at least 1 EMT-P, or an individual who is a licensed EMT-P.
Medical Priority Dispatch System (MPDS)	A proprietary emergency medical dispatch system owned by Medical Priority Consultants, Inc©. It is a method of triaging and categorizing calls that is required by the EMS Agency for permitted ambulance providers in San Francisco. Characteristics of this system include: systematized caller interrogation questions, systematized pre-arrival instructions, and protocols that match the dispatchers evaluation of injury or illness severity with vehicle response mode and configuration (a.k.a., Clausen Method).
Automated External Defibrillator (AED)	An external defibrillator capable of cardiac rhythm analysis which will charge and, with or without further operator action, deliver a shock after electronically detecting and assessing ventricular fibrillation or ventricular tachycardia. These devices are known as semi or fully automatic defibrillators.
Air Ambulance	Any aircraft specifically constructed, modified, or equipped, and used for the primary purpose of responding to emergency medical calls and transporting critically ill patients whose flight crew has, at a minimum, two attendants certified or licensed to perform Advanced Life Support.
ALS Contact	For the purposes of an EMT-P evaluation or remediation: any call in which the candidate or intern provides ALS level intervention or assessment (except cardiac monitoring) as the primary care provider from their arrival on scene and throughout transport or other disposition of the patient.
ALS First Response Services	The provision of ALS services provided in a non-patient-transporting vehicle by an authorized ALS provider pursuant to a Paramedic Service Provider MOU consistent with State law and EMS Agency policies and procedures.
ALS Ground Ambulance Services	The provision of ALS services provided in an ambulance by an authorized ALS Provider pursuant to a EMT-P Service Provider MOU consistent with State law and EMS Agency policies and procedures.

ALS Optional Scope of Practice	ALS treatments, procedures, and/or pharmaceutical agents approved for local optional scope of practice for EMT-Ps accredited by the San Francisco EMS Agency and on duty with a San Francisco EMS Agency permitted ALS Provider.
ALS Provider	A public or private entity permitted to provide EMT-P response and/or ambulance transportation within San Francisco in accordance with EMS Agency policy and the entity's Paramedic Service Provider MOU.
ALS Rescue Aircraft	Rescue aircraft staffed with at least one ALS certified person.
Ambulance Permit	A permit issued by the Director of Public Health for an ambulance or routine medical transport vehicle pursuant to San Francisco Health Code, Article 14. This permit is required to operate an ambulance or routine medical transport vehicle within the City and County of San Francisco.
ARC	American Red Cross
ARES	Amateur Radio Emergency Service
Authorizing EMS Agency or authorizing agency	The local EMS Agency which approves utilization of specific EMS providers, policies, and procedures in accordance with local and State law. In San Francisco, this authority is vested in the Department of Public Health, EMS Agency.
Austere Care	Simple, life saving care that does not require unusual equipment, or excessive use of time or personnel. Opening the airway by repositioning the head is austere care; intubating a patient is not.
Auxiliary Communications Service (ACS)	Volunteer organization attached to OES to provide HAM radio services during critical incidents or large events.
Auxiliary Rescue Aircraft	A rescue aircraft which does not have a medical flight crew, or whose crew is not qualified to perform medical services.
AVL	Automatic Vehicle Locator
Base Hospital (BH) or Base Station	A designated medical facility that provides on-line medical control for EMT-Ps and consultation for various ALS activities under State EMT-P Regulations.
Base Hospital Physician (BHP)	A physician or surgeon who is currently licensed in California, who is assigned to the emergency department of a Base Hospital, and who has been trained to issue advice and instructions to EMT-Ps consistent with EMS Agency policies and protocols, and the EMT-P scope of practice as defined in State law.
Basic Life Support (BLS)	Medical care in the treatment of prehospital or interfacility transport patients as defined in Title 22 under EMT-1 Scope of Practice. Also refers to the capabilities of a crew configuration containing at least one EMT-1, a vehicle equipped appropriately and staffed by at least one EMT-1, or an individual who is a certified EMT-1.
Bay Area Medical Mutual Aid (BAMMA)	Refers to a loose affiliation of the counties of Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, and Sonoma for the purposes of medical mutual aid.
Bed Availability	The number of staffed, in-patient beds available at a particular hospital. Generally referred to in this Policy Manual with regards to MCI and disaster capacity.
BLS Ground Ambulance	An ambulance staffed and equipped to provide basic life support in full compliance with State and local law, as well as EMS Agency policies and procedures. Synonymous with "routine medical transport vehicle" for the purposes of this Policy Manual.
BLS Provider	A public or private entity permitted by San Francisco EMS Agency to provide BLS services within San Francisco consistent with EMS Agency policies and procedures, local, and State laws.

BLS Rescue Aircraft	A rescue aircraft whose medical flight crew has, at a minimum, one attendant certified as an EMT-1 with at least 8 hours of hospital clinical training and whose field/clinical experience specified in Section 10074(c) of Title 22, California Code of Regulations, is in the aeromedical transport of patients.
BTLS	Basic Trauma Life Support
CAD	Computer Aided Dispatch
California EMS Information System (CEMSIS)	The standardized EMS data and quality improvement system developed by the California State EMS Authority.
CARES	California Amateur Radio Services
CHP	California Highway Patrol
Classifying EMS Agency	The agency which categorizes EMS aircraft or other EMS response vehicles as necessary or required by law.
Clinical Indicator	A measurable variable relating to the structure, process, or outcome of care.
COBRA	Consolidated Omnibus Budget Reconciliation Act.
Cold Zone	The area of a hazardous scene which is determined to be free of hazardous materials.
Command Staff	Incident Command System positions including the Incident Commander, Safety Officer, Liaison Officer, Public Information Officer, and any Medical / Technical Specialists who serve as consultants guiding incident response
County Health Officer	The local health officer appointed by a board of supervisors who is delegated the responsibility for enforcement of public health laws and regulations. In San Francisco, the Health Officer is the Director of Public Health.
CPAP	Continuous Positive Airway Pressure (Ventilation)
CPR	Cardiopulmonary resuscitation
Critical Incident	Synonymous for an incident producing multiple casualties or a disaster; can be a Level I, II, or III critical incident.
Critical Incident Stress Debriefing (CISD)	An organized approach for personnel who have experienced stressful situations to help prevent long term emotional trauma syndromes
DCAP-BTLS	A mnemonic that stands for: **D**eformity **C**ontusion/Crepitus **A**brasion **P**uncture **B**ruising/Bleeding **T**enderness **L**aceration **S**welling
Deceased	Absence of life signs; a triage category in which there are no signs of life or, due to limited resources, the critical casualty has minimal chance of survival (known previously as expectant category).
Decontamination	The process by which hazardous materials are removed from an exposed person by the removal of the victim's clothing and washing with a neutralizing agent.
Delayed (triage category)	A triage category where treatment is required, but may be delayed without significant risk to life or limb.
DPH	Department of Public Health
Department Operations Center (DOC)	Refers to the operations center for city departments for disaster or emergency operations. When referenced in this document, this refers specifically to the DPH Department Operations Center which is responsible for coordinating health and medical resources during times of disaster or emergency operations.
Designated EMS Dispatch Center	An organization designated by the EMS Agency to receive requests for medical assistance, and to coordinate and dispatch EMS resources to these requests.
Disrupted Communications Protocol	Protocols that delineate procedures an EMT-P can perform if base hospital contact cannot be established.
Division of Emergency Communications (DEC)	The agency of the City and County of San Francisco responsible for the operations of the 911 communication system including police, fire, and EMS communications

Department of Emergency Management (DEM)	Agency responsible for the overall coordination of resources prior to, during, and after an emergency or disaster.
Emergency (Federal Definition)	Any hurricane, tornado, storm, high water, wind driven water, tidal wave, tsunami, earthquake, volcanic eruption, landslide, mudslide, snowstorm, drought, fire, explosion or other catastrophe in any part of the United States which requires federal emergency assistance to supplement state and local efforts to save lives and protect public health and safety or to avert or lessen the threat of a major disaster.

Emergency (State Definition)	A disaster situation or condition of extreme peril to life and/or property, resulting from other than war or labor controversy, which is or is likely to be beyond local capability to control without assistance from other political entities.
Emergency Alert System (EAS)	System allows government officials to address all citizens at the same time. The system works by "chain-broadcasting," which means each FM radio station picks up the signal, broadcasts it, and relays it to the next station. If one station in the link is disabled, then the chain is broken.
Emergency Helispot	A site at or near the scene of an emergency designated by the Incident Commander as an appropriate place for landing and takeoff of helicopters.
EMS	Emergency Medical Services
EMS Aircraft	Any aircraft utilized for the purpose of prehospital emergency patient response and transport. EMS aircraft includes air ambulances and all categories of rescue aircraft.
Emergency Medical Services Authority (EMSA)	The state agency charged with coordinating the state emergency medical response. The Authority will mobilize and coordinate medical services mutual aid resources to mitigate health problems. It coordinates, through local emergency management system agencies, medical hospital disaster preparedness with other local, state, and federal agencies having a responsibility relating to disaster response.
Emergency Medical Dispatcher (EMD)	A public safety telecommunicator with additional specific training in emergency medical dispatch practices and protocols essential for the efficient management of emergency call taking and emergency medical dispatch communications. All Emergency Medical Dispatchers are certified as an EMD by the National Academy of Emergency Medical Dispatch.
EMResource	A computer program that shows the status of all prehospital resources in the City of San Francisco
Emergency Medical Personnel	All public safety first responders, Emergency Medical Dispatchers, EMT-1s, and EMT-Ps functioning within the emergency medical services system.
Emergency Medical Dispatching	The reception, evaluation, and processing of requests for emergency medical assistance and the dispatch of EMS resources.
Emergency Medical Dispatch Priority Reference System	A medially approved reference system used by a designated Emergency Medical Dispatch Center to dispatch aid to medical emergencies. The reference system includes: systematized caller interrogation questions, systematized pre-arrival instructions, and protocols that match the dispatcher's evaluation of injury or illness severity with vehicle response mode and configuration.
EMS Landing Site	A site at or near a medical facility, a mass gathering, or a multi-casualty incident which has been pre-selected and approved for the landing and taking off of EMS aircraft, but not designed or used exclusively for helicopter flight operations.
EMS Medical Director	The Medical Director of the Department of Public Health EMS Agency, fulfilling the responsibilities defined in California Health and Safety Code, Section 1797.202.
EMDAC	Emergency Medical Services Directors Association of California

Emergency Medical Services Agency (EMSA)	The Agency of the San Francisco Department of Public Health that regulates the EMS System in San Francisco and fulfills the role of the Local EMS Agency as required by California Health and Safety Code.
Emergency Medical Technician (EMT-1, EMT-B)	A person trained in BLS and currently certified as an EMT-1 or EMT-1 Basic. When used in this Policy Manual, it normally refers specifically to those EMT-1s certified in California unless otherwise noted.
EMSA Orientation Course	A program developed by the EMS Agency that describes the local EMS System; providers are required to present the course to all newly hired employees prior to their being released to working in the field either with a field training officer or independently.
EMS Agency Policies, Procedures, and Protocols	All policy, procedure, and protocol documents developed through the EMS Agency policy development process.
EMS System Quality Indicators	Structure, process, or outcome variables that define quality of care in the EMS System.
Emergency Medical Technician – Paramedic (EMT-P)	An EMT-1 or EMT-2 who has additional training in ALS and is licensed by the State of California as an EMT-P or Paramedic.
Emergency Period	A period which begins with the recognition of an existing, developing, or impending situation that poses a potential threat to a community. It includes the warning (where applicable) and impact phase and continues until immediate and ensuing effects of the disaster no longer constitute a hazard to life or threat to property.
Emergency Policy	A new or revised policy implemented by the EMS Medical Director to remedy an immediate threat to public health and safety.
Emergency Public Information (EPI)	Information disseminated to the public by official sources during an emergency, using broadcast and print media. Includes: Instructions on survival and health preservation, status information on the disaster situation, and other useful information.
Emergency Public Information System	The network of information officers and their staff who operate at all levels of government within the State. The system also includes the news media through which emergency information is released to the public.
Emergency Operations Center (EOC)	The EOC serves as central command and control post for city government during a disaster.
Emergency Operations Plan (EOP)	A plan for managing critical incidents. May refer to the San Francisco EOP, which is a City wide plan developed and coordinated by OES or the DPH EOP which is a plan specific to the medical, health, and EMS aspects of the City and is maintained by the EMS Agency.
Exclusive Operating Area (EOA)	An EMS area or sub-area defined by the EMS Plan for which the EMS Agency restricts operations to one or more providers of emergency ambulance services and ALS services.
First Responders	Prehospital personnel trained to the First Responder level of care as approved by the EMS Agency.
FCC	Federal Communications Commission, a regulatory agency for broadcast media
Federal Emergency Management Agency (FEMA)	The agency charged with focusing federal efforts to lessen the impact of emergencies before they occur and to respond to emergencies of all types.
Finance Section	Component of ICS designed to handle all financial aspects of the incident.
FTO	Field Training Officer
GPS Transmitter	A device that transmits a location using the Global Positioning System to a known receiver.
Hazardous Material (HAZMAT)	Chemicals or materials that pose the threat of illness or death via contact, inhalation, or ingestion.
Hazard	Any source of danger or element of risk

Hazard Area	A geographically identifiable area in which a specific hazard presents a potential threat to life and property.
HAM	Amateur radio operator
HEARNet	Hospital Emergency Administrative Radio Network. The VHF voice radio used by hospitals, DEC, and the DPH DOC to communicate during disasters.
HIPPA	Health Insurance Portability and Accountability Act of 1996 - legislation regarding privacy of personal health information
Hot Zone	The area of the EMS Scene which is considered to be contaminated with a HAZMAT.
Immediately Available	"Immediately" or "immediately available" means: 1. unencumbered by conflicting duties or responsibilities; 2. responding without delay when notified; and 3. being physically available to the specified area of the trauma center when the patient is delivered in accordance with EMS Agency policies and procedures.
Implementation	"Implementation" or "implemented" or "has implemented" means the development and activation of a trauma care system plan by the EMS Agency, including the actual triage, transport and treatment of trauma patients in accordance with the plan.
Incident Action Plan	A general plan prepared by the participant to provide responders with general objectives for the management strategy of a critical incident.
Incident Command System (ICS)	A specific nationally recognized method of organizing and managing incidents.
Injury Severity Score	"Injury Severity Score" or "ISS" means the sum of the squares of the Abbreviated Injury Scale score of the three most severely injured body regions.
Inner Perimeter	Perimeter surrounding an immediate hazard area
Integrated Response Plan (IRP)	The plan, as described in policy, that provides for permitted ALS service providers to coordinate with the DEC to provide additional ambulance resources.
Investigative Review Panel (IRP)	An impartial advisory body, the members of which are knowledgeable in the provision of prehospital emergency medical care and local EMS system policies and procedures, which may be convened to review allegations against an applicant for, or the holder of, a certificate, assist in establishing the facts of the case, and provide its findings and recommendations to the medical director of a local EMS Agency, in accordance with the process described in Section 100211 of the California Code of Regulations.
IO	Intra-Osseous
IV	Intravenous
Jurisdiction of Origin	The local EMS jurisdiction within which the authorized resource is located. Usually referring to origin of air ambulances and rescue aircraft.
Land line	Public or private hardwired telephone communications system.
LZ	Land Zone for air medical assets
Level I Disaster	A moderate to severe incident where local resources are adequate and available, either on duty or by call back. There are adequate local resources to provide field medical triage and stabilization, and transport patients to an appropriate local facility. Generally geographically limited without interruption of command and control infrastructure.
Level II Disaster	A moderate to severe incident where resources are not adequate and multi-jurisdictional/regional mutual aid may be required due to a large number of casualties and/or a lack of local healthcare facilities. A local emergency will be proclaimed and a State of Emergency might be proclaimed. Generally categorized as a City-wide disaster without interruption of command and control infrastructure.
Level III Disaster	A major disaster where local and regional resources in or near the impacted

	areas are overwhelmed and extensive outside mutual aid is required. A State of Emergency will be proclaimed and a Presidential Declaration of an Emergency or Major Disaster will be requested. Citywide or regional disaster with multiple sites and interrupted command and control infrastructure.
Local EMS Information System (LEMSIS)	A database of defined data elements from dispatch, prehospital and hospital provider data collection records used to define the EMS System quality indicators.
Logistics (LOGS)	Component of ICS which provides all support and service needs to the incident. All requests for assets, whether internal or external, are directed to this Section. Logistics consists of personnel, supplies and equipment, communications, and facilities management.
Mass Casualties	In the event of an emergency with a large number of casualties, the volume of casualties and the disaster environment may create barriers to care and delay transport of the most seriously injured.
Mass Gathering	A mass gathering is a large group of people that have medical care of some type available on scene due to the size or nature of the gathering. This medical care may be provided by a variety of health care professionals to include EMT-Ps and EMT-1s. Mass gatherings may occur in permanent or temporary venues.
Material Change	A material change is any change in policy other than a minor revision. Material change specifically includes new policy or policy changes that create a significant expense to a provider, substantially changes the scope of practice, or substantially changes the function, direction, or operation of the EMS System.
Medical Control	The medical management of the EMS System pursuant to the provisions of the California Health and Safety Code, Division 2.5, Chapter 5.
Medical Emergency	The term used to denote a condition or situation in which an individual has a need for immediate medical attention, or where the potential for such need is perceived by public safety personnel or emergency medical personnel at the scene of an emergency or dispatch personnel at a designated EMS dispatch center.
Medical Mutual Aid	An agreement by 2 or more counties to provide medical resources, services, and facilities to each other as emergency assistance.
Medical Mutual Aid Threshold Situation (MMATS)	A situation where the EMS system is unable to timely meet demand for services, as determined by the EMS Agency Medical Director or Director of Health or their respective designees.
Minor	1. [context of disaster or MCI management]Triage category indicating treatment may be delayed with little risk to life or limb. 2. [context of medical legal, AMA, refusal of service] a person who has not reached the age of consent and is otherwise ineligible for the right of self determination.
Minor revision	A minor revision to EMSA Policy is one which makes minor corrections without affecting the status quo of the policy or makes changes that implement mandatory changes federal, state, or local law or regulation.
Multi-Casualty Incident (MCI)	Any incident which generates a large number of medical casualties – injuries or illnesses – that cannot be treated by the initial EMS response. The incident can be as few as 2 patients, but would normally involve at least 6 patients.
MCI Plan	The procedure followed per EMS Agency Policy in the event that a multi-casualty incident is declared.
MCI Polling	Polling performed by the DEC to determine bed availability of local hospitals
MHOAC	Medical Health Operations Area Coordinator
On-Call	"On-call" means agreeing to be available to respond to the trauma center in order to provide a defined service.
Operations Section (Ops)	Component of ICS responsible for the direct management of all incident tactical activities. Staff assists in the formulation of the incident action plan and oversees activities for the Public Health and Casualty Care Branches of

	DPH Command.
Outer Perimeter	Entire operational area of an incident.
PALS	Pediatric Advanced Life Support
PAPRs	Powered Air Purifying Respirators. The equipment is battery operated, consists of a half or full face piece, breathing tube, battery-operated blower, and particulate filters (HEPA only).
Paramedic	A person licensed by the California State EMS Authority as an EMT-P
Paramedic Intern	A person enrolled in an authorized EMT-P education program who has completed sufficient didactic hours to begin working in a hospital or field clinical setting under the direct supervision of an assigned EMT-P or nurse preceptor and who is allowed to utilize ALS skills and administer approved medications while working as an intern and under the direct supervision of a preceptor. EMT-P interns may not utilize ALS skills or administer medications while not engaged or an approved education activity in an approved clinical setting under the direct supervision of a nurse or EMT-P preceptor.
Paramedic Field Supervisor	An individual who meets all criteria required by EMS Agency policy, who is directly responsible for providing supervision to EMT-Ps and EMT-1s. An EMT-P field supervisor may operate within the guidelines established by EMS Agency and provider policy, but may not supplant required medical control through a Base Station Physician or authorize or instruct other EMT-Ps to deviate from EMS Agency Policies and Protocols.
Paramedic Preceptor/Evaluator	An EMT-P approved by the EMS Agency and permitted ALS provider in accordance with State Law and EMS Agency policy to instruct EMT-P interns in a field clinical setting and evaluate accreditation candidates during the pre-accreditation evaluation.
PEPP	Pediatric Education for Prehospital Professionals
Permitted ALS Provider	A publicly or privately owned or operated entity that is permitted by the SF EMS Agency to provide ALS services in accordance with State Law, Local Ordinance, and EMS Agency Policy.
PCI (Percutaneous Coronary Infusion)	Percutaneous Coronary Infusion: A broad group percutaneous techniques utilized for the diagnosis and treatment of patients with STEMI
Plans Section	Component of ICS responsible for maintaining current situation status, and preparation and documentation of the incident action plans. Coordinates closely with the other sections of ICS. Planning disseminates information regarding the incident to all sections and maintains the status of resources assigned to incident activities.
PHTLS	Prehospital Trauma Life Support
Permitted BLS Provider	A publicly or privately owned or operated entity that is permitted by the SF EMS Agency to provide BLS services, including non-emergency medical transportation, in accordance with State Law, Local Ordinance, and EMS Agency Policy.
Pre-Arrival Instructions	Medically approved scripted instructions given by certified EMDs to callers for providing necessary assistance and control of a medical emergency prior to arrival of emergency medical personnel.
Prehospital personnel	Emergency medical personnel including first responders, EMT-Is, and EMT-Ps who responds to calls while on duty and provide care in the out-of-hospital setting.
Presumptively Defined Life Threatening Emergency	A request for emergency medical services that would be properly categorized by the dispatch call taker using MPDS protocols as Charlie, Delta, or Echo response.
Primary Public Safety Answering Point (PSAP)	The location where a 911 call is first answered.

Promptly Available	"Promptly" or "promptly available" means: 1. responding without delay when notified and requested to respond to the hospital; and 2. being physically available to the specified area of the trauma center within a period of time that is medically prudent and in accordance with EMS Agency policies and procedures.
Public Access Defibrillation (PAD)	A program enabling lay persons rescuers to use an AED to treat patients in cardiac arrest.

PAD: Prescribing Physician	A physician or surgeon licensed in California who issues a written order for the use of an AED by authorized individual(s), and who develops, implements, and maintains the medical control provisions specified in State Law and EMS Agency Policy.
PAD: Enabling Agency	The agency, organization, or company that sponsors a PAD program and allows an AED on their premises.
PAD: Internal emergency response system	A plan of action which utilizes responders within a facility to activate the 911 emergency response system, and which provides for the access, coordination, and management of immediate medical care to seriously ill or injured individuals.
Public Information Officer (PIO)	An official responsible for releasing information to the public through the news media.
Public Safety Helipad	A heliport that has been approved and permitted by the California Department of Transportation (DOT) for the landing and takeoff of EMS and other public safety aircraft and is designed for helicopter flight operations.
Qualified Specialist	"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means a physician licensed in California who is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.
Rapid Trauma Assessment	Using DCAP-BTLS is very rapid assessment of the patient from head to toe without getting into the specifics of a detailed physical examination.
Receiving Hospital	"Receiving hospital" means a licensed general acute care hospital with a special permit for basic or comprehensive emergency service, which has not been designated as a trauma center according to Title 22, Division 9, Chapter 7, but which has been formally assigned a role in the trauma care system by the EMS Agency.
Record of Calls	A record of calls as required in 13 CCR 1100.7 which includes a record of each call be maintained for a minimum of 3 years and that includes specific information listed in the statute.
Red Alert	An alert issued by the DEC indicating that a critical incident has occurred producing causalities confirmed by the Incident Commander.
Residency Program	"Residency program" means a residency program of the trauma center or a residency program formally affiliated with a trauma center where senior residents can participate in educational rotations, which has been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.
Rescue Aircraft	An aircraft whose usual function is not prehospital emergency transport, but which may be utilized in compliance with EMS Agency policy, for prehospital emergency patient transport when the use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft includes ALS rescue aircraft, BLS rescue aircraft, and auxiliary rescue aircraft.
Response codes	The dispatch term which denotes the level of priority for units responding to the scene: • Code 2: a non-life threatening medical emergency requiring

	immediate response without the use of red lights or siren. • Code 3: a medical emergency requiring immediate response with red lights and siren.
Reporting party	911 caller - the person calling 911 or otherwise making a report of a situation and/or requesting a response from a PSAP.
RIMS	Resource Information Management System

Routine Medical Care	A group of standard assessments and treatments, including but not limited to the airway, breathing, and circulation, and the use of routine monitoring devices.
Routine Medical Transport Vehicle	A vehicle specifically constructed, modified, equipped, or arranged to accommodate a stretcher and operated commercially for the purpose of transporting sick, injured, convalescent, infirm, or otherwise incapacitated persons not requiring urgent transportation, as further defined in the San Francisco Health Code, Article 14. For the purposes of EMS System policies, this term is synonymous with BLS ambulance, requiring the same staffing and equipment and constrained by the same limitations regarding response, patient transport, and utilization.
Search and Rescue (SAR)	Systematic investigation of an area or premises to determine the presence and/or location of persons entrapped, injured, immobilized, or missing, and the removal of the persons for transportation to appropriate medical care.
Self Help	A concept describing self-reliance and self-sufficiency within an adverse environment with limited or no external assistance.
Senior Resident	"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least 3 years of residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of the residency program as defined in these standards, at the designated trauma center.
Service Area	"Service area" or "catchment area" means that geographic area defined by the EMS Agency in its trauma care system plan as the area served by a designated trauma center.
Simple Triage and Rapid Treatment (START)	Field triage that allows field care personnel to triage patients into one of 4 categories within 60 seconds.
Staging Area	A receiving area for staff, patients, or supplies.
Standard Emergency Management System (SEMS)	The State mandated system for disaster management utilizing the principles of the Incident Command System applied to all levels of emergency response agencies and government to provide a uniform and standard organizational structure and guidance for operations to mitigate major incidents.
Standard of Care	The usual, reasonable level of care to be rendered to patients. This level of care varies from community to community, but should be a constant standard for all patients from all providers in any given community.
Standard Operating Procedures (SOP)	A set of instructions having the force of a directive, covering those features of operations which lend themselves to a definite or standardized procedure.
Standing Orders	Certain medical procedures (refer to EMS Agency *Adult and Pediatric Treatment Protocols*) determined by the EMS Agency Medical Director that may be done without contacting the Base Hospital or during radio communications failure.
Special Circumstances	Events, incidents, or patient conditions for which the most effective clinical care may require prehospital personnel to deviate from the "Standard EMS Treatment Protocols."
STEMI	ST-Elevation Myocardial Infarction. A significant 12 lead EKG change. A significant 12 lead EKG change is defined as ST elevation greater than 2mm, one small box, in anatomically contiguous leads
STEMI) Receiving	A hospital licensed for cardiac catheterization laboratory by the State

Centers (SRC) (In Development)	Department of Health Services and approved as a SRC by the San Francisco EMS Agency. With the initiation of 12 lead EKGs by paramedics and rapid transport to a STEMI Receiving Center with 24-hour cardiac catheterization laboratories and cardiovascular surgery capabilities, patients with STEMI will receive definitive care
Supportive Care	Basic Life Support and Advanced Life Support procedures designed to reduce pain and suffering, provide safety, alleviate discomfort and maintain the patient's dignity. Supportive care consists of, but is not limited to, BLS airway maneuvers, removal of airway obstructions, oxygen administration, hemorrhage control, hydration, glucose administration, and pain control.
Trauma Care System	"Trauma care system" or "trauma system" or "inclusive trauma care system" means a system that is designed to meet the needs of all injured patients.
Trauma Center	"Trauma Center" or "designated trauma center" means a licensed hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV trauma center and/or Level I or II pediatric trauma center by the EMS Agency, in accordance EMS Agency Policy #5013, *Trauma Center Designation*..
Trauma Center Criteria	A method for deciding which patients need a trauma center, based on the patient's injuries, vital signs, mechanism of injury, and the paramedic's judgment.
Trauma Override	SFGH continues Total Diversion during a period of Total Diversion Suspension. They continue to divert medical patients, but accept trauma patients.
Trauma Resuscitation Area	"Trauma Resuscitation Area" means a designated area within a trauma center where trauma patients are evaluated upon arrival.
Trauma Service	A "trauma service" is a clinical service established by the organized medical staff of a trauma center that has oversight and responsibility of the care of the trauma patient. It includes, but is not limited to; direct patient care services, administration, and as needed, support functions to provide medical care to injured persons.
Trauma Team	"Trauma team" means the multi-disciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated trauma center. The trauma team consists of physicians, nurses and allied health personnel. The composition of the trauma team may vary in relationship to trauma center designation level and severity of injury which leads to trauma team activation.
Triage	Literally means, "to sort:" commonly means prioritizing patients into categories according to the severity of their condition. Patients requiring life saving care are treated before those requiring only first aid (see START).
Triage Criteria	"Triage criteria" means a measure or method of assessing the severity of a person's injuries that is used for patient evaluation and that utilizes anatomic or physiologic considerations or mechanism of injury.
Triage Tags	A tag used by triage workers as a patient chart to identify the patient and document the patient's care and condition.
Unstable Patients	Defined as those with any of the following: • Cardiac or respiratory arrest • Unstable airway • Respiratory distress (<10 or >29 breaths per minute) with acute altered mental status • Shock as defined as blood pressure <80 systolic and pulse rate >120 with poor skin signs (cool, pale, diaphoretic) • Status seizures • Obstetric emergencies: third trimester bleeding, prolapsed or nuchal cord, imminent breech delivery • Trauma patients with any of the above, or who is unconscious, or with

	uncontrolled bleeding
Weapons of Mass Destruction (WMD)	Includes any chemical, radiological, nuclear, incendiary, explosive, or biological agent used in terrorist activities to threaten or inflict intentional harm or death to a given population.
Yellow Alert	Official status used by DEC indicating that a potential critical incident has occurred which may result in casualties confirmed by first responders.

Section 2:
Personnel & Training

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 2000
Effective Date: January 30, 2017
Supersedes: May 15, 2010

PREHOSPITAL PERSONNEL STANDARDS & SCOPE OF PRACTICE

I. PURPOSE

Define the scope of local practice and standards for prehospital personnel.

II. POLICY

A. All prehospital personnel shall operate within the scope of practice applicable to their level of certification or licensure. Personnel shall not exceed their scope of practice as defined in State law and San Francisco EMS Policy and Protocol.

B. This policy applies to all prehospital personnel employed by, and on duty with, a permitted San Francisco ALS or BLS provider.

1. A paramedic must be employed with an approved paramedic service provider in order to perform the scope of practice as specified in this policy.
2. Paramedics not accredited in San Francisco, but employed as BLS personnel may not utilize any part of the Paramedic Scope of Practice as defined in this policy.
3. Accreditation candidates may utilize the Paramedic Basic Scope of Practice when working with a second accredited Paramedic prior to receiving their accreditation.

C. San Francisco EMS personnel responding into, or transporting through, another jurisdiction, shall continue to operate under San Francisco policies and protocols including the local Scope of Practice as defined in this policy.

D. The requirements and process for EMT certification in San Francisco is described in Policy 2040 Emergency Medical Technician Certification.

E. The requirements and process for paramedic accreditation in San Francisco is described in Policy 2050 Paramedic Accreditation.

III. EMERGENCY MEDICAL TECHNICIAN: LOCAL SCOPE OF PRACTICE

A. During training, while at the scene of an emergency, during transport of the sick or injured, or during an interfacility transfer, a certified EMT or supervised EMT student is authorized to do any of the following:
1. Evaluate the ill and injured.

2. Render basic life support, rescue and emergency medical care to patients.
3. Obtain diagnostic signs to include, but not be limited to, temperature, blood pressure, pulse and respiration rates, pulse oximetry, level of consciousness, pupil status (and blood glucose level if authorized by Provider Medical Director).
4. Perform cardiopulmonary resuscitation (CPR), including the use of mechanical adjuncts to basic cardiopulmonary resuscitation.
5. Perform Automated External Defibrillation.
6. Administer oxygen.
7. Remove a directly visualized foreign body from the airway.
8. Use the following adjunctive airway and breathing aids:
    a. Oropharyngeal airway;
    b. Nasopharyngeal airway;
    c. Suction devices;
    d. Basic oxygen delivery devices for supplemental oxygen therapy;
    e. Manual and mechanical ventilating devices designed for prehospital use including continuous positive airway pressure.
9. Use various types of stretchers and spinal immobilization devices.
10. Provide initial prehospital emergency care of trauma, including:
    a. Bleeding control through the application of tourniquets;
    b. Use of approved hemostatic dressings (e.g. Quick Clot);
    c. Spinal motion restriction;
    d. Extremity splinting; and
    e. Traction splinting.
11. Administer the following approved over the counter medications:
    a. Oral glucose or sugar solutions; and
    b. Aspirin.
12. Extricate entrapped persons.
13. Perform field triage.
14. Transport patients.
15. Mechanical patient restraint.
16. Set up for ALS procedures, under the direction of a Paramedic.
17. Administration of naloxone intranasally for altered mental status, respiratory depression and/ or suspected opioid overdose, if authorized by Provider Medical Director.
18. Administration of intramuscular epinephrine by auto-injector for suspected anaphylaxis and/or severe asthma, if authorized by Provider Medical Director.
19. Assist patients with the administration of physician-prescribed devices including, but not limited to, patient-operated medication pumps, sublingual nitroglycerin, and self-administered emergency medications.

IV. EMERGENCY MEDICAL TECHNICIAN: LOCAL SCOPE OF PRACTICE FOR INTERFACILITY TRANSFERS

A. EMTs, during an interfacility transfer, may do the following:

1. Monitor, maintain, and adjust if necessary in order to maintain, a preset rate of flow and turn off the flow of intravenous fluid:
   a. Glucose solutions including Dextrose 10%;
   b. Isotonic balanced salt solutions including Normal Saline and Ringer's lactate.
2. Solutions may NOT be controlled by a mechanical IV pump or flow control device. Dial-a-flow and similar aperture or constriction flow control devices may be monitored.
3. EMTs may NOT monitor any fluid or medication infusion delivered through a central venous access device unless delivered by means of a patient controlled pump.
4. Monitor a patient, who is deemed appropriate for transfer by the transferring physician, and who has the following:
   a) Nasogastric (NG) tubes,
   b) Gastrostomy tubes,
   c) Heparin or saline locks,
   d) Foley catheters,
   e) Tracheostomy tubes,
   f) Indwelling vascular access lines.
   g) **Patients with arterial lines MAY NOT be monitored by EMT's**.

5. Tracheostomy patients and suctioning: Patients must be able to breathe without mechanical assistance. Suctioning by EMTs is limited to inserting a soft suction catheter to clear secretions from the proximal end of the tracheostomy tube. EMTs may not perform deep tracheal suctioning or sterile suctioning. In no case, should the suction catheter pass beyond the distal end of the tracheostomy tube.

V. EMERGENCY MEDICAL TECHNICIAN: TRAINING STANDARDS

A. EMTs will complete and maintain current certifications in Basic Life Support CPR

B. All EMTs will complete a local orientation approved by EMS Agency that includes, at a minimum:
   1. San Francisco EMS System organization
   2. San Francisco EMS Policies and Patient Treatment Protocols
   3. San Francisco EMS Agency MCI Plan
   4. San Francisco geography
   5. ICS-100 and ICS-200 (Basic ICS).
   6. FEMA IS-700a (Introduction to National Incident Management System).
   7. Hazmat First Responder Awareness course (FRA) per 29 CFR 1910-120.

VI. EMERGENCY MEDICAL TECHNICIAN: REQUIRED TRAINING FOR INDEPENDENT WORK ASSIGNMENT ON AN ALS AMBULANCE

A. EMT eligibility for independent work assignment is determined by their passing an advanced life support partner training approved by their EMS provider Medical Director. If they have not passed such a course, they may work as a primary EMT on a BLS response vehicle, or as an EMT partnered with another EMT on a BLS ambulance. If they

have passed such a course, they may work as an EMT on an ALS ambulance with any San Francisco accredited paramedic.

VII. PARAMEDIC: LOCAL SCOPE OF PRACTICE

A. A paramedic may perform any activity identified in the EMT local scope of practice in Sections III and IV of this policy.

B. During training, while at the scene of an emergency, during transport of the sick or injured, or during an interfacility transfer, an accredited Paramedic or a supervised Paramedic accreditation candidate or a supervised Paramedic student is authorized to do any of the following:

1. Utilize electrocardiographic devices and monitor electrocardiograms, including 12-lead electrocardiograms (ECG).

2. Perform defibrillation, synchronized cardioversion, and external cardiac pacing.

3. Visualize the airway by use of the laryngoscope and remove foreign bodies with Magill forceps.

4. Perform pulmonary ventilation by use of:
   a) Approved extraglottic airways (e.g. King Tube)
   b) Stomal intubation,
   c) Adult nasotracheal intubation and
   d) Adult oral endotracheal intubation.

5. Perform deep suctioning after completion of Provider Medical Director approved training protocol.

6. Utilize mechanical ventilation devices for continuous positive airway pressure (CPAP)/bi-level positive airway pressure (BiPAP) and positive end expiratory pressure (PEEP) in the spontaneously breathing patient.

7. Institute intravenous (IV) catheters, saline locks, needles, or other cannulae (IV lines), in peripheral veins and monitor and administer medications through pre-existing vascular access.

8. Institute intraosseous (IO) needles or catheters.

9. Administer IV or IO glucose solutions or isotonic balanced salt solutions, including normal saline and Ringer's lactate solution.

10. Obtain venous blood samples.

11. Use laboratory devices, including point of care testing, for pre-hospital screening to measure the following lab values: glucose, capnometry, capnography, and carbon monoxide when appropriate authorization is obtained from State and Federal agencies, including from the Centers for Medicare and Medicaid Services pursuant to the Clinical Laboratory Improvement Amendments (CLIA).

12. Utilize Valsalva maneuver.

13. Perform percutaneous needle cricothyroidotomy.

14. Perform needle thoracostomy.

15. Perform nasogastric and orogastric tube insertion and suction.

16. Monitor thoracostomy tubes.

17. Monitor and adjust IV solutions containing potassium, equal to or less than 40 mEq/L.

18. Administer approved medications by the following routes: IV, IO, intramuscular, subcutaneous, inhalation, transcutaneous, rectal, sublingual, endotracheal, intranasal, oral or topical.

19. Administer the following medications:
    a) 10%, 25% and 50% dextrose;
    b) Activated charcoal;
    c) Adenosine;
    d) Aerosolized or nebulized beta-2 specific bronchodilators;
    e) Amiodarone;
    f) Aspirin;
    g) Atropine sulfate;
    h) Pralidoxime (2-PAM) chloride;
    i) Calcium chloride;
    j) Cetacaine Spray;
    k) Diazepam;
    l) Diphenhydramine hydrochloride;
    m) Dopamine hydrochloride;
    n) Epinephrine;
    o) Fentanyl
    p) Glucagon;
    q) Lidocaine hydrochloride;
    r) Magnesium sulfate;
    s) Midazolam;

t) Morphine sulfate;
u) Naloxone hydrochloride;
v) Neosynephrine
w) Nitroglycerine preparations, except IV, unless certified as a Critical Care Paramedic
x) Ondansetron;
y) Sodium bicarbonate;
z) Sodium Thiosulfate

VIII. PARAMEDIC: TRAINING STANDARDS

A. Paramedics will complete and maintain current certifications in the following core courses:
    1. Basic Life Support CPR
    2. Advanced Cardiac Life Support (ACLS) or approved equivalent.
    3. Pediatric Advanced Life Support (PALS), Pediatric Education for Prehospital Professionals (PEPP) or Emergency Pediatric Care (EPC).
    4. International Trauma Life Support (ITLS) or Prehospital Trauma Life Support (PHTLS), for initial certification only.
B. Additionally, all Paramedics will complete the following during an initial orientation:

    1. San Francisco EMS System organization.
    2. San Francisco EMS Policies and Patient Treatment Protocols
    3. San Francisco EMS Agency MCI Plan Initial & Recurring training.
    4. San Francisco geography.
    5. ICS-100 and ICS-200 (Basic ICS).
    6. FEMA IS-700a (Introduction to National Incident Management System).
    7. Paramedic supervisors must complete ICS-300 training.
    8. Hazmat First Responder Awareness course (FRA) per 29 CFR 1910-120.

C. Paramedics must complete 10 ALS patient contacts with Field Training Officer (FTO) as a third person and successfully pass FTO evaluation in the following areas, appropriate to the knowledge expected of the level:
    1. Knowledge of San Francisco geography
    2. Knowledge of San Francisco EMS policies and protocols

IX. CRITICAL CARE PARAMEDIC SCOPE OF PRACTICE

A. A licensed and accredited paramedic may practice as a Critical Care Paramedic after completing the following:
    1. Successful completion of a Critical Care Paramedic (CCP) training program as specified in California Code of Regulations Section 100160(b).
    2. Successful completion of Critical Care Paramedic competency testing.

3. Holds a current certification as a Critical Care Paramedic from the Board for Critical Care Transport Paramedic

B. In addition to the approved paramedic scope of practice, the Critical Care Paramedic may perform the following procedures and administer medications during interfacility transports:
    1. Set up and maintain thoracic drainage systems;
    2. Set up and maintain mechanical ventilators;
    3. Set up and maintain IV fluid delivery pumps and devices;
    4. Blood and blood products;
    5. Glycoprotein IIB/IIIA inhibitors;
    6. Heparin IV;
    7. Nitroglycerin IV;
    8. Norepinephrine;
    9. Thrombolytic agents and
    10. Maintain total parenteral nutrition.

X. AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.160 - 1797.197a
California Code of Regulations, Title 22, Section 10063 – 100064 and 100146

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 2001
Effective Date: January 1, 2011
Review Date: January 1, 2013
Supersedes: August 1, 2007

USE OF STANDARD AND SPECIAL CIRCUMSTANCES TREATMENT PROTOCOLS

I. PURPOSE

A. To develop a standard approach to utilizing the San Francisco EMS Agency Standard Treatment Protocols.
B. To develop a standard approach for utilizing the San Francisco EMS Agency Treatment Protocols for Special Circumstances.

II. AUTHORITY

A. California Health and Safety Code, Section 1797 et seq. and 1798 et seq.
B. California Code of Regulations, Title 22, Division 9
C. San Francisco Health Code, Section 901

III. POLICY

1. STANDARD CIRCUMSTANCES

A. Prehospital personnel shall initiate BLS measures and then proceed to ALS measures as dictated by the patient assessment and scope of practice.

B. Prehospital personnel shall utilize good clinical judgment and consider additional resources as needed.

C. BLS personnel shall request an ALS response unit to the scene or rapidly transport the patient to the nearest open Receiving Hospital according to EMS Agency Policy.

D. Routine Medical Care should be provided to every patient as guided by assessment of the scene and the patient's condition.

E. When situations and/or patient conditions are not addressed by a Standard Treatment Protocol, prehospital personnel shall utilize other pre-existing standard life support guidelines, including PHTLS, ACLS, PALS and good medical judgment. Paramedics must make Base Hospital Physician contact for deviations from EMS Agency treatment protocols and/or policies.

F. The Base Hospital Physician provides on-line medical consultation according to EMS Agency Policy.

G. ALS Optional Scope practices shall be reviewed at the EMS Agency Clinical Advisory Committee.

2. SPECIAL CIRCUMSTANCES

H. Prehospital personnel shall consider the use of a Treatment Protocol for Special Circumstances only if the indications for treatment are met AND the appropriate authority has approved its use.

I. The authority to initiate care according to the "Treatment Protocols for Special Circumstances" is cited in the individual protocols. This authority must come from the San Francisco Emergency Medical Director or his/her designee

1. The EMS Agency Duty Officer is the primary point of contact for the EMS System and will notify the providers that approval to initiate using the Special Treatment Protocols has been obtained from the EMS Agency Medical Director or his/her designee.

J. Prehospital personnel shall contact the Base Hospital Physician when the protocol states that BHMD approval is required, for clinical consultation, and/or for deviation from clinical care described in the treatment protocols.

K. Routine Medical Care (RMC), Advanced Life Support (ALS) and Basic Life Support (BLS) are as defined in this Policy: Use of Standard and Special Treatment Protocols, unless otherwise defined in the individual protocol within this section.

L. EMS prehospital and Base Hospital personnel shall maintain proficiency in the use of all EMS Agency Treatment Protocols for Special Circumstances.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 2010
Effective Date: August 1, 2008
Review Date: January 1, 2010
Supersedes: 3080

PUBLIC SAFETY FIRST AID TRAINING AND APPROVAL

I. PURPOSE

A. To provide guidelines for the approval of a public safety first aid training program in the City and County of San Francisco

II. AUTHORITY

A. California Code of Regulations, Title 22, Sections 100005 - 100041

III. POLICY

A. A public safety agency wishing to offer a Cardio-Pulmonary Resuscitation (CPR) and/or First Aid training program authorized by the Emergency Medical Services (EMS) Agency shall submit a written request to the local EMS Agency.
B. Program approval or disapproval shall be made in writing by the EMS Agency to the requesting training program within 90 days after receipt of all required documentation.
C. Program approval shall be for four years following the effective date of program approval and may be renewed every four years by following the procedure outlined above for initial program approval
D. All programs and program materials shall be subject to on-site evaluations by the EMS Agency and the State EMS Authority.
E. Program director must ensure that the program maintains compliance with applicable sections contained in the California Code of Regulations, Title 22, Division 9, Chapter 1.5.
F. When changes occur in regulations or local policy, the program director must notify the EMS Agency of compliance with changes within 30 days of the effective date of the regulations.
G. Denial, Revocation, or Suspension of Approval

1. Non-compliance with any criteria required for program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provisions of California Code of Regulations, Title 22, Division 9, Chapter 1.5, may result in suspension, or revocation of program approval by the local EMS Agency.
2. The Program Director will be notified in writing of the deficiency and be given an opportunity to comply within a specified period of time.
3. Failure to correct deficiencies and/or to otherwise respond to directions will be cause for the EMS Agency to:

a) Place the program on a probationary status with conditions for improvement and/or

b) Denial, withdrawal, or suspension of program approval.

IV. PROCEDURE

A. Applications for approval shall be made in writing and include:

1. A statement verifying equivalency to American Heart Association (AHA) or American Red Cross CPR and/or First Aid standards which include learning objectives, skills protocols, and treatment guidelines.
2. Session guidelines or lesson plans.
3. A course outline if different than the AHA or Red Cross CPR and/or First Aid guidelines.
4. Performance objectives for each skill.
5. Samples of written and skills examinations used for periodic testing.
6. A final skills competency examination.
7. A final written examination.
8. The name and qualifications of the program director and principal instructor(s).
9. The location at which the courses are to be offered and their proposed dates.
10. A copy of the course completion certificate.
11. Table of contents listing the required scope of the course and required topics pursuant to the California Code of Regulations, Title 22, Division 9, Chapter 1.5, Sections 100019 and 100020.

B. The EMS Agency shall be notified of all course offerings 30 days before the starting date of the course.

C. Persons or agencies conducting an approved training program must notify the EMS Agency in writing, in advance when possible and in all cases within 30 days of any change in course content, hours of instruction, program director, or principal instructor(s), with name and qualifications of any new personnel.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 2020
Effective Date: January 1, 2011
Review Date: January 1, 2013
Supersedes: February 1, 2004

EMERGENCY MEDICAL TECHNICIAN PROGRAM APPROVAL

I. PURPOSE

A. Establish the standards for EMT training programs in San Francisco
B. Define the approval process for application submission and site review

II. AUTHORITY

A. California Health and Safety Code, Division 2.5, Section 1797.208
B. California Code of Regulations, Title 22, Sections 100065-100078

III. POLICY

A. A qualified agency wishing to offer an Emergency Medical Technician-1 (EMT-1) training program shall submit a written request to the local Emergency Medical Services (EMS) Agency.
B. Training shall be in compliance with requirements set forth in 22 CCR 100065 – 100078.
C. Program approval or disapproval shall be made in writing by the local EMS Agency to the requesting training program within 90 days after receipt of all required documentation.
D. Program approval shall be for four years following the effective date of program approval and may be renewed every four years by following the procedure outlined above for initial program approval.
E. All programs and materials shall be subject to periodic on site evaluations by the EMS Agency and the EMS Authority.
F. Denial, Revocation, or Suspension of Program Approval
    1. Non-compliance with any criteria required for program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provisions of the California Code of Regulations, Title 22, Division 9, Chapter 2, may result in suspension, or revocation of program approval by the local EMS Agency.
    2. The program director will be notified in writing of the deficiency and be given an opportunity to comply within a specified period of time.
    3. Failure to correct deficiencies and/or to otherwise respond to directions will be cause for the local EMS Agency to:
        a) Place the program on a probationary status with conditions for improvement and/or
        b) Denial, withdrawal, or suspension of program approval.

IV. PROCEDURE

A. All applications made to the EMS Agency shall include:

1. A statement verifying usage of United States Department of Transportation's EMT-Basic curriculum, DOT HS 808 149, August 1994, which includes learning objectives, skills protocols, and treatment guidelines
2. Session guidelines or lesson plans
3. A course outline if different than the State EMT-1 curriculum format
4. Performance objectives for each skill
5. Samples of written and skills examinations used for periodic testing
6. A final skills competency examination
7. A final written examination
8. The name and qualifications of the program director, program clinical coordinator, and principal instructor(s)
9. Provisions for clinical hospital and ambulance experience training for EMT-1 programs to include performance objectives
10. Provisions for course completion by challenge including a challenge examination (if different from final examination)
11. Provisions for refresher course or any courses required for recertification, plus a refresher exam
12. The location at which the courses are to be offered and their proposed dates
13. A copy of the course completion certificate
14. Procedure for the distribution of the local EMS Agency's rules, regulations, and certification process to all categories of students
15. Table of contents listing the required information listed in this subsection, with corresponding page numbers

B. Notification of Courses

1. The local EMS Agency shall be notified of all course offerings 30 days before the starting date of the course.
2. Persons or agencies conducting an approved training program must notify the local EMS Agency in writing, in advance when possible and in all cases within 30 days of any change in course content, hours of instruction, program director, program clinical coordinator, or principal instructor(s), with name and qualifications of any new personnel.
3. Program director must ensure that the program maintains compliance with applicable sections contained in the California Code of Regulations, Title 22, Division 9, Chapter 2.
4. When changes occur in regulations, the program director must notify the local EMS Agency of compliance with changes within 30 days of the effective date of the regulations.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 2030
Effective Date: January 7, 2013
Supersedes: January 1, 2011

PARAMEDIC PROGRAM APPROVAL

NOTE: *Policy reposted on website with new effective date January 7, 2013. Minor change to section III. C. stating program approval must be renewed every four years. There were no other changes to policy content.*

I. PURPOSE

A. Establish standards for paramedic training programs in San Francisco
B. Provide a mechanism for approval for programs by the EMS Agency

II. AUTHORITY

A. California Health and Safety Code, Division 2.5, Sections 1797.172 and 1797.208
B. California Code of Regulations, Title 22, Sections 100047-100062.1

III. POLICY

A. Eligible training institutions that wish to be approved as an Emergency Medical Technician-Paramedic (EMT-P) training program shall submit a written request to the local Emergency Medical Services (EMS) Agency.
B. Program approval or disapproval will be made by the local EMS Agency in writing within 90 days of receipt of all required documentation.
C. Program approval must be renewed every four years subject to the procedures specified in this policy.
D. All program materials are subject to periodic reviews.
E. All programs are subject to periodic on-site evaluation.
F. Persons or agencies conducting an approved training program must notify the local EMS Agency in writing, in advance when possible and in all cases within 30 days, of any change in course content, hours of instruction, program director, course director, program medical director, provisions for hospital clinical experience or field internship, with name and qualifications of any new personnel.
G. Course director shall ensure that the program maintains compliance with applicable sections contained in Title 22 of the California Administrative Code, Division 9, Chapter 4. When changes occur in regulations which affect this program, the program director must notify the local EMS Agency of compliance with changes within 30 days of the effective date of the regulations.
H. Denial, Revocation, or Suspension of Program Approval
    1. Non-compliance with any criteria required for program approval, use of any unqualified teaching personnel, or non-compliance with any other applicable provisions of Title 22 of the California Administrative Code,

Division 9, Chapter 4, may result in suspension, or revocation of program approval by the local EMS Agency.

2. The program director will be notified in writing of the deficiency and be given an opportunity to comply within a specified period of time.

3. Failure to correct deficiencies and/or to otherwise respond to directions will be cause for the local EMS Agency to:

    a) Place the program on a probationary status with conditions for improvement and/or

    b) Denial, withdrawal or suspension of program approval.

IV. PROCEDURE

A. Applications to the EMS Agency shall include:

1. A statement of course objectives
2. A course outline
3. Performance objectives for each skill
4. The name and qualifications of the training program course director, program medical director, and principal instructors
5. Provisions for supervised hospital clinical training including student evaluation criteria and standardized forms for evaluating EMT-P students; and monitoring of preceptors by the training program
6. Provisions for supervised field internship including student evaluation criteria and standardized forms for evaluating EMT-P students; and monitoring of preceptors by the training program
7. The location at which the courses are to be offered and their proposed dates
8. Table of Contents listing the required topics and skills pursuant to Section 100159, Required Course Content
9. Course material related to any approved optional procedures

B. Examination Review

1. The local EMS Agency shall review the following prior to program approval:

    a) Samples of written and skills examinations administered by the training program for periodic testing

    b) A final skills competency examination

    c) A final written examination administered by the training program

    d) Evidence that the program provide adequate facilities, equipment, examination security, and student record keeping

    e) A copy of the course completion certificate

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 2040
Effective Date: September 9, 2013
Supersedes: January 1, 2011

EMERGENCY MEDICAL TECHNICIAN CERTIFICATION

I. PURPOSE

Indentify requirements for Emergency Medical Technician (EMT) certification in the City and County of San Francisco.

II. POLICY

A. Initial or re-certification applicants for as an EMT in the City and County of San Francisco apply to the San Francisco EMS Agency for an EMT Certificate. Applicants must meet all minimum requirements identified in this policy.

B. The California Health & Safety Code, Section 1798.200 lists categories of actions constituting a threat to public health safety that may preclude an individual from obtaining an EMT Certification. EMT applicants may be required to submit additional information or have an in-person interview for determination of the applicability of Health & Safety Code, Section 1798.200. The EMS Agency Medical Director retains the final decision through his/her medical authority whether to grant or revoke an EMT certification in San Francisco.

III. GENERAL REQUIREMENTS FOR ALL EMT APPLICANTS

A. Be 18 years of age or older.
B. Complete a San Francisco EMS Agency EMT certification application form and provide all requested information on that form (obtained directly from the EMS Agency office or downloaded from the website) along with the required fee.
C. Submit photocopy of current picture identification (State driver's license or ID card, valid Passport, valid US military ID card or other government-issued ID).
D. Submit photocopy of current Basic Life Support (Healthcare Provider Level) CPR Card from the American Heart Association, American Red Cross or American Safety & Health Institute.

IV. INITIAL EMT CERTIFICATION / OUT-OF-STATE CURRENT EMT CERTIFICATE

A. Meet all general requirements listed in Section III above.
B. Submit photocopy of a valid EMT course completion record, or other documented proof of successful completion of an approved EMT course, or out-of-state EMT training course within the last 2 years. **First-time EMT applicants in any California county only have 24 months, after they pass their EMT course to apply for**

California EMT certification. Out-of-state applicants must also provide the name, address and telephone number of the EMT course director.

C. Submit photocopy of National Registry of EMT Certificate and Certification Card. Out-of-state applicants must also provide the name, address and telephone number of the issuer of the National Registry EMT Certificates and cards.
D. Complete a *Live Scan Fingerprint and Department of Justice / FBI Background Check* (obtained directly from the EMS Agency office or downloaded from the website).

V. RECERTIFICATION- CURRENT EMT CERTIFICATE

A. Meet all general requirements listed in Section III.
B. Submit a photocopy of a current EMT certification card.
C. Complete the *State of California EMT Skills Competency Verification Form - EMSA-SCV 7/03* (obtained directly from the EMS Agency office or downloaded from the website).
D. Submit photocopy of completed *Live Scan Fingerprint and Department of Justice / FBI Background Check* (obtained directly from the EMS Agency office or downloaded from the website) if the previous EMT Certification was not issued by the San Francisco EMS Agency.
E. Provide proof of **24-hours** of continuing education (CE) training:
    1. Photocopy of EMT Refresher Course Completion Certificate from an approved EMT training program;
    2. Photocopies of Continuing Education Unit (CEU) Certificates from an approved continuing education provider;
    3. No more than 12 hours of on-line CEUs will be accepted.
F. The EMS Medical Director must approve other courses such college anatomy or physiology / etc. for CE credit. Generally, applicants will be asked to provide additional course documentation.

VI. RECERTIFICATION - LAPSED CERTIFICATE LESS THAN 6 MONTHS

Same steps for recertification of a current certificate listed in Sections V above.

VII. RECERTIFICATION - LAPSED CERTIFICATE GREATER THAN 6 MONTHS, BUT LESS THAN 12 MONTHS

A. Same steps for recertification of a current certificate listed in Section V except the total number of required continuing education units is **36-hours.**
B. Provide photocopy of NEW completed *Live Scan Fingerprint and Department of Justice / FBI Background Check* (obtained directly from the EMS Agency office or downloaded from the website).

VIII. RECERTIFICATION - LAPSED CERTIFICATE GREATER THAN 12 MONTHS, BUT LESS THAN 24 MONTHS

A. Same steps for recertification of a current certificate listed in Section V except the total number of required continuing education units is **48-hours.**
B. Provide photocopy of CURRENT National Registry of EMT Certificate and Certification Card.
C. Provide photocopy of NEW completed *Live Scan Fingerprint and Department of Justice / FBI Background Check* (obtained directly from the EMS Agency office or downloaded from the website).

IX. RECERTIFICATION - LAPSED CERTIFICATE GREATER THAN 24 MONTHS

Follow procedures listed in Section IV for Initial EMT Certification in San Francisco.

X. OUT-OF-STATE CERTIFICATION WITH LAPSED CERTIFICATE

There is no reciprocity for expired out-of-state EMTs. Start by taking an EMT course in California to obtain an EMT course completion record.

XI. AUTHORITY

California Health and Safety Code, Sections 1797.210 and 1798.200
California Code of Regulations, Title 22, Chapter 2, Sections 100079 - 100081

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 2050
Effective Date: February 1, 2015
Supersedes: September 9, 2013

PARAMEDIC ACCREDITATION

I. PURPOSE

To establish procedures for a California licensed Paramedic to become accredited in the City and County of San Francisco.

II. POLICY

A. Applicants for initial or re-accreditation as a Paramedic in the City and County of San Francisco must apply to the San Francisco EMS Agency for a Paramedic accreditation. Applicants must meet all minimum requirements identified in this policy.

B. No person shall use the Paramedic scope of practice in San Francisco unless they are currently an accredited Paramedic or have completed the requirements to be an accreditation candidate.

C. Paramedic applicants with background issues listed under Health & Safety Code, Section 1798.200 in the categories of actions constituting a threat to public safety may be precluded from obtaining a Paramedic accreditation. The Paramedic applicant may be required to submit additional information or participate in an in-person interview for determination of the applicability of Health & Safety Code, Section 1798.200. Denial of accreditation shall be subject to provisions of this policy and *Policy 2070 Certificate / License Discipline Process for Prehospital Personnel*. The EMS Agency Medical Director retains the final decision through his/her medical authority whether to grant or revoke a Paramedic accreditation in San Francisco.

III. GENERAL REQUIREMENTS FOR ALL PARAMEDIC APPLICANTS

A. Submit a completed San Francisco EMS Agency Paramedic Accreditation application along with the required fee. Go to the EMS Agency office or www.sfdem.org.

B. Provide ~~a~~ photocopy of the following:

1. Current picture identification (State driver's license or ID card, valid Passport, valid US military ID card or other government-issued ID).
2. Current California Paramedic license.
3. Current Basic Life Support (Healthcare Provider Level) CPR Card from the American Heart Association, American Red Cross or American Safety & Health Institute.

IV. INITIAL ACCREDITATION

A. Submission of all general requirements listed in Section III.

B. Submit photocopies of current certification cards or proof of course completion for the following:
   1. Advanced Cardiac Life Support (ACLS).
   2. Pediatric Advanced Life Support (PALS) or Pediatric Education for Prehospital Professionals (PEPP).
   3. Prehospital Trauma Life Support (PHTLS) or Basic Trauma Life Support (BTLS).
   4. Incident Command System Training (ICS) 100, 200 and IS 700a, Introduction to National Incident Management System.
   5. Hazmat First Responder Awareness course (FRA) per 29 CFR 1910-120.

C. Provide verification of successful completion of a San Francisco EMS system orientation given by the employer. The verification form should include any San Francisco EMS approved Optional Scope of Practice protocols

D. The EMS Agency shall process the accreditation application within 15 days of receiving it. The accreditation applicant may perform the basic Paramedic scope of practice with a second accredited Paramedic until he/she receives local accreditation.

E. The initial accreditation term shall be from the date issued until the applicant's license expires. Upon renewal, accreditation will be concurrent with California Paramedic License.

V. RE-ACCREDITATION

A. Accreditation for practice shall be continuous as long as licensure is maintained and the following requirements are met:
   1. Submission of all general requirements listed in Section III.
   2. Verification of employment as a Paramedic from a permitted San Francisco ambulance provider.
   3. Verification from the employer of completion of training on EMS Agency policy and protocols and updates or any other trainings required by the EMS Agency Medical Director that have been issued in the previous 12 months.
   4. Submit photocopies of current certification cards for the following:
      a) Advanced Cardiac Life Support (ACLS)
      b) Pediatric Advanced Life Support (PALS) or Pediatric Education for Prehospital Professionals (PEPP).

VI. LICENSE OR ACCREDITATION LAPSES

A. Accreditation lapse less than 30 days:
   1. Meet the requirements for Re-accreditation in Section V.

B. Accreditation lapse greater than 30 days, but less than 1 year:
   1. Meet the requirements for Re-accreditation in Section V, and
   2. Submit written request from employer that the individual to be re-accredited.

C. Accreditation lapse between 1 and 2 years:
   1. Meet the requirements for Re-accreditation in Section V;
   2. Submit ~~a~~ written request from ~~an~~ employer for re-accredited; and
   3. Successfully pass a supervised skills competency examination provided by the ALS ambulance provider.

D. Accreditation lapse 2 or more years:
   1. Follow Section IV Initial Accreditation.

VII. TRANSFER OF SAN FRANCISCO PARAMEDIC ACCREDITATION

A. A Paramedic seeking to transfer employment between San Francisco based ALS providers remains an accredited Paramedic when:
   1. He/she is employed and working in the field as a Paramedic for the new employer within 90 days of the date last worked in the field as a Paramedic from the last employer; and
   2. The accreditation period is current.

B. The new employer must submit written notification to the EMS Agency at least 2 business days in advance of the Paramedic's new employment start date. The notification must include:
   1. Name of the Paramedic and his/her current San Francisco EMT-P accreditation number;
   2. Name of the previous employer and date last worked in the field with that employer.
   3. Termination date with previous employer.
   4. Name of new employer and date of hire.
   5. Start date in the field with the new employer.

C. The Paramedic must submit a completed, signed EMS Agency Transfer application to the EMS Agency at least 2 business days in advance of the assignment to the field as a

Paramedic with the new San Francisco based ALS Provider. Include from the new employer verification of completed training on San Francisco EMS Agency policy and protocols, including updates or revisions issued within the previous 12 months.

D. Any Paramedic seeking to transfer employment between San Francisco based ALS providers who does not meet the requirements in the section will be considered an Initial Accreditation applicant.

VIII. AUTHORITY

California Health and Safety Code, Sections 1797.172 et seq., 1797.214, 1797.185 et seq. California Code of Regulations, Sections Title 22, Division 9, Article 1, Section 100142; and Article 6, Sections 100165 & 100166., Article 8, Section 100171; and Article 9, Section 100172.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 2051
Effective Date: September 9, 2013
Supersedes: August 1, 2011

PRECEPTORS FOR PARAMEDIC STUDENT INTERNS

I. PURPOSE

A. Establish standards for preceptors supervising paramedic student interns.
B. Identify the ALS provider agency responsibilities when providing preceptors and field training for paramedic student interns.
C. Identify the paramedic training program responsibilities for oversight of their paramedic student interns receiving field training through an ALS provider agency.

II. POLICY

Paramedic training programs and ALS provider agencies are jointly responsible for ensuring that student preceptors meet the standards delineated in the policy and that patient care delivered by paramedic student interns is done in a safe manner.

III. PRECEPTOR MINIMUM REQUIREMENTS

A. Current California Paramedic license.
B. Current accreditation as a Paramedic in San Francisco
C. At least two (2) years (full time or equivalent) as a paramedic on an ALS ambulance within the prior three (3) years. One of years of experience must be in the San Francisco EMS System. Experience outside of San Francisco must have been in a moderately busy urban or suburban EMS system.
D. No disciplinary or clinical actions currently pending or within the prior 12 months against his / her accreditation, licensure, or employment.
E. Successful completion of a Preceptor course that satisfies the requirements in CCR, Title 22, Section 100150 (f)(4).
F. All preceptors must attend at least 12 hours of continuing education per accreditation cycle that is related to adult teaching techniques and /or paramedic education theory and practice.

IV. ALS AMBULANCE PROVIDER RESPONSIBILTIES

A. ALS provider agencies must verify that any paramedic training programs has been approved by a local Agency before they can enter into a written agreement with that program to provide preceptors and field training to paramedic student interns.

B. Ambulance provider companies must ensure that sufficient staffing levels to allow preceptors to maintain direct supervision of an intern during the course of all patient care provided. Interns must have an assigned preceptor, and may not provide patient care without the assigned preceptor being present. The company must also maintain records of the student intern field assignments and patient contacts.

C. No more than one (1) student trainee shall be assigned to a response vehicle at any one time during the paramedic student's field internship.

D. Preceptors must co-sign all patient care records completed by a paramedic student intern.

V. PARAMEDIC TRAINING PROGRAM RESPONSIBLITIES

A. Paramedic training programs must be approved by a local EMS Agency before they can enter into a written agreement with a San Francisco permitted ALS provider agencies to provide preceptors and field training to paramedic student interns.

B. Paramedic training programs are responsible for ensuring that the field preceptor has the experience and training as required by California Code of Regulations, Title 22, Section 100150 (f).

C. The paramedic training program shall be responsible for continuously monitoring the progress of the intern during the field internship.

VI. AUTHORITY

California Code and Regulations, Title 22, Sections 100148, 100150, 100152 - 100153

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 2052
Effective Date: September 9, 2013
Supersedes: August 1, 2011

PARAMEDIC FIELD SUPERVISOR

I. PURPOSE

A. To establish minimum qualifications and scope of responsibilities for field paramedics supervisors.
B. Identify the ALS provider agency responsibilities when providing field supervisors.

II. POLICY

A. Paramedic supervisors are responsible for the day-to-day clinical and operational supervision of field paramedics and supervisory roles within the ICS structure during a multi-casualty incident.

B. All ALS Providers shall have at a minimum at least one Paramedic Field Supervisor on duty and available to respond 24-hours a day. The Paramedic Supervisor staffing ratio shall be one on-duty Paramedic Field Supervisor for every 10 on-duty ALS response or transport vehicles in order to maintain a reasonable span of control and availability for a field response. The EMS Medical Director may approve alternate supervisor to staff ratios provided only if they are included in the individual Paramedic Service Provider Agreement.

III. PARAMEDIC SUPERVISOR MINIMUM QUALIFICATIONS

A. Meet all San Francisco EMS paramedic accreditation standards as outline in *Policy 2050 Paramedic Accreditation*.

B. Have two years experience as a paramedic (full time or equivalent) in an urban or suburban area that included 911 emergency responses.

C. Successfully complete an approved Paramedic Supervisor Training course within six months of placement.

D. Have proof of training or participation in the following:

1. Incident Command System (ICS) 100, 200, 300 and IS 700 or Standardized Emergency Management System (SEMS) Orientation, Basic, Intermediate and Advanced courses, or an approved equivalent;

2. Incident Command System (ICS) 100, 200, 300 and IS 700 or Standardized Emergency Management System (SEMS) Orientation, Basic, Intermediate and Advanced courses, or an approved equivalent;
3. San Francisco EMS Policies and Protocols with emphasis on the Medical Group Supervisor role in Multi-Casualty Incidents and Level I, II, and III disasters;
4. At least one annual MCI training and exercise with participation in a supervisory role within the ICS structure;
5. Radio communications protocols and troubleshooting;
6. Provider Internal Disaster Plan;
7. Federal HIPPA and EMTALA regulations relating to EMS;
8. California Code of Regulations, Title 22, Division 9 and California Health and Safety Code, Division 2.5 (The "EMS Act").
9. Techniques for basic incident investigation and follow up; and
10. Conflict resolution & interpersonal communication.

C. Paramedics are prohibited from being a Paramedic Field Supervisor for any of the following reasons:
   1. Have currently pending action or past action in the previous three years against any medical license, accreditation, or certification.
   2. Are currently on probation or suspension as a result of any action against any medical license, accreditation, or certification.
   3. Paramedics who were on probation which exceeded the 3 year exclusionary period may be a Paramedic Field Supervisor upon successful completion of the probationary period, provided no more recent licensure actions are pending or have been taken.

IV. FIELD DEPLOYMENT

A. Paramedic Field Supervisors will respond when requested by the DEC, provider dispatch, hospital, or field personnel and in accordance with provider policy.

B. Paramedic Field Supervisors may respond on any call when their agency is responding, or to assist another agency's personnel as requested by that agency.

V. PATIENT CARE AUTHORITY

A. The Base Hospital Physician has the final authority over patient care decisions in the field. Paramedic Field Supervisors may not authorize deviations from EMS Agency policy or protocol, or in any way act as a substitute for the Base Hospital Physician.

B. Paramedic Field Supervisors may assist and provide clinical guidance with patient care without assuming all patient care responsibilities. Paramedic Field Supervisors

are **not** considered to have expanded clinical authority under EMS Agency Policy or State law.

C. Paramedic Field Supervisors may not unilaterally assume care of a patient from another paramedic unless it is a mutually agreed to transfer of care. No Paramedic Field Supervisor shall assume authority over another agency's personnel except under the following circumstances:
    1. Under prearranged agreements between individual agencies;
    2. When directed to do so by the Base Hospital Physician; and
    3. During a multi-agency response in which the Paramedic Field Supervisor has been assigned by an Incident Commander to be branch or section leader in the ICS structure (e.g. Medical Group Supervisor) and the personnel are reporting to that branch or section are directly involved in the multi-agency response.

D. In any event when a Paramedic Field Supervisor assumes all patient care responsibilities, the Paramedic Field Supervisor must accompany the patient to the hospital and document care provided on the patient's Prehospital Care Report.

VI. AUTHORITY

California Health & Safety Code, Division 2.5, Section 1797.220
U.S. Code of Federal Regulations 42 1395dd

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 2060
Effective Date: December 1, 2004
Review Date: January1, 2011
Supersedes: February 1, 2004

CONTINUING EDUCATION APPROVAL

I. PURPOSE

A. Establish standards for Prehospital Continuing Education (CE) providers located in San Francisco.
B. Provide a mechanism for course approval and establish the procedural requirements of Prehospital CE providers.
C. Identify those programs or courses with standing approval from the EMS Agency for the purposes of prehospital continuing education.

II. AUTHORITY

A. California Health and Safety Code, Division 2.5, Sections 1797.173 – 1797.175
B. California Code of Regulations, Title 22, Chapter 12

III. POLICY

A. Continuing Education providers shall comply with the requirements of Chapter 11 of Title 22 of the California Code of Regulations.
B. The San Francisco (SF) Emergency Medical Services (EMS) Agency shall grant or deny approval of CE providers whose training sites are located in the City and County of San Francisco.
C. The EMS Agency may audit the records of, or visit the site of, any CE Provider program for the purposes of compliance monitoring.
D. Probation, Revocation, and Denial of CE Provider Authorization
    1. The SF EMS Agency may, for cause, disapprove an application for approval, revoke CE provider approval or place the CE provider on probation. Written notice will be issued by the EMS Agency specifying the reasons for disapproval, revocation, or probation. Reasons for negative actions include, but are not limited to:
        a) Violations of CE guidelines, provisions of this policy, and/or applicable section of Title 22 of the California Code of Regulations.
        b) Willful misrepresentation of fact by CE provider or applicant.
        c) Repeated failures to correct identified deficiencies.
    2. CE credit issued *after* the date of disapproval or revocation will be revoked.
    3. Terms of probation will include a corrective action plan to be determined by the EMS Agency.

4. Renewal during probation is contingent upon successful implementation of the corrective action plan.

IV. PROCEDURE

A. Approval Process

1. Interested organizations or individuals shall submit an application to the EMS Agency.
2. The EMS Agency will provide, upon request, an application packet for CE provider approval.
3. The application shall be considered for approval if it is complete, if all supplemental material requested is submitted, and if it meets requirements of Section III of the State of California Guidelines for Prehospital Continuing Education.
4. The EMS Agency will review the materials for compliance with State guidelines and issue a "CE provider number" in accordance with State regulations and guidelines.
5. If the above conditions are met, the EMS Agency will grant approval for a four year period expiring on the last day of the month in which the CE application was approved.

B. CE Provider Responsibilities and Requirements

1. Approved CE providers are responsible for adherence to all requirements as outlined in the State of California Guidelines for Prehospital Continuing Education, Title 22, and SF EMS Agency policy and procedure.
2. CE provider shall ensure, at a minimum, the following:
    a) Relevant EMS or prehospital content of all CE.
    b) Maintenance of records as specified in the State of California Guidelines for Prehospital Continuing Education.
    c) Notifying the SF EMS Agency of any changes in program name, address, phone, program director, and/or clinical director.
3. All records are made available to the EMS Agency upon request, and classes and courses are open to the SF EMS Agency for scheduled or unscheduled visits.
4. Training program staff meets requirements as specified in the State of California Guidelines for Prehospital Continuing Education.
5. Award of CE hours, record keeping, certificates and documents, advertising and sponsorship are done in accordance with the State of California Guidelines for Prehospital Continuing Education.

C. CE Provider Renewal

1. The SF EMS Agency shall renew CE provider approval if all provisions of the State of California Guidelines for Prehospital Continuing Education, local policy, and Title 22 are continuously met and an application with required materials has been submitted.

2. Applications for renewal shall be submitted to the SF EMS Agency at least 60 calendar days before the date of program expiration in order to maintain continuous approval.
3. All CE provider requirements must be met and maintained for renewal.

V. CONTINUING EDUCATION COURSE APPROVAL

A. The following courses have standing approval for an authorized CE Provider to award prehospital CE hours for students completing the course:

1. Advanced Cardiac Life Support (ACLS)
2. Advanced Medical Life Support (AMLS)
3. Pediatric Advanced Life Support (PALS)
4. Advanced Pediatric Life Support (APLS)
5. Pediatric Education for Prehospital Professionals (PEPP)
6. Prehospital Trauma Life Support (PHTLS)
7. Basic Trauma Life Support (BTLS)

B. Other topics that provide a course of study that is directly relevant to the delivery of prehospital care and/or EMS may be awarded CE for the actual hours of study without prior approval from the EMS Agency.

C. Topics with indirect or peripheral application to EMS or prehospital care (i.e. health and safety training, fire science, etc) must be presented to the EMS Agency, prior to offering the class, for approval.

1. The EMS Agency will determine if the topic has relevance to EMS and, if so, what portion of the total hours may be awarded as prehospital CE.

D. Authorized providers may only issue a certificate for the actual hours spent on a given topic as allowed in California State law.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 2070
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Supersedes: September 1, 2009

CERTIFICATE/LICENSE DISCIPLINE PROCESS FOR PREHOSPITAL PERSONNEL

I. PURPOSE

A. To establish procedures and ensure due process for EMT certificates and Paramedic license disciplinary actions.
B. To comply with all applicable state statutes and regulations regarding EMT (or EMT-1) certificates and EMT-P (or Paramedic) license disciplinary actions.

II. AUTHORITY

A. California Health & Safety Code ("H&S Code"), Division 2.5, Sections 1797.202(c); 1798.200-1798.211.
B. California Code of Regulations ("CCR"), Title 22, Sections 100166, 100201-100217.
C. California Government Code, Sections 11370 et seq. (Administrative Procedure Act), CCR, Title 1, Sections 1000-1050;
California Business & Professions Code Sections 125.3, 162, 494;
Code of Civil Procedure Sections 1985-1987.
D. California Government Code, Sections 3250 et seq. (Firefighters Procedural Bill of Rights Act)

III. GENERAL POLICY

The EMS Agency, also known as the San Francisco EMS Agency (hereinafter "EMS Agency"), shall follow all of the provisions listed above in Section II. This policy shall apply when the EMS Agency Medical Director or his or her designee[1] takes any of the following prehospital certification actions:

1. Suspension of EMT-I certification
2. Revocation of EMT-I certification
3. Denial of EMT-I certification
4. Placement of an EMT-I certificate holder on probation
5. Suspension of EMT-P accreditation
6. Revocation of EMT-P accreditation
7. Temporary suspension of EMT-P license

(H&S Code Sec. 1798.200)

[1] California Health & Safety Code, Section 1797.202(c) provides that the Medical Director of the local EMS Agency "may assign to administrative staff of the local EMS agency for completion under the supervision of the medical director, any administrative functions of his or her duties which do not require his or her professional judgment as medical director." Therefore, the Medical Director of the EMS Agency may assign his or her duties and authorities under this *Certificate/License Discipline Process for Prehospital Personnel* Policy to administrative staff of the EMS Agency.

IV.POLICY REGARDING EMT-P LICENSES

(A) **Grounds for Discipline**. The State EMS Authority may deny, suspend, or revoke any EMT-P license, or may place any EMT-P license or license holder on probation upon the finding by the Director of the State EMS Authority of any of the following actions, which shall be considered evidence of a threat to the public health and safety:

1. Fraud in the procurement of any certificate or license under this division;
2. Gross negligence;
3. Repeated negligent acts;
4. Incompetence;
5. The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of prehospital personnel;
6. Conviction of any crime that is substantially related to the qualifications, functions, and duties of prehospital personnel. The record of conviction or a certified copy of the record shall be conclusive evidence of the conviction;
    a) For the purposes of denial, placement on probation, suspension, or revocation of a certificate, pursuant to California Health and Safety Code §1798.200, a crime or act shall be considered to be substantially related to the qualifications, functions, or duties of a certificate holder if to a substantial degree it evidences present or potential unfitness of a certificate holder to perform the functions authorized by the certificate in a manner consistent with the public health and safety. (22 CCR §100208(a)). For the purposes of a crime, the record of conviction or a certified copy of the record shall be conclusive evidence of such conviction. "Crime" means any act in violation of the penal laws of this state, any other state, or federal laws. This also means violation(s) of any statute that imposes criminal penalties for such violations. "Conviction" means the final judgment on a verdict of finding of guilty, a plea of guilty, or a plea of nolo contendere. (22 CCR §100208(b)).
7. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel;
8. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances;
9. Addiction to the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances;
10. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification;
11. Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired;

12. Unprofessional conduct exhibited by any of the following: (A) The mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance. Nothing in this section shall be deemed to prohibit an EMT-1 or EMT-P from assisting a peace officer, or a peace officer who is acting in the dual capacity of peace officer and EMT-I or EMT-P, from using that force that is reasonably necessary to effect a lawful arrest or detention; (B) The failure to maintain confidentiality of patient medical information, except as disclosure is otherwise permitted or required by law in Sections 56 to 56.6, inclusive, of the Civil Code; (C) The commission of any sexually related offense specified under Section 290 of the Penal Code. (California Health and Safety Code §1798.200 (b-c)).

(B) **Evaluation by Medical Director**. When information comes to the attention of the Medical Director of the EMS Agency that an EMT-P license holder has committed any act or omission that appears to constitute grounds for disciplinary action under Division 2.5 of the California Health and Safety Code, the Medical Director of the EMS Agency may evaluate the information to determine if there is reason to believe that disciplinary action may be necessary. (California Health and Safety Code §1798.201(a)).

(C) **Recommendation by Medical Director**. If the Medical Director of the EMS Agency sends a recommendation to the State EMS Authority for further investigation or discipline of the license holder, the recommendation shall include all documentary evidence collected by the Medical Director in evaluating whether or not to make that recommendation. The recommendation and accompanying evidence shall be deemed in the nature of an investigative communication and be protected by Section 6254 of the California Government Code. In deciding what level of disciplinary action is appropriate in the case, the Authority shall consult with the Medical Director of the EMS Agency. (California Health and Safety Code §1798.201(b)).

(D) **Temporary suspension**

1. Authority. The director of the State EMS Authority or the Medical Director of the EMS Agency, after consultation with the relevant employer, may temporarily suspend, prior to hearing, any EMT-P license upon a determination that: (1) the licensee has engaged in acts or omissions that constitute grounds for revocation of the EMT-P license; and (2) permitting the licensee to continue to engage in the licensed activity, or permitting the licensee to continue in the licensed activity without restriction, would present an imminent threat to the public health or safety. (California Health and Safety Code §1798.202(a)).

2. Notice. When the suspension is initiated by the EMS Agency, the EMS Agency shall notify the licensee that his or her EMT-P license is suspended and shall identify the reasons therefore. Within three (3) working days of the initiation of the suspension by the EMS Agency, the EMS Agency shall transmit to the State EMS Authority, via facsimile transmission or overnight mail, all documentary evidence collected by the EMS Agency relative to the decision to temporarily suspend. Within two (2) working days of receipt of the EMS Agency's documentary evidence, the director of the State EMS Authority shall determine the need for the licensure action. Part of that determination shall include an evaluation of

the need for continuance of the suspension during the licensure action review process. If the director of the State EMS Authority determines that the temporary suspension order should not continue, the State EMS Authority shall immediately notify the licensee that the temporary suspension is lifted. If the director of the State EMS Authority determines that the temporary suspension order should continue, the State EMS Authority shall immediately notify the licensee of the decision to continue the temporary suspension and shall, within fifteen (15) calendar days of receipt of the EMS Agency's documentary evidence, serve the licensee with a temporary suspension order and accusation pursuant to California Government Code §§ 11503, 11505, 11507. Within fifteen (15) days after service of the accusation the respondent may file with the State EMS Authority a Notice of Defense pursuant to California Government Code § 11506. (California Health and Safety Code §1798.202 (b)). If the respondent files a notice of defense, the respondent shall be entitled to a hearing on the merits within thirty (30) days of the State EMS Authority's receipt of the notice of defense (California Government Code §11506; California Health and Safety Code §1798.202 (d)).

(E) **Suspension or Revocation of Accreditation**. The Medical Director of the EMS Agency may suspend or revoke the accreditation of an EMT-P license holder if the paramedic does not maintain current licensure or meet local accreditation requirements. The paramedic shall be granted the same due process rights afforded EMT-1 certificate holders facing suspension or revocation as set out below in Sections V., H of this Policy. (22 CCR §100165(i)).

(F) **Employer Reporting of Disciplinary Actions and Investigations**.

(a) EMT-P employers shall report in writing to the local EMS agency Medical Director and the Authority and provide all supporting documentation within 30 days of whenever any of the following actions are taken:

(1) An EMT-P is terminated or suspended for disciplinary cause or reason.

(2) An EMT-P resigns following notice of an impending investigation based upon evidence indicating disciplinary cause or reason.

(3) An EMT-P is removed from paramedic duties for disciplinary cause or reason following the completion of an internal investigation. (b) The reporting requirements of subdivision (a) do not require or authorize the release of information or records of an EMT-P who is also a peace officer protected by Section 832.7 of the Penal Code.

(c) For purposes of this section, "disciplinary cause or reason" means only an action that is substantially related to the qualifications, functions, and duties of a paramedic and is considered evidence of a threat to the public health and safety as identified in subdivision (c) of Section 1798.200.

(d) Pursuant to subdivision (i) of Section 1798.24 of the Civil Code, upon notification to the paramedic, the Authority may share the results of its investigation into a paramedic's misconduct with the paramedic's employer, prospective employer when requested in writing as part of a pre-employment background check, and the local EMS agency.

(e) The information reported or disclosed in this section shall be deemed in the nature of an investigative communication and is exempt from disclosure as a public record by subdivision (f) of Section 6254 of the Government Code.

(f) A paramedic applicant or licensee to whom the information pertains may view the contents, as set forth in subdivision (a) of Section 1798.24 of the Civil Code, of a closed investigation file upon request during the regular business hours of the Authority. (H&S Code §1799.112)

V. POLICY REGARDING EMT-1 CERTIFICATES

A. **General Provisions**. The Medical Director of the EMS Agency and all relevant employers shall adhere to the provisions of California Code of Regulations, Title 22, Chapter 6, when investigating or implementing any actions for disciplinary cause. (22 CCR §100207(a)).

B. **Grounds for Discipline**. In order to place a certificate holder on probation or deny, suspend, or revoke a certificate, the Medical Director of the EMS Agency must first determine there exists a threat to the public health and safety, as evidenced by the occurrence of any of the following actions by the applicant or certificate holder:

1. Fraud in the procurement of any certificate or license under this division;
2. Gross negligence;
3. Repeated negligent acts;
4. Incompetence;
5. The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of prehospital personnel;
6. Conviction of any crime that is substantially related to the qualifications, functions, and duties of prehospital personnel. The record of conviction or a certified copy of the record shall be conclusive evidence of the conviction;
    a) For the purposes of denial, placement on probation, suspension, or revocation of a certificate, pursuant to California Health and Safety Code §1798.200, a crime or act shall be considered to be substantially related to the qualifications, functions, or duties of a certificate holder if to a substantial degree it evidences present or potential unfitness of a certificate holder to perform the functions authorized by the certificate in a manner consistent with the public health and safety. (22 CCR §100208(a)). For the purposes of a crime, the record of conviction or a certified copy of the record shall be conclusive evidence of such conviction. "Crime" means any act in violation of the penal laws of this state, any other state, or federal laws. This also means violation(s) of any statute that imposes criminal penalties for such violations. "Conviction" means the final judgment on a verdict of finding of guilty, a plea of guilty, or a plea of nolo contendere. (22 CCR §100208(b)).
7. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel;
8. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances;

9. Addiction to the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances;
10. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification;
11. Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired;
12. Unprofessional conduct exhibited by any of the following: (A) The mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance. Nothing in this section shall be deemed to prohibit an EMT-I or EMT-P from assisting a peace officer, or a peace officer who is acting in the dual capacity of peace officer and EMT-I or EMT-P, from using that force that is reasonably necessary to effect a lawful arrest or detention; (B) The failure to maintain confidentiality of patient medical information, except as disclosure is otherwise permitted or required by law in Sections 56 to 56.6, inclusive, of the Civil Code; (C) The commission of any sexually related offense specified under Section 290 of the Penal Code. (22 CCR §100207(b); California Health and Safety Code §1798.200(c)).

C. Denial of Application without Administrative Hearing. An application for certification or recertification shall be denied without prejudice and does not require an administrative hearing, when an applicant does not meet the requirements for certification or recertification, including but not limited to, failure to pass a certification or recertification examination, lack of sufficient continuing education or documentation of a completed refresher course, failure to furnish additional information or documents requested by the certifying authority, or failure to pay any required fees. The denial shall be in effect until all requirements for certification or recertification are met. An application shall be deemed abandoned if the applicant does not complete the requirements of licensure within one year from the date on which the application was filed. If a certificate expires before recertification requirements are met, the certificate shall be deemed a lapsed certificate and subject to the provisions of a lapsed certificate. (22 CCR §100207(c).

D. **Applicant Rehabilitation**. The EMS Agency, when determining the certification action to be imposed or reviewing a petition for reinstatement or reduction of penalty under Section 11522 of the Government Code, shall evaluate the rehabilitation of the applicant and present eligibility for certification of the respondent. When the certification action warranted is probation, denial, suspension, or revocation the following factors may be considered:

(1) Nature and severity of the act(s), offense(s), or crime(s) under consideration;
(2) Actual or potential harm to the public;
(3) Actual or potential harm to any patient;
(4) Prior disciplinary record;
(5) Prior warnings on record or prior remediation;
(6) Number and/or variety of current violations;
(7) Aggravating evidence;

(8) Mitigating evidence;

(9) Rehabilitation evidence;

(10) In the case of a criminal conviction, compliance with terms of the sentence and/or court-ordered probation;

(11) Overall criminal record;

(12) Time that has elapsed since the act(s) or offense(s) occurred;

(13) If applicable, evidence of expungement proceedings pursuant to Penal Code 1203.4.

(14) In determining appropriate certification disciplinary action, the EMS Agency medical director may give credit for prior disciplinary action imposed by the respondent's employer. (22 CCR § 100208)(c)

E. **Relevant Employer Responsibilities**. For purposes of this policy, "Relevant employer" means those ambulance services permitted by the Department of the California Highway Patrol or a public safety agency that the certificate holder works for or was working for at the time of the incident under review, as an EMT, either as a paid employee or as a volunteer. For purposes of this policy, "disciplinary plan" means a written plan of action that can be taken by a relevant employer as a consequence of any action listed in H&S Code Sec. 1798.200(c).

Under the provisions of Cal. Code of Regulations, Chapter 6, relevant employers:

(a) May conduct investigations, according to the requirements of Chapter 6, to determine disciplinary cause.

(b) Upon determination of disciplinary cause, the relevant employer may develop and implement, a disciplinary plan, in accordance with the Model Disciplinary Orders (MDOs). "Model Disciplinary Orders" means the "RECOMMENDED GUIDELINES FOR DISCIPLINARY ORDERS AND CONDITIONS OF PROBATION FOR EMT (BASIC) AND ADVANCED EMT" (EMSA document #134, 4/1/2010) which were developed to provide consistent and equitable discipline in cases dealing with disciplinary cause.

(1) The relevant employer shall submit that disciplinary plan, along with the relevant findings of the investigation related to disciplinary cause to the EMS Agency that issued the certificate, within three (3) working days of adoption of the disciplinary plan. In the case where the certificate was issued by a non-LEMSA certifying entity, the disciplinary plan shall be submitted to the San Francisco EMS Agency.

(2) The employer's disciplinary plan may include a recommendation that the medical director consider taking action against the holder's certificate to include denial of certification, suspension of certification, revocation of certification, or placing a certificate on probation.

(c) Shall notify the medical director that has jurisdiction in the county in which the alleged action occurred within three (3) working days after an allegation has been validated as potential for disciplinary cause.

(d) Shall notify the medical director that has jurisdiction in the county in which the alleged action occurred within three (3) working days of the occurrence of any of following:

(1) The EMT is terminated or suspended for a disciplinary cause,

(2) The EMT resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause, or

(3) The EMT is removed from EMT-related duties for a disciplinary cause after the completion of the employer's investigation.

22 CCR 100208.1.

F. **Jurisdiction of the Medical Director**.

(a) The medical director who issued the certificate, or in the case where the certificate was issued by a non-LEMSA certifying entity, the LEMSA medical director that has jurisdiction in the county in which the headquarters of the certifying entity is located, shall conduct investigations to validate allegations for disciplinary cause when the certificate holder is not an employee of a relevant employer or the relevant employer does not conduct an investigation. Upon determination of disciplinary cause, the medical director may take certification action as necessary against an EMT certificate.

(b) The medical director may, upon determination of disciplinary cause and according to the provisions of this policy, take certification action against an EMT to deny, suspend, or revoke, or place a certificate holder on probation, upon the findings by the medical director of the occurrence of any of the actions listed in Health and Safety Code, Section 1798.200 (c) and for which any of the following conditions are true:

(1) The relevant employer, after conducting an investigation, failed to impose discipline for the conduct under investigation, or the medical director makes a determination that discipline imposed by the relevant employer was not in accordance with the MDOs and the conduct of the certificate holder constitutes grounds for certification action.

(2) The medical director determines, following an investigation conducted in accordance with this policy, that the conduct requires certification action.

(c) The medical director, after consultation with the relevant employer or without consultation when no relevant employer exists, may temporarily suspend, prior to a hearing, an EMT certificate upon a determination of the following:

(1) The certificate holder has engaged in acts or omissions that constitute grounds for revocation of the EMT certificate; and

(2) Permitting the certificate holder to continue to engage in certified activity without restriction poses an imminent threat to the public health and safety.

(d) If the medical director takes any certification action the medical director shall notify the Authority of the findings of the investigation and the certification action taken by entering it directly into the Central Registry by the EMS Agency within three (3) days (Health & Safety Code § 1797.211) (22 CCR § 100209).

G. **Evaluation and Investigation**.

(a) A relevant employer who receives an allegation of conduct listed in Section 1798.200 (c) of the Health and Safety Code against an EMT and once the allegation is validated, shall notify the medical director of the EMS Agency that has jurisdiction in the county in which the alleged violation occurred within three (3) working days, of the EMT's name, certification number, and the allegation(s).

(b) The EMS Agency that receives any complaint against an EMT shall forward the original complaint and any supporting documentation to the relevant employer for investigation pursuant to subsection (a) of this section, if there is a relevant employer, within three (3) working days of receipt of the information. If there is no relevant employer or the relevant employer does not wish to investigate the complaint, the medical director shall evaluate the information received from a credible source, including but not limited to, information obtained from an

application, medical audit, or public complaint, alleging or indicating the possibility of a threat to the public health and safety by the action of an applicant for, or holder of, a certificate issued pursuant to this policy.

(c) The relevant employer or medical director shall conduct an investigation of the allegations in accordance with the provisions of this policy, if warranted.

(d) Statewide public safety agencies shall provide the State EMS Authority with current relevant employer contact information for their individual agencies. (22 CCR §100210).

H. **Due Process**. The certification action process shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, known as the Administrative Procedure Act. (22 CCR § 100211.1)

Within 15 days of receipt of the negative disposition letter signed by the EMSA Medical Director, the applicant or EMT has the right to file with the EMS Agency, in writing and by certified mail, a response to this decision, known as a "notice of defense", in which he or she may:

1. Request a hearing, which would be conducted by an Administrative Law Judge (ALJ) from the State Office of Administrative Hearings ;Object to all or parts of the Summary of Findings contained in the disposition letter;
2. Admit to the Summary of Findings in whole or in part; or,
3. Present new matter by way of defense.

Section 11506 of the Administrative Procedure Act (APA) provides the complete details regarding these options.

A formal hearing is a review process before an ALJ selected by the State Office of Administrative Hearings. The ALJ hearing reviews all of the available information. The applicant or EMT has the right to be represented by legal counsel or to be accompanied to the ALJ hearing by any person to provide advice and support. The ALJ then prepares a written report containing findings, makes recommendations, and submits the matter to the Medical Director. The ALJ may recommend a more lenient, more harsh or similar sanctions to the ones contained in the disposition letter. The Medical Director retains the final decision-making authority.

I. **Determination of Certification Action**

(a) A certification action relative to the individual's certificate(s) shall be taken as a result of the findings of the investigation.

(b) Upon determining the disciplinary or certification action to be taken as authorized by this policy, the relevant employer or medical director shall complete and place in the personnel file or any other file used for any personnel purposes by the relevant employer or EMS Agency, a statement certifying the decision made and the date the decision was made. The decision must contain findings of fact and a determination of issues, together with the disciplinary plan and the date the disciplinary plan shall take effect.

(c) In the case of a temporary suspension order pursuant to 22 CCR Section 100209 (c), it shall take effect upon the date the notice required by 22 CCR Section 100213 is mailed to the certificate holder.

(d) For all other certification actions, the effective date shall be thirty days from the date the notice is mailed to the applicant for, or holder of, a certificate unless another time is specified or an appeal is made.

J. Temporary Suspension Order

(a) A medical director may temporarily suspend a certificate prior to hearing if, the certificate holder has engaged in acts or omissions that constitute grounds for denial or revocation according to Section 100214.3 (c) and (d) of Chapter 6 of the Cal. Code of Regulations and if in the opinion of the medical director permitting the certificate holder to continue to engage in certified activity would pose an imminent threat to the public health and safety.

(b) Prior to, or concurrent with, initiation of a temporary suspension order of a certificate pending hearing, the medical director shall consult with the relevant employer of the certificate holder.

(c) The notice of temporary suspension pending hearing shall be served by registered mail or by personal service to the certificate holder immediately, but no longer than three (3) working days from making the decision to issue the temporary suspension. The notice shall include the allegations that allowing the certificate holder to continue to engage in certified activities would pose an imminent threat to the public health and safety.

(d) Within three (3) working days of the initiation of the temporary suspension by the LEMSA, the LEMSA and relevant employer shall jointly investigate the allegation in order for the LEMSA to make a determination of the continuation of the temporary suspension.

(1) All investigatory information, not otherwise protected by the law, held by the LEMSA and the relevant employer shall be shared between the parties via facsimile transmission or overnight mail relative to the decision to temporarily suspend.

(2) The LEMSA shall serve within fifteen (15) calendar days an accusation pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code (Administrative Procedures Act).

(3) If the certificate holder files a Notice of Defense, the administrative hearing shall be held within thirty (30) calendar days of the LEMSA's receipt of the Notice of Defense.

(4) The temporary suspension order shall be deemed vacated if the LEMSA fails to serve an accusation within fifteen (15) calendar days or fails to make a final determination on the merits within fifteen (15) calendar days after the Administrative Law Judge (ALJ) renders a proposed decision.(22 CCR §100213).

K. Final Determination of Certification Action

Upon determination of certification action following an investigation, and appeal of certification action pursuant to 22 CCR 100214 and Section V. (H) of this policy, if the respondent so chooses, the medical director may take the following final actions on an EMT certificate:

(a) Place the certificate holder on probation;

(b) Suspension;

(c) Denial; or,

(d) Revocation (22 CCR § 100214).

L. **Placement of a Certificate Holder on Probation.** Pursuant to 22 CCR §100207, the Medical Director of the EMS Agency may place a certificate holder on probation any time an infraction or performance deficiency occurs that indicates a need to monitor the individual's conduct in the EMS system in order to protect the public health and safety. The term of the probation and any conditions shall be in accordance with MDOs established by the EMS Authority. The medical director that placed the certificate holder on probation may revoke the EMT certificate if the certificate holder fails to successfully complete the terms of probation. (22 CCR §100214.1).

M. **Suspension of a Certificate**.

a) The medical director may suspend an individual's EMT certificate for a specified period of time for disciplinary cause in order to protect the public health and safety.

(b) The term of the suspension and any conditions for reinstatement, shall be in accordance with MDOs established by the EMS Authority.

(c) Upon the expiration of the term of suspension, the individual's certificate shall be reinstated only when all conditions for reinstatement have been met. The medical director shall continue the suspension until all conditions for reinstatement have been met.

(d) If the suspension period will run past the expiration date of the certificate, the EMT shall meet the recertification requirements for certificate renewal prior to the expiration date of the certificate. (22 CCR §100214.2).

N. **Denial or Revocation of a Certificate**.

(a) The medical director may deny or revoke any EMT certificate for disciplinary cause that has been investigated and verified by application of this policy.

(b) The medical director shall deny or revoke an EMT certificate if any of the following apply to the applicant:

(1) Has committed any sexually related offense specified under Section 290 of the Penal Code.

(2) Has been convicted of murder, attempted murder, or murder for hire.

(3) Has been convicted of two (2) or more felonies.

(4) Is on parole or probation for any felony.

(5) Has been convicted and released from incarceration for said offense during the preceding fifteen (15) years for the crime of manslaughter or involuntary manslaughter.

(6) Has been convicted and released from incarceration for said offense during the preceding ten (10) years for any offense punishable as a felony.

(7) Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to the use, sale, possession, or transportation of narcotics or addictive or dangerous drugs.

(8) Has been convicted of two (2) or more misdemeanors within the preceding five (5) years for any offense relating to force, threat, violence, or intimidation.

(9) Has been convicted within the preceding five (5) years of any theft related misdemeanor.

(c) The medical director may deny or revoke an EMT certificate if any of the following apply to the applicant:

(1) Has committed any act involving fraud or intentional dishonesty for personal gain within the preceding seven (7) years.

(2) Is required to register pursuant to Section 11590 of the H&S Code.

(d) Subsection (a) and (b) shall not apply to convictions that have been pardoned by the Governor, and shall only apply to convictions where the applicant/certificate holder was prosecuted as an adult. Equivalent convictions from other states shall apply to the type of offenses listed in (b) and (c). As used in this Section, "felony" or "offense punishable as a felony" refers to an offense for which the law prescribes imprisonment in the state prison as either an alternative or the sole penalty, regardless of the sentence the particular defendant received.

(e) This Section shall not apply to those EMT's who obtain their California certificate prior to the effective date of this Section; unless:

(1) The certificate holder is convicted of any misdemeanor or felony after the effective date of this Section.

(2) The certificate holder committed any sexually related offense specified under Section 290 of the Penal Code.

(3) The certificate holder failed to disclose to the certifying entity any prior convictions when completing his/her application for initial EMT or Advanced EMT certification or certification renewal.

(f) Nothing in this Section shall negate an individual's right to appeal a denial of an EMT certificate pursuant to this policy.

(g) Certification action by a medical director shall be valid statewide and honored by all certifying entities for a period of at least twelve (12) months from the effective date of the certification action. An EMT whose application was denied or an EMT whose certification was revoked by a medical director shall not be eligible for EMT application by any other certifying entity for a period of at least twelve (12) months from the effective date of the certification action. EMT's whose certification is placed on probation must complete their probationary requirements with the LEMSA that imposed the probation. (22 CCR §100214.3).

O. **Notification of Action**.

(a) For the final decision of certification action, the medical director shall notify the applicant/certificate holder and his/her relevant employer(s) of the certification action within ten (10) working days after making the final determination.

(b) The notification of final decision shall be served by registered mail or personal service and shall include the following information:

(1) The specific allegations or evidence which resulted in the certification action;

(2) The certification action(s) to be taken, and the effective date(s) of the certification action(s), including the duration of the action(s);

(3) Which certificate(s) the certification action applies to in cases of holders of multiple certificates;

(4) A statement that the certificate holder must report the certification action within ten (10) working days to any other LEMSA and relevant employer in whose jurisdiction s/he uses the certificate (22 CCR § 100215).

VI. FIREFIGHTERS PROCEDURAL BILL OF RIGHTS

A. Government Code Sections 3250-3262, known as the "Firefighters Procedural Bill of Rights Act (FPBRA)," shall be adhered to for the following:

1. All Civil Service firefighter job classifications in the San Francisco Fire Department, except those employees on probationary status.

2. Non-firefighter job classifications in the SFFD are not covered by this act. However, the EMS Agency will follow FPBRA for paramedics and EMT's who are not firefighters and who have passed their probationary period.

3. Firefighter positions in the Presidio Fire Department, National Park Service and U.S. Department of the Interior are covered.

4. The rights and protections in the FPBRA shall only apply to a firefighter during events and circumstances involving the performance of his or her official duties.

B. For those firefighter/EMT's subject to the FPBRA, a "Notice" document and an "Admonishment of Rights" document shall be given to him or her prior to the commencement of an investigation. It shall adhere to the provisions of the FPBRA at Government Code § 3250-3262.

C. Punitive action on grounds other than merit shall not be undertaken for any act, omission, or other allegation of misconduct if the investigation of the allegation is not completed within one year of discovery by EMSA. If EMSA determines that a punitive action may be taken, EMSA shall complete its investigation and notify the applicant/certificate holder of its proposed punitive action within that year.

D. If a certificate holder covered under the FPBRA is being investigated for a matter that may lead to criminal prosecution, the EMSA may request from local and/or federal prosecutors a formal grant of immunity from criminal prosecution regarding any information and evidence that may result from the EMSA investigation. Subject to that grant of immunity from criminal prosecution, a certificate holder refusing to respond to questions or submit to interrogations shall be informed that the failure to answer questions directly related to the investigation or interrogation may result in punitive action. (22 CCR § 100211; Government Code § 3250-3262, 3253(e) (1)

Section 3:
Communications

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 3000
Effective Date: September 9, 2013
Supersedes: August 1, 2007

MEDICAL DISPATCH CENTER STANDARDS

I. PURPOSE

To establish the minimum standards for Medical Dispatch Centers serving the San Francisco Emergency Medical Services system.

II. POLICY

A. Only Medical Dispatch Centers designated by the San Francisco EMS Agency may provide emergency medical dispatching for permitted Basic or Advanced Life Support Ambulance providers.

B. Advanced Medical Priority Dispatch System® (AMPDS) is the designated Emergency Medical Dispatch Priority Reference System authorized for use within the San Francisco EMS system.

III. REQUIREMENTS

A. Be designated by the San Francisco EMS Agency as a Medical Dispatch Center by demonstrating compliance with this policy and applicable State and Federal statues, codes and regulation through written internal policies and procedures and by allowing announced or unannounced audits and on-site inspections.

B. Maintain a written agreement with the San Francisco EMS Agency to provide emergency medical dispatch services.

C. Have a current Federal Communications Commission (FCC) license.

D. Have internal policies for the retention of medical dispatch call logs, records, and tapes for a minimum of 180 days, or as required by departmental or company record retention and destruction policies, whichever is greater.

E. Every dispatcher must have current certification as an Emergency Medical Dispatcher (EMD) that meets the standards defined in *Policy 3000.1 Emergency Medical Dispatch Standards*.

F. At least one certified Emergency Medical Dispatcher must be available to perform dispatching at all times.

G. Have available at all times a Dispatch Supervisor for the emergency medical dispatchers. All Dispatch Supervisor(s) must meet the standards in *Policy 3000.1 Medical Dispatcher Standards.*

H. Provide a structured training program for dispatchers that minimally includes:
   1. Certifying call taking personnel as Emergency Medical Dispatchers.
   2. Orientation to the EMS System including any current or updated revisions to applicable EMS Agency policies and procedures.

I. Medical Dispatch Centers must use the AMPDS Card Set or the Pro QA computerized system. Each on-duty call taker workstation must be provided with an AMPDS Card Set or properly enabled computer terminal for AMPDS.

J. AMPDS must be used on every request for medical assistance. This includes:
   1. The standardized caller interrogation and response assignment protocols; and
   2. Pre-arrival instructions when appropriate for a call.
   3. Use of AMPDS may be suspended during disaster situations or during periods of unusual extreme call demand. The Medical Dispatch Center must notify the EMS Agency Medical Director of all incidents that trigger suspension of AMPDS. Notification must occur within 1 business day after the suspension.

K. Have a Quality Improvement program that meets the standards listed in Section V of this policy.

L. Provide a dedicated web enabled computer to display EM System on a continuous 24-hour per day basis.

M. Have designated representative(s) that participate in the relevant EMS Agency committee meetings.

N. Participate in research studies on prehospital care approved by the San Francisco EMS Agency Medical Director.

O. Participate in EMS system-wide disaster training exercises as determined by the EMS Agency.

P. Maintain a disaster plan that defines medical dispatch center actions to assure continuous operations during a disaster that includes:
   1. Personnel disaster response roles;
   2. Call-back procedures for staff;
   3. Disaster training and exercise plan;
   4. Coordination with other disaster response agencies; and
   5. Contingency plans for off-site medical dispatch operations in the event the Medical Dispatch Center is rendered inoperable.

IV. DESIGNATION PROCESS

A. The EMS Agency shall evaluate all Medical Dispatch Centers through a designation survey for their compliance with the standards listed in this policy. This survey maybe combined with a Certificate of Operation application process for a new ambulance provider agency.

B. Prior to the designation survey, the EMS Agency shall provide to Emergency Medical Dispatch Centers the evaluation criteria and the minimum passing score requirements. After the survey completion, the EMS Agency will provide to Emergency Medical Dispatch Centers a written survey evaluation and score. The Medical Dispatch Center must attain a passing score to be designated as a San Francisco EMS provider.

C. If the Medical Dispatch Center fails to achieve the minimum passing score on the initial designation survey, they may petition the EMS Agency for a re-survey within three months of the initial survey date. The Medical Dispatch Center must correct the deficiencies noted in the initial designation survey to pass the second survey. Failure to attain the minimum passing score requirement may result in the EMS Agency Medical Director terminating the Emergency Medical Dispatch Center's participation as an Emergency Medical Dispatch Center in the San Francisco EMS system. The decision of the Medical Director is final.

V. QUALITY IMPROVEMENT PROGRAM REQUIREMENTS

A. Appoint at least one quality improvement (QI) coordinator(s) to implement and manage the Medical Dispatch Center's QI program.

B. Have a QI Plan approved by the EMS Agency Medical Director that describes the following:
   1. Methods for evaluating dispatch services using objective structure, process, and outcome indicators.
   2. Identifies the QI feedback methods (e.g. tape review, documentation or training) for individual dispatchers, dispatch management, internal medical dispatch review committees, other EMS providers, and the EMS Agency.
   3. Internal policy and procedures for submitting QI data reports and Sentinel Event and Exception Reports to the EMS Agency.
   4. Internal policy and procedure for providing tapes or call logs to the EMS Agency, other City and County of San Francisco agencies or other external agencies external for quality improvement review.
   5. The formal means to recognize excellence through employee recognition initiatives.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 3000.1
Effective Date: September 9, 2013
Supersedes: New

MEDICAL DISPATCHER STANDARDS

I. PURPOSE

To delineate the standards for medical dispatchers working in the San Francisco EMS system.

II. POLICY

Every San Francisco EMS System emergency medical dispatcher must meet the minimum requirements of this policy.

III. MEDICAL DISPATCHER SCOPE OF PRACTICE

A. The Medical Dispatcher Scope of Practice includes:
   1. Receive and process calls for emergency medical assistance;
   2. Determine the nature and severity of medical incident calls;
   3. Prioritize the response urgency;
   4. Dispatch the appropriate emergency medical service resource;
   5. Give post-dispatch and pre-arrival instructions to callers at the scene of an emergency;
   6. Relay pertinent information to responding personnel;
   7. Coordination with public safety and EMS providers as needed, and
   8. Other medical activities as approved by the EMS Agency Medical Director.

IV. EMERGENCY MEDICAL DISPATCHER REQUIREMENTS

A. Be employed by the primary Public Safety Answering Point for the City and County of San Francisco or by a permitted ALS or BLS ambulance company.

B. Current certification as an Emergency Medical Dispatcher by the National Academy of Emergency Medical Dispatch.

C. Current certification in cardio-pulmonary resuscitation (CPR) (public level) from either the American Heart Association, American Red Cross or American Safety & Health Institute.

D. Demonstrated compliance with the Advanced Medical Priority Dispatch standards including call triage, response assignment, and pre-arrival instructions.

E. Demonstrated current knowledge about applicable San Francisco EMS Agency policies and procedures.

F. Demonstrated knowledge about the components and operations of the San Francisco EMS system to adequately meet the operational needs for daily operations, MCI's and disasters.

G. Familiarity with the employer's internal disaster plans.

H. Demonstrated proficiency in use of all telecommunications and dispatching equipment.

V. **AUTHORITY**

California Health and Safety Code, Sections 1797.220 and 1798(a);
California EMS Authority Publication #132: Emergency Medical Services Dispatch Program Guidelines, March 2003

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 3010
Effective Date: August 1, 2007
Review Date: January 1, 2011
Supersedes: June 1, 2004

EMS COMMUNICATIONS EQUIPMENT AND PROCEDURES

I. PURPOSE

A. To prescribe and define EMS communications within the City and County of San Francisco.
B. To provide an organized system for communications among all EMS providers during daily operations, multi-casualty incidents and disasters.

II. AUTHORITY

A. California Health and Safety Code, Division 2.5, Section 1797.220 and Section 1798(a);
B. California Code of Regulations, Section 100173(b) (2), 100174(b) (4), 100175(a).

III. POLICY

A. All EMS providers shall:
   1. Be responsible for developing and maintaining internal policies and procedures for regularly scheduled maintenance and prompt repairs of EMS communications equipment to assure its good working order at all times.
   2. Have internal policies and procedures for communications and staff training that adhere to the standards set forth in this policy.
   3. Provide adequate training for all new and existing personnel to competently use all of these forms of communication.
   4. Constantly strive to improve their communications and to directly resolve any problems affecting communications.

IV. EQUIPMENT

A. EMS providers are minimally required to have the following communications equipment:
   1. Ambulance providers:
      a) 800 MHz radio system in their dispatch communications centers and in each ALS and BLS ambulance.
      b) EM Resource in their dispatch communications centers.
      c) Automatic Vehicle Locators in each ALS Ambulances.

   2. Receiving Hospital Emergency Departments and San Francisco General Hospital Base Hospital:
      a) 800 MHz radio system.
      b) HEARNet radio system.
      c) EM Resource.

3. Emergency Communications Department (ECD):
    a) 800 MHz radio system,
    b) HEARNet
    c) EM Resource.
    d) Automatic Vehicle Locator

B. All EMS Providers are encouraged to have satellite telephones and HAM radios available for disaster communications.

V. ROUTINE EMS COMMUNICATIONS PROCEDURES

A. 800 Megahertz Radio Communications:

1. ECD shall use:
    a) Talk groups FD-A1, A2 and A3 to dispatch San Francisco Fire Department and Presidio Fire Department ambulances.
    b) Talk group EMS-4/B16 to dispatch private ambulances.
2. ALS and BLS ambulance units shall use
    a) Talkgroup EMS-1/B13 to notify all Receiving Hospitals, except San Francisco General Hospital, of in-coming patients.
    b) Talkgroup EMS-2/B14 to notify San Francisco General Hospital Emergency Department of in-coming patients or for Base Hospital contacts.

3. Receiving hospital nursing personnel shall answer radio calls from in-coming ambulance units and respond to daily communication checks by the ECD using the emergency department 800 MHz base station.

4. Standard radio procedures using plain English (no 10-codes) shall be used by hospital and ambulance personnel while communicating on the radio.

B. EM Resource Communications:

1. ECD shall use EM Resource for:
a) Ascertaining hospital diversion status in accordance with EMS Agency Diversion Policy.
b) Poll hospitals to ascertain Emergency Department bed availability and poll ambulance providers for the number of available ambulances during daily EMS communication checks.

2. Receiving Hospitals shall use EM Resource for:
    a) Posting current hospital diversion status to the ECD and ambulance providers in accordance with EMS Agency Policies.
    b) Monitoring for EMS Agency or Department of Public Health Communicable Disease Control advisory communications.

c) Posting Emergency Department bed availability during daily EMS communication checks done by ECD.

C. Hospital Emergency Administrative Radio Network (HEARNet)

1. The HEARNet is not used during routine EMS communications.
2. See Section VII for HEARNet's use during MCI Level 2 and 3 disaster operations.

D. Automatic Vehicle Locator (AVL)

The Emergency Communications Department shall dispatch the closest public or private ALS ambulance as indicated by the AVL system to all Code 3 requests for EMS services.

VI. MULTI-CASUALTY INCIDENTS (MCI-Level 1) COMMUNICATIONS PROCEDURES

A. 800 Megahertz Radios will be used similarly as for routine communications, with the following exceptions:

1. The ECD shall assign ambulance units to specific talk groups as necessary.
2. The ECD shall initiate an all-call announcement to receiving hospitals when a MCI occurs.
3. Ambulances transporting MCI patients originating from the incident are not required to provide advance notification to emergency departments or to contact the Base Hospital for those patients.
4. Hospital emergency departments should anticipate receiving ambulance transports of unannounced patients originating from the MCI incident.

B. EM Resource

1. The ECD shall use EM Resource to alert EMS Providers that a MCI is in progress on the system alert line and as the primary mode for hospital polling to ascertain Emergency Department bed availability for immediate, delayed and minor patients. ECD staff shall report this information to the MCI Incident Commander(s).
2. Receiving Hospitals shall use EM Resource to report emergency department bed availability for immediate, delayed and minor patients to the Emergency Communications Department.
3. Provide a dedicated web enabled computer to display EM Resource on a continuous 24-hour per day basis.

C. Automatic Vehicle Locator (AVL)

The Emergency Communications Department shall dispatch the closest public or private ALS ambulances as indicated by the AVL system to the MCI

VII. DISASTER SITUATIONS (MCI Level 2 & Level 3)

A. 800 MHz Radios will be used similarly as for routine communications, with the following exceptions:

1. The ECD shall assign ambulance units and other relevant responders to specific talk groups as necessary.
2. The ECD shall initiate an all-call announcement to alert receiving hospitals.
3. Ambulances transporting patients are not required to provide advance notification to emergency departments or to contact the Base Hospital. Hospital emergency departments should anticipate receiving ambulance transports of unannounced patients.
4. In the event the 800 MHz radio system should fail, or gridlock, at any time, the system will default to the "failsoft" mode, which allows for ongoing communications at a reduced level. This also means that only one conversation can happen at a time instead of the normal "trunked" system of handling many conversations simultaneously on different talk groups. Talk-groups will now be shared with other users in the "failsoft" mode. The ECD will advise users that the system is in Fail Soft mode. During Fail Soft, the 800 MHz radio must only be used for critical communications delivered in a brief and succinct format.

B. EM Resource

1. The ECD shall use EM Resource to alert EMS Providers that a disaster is in progress on the system alert line and as the primary mode for hospital polling to ascertain Emergency Department bed availability for immediate, delayed and minor patients. ECD staff shall report this information to the MCI Incident Commander(s).
2. Receiving Hospitals shall use EM Resource to report emergency department bed availability for immediate, delayed and minor patients to the Emergency Communications Department and as a primary mode for hospital command center reporting to the EOC/DOC the in-patient bed availability for patients from the disaster scene.
3. The city Emergency Operations Center (EOC) and Department of Public Health – Department Operations Center (DPH DOC) shall use the EM Resource system to obtain the number of available, staffed in-patient beds.

C. HEARNet

1. The HEARNet radio system is used for communications among receiving hospitals, the blood bank, the ECD and the EOC or DPH DOC to report facility damage and requirements for emergency assistance, supplies and personnel and if resources permit, notify receiving hospitals of the number and severity of incoming patients during the course of a disaster.
2. The ECD will initiate an all-call announcement to the receiving hospitals when an MCI occurs.

3. The EMS Agency, through the EOC or DPH DOC, may initiate and maintain communications through the HEARNet.

D. Land Lines (Telephone)

1. Each receiving hospital shall maintain a conventional land line in their command center solely dedicated to communication with the Department of Public Health's Department Operations Center (DOC). Each receiving hospital shall notify the EMS Agency of the number.
2. The EMS Agency shall inform all receiving hospitals of the contact phone numbers at the DPH DOC.

VIII. BLOOD BANK COMMUNICATIONS

A. The Blood Centers of the Pacific – Irwin Center shall use the 800 MHZ radio and HEAR Net radio system during a disaster for:

1. Back up communications to and from hospitals for blood and blood product requests.
2. Reporting the DPH DOC the available inventory of blood and blood products and notification of inventory shortages.
3. Reporting to the Emergency Operations Center / Department Operations Center blood availability.

IX. QUALITY ASSURANCE

1. All EMS providers shall assure compliance with this policy through their own quality assurance plans.
2. The EMS Agency may randomly check recorded EMS calls and periodically visit providers to assure compliance with this policy.
3. The EMS Agency will investigate unusual occurrence reports pertaining to EMS communications and make recommendations as appropriate.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 3011
Effective Date: September 1, 2009
Review Date: January 1, 2011
Supersedes: August 1, 2007

COMMUNICATION DRILLS

I. PURPOSE

A. To ensure the integrity of all EMS System communications equipment.
B. To ensure training for all communications equipment users.

II. AUTHORITY

A. California Health and Safety Code, Division 2.5, Section 1797.220 and Section 1798(a);
B. California Code of Regulations, Title 22, Division 9, Sections 100173-100175.

III. POLICY

A. The Division of Emergency Communications (DEC) shall perform regular communication checks at intervals determined by the EMS Agency. These communication checks shall include:
    1. The 800 MHz system to the blood bank.
    2. The EM Resource MCI polling feature to poll hospitals for available Emergency Department beds and ambulance providers for available ambulances.
    3. HEARNet radio system roll call of all receiving hospitals, the blood bank, Laguna Honda Hospital, the National Park Service, the EOC, and the EMS Agency.
    4. Other communication equipment as determined by the EMS Agency.

B. All tests shall be documented by the DEC using forms designed for this purpose. These forms shall indicate the date and time of the test, the DEC staff member conducting the test, and the response or non-response of each hospital or facility. These forms shall be retained for one year. The DEC shall forward the forms to the EMS Agency after each drill.

C. The EMS Agency is responsible for evaluating the system test performance indicators and implementing performance improvement actions to ensure a functioning emergency communications system.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 3020
Effective Date: August 1 2007
Review Date: January 1, 2011
Supersedes: September 1, 2006

FIELD TO HOSPITAL COMMUNICATIONS

I. PURPOSE

A. To establish consistent criteria for field personnel to determine when it is appropriate to contact:
   1. Receiving Hospitals for advance notification of an incoming patient.
   2. Base Hospital Physicians for medical consultation or treatment authorization.
   3. Field Supervisors for administrative consultation.

B. To provide field personnel with guidelines for providing a clear and concise report that conveys pertinent patient information to Receiving Hospital personnel, Field Supervisors, or Base Hospital Physicians.

C. To establish consistent procedures for field personnel to utilize alternative communication methods in the event of a radio failure.

II. AUTHORITY

A. California Health and Safety Code 1797.204 and 1797.220.
B. California Code of Regulations, Title 22, Sections 100173-100175.

III. POLICY

A. 800 MHz radio communications between field personnel, Receiving Hospital personnel, Field Supervisors, and Base Hospital Physicians shall adhere to the standards presented within this policy.

B. Field personnel shall document radio contacts with Receiving Hospital personnel, Field Supervisors, or Base Hospital Physicians on the prehospital care record (PCR).

C. Field personnel shall also adhere to any additional operational reporting guidelines for Field Supervisor contact as required by their respective ambulance provider. Any additional operational reporting guidelines required by the respective ambulance provider shall be consistent with the guidelines noted in this policy.

IV. RECEIVING HOSPITAL NOTIFICATION

A. Field personnel shall provide advance notification to a Receiving Hospital except San Francisco General Hospital, for **all** direct emergency department patient transports. This includes all Advanced Life Support and Basic Life Support direct emergency department transports of stable and unstable patients.

B. Field personnel shall provide SFGH with advance notification for an incoming patient **only** if the patient's condition is critical or meets specialty care need (e.g., trauma, pediatrics, etc.).
C. Interfacility transfers pre-arranged with a physician and hospital are excluded from advance notification except in situations where the patient has unexpectedly deteriorated and requires immediate care in the emergency department.
D. Field personnel shall provide a brief, clear report that provides pertinent information to Receiving Hospital personnel (see *Attachment 1*).
E. Under no circumstances shall the Receiving Hospital physician or nursing personnel provide medical direction to field personnel.
F. Hospital notification during periods of diversion:
    1. EMS providers should determine diversion status before transport
        a) EMResource displays current diversion information.
        b) Hospitals will accept any patient in which the diversion status has changed after initiation of transport.
G. For suspension of Receiving Hospital contact in the event of a multi-casualty incident (MCI), please refer to EMS Agency Policy #3010, *EMS System Communication Standards*.

V. BASE HOSPITAL PHYSICIAN CONTACT CRITERIA

A. EMT-Ps shall contact the Base Hospital Physician for treatment authorization or medical consultation for any of the following circumstances:
    1. Prior to administering any drug or initiating any treatment that requires Base Hospital Physician contact according to the EMS Agency *Treatment Protocols*.
    2. Any questions or clarifications regarding the appropriate destination or specialty care receiving facility for a patient.
    3. Any patient whose care requires deviation from the EMS Agency *Treatment Protocols*.
    4. Any patient, who in the EMT-P's judgement, would benefit from a Base Hospital Physician medical consultation.
    5. Any patient in which an on-scene physician wishes to assume total responsibility for medical care.
    6. Any patient refusal that requires Base Hospital contact in accordance with EMS Agency Policy #4040*, Prehospital Evaluation and Transport*.
B. The EMT-P shall provide a brief, clear report that provides pertinent information to the Base Hospital Physician in accordance with *Attachment 1* of this policy.
C. The Base Hospital Physician shall provide medical consultation to EMT-P personnel in the circumstances noted in accordance with EMS Agency Policies #5011 *Base Hospital Standards* and #5000 *Destination Policy*, and all other applicable EMS Agency policies.
D. After the EMT-P has made Base Hospital Physician contact, the EMT-P shall then notify the Receiving Hospital of any patient enroute to that facility. In rare

circumstances such as a critical patient, the EMT-P's respective dispatch center shall relay this information if the EMT-P is unable to do so.

E. For suspension of Base Hospital contact in the event of an MCI, please refer to EMS Agency Policy #8000 *EMS MCI Policy*.

VI. FIELD SUPERVISOR CONTACT CRITERIA

A. Field personnel shall contact their respective Field Supervisor for advice or consultation for any internal administrative or operational issues.

VII. RADIO COMMUNICATION FAILURE IN THE FIELD

A. In the event of radio communication failure in the field, the field personnel's respective dispatch center shall relay information from the field personnel to the Receiving Hospital as needed according to the approved reporting guidelines.

VIII. QUALITY IMPROVEMENT

A. The EMS Agency will monitor implementation of this policy through EMS Agency Policy #6020, *Performance Management Reporting*, and, at its discretion, random audits of field communication records.

ATTACHMENT 1

I. FIELD COMMUNICATION: REPORT FORMAT

A. For Receiving Hospital Notification – Always confirm the name of the contacted hospital.

B. For Base Hospital Consultation – Always confirm the name of the contacted physician.

C. For Field Supervisor Contact – Always confirm the name of the contacted supervisor.

D. Field personnel ID number. Confirm that the Receiving Hospital, Field Supervisor, or Base Hospital Physician can clearly hear the transmission.

E. Reason for Receiving Hospital, Field Supervisor, or Base Hospital Physician contact.

F. Transport code and ETA.

G. Age, gender, chief complaint, mechanism of injury, or onset of illness.

H. Level of consciousness.

I. Vital signs.

J. Pertinent positive and negative physical findings.

K. Interventions already instituted, patient's response, and any problems encountered (e.g., unable to intubate the patient).

II. ADDITIONAL CONSIDERATIONS

A. Receiving Hospital personnel and Base Hospital Physicians should avoid requesting information from Field Personnel that is not essential.

B. Receiving Hospital personnel and Base Hospital physicians shall repeat reports only when the transmission is unclear.

C. Every reasonable effort shall be made to minimize voice radio traffic.

D. Radio transmissions should be in plain English.

Section 4:
Response and Transportation

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4000
Effective Date: September 1, 2011
Review Date: January 1, 2013
Supersedes: August 1, 2007

PREHOSPITAL PROVIDER STANDARDS

I. PURPOSE

A. To establish standards for EMS providers that supports the seamless delivery of high quality prehospital care and ambulance transportation to the residents and visitors of San Francisco, from a patient's perspective.

B. To define the roles of each category of participant within the EMS System and identify the parameters within which those providers will conduct their business.

II. AUTHORITY

A. California Health and Safety Code, Division 2.5, Sections 1797.200, 1797.201,1797.204, 1797.206, 1797.220, 1797.224, 1797.252, and 1798.

B. California Code of Regulations, Title 22, Sections 100063 et seq., 100142, 100145, 100147, 100173, 100175, and 100254(f).

C. City and County of San Francisco Health Code, Article 14

III. POLICY

A. General Requirements for all EMS providers:

1. EMS providers operating in San Francisco will comply with all Federal, State, and local laws pertaining to the operation of ambulances and emergency vehicles, and the delivery of prehospital care and medical transportation.
2. EMS providers shall comply with all EMS Agency Policies and Procedures and Protocols.
3. All EMS providers shall have and enforce a policy that prohibits employees from performing any ALS or BLS service under the influence of any alcoholic beverage, illegal drug, or narcotic. In addition, said policy shall prohibit employees from performing such services under the influence of any other substances, including prescription or non-prescription medications, which impairs their physical or mental performance.
4. Pursuant to 22 CCR 100254(f), all providers shall have policy requiring early notification for trauma patients being transported to an EMS designated trauma center
5. EMS providers responding to requests for service, delivering care, or transporting patients within the City and County of San Francisco shall have a permit issued by the San Francisco EMS Agency.

6. Managerial personnel with such authority necessary to act on behalf of the provider for all operational issues shall be available to the provider's personnel and the EMS system 24 hours a day.
7. EMS Providers will maintain such staffing, equipment, and vehicles as necessary to be available to respond at all times. Vehicles will be equipped as detailed in the *Vehicle Equipment and Supply* list.
8. EMS Providers will maintain or contract for services with a designated EMS Dispatch Center operating within the requirements of EMS Agency Policy. All responses shall be in accordance with the minimum required response associated with the AMPDS determinant assigned by the designated EMS Dispatch Center.
9. EMS Providers will maintain capability to communicate directly with the Emergency Communications Department, using the 800MHz radios, from any vehicle operating within the City and County of San Francisco.
10. Current EMS Agency Policy and Protocol manuals will be accessible by all employees at each station and in each permitted vehicle.
11. EMS Providers will allow periodic site visits and vehicle inspections by the EMS Agency Medical Director, or his/her designee, as part of the EMS Agency Compliance Verification Process.
12. All EMS providers shall have and enforce a written policy that requires employees to safely secure any durable medical equipment belonging to a patient about to be transported to any destination. Examples include wheel chairs, scooters, portable oxygen, and any other type of durable medical equipment owned by the patient. Each field provider, public or private, shall be responsible for the safekeeping of a patient's durable medical equipment. This does not apply to a patient's home, or other facility able to secure the item safely. Each field provider will give to the patient a written notice of how the item will be secured and how s/he can retrieve the item of durable medical equipment when s/he is released from the facility to which they were transported. Providers shall not charge the patient for this service or pass the cost along to the patient at a later time. Once a field provider has made patient contact, they will be financially liable for any lost durable medical equipment. Each field provider shall forward a copy of their policy to the EMS Agency by the effective date of this policy.

B. First Responder

1. No less than one certified EMT-1 shall, at all times, staff each apparatus used for first response.
   a) SFFD and National Park Service Fire Department are also ALS providers and may, in accordance with other policies and agreements with the EMS Agency, staff first response apparatus with ALS equipment and at least one paramedic.
   b) If an ambulance is used for ALS first response, the standards described under "On Viewed" incidents, V, C shall be used to determine if transport should be initiated.
2. SFFD will provide first response services for all presumptively defined life threatening emergency responses in San Francisco without regard to the ALS provider responding.

a) SFFD will respond to all requests for on scene assistance made by ALS providers on emergency calls.
b) If requested by a transporting unit, first responders will accompany the patient to the hospital to assist with patient care.
c) SFFD, at its discretion, may choose to limit response to requests made by providers for non-emergency purposes, based on the operational needs of the Department.

C. BLS Provider

1. BLS ambulances will be staffed with two certified EMT-1s consistent with the established personnel and training standards in EMS Agency Policy.
2. BLS ambulances shall be equipped with an AED and providers shall meet the requirements of 22 CCR 100063.1.
3. BLS ambulances may respond to the following requests for service:
   a) Interfacility transfers;
   b) Service requests that have an AMPDS response determinant approved for BLS response by the EMS Agency Medical Director;
   c) Prearranged medical transportation from a residence or sub-acute facility to a clinic, medical office, sub-acute facility, or hospital for non-urgent care of a pre-existing medical condition; and
   d) Multi-Casualty Incidents as described in the *Integrated Response Plan*.
4. BLS personnel may provide emergency care within their scope of practice in the following situations:
   a) When they come across medical emergencies during the normal course of business (on view) and until relieved by ALS personnel;
   b) When a patient's clinical condition suddenly deteriorates during transport;
   c) As requested by ALS personnel present on the same emergency scene.
   d) BLS providers will not actively seek out, shadow, or be dispatched to emergency calls.
   e) BLS providers and personnel may not accept a patient from ALS providers or personnel for the purposes of unsupervised care and/or transport from an emergency scene, except during a disaster or MCI when approved by the EMS Agency Medical Director.

D. ALS Providers

1. The City and County of San Francisco is an Exclusive Operating Area (EOA) as defined in Section 1797.204 of the California Health and Safety Code.
2. Each Advanced Life Support Provider must have a current Paramedic Service Provider Agreement with the San Francisco EMS Agency to operate as an authorized ALS Provider.
3. ALS Providers will staff Paramedic Field Supervisors as required by EMS Agency Policy.
4. ALS Providers shall dispatch, or require to be dispatched, 2 California licensed and San Francisco accredited paramedics, who may be responding in separate vehicles, to all AMPDS Response Determinants identified as requiring a dual paramedic response by the EMS Medical Director.

5. ALS transport vehicles will be staffed with a minimum of one currently licensed and San Francisco accredited paramedic, and one EMT-1 consistent with the personnel and training standards in EMS Agency Policy.
    a) A second licensed and San Francisco accredited paramedic may replace the EMT-1 on a transport vehicle, at the discretion of the provider.
    b) ALS apparatus intended for response only will have a minimum of one currently licensed and San Francisco accredited paramedic in order to quality as an authorized ALS resource.
6. ALS providers will respond to all requests for service in accordance with response patterns determined by AMPDS and approved by the EMS Agency Medical Director. This requirement pertains to all emergent, urgent, immediate, and/or unscheduled requests for service received by any means.
7. ALS providers will respond an appropriately staffed and equipped ALS vehicle to the following requests for service:
    a) All service requests assigned an AMPDS determinant that requires ALS response;
        1) Those requests with an Echo determinant must be assigned to the closest ALS response and transport vehicles without preference to any particular provider.
    b) All requests for assistance made by a First Response, Law Enforcement, or BLS provider;
        1) This provision applies to private ALS providers when they are available in accordance with the Integrated Response Plan.
8. At the provider's discretion, an ALS ambulance may be assigned to requests for interfacility transports requiring a paramedic in attendance;
9. At the provider's discretion, an ALS ambulance may be assigned to any or all requests outlined in C, 3, a-d.

E. Quality Improvement & Training

1. All EMS providers shall prepare and submit to the EMS Agency, a Quality Improvement plan that complies with State law and EMS Agency Policy.
2. Providers shall employ a registered nurse, a physician, or a paramedic knowledgeable in prehospital care and quality improvement who is responsible for the QI oversight in accordance with EMS Agency Policy.
    a) ALS providers shall employ a physician knowledgeable in prehospital care and quality improvement to act as a provider Medical Director.
3. Providers will compile and submit all reports and data as required by Policy and as requested by the EMS Agency.
4. Training programs, with mandatory attendance requirements for all employees, structured from information gained through QI activities will be presented to all employees not less than 4 times per year.
5. All employees will receive training, with mandatory attendance requirements, on all EMS Agency Policy, Procedure, and Protocols.
    a) EMS personnel who are working as professional responders in San Francisco and fail to attend training mandated by the EMS Medical Director, may, at the direction of the EMS Medical Director, have their certification or accreditation suspended and be subject to disciplinary action, up to an including revocation of

their certification or accreditation for failing to attend training mandated by the EMS Medical Director.

6. Providers will develop a new employee training process that meets the current personnel and training standards in EMS Agency Policy.

F. Response Standards and Goals

1. The entire EOA of the City and County of San Francisco is defined as a "metropolitan and urban" area.
2. The dispatch interval will be measured from the time an incident is created in the provider's computer aided dispatch computer until a response vehicle is notified of the call.
3. Response intervals will be measured from the time assigned vehicle is notified of an incident until the responding vehicle stops at the scene.
4. While recognizing that the current San Francisco EMS System is not yet capable of meeting them, the EMS Agency has identified that the EMDAC recommended Response Time Intervals are a worthy goal, and will evaluate and improve the San Francisco EMS System by using the following Response Call Intervals, as recommended by EMDAC, as benchmarks:
    a) BLS with AED on scene – 5 minutes from time of first ring at primary PSAP to vehicle arrival at the scene with the wheels stopped.
    b) ALS – 10 minutes from time of first ring at primary PSAP to vehicle arrival at the scene with the wheels stopped.
    c) Patient Transport Vehicle – 12 minutes from time of first ring at primary PSAP to vehicle arrival at the scene with the wheels stopped.
5. Emergency Dispatch Centers shall ensure that an appropriate AMPDS response determinant is assigned and the approved response vehicles for that determinant are notified of the assignment within 2 minutes, 0 seconds 90 percent of the time for all presumptively defined life threatening emergencies.
6. The SFFD shall ensure that responders capable of performing Basic Life Support and Defibrillation are on scene of all presumptively defined life-threatening emergencies within 4 minutes and 30 seconds, 90 percent of the time as measured each month within the Emergency Response Districts. The SFFD shall be responsible for complying with this response interval requirement for all presumptively defined life-threatening emergencies, including those calls responded to by other Emergency Ground Ambulance Providers on a mutual aid or IRP request.
7. Providers shall ensure that responders capable of performing Advanced Life Support are on the scene of all presumptively defined life threatening emergencies within 7 minutes and 0 seconds, 90 percent of the time as measured each month within the Emergency Response Districts.
    a) Private ALS Providers may request the SFFD to assign an ALS First Response Company as needed to comply with this requirement.
    b) The SFFD shall respond an ALS First Response Company when requested by other Emergency Ground Ambulance Providers on a mutual aid or IRP request.
    c) All time intervals shall be indexed from the time the incident was created at the initiating agency.

1) Each involved agency will reference the index time but report their response separately.

8. Providers shall ensure that a Patient Transportation Capable Vehicle, staffed by at least 2 personnel including one paramedic and permitted as an ALS ambulance by the EMS Agency, is on the scene of all presumptively defined life threatening emergencies within 10 minutes, 0 seconds 90 percent of time as measured each month within the Emergency Response Districts.
9. Providers shall ensure that a Patient Transport Capable Vehicle, staffed by at least 2 people including one paramedic and permitted as an ALS ambulance by the EMS Agency is on the scene of all Code 2 dispatches within 20 minutes, 0 seconds 90 percent of the time as measured each month within the Emergency Response Districts.
10. If a response is appropriately changed from code 3 to code 2 enroute to the scene, the entire response time interval shall be calculated against the standard for a code 2 response, except in those cases in which the response has be reduced to code 2 after exceeding the code 3 response time standard.
11. If a response is changed from code 2 to code 3 enroute to the scene, the entire response time shall be calculated against the standard for a code 3 response.
    a) Providers shall file an exception report, and these incidents shall not be included the response time standards calculations.
12. The response interval standard applies only to the first unit of each category to arrive on scene. The response unit categories are 1) responder capable of performing BLS and Defibrillation, 2) responder capable of performing ALS and, 3) patient transportation capable vehicle.
13. For non-emergency patients being cared for by a physician or RN requesting transport to an ED or for direct hospital admit the call taker may use Card 33A – Transfer/Interfacility/Palliative Care under the following rules:
    a) If the call taker is not able to speak directly with someone who is physically with the patient and is not able to verify that a physician or RN has examined the patient, then the call taker shall switch to another appropriate card for a Code 2 or 3 dispatch;
    b) That the physician or RN confirms that for Card 33A Acuity Level I responses, that a 60-minute response time is appropriate.
    c) That the physician or RN confirms that for Card 33A Acuity Level II responses, that a 4 hour response time is appropriate.
    d) For non-emergency calls originating from a third party who is not at the patient location, such as a transport hub or institutional security, Card 33 cannot be used unless the call taker is provided with a phone number for contacting the RN or MD on scene with the patient;
    e) The call taker does not need permission from the physician or RN to upgrade the response to Code 2 or 3.
    f) If a private ambulance provider cannot respond within 60-minutes to a Card 33 Alpha, Acuity I, the ambulance provider shall attempt to transfer the call to another permitted private provider. Only if another provider is unavailable, the call shall be transferred to the San Francisco 911 Center;

g) San Francisco ALS providers may refer 33A, Acuity Level II calls to a permitted BLS provider for service;

14. The following summarizes the Response Time Requirements described above:

Vehicle Response	**Dispatch Interval**	**Response Time Interval**		
(AMPDS determinants are representative only and subject to modification on approval of EMS Medical Director)		**BLS & AED On Scene**	**ALS On Scene**	**Transport On Scene**
Code 3 (Red lights and siren) AMPDS Echo, Delta, some Charlie, and some Bravo determinants	2 minutes	4 minutes, 30 seconds	7 minutes, 0 seconds	ALS 10 minutes, 0 seconds
Code 2 (no red lights or siren) AMPDS Alpha, some Bravo, and some Charlie determinants	2 minutes	NA	20 minutes, 0 seconds	ALS 20 minutes, 0 seconds
Code 1 Only for Card 33A Acuity LI	2 minutes	NA	60 minutes ALS responds only if any question exists or BLS unavailable	60 minutes BLS or ALS if BLS unavailable
NonUrgent Only for Card 33A Acuity LII	NA	NA	4 hours ALS responds only if any question exists or BLS unavailable. ALS providers may refer caller to permitted BLS provider.	4 hours BLS

15. Response time and interval reporting
    a) Providers shall report all response time data to the EMS Agency through an "incident based reporting system," by which the response of first responders and ambulances and other vehicles are recorded, as indexed to a request for service.
    b) For each request for emergency medical service, Providers shall record or cause to be recorded the incident location and the times for each responding unit at each of the stages of a response:
        1) For each ALS or BLS First Response vehicle the SFFD shall record:
            (a) Time incident created in CAD;
            (b) Time unit notified;
            (c) Time response unit was mobile;
            (d) Time vehicle stopped at scene;
            (e) Time arrived at patient's side;
            (f) Scene departure time; and
            (g) Available time.

2) For each responding ambulance, the provider shall record:
   (a) Time incident created in CAD;
   (b) Time unit notified;
   (c) Time response unit was mobile;
   (d) Time vehicle stopped at scene;
   (e) Time arrived at patient's side;
   (f) Scene departure time;
   (g) Destination arrival time; and
   (h) Available time.
3) Providers shall also record the response code to the incident location, the destination/disposition of each vehicle, and the response code to the destination for transported patients.
4) Response times shall be measured and reported by the geographic boundaries of each Emergency Response District. Response times shall also be measured and reported in the aggregate.
5) All response times and interval measurements shall be measured and reported monthly in an electronic format approved by the EMS Agency.

IV. PROCEDURE

A. Ambulance Permit Process
   1. Obtain the Application for Ambulance Permit from the EMS Agency offices and submit the completed application and required documentation.
   2. Pay the required fee.
   3. Make the ambulance(s) and operations facilities available for inspection by the EMS Agency.
   4. No ambulance shall be operated within San Francisco without a permit from the EMS Agency

B. Compliance Verification
   1. In order to verify continuing compliance with EMS Agency Policy, the EMS Agency will periodically perform site surveys for the purposes of inspection and evaluation of a providers policies and practices. If a provider agency fails to attain a passing score on any site survey, the EMS Agency shall notify that agency in writing of deficiencies.
   2. The provider agency will develop a corrective action plan submit it to the EMS Agency within 30 days of notification
      a) Plan will address all noted deficiencies;
      b) Plan will include proposed timeframe for correction; and
      c) Plan must be approved by the EMS Agency Medical Director.
   3. If determined as necessary by the EMS Agency Medical Director, the EMS Agency shall resurvey the provider in no less than 90 days from the date of notification.
   4. If, as determined by the EMS Agency Medical Director, there exist circumstances deemed to jeopardize public health and safety, the EMS Agency Medical director may:
      a) Require that the provider agency suspend all operations until such time that corrections are made and verified; and

b) Resurvey the provider agency in less than 90 days

5. Failure to correct noted deficiencies shall be cause for any or all of the following actions:
   a) Revocation of the provider agencies ambulance permit and/or Paramedic Service Provider agreement.
   b) Placing the provider agency on a probationary status during which time the provider agency will follow an approved corrective action plan and be closely monitored for compliance.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4000.1
Effective Date: November 1, 2015
Review Date: June 1, 2016

AMBULANCE TURNAROUND TIME STANDARD

I. PURPOSE

To define the goals for ambulance turnaround and patient offload times.

II. AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.206, 1797.220, 1797.224, 1797.252, and 1798.

III. BACKGROUND

Patient transfer from ambulance to hospital is a critical part of emergency care, both for the individual patient at the hospital and to preserve the availability of ambulances to answer 911 calls for medical assistance throughout the San Francisco EMS System.

IV. DEFINITIONS

Ambulance arrival at the emergency department – The time the ambulance stops (actual wheel stop) at the location outside the hospital emergency department where the patient is unloaded from the ambulance.

Ambulance patient offload time – The time when a patient is physically removed from the ambulance gurney to hospital equipment and transfer of care has been completed, as recorded by a signature from an emergency department nurse or doctor in a patient's EMS electronic health record.

Ambulance return to service time – The time the ambulance is response ready after transporting a patient to a hospital emergency department.

Offload time interval - The period of time between ambulance arrival at emergency department and ambulance patient offload time.

Ambulance turnaround interval - The period of time between ambulance arrival at emergency department and ambulance return to service time.

V. POLICY

The goal for the offload time interval is 20 minutes or less, 90 percent of the time.

The goal for the ambulance turnaround interval is 30 minutes or less, 90 percent of the time.

VI. DATA COLLECTION

A. All interval measurements shall be reported monthly (on the first business day of the month) to the EMS Agency in an approved electronic format.
B. Turnaround time data submitted by providers shall include date, time, location, call disposition (Code 2 or Code 3), arrival time at hospital, ambulance patient offload time and ambulance return to service time.

VII. QUALITY IMPROVEMENT

A. The EMS Agency will report monthly the following:
    1. Offload time interval for each provider at each emergency department.
    2. Ambulance turnaround interval for each provider at each emergency department.
    3. System aggregate intervals for patient offload and ambulance turnaround intervals.
B. The EMS Agency will focus on identifying the root causes for delays, surges in demand and to what extent diversion impacts offload and turnaround intervals.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4001
Effective January 30, 2017
Supersedes: August 1, 2016

VEHICLE EQUIPMENT & SUPPLY LIST

I. PURPOSE

To establish consistent minimum equipment and supplies standards for Basic Life Support and Advanced Life Support vehicles in the City and County of San Francisco.

II. POLICY

A. This policy does not supersede the California Vehicle Code or the California Code of Regulations requirements for ambulance equipment.

B. All ambulances shall be inspected by the EMS Agency to receive a permit to operate in the City and County of San Francisco. Inspections shall be done at the time of issuing the initial permit, then annually thereafter. Ambulances must demonstrate compliance to the equipment standards in this policy to qualify for a permit.

C. All first responder units, ambulances and supervisory units shall minimally stock the equipment and supplies as listed in the attachment to this policy. **Actual quantities stocked should take into consideration the amounts typically used in a shift(s) plus additional quantities to maintain adequate supplies for periods of high demand or re-stocking delays.**

D. Every ALS and BLS first response, ambulance and supervisory units shall have an 800MHz radio in compliance with *Policy 3010 EMS Communications Equipment and Procedures*.

E. Every BLS and ALS mobile team (foot, bicycle or gator) ALS units and field supervisor units shall have the appropriate medical supplies and equipment to provide patient care.

F. First responder vehicles, supervisor vehicles, or ambulances may not stock any medications, or medical devices or equipment that is not approved, in advance, by the EMS Agency Medical Director.

G. Each ambulance company provider shall create a “par-list” check out sheet (or electronic equivalent) for every first responder unit, ambulance and engine that identifies the minimum number of each piece of equipment required on each unit. Crew members shall inspect their unit at least once every 24-hour period to verify

that the minimum level of equipment is present on the vehicle. A crew member shall attest to the completed inspection, by signing the check out sheet. The ambulance provider company shall maintain document as a record for six months.

III. AUTHORITY

San Francisco Health Code, Article 14, Section 903
California Vehicle Code, Section 2500 - 2505
California Health and Safety Code, Section 1797.220
California Code of Regulations, Title 13, Division 2, Chapter 5, Article 1, § 1100

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4001
Effective January 30, 2017
Supersedes: August 1, 2016

VEHICLE EQUIPMENT & SUPPLY LIST

Attachment: Policy 4001 Minimum Equipment Requirements					
Line #	**AIRWAY / RESPIRATORY**	**BLS First Response**	**BLS Amb**	**ALS First Response**	**ALS Amb**
1	M, or H oxygen cylinder	-	1	-	1
2	Oxygen Flowmeter capable of delivering 2-15 LPM	-	1	-	1
3	D or E size oxygen cylinders	2	3	2	3
4	Regulators for D/E Oxygen Cylinders capable of delivering 2-15 LPM	1	1	1	1
5	Nasal Cannulas - Adult	2	2	2	2
6	Nasal Cannulas - Pedi	1	2	1	2
7	Simple Oxygen Masks - Infant	-	1	-	1
8	Non-Rebreather Masks - Adult	1	2	1	2
9	Non-Rebreather Masks - Pedi	1	1	1	1
10	Bag Valve Masks - Adult	2	2	2	2
11	Bag Valve Masks - Pedi	2	2	2	2
12	Bag Valve Masks - Infant	2	2	2	2
13	Oral Airway, Set, with sizes 0, 1, 2, 3, 4, 5, & 6	1	1	1	1
14	Nasal Pharyngeal Airways Set of sizes 26, 28, 30, 32, & 34 Fr	1	1	1	1
15	Tongue Depressors	2	2	2	2
16	Portable Suction Device - Manual Pump Type **OR** Battery Operated	1	1	1	1
17	Rigid Pharyngeal Tonsil Tip (Yankauer Suction)	1	1	1	1
18	Suction Tubing	1	2	1	2
19	Pediatric Suction Bulb (sterile)	-	1	-	1
20	Suction Catheters 6, 8, 10, 12, & 14 Fr	-	-	1	1
21	Supra-Glottic Laryngeal Airway (King Tube), Adult, Sizes 3, 4 & 5	-	-	1	1

22	Supra-Glottic Laryngeal Airway (King Tube), Pedi/Infant, Size 2.0, 2.5	-	-	1	1
23	Uncuffed Endotracheal Tubes, 2.0, 2.5, 3.0	-	-	2	2
24	Meconium Aspirator	-	-	2	2
25	Cuffed Endotracheal Tubes, 6.0, 6.5, 7.0, 7.5, 8.0, & 8.5	-	-	2	2
26	ET Tube holder or ties	-	-	2	2
27	Laryngoscope Blades w/ extra bulbs, Miller Type: 0, 1, 2, 3, & 4	-	-	1	1
28	Laryngoscope Blades w/ extra bulbs, Macintosh Type: 1, 2, 3, & 4	-	-	1	1
29	(**Optional**:) Video Laryngoscope Blades (Vivid Trac, Glidescope, CMAC), Adult and Child Sizes	-	-	1	1
30	Large Laryngoscope Handle	-	-	1	1
31	Small Laryngoscope Handle	-	-	1	1
32	Stylettes: Adult (If not in ETT)	-	-	1	1
33	Magill Forceps, Adult	-	-	1	1
34	Magill Forceps, Pedi	-	-	1	1
35	Beck Airway Airflow Monitor (BAAM) Whistle	-	-	1	1
36	Cetacaine Spray bottle	-	-	1	1
37	Lidocaine gel 2% tube or bottle	-	-	1	1
38	Phenylephrine HCL 0.25% or 0.50% nasal spray bottle	-	-	1	1
39	Handheld Nebulizer	-	-	2	2
40	Needle Cricothyroidotomy Kit (WITHOUT scalpel)	-	-	1	1
41	CPAP Device able to deliver PEEP of 10 cm H2O, breathing circuits, masks	-	-	1	1
42	Electronic Capnography device (may be integrated in cardiac monitor)	-	-	1	1
43	Capnography filterline with adapter to connect to ET tube	-	-	1	1
44	Pulse Oximeter (may be integrated into cardiac monitor)	-	-	1	1
45	(**Optional**:) Carboxyhemoglobin Monitor (may be integrated into cardiac monitor)	-	-	1	1
46	Adult Finger Probes for pulse oximetry (reusable)	-	-	1	1

47	Pediatric Finger Probes for pulse Oximetry	-	-	1	1
48	Infant Finger Probes for pulse Oximetry	-	-	1	1
49	Jet Insufflation Ventilator for Needle Cricothyroidotomy	-	-	1	1
CARDIOVASCULAR		**BLS First Response**	**BLS Amb**	**ALS First Response**	**ALS Amb**
50	Semi-automatic defibrillator	1	1	-	-
51	Semi-automatic defibrillator pads – Adult (disposable razors are recommended as optional stock)	1	1	-	-
52	Semi-automatic defibrillator pads - Pedi	1	1	-	-
53	Stethoscope	1	1	1	1
54	Blood Pressure Cuff - Adult	1	1	1	1
55	Blood Pressure Cuff - Obese or Thigh	-	1	1	1
56	Blood Pressure Cuff - Pedi	-	1	1	1
57	Blood Pressure Cuff - Infant	-	1	1	1
58	Portable Cardiac Monitor-Defibrillator w/ cables capable of monitoring, defibrillation, transcutaneous pacing, printing 12-lead EKG and electrical discharge < 25 joules	-	-	1	1
59	ECG recording paper, compatible with monitor	-	-	1	1
60	Multi-function defibrillation pads - Adult, compatible with monitor	-	-	1	2
61	Multi-function defibrillation pads - Pedi, compatible with monitor	-	-	1	1
BURNS / TRAUMA / WOUND CARE		**BLS First Response**	**BLS Amb**	**ALS First Response**	**ALS Amb**
62	Burn Sheets - Sterile (disposable type)	1	1	1	1
63	Quick Clot Combat Gauze (No Size)	-	-	2	2
64	Sterile gauze pads 4" x 4," 12 per box	1	1	1	1
65	Nonsterile 4" x 4" gauze pads, 200 per box	1	1	1	1
66	Abdominal Dressing, 8" x 10" or 5"x9" or similar size	2	4	2	4
67	Trauma Dressings, 10" x 30" or larger	2	2	2	2
68	Stretch-style Sterile Gauze Rolls 4" or 5"	4	4	4	4

69	Petroleum Gauze Pads, 4" x 6" or 3" x 9" (or similar size)	4	4	4	4
70	Triangular Bandages	2	2	2	2
71	Cloth Tape 2"	3	3	3	3
72	Combat Application Tourniquets **OR** approved equivalent*	1	1	1	1
73	Elastic Bandages 3"	1	1	1	1
74	Band-Aids 1", 10 strips	1	1	1	1
75	Instant Cold Packs (8 reserved for ROSC pts on ALS Ambs)	2	2	2	10
	****Acceptable equivalent includes Combat Application Tourniquet, Emergency and Military Tourniquet, or Special Operations Forces Tactical Tourniquet***				

IMMOBILIZATION / EXTRICATION		**BLS First Response**	**BLS Amb**	**ALS First Response**	**ALS Amb**
76	Spine Board	1	1	1	1
77	Lightweight head immobilizer blocks (set)	1	1	1	1
78	4 seatbelt type straps, 3 long/box straps, or 1 set of spider straps	1	1	1	1
79	Cervical Collars: Adult	2	2	2	2
80	Cervical Collars: Pedi	2	2	2	2
81	Extremity splint, cardboard or similar product, small 12 - 18"	2	2	2	2
82	Extremity splint, cardboard or similar product, medium 18 - 24"	1	1	2	2
83	Extremity splint, cardboard or similar product, large 24 -36"	2	2	2	2
84	Traction Splints : Sager or HARE, adult and pedi size	1 each size	1 each size	1 each size	1 each size
85	Kendrick Extrication Device (KED)	1	1	1	1
86	Pediatric Spinal Immobilization Device	1	1	1	1
87	"Breakaway" **OR** "Flat" Stretcher	-	1	-	1
88	Patient Gurney with shoulder harness and limb belts	-	1	-	1
89	Stair chair (**OR** feature that allows gurney to adjust to seated position)	-	1	-	1
90	(**OPTIONAL**:) Scoop Stretcher	-	1	-	1
91	Extremity Restraints - Wrist & Ankle	-	1	-	1

	INFECTION CONTROL / CREW PPE	BLS First Response	BLS Amb	ALS First Response	ALS Amb
92	Disinfectant Solution or Spray	1	1	1	1
93	Disinfectant Wipes	-	1	-	1
94	Hand sanitizer	1	1	1	1
95	Long-sleeve impermeable gowns	-	1/crew member	-	1/crew member
96	Pair of heavy duty gloves	-	1/crew member	-	1/crew member
97	Safety glasses or goggles	-	1/crew member	-	1/crew member
98	Plastic trash bags	-	1	-	1
99	Infectious waste bags (red biohazard bags)	1	1	1	1
100	Spit socks or hoods	1	2	1	2
101	Helmet: OSHA approved "hard hat" or equivalent	-	1/crew member	-	1/crew member
102	N-95 Masks, in sizes for all crew members	5	5	5	5
102a	P100 Masks, as Required for Interventions	-	-	2	2
103	On Supervisor Rig, ONLY (if available): DuoDote Autoinjectors	18	18	18	18
104	On Supervisor Rig, ONLY: Level C PPE Suit	-	2	-	2
105	On Supervisor Rig, ONLY: PAPR (**OR** SCBA with extra air cylinders) for each Level C Suit	-	2	-	2
	PEDIATRIC	**BLS First Response**	**BLS Amb**	**ALS First Response**	**ALS Amb**
106	Pediatric Length-Based Resuscitation Tape	-	-	1	1
107	Stuffed toy for children	-	1	-	1
	OBSTETRIC	**BLS First Response**	**BLS Amb**	**ALS First Response**	**ALS Amb**
108	Obstetrical Kit w/ umbilical cord clamps; receiving blanket; infant bunting blanket; infant warming cap; sterile scissors or scalpel; suction bulb; OB pad; plastic bag for placenta	1	1	1	1

	MISCELLANEOUS	BLS First Response	BLS Amb	ALS First Response	ALS Amb
109	Digital Thermometer	1	1	1	1
110	Trauma Shears	1	1	1	1
111	Water soluble lubricant, small packets	10	10	10	10
112	Penlights	2	2	2	2
113	1 Roll of Paper Towels, OR Equivalent of Disposable Towels	-	1	-	1
114	Disposable Blankets	1	2	1	2
115	Wool blend blankets	1	1	1	1
116	Chemical Heating Blanket (Ready-Heat Blanket or equivalent)	-	1	-	1
117	Sealable bags, gallon-size (e.g. Ziploc)	3	3	3	3
118	Emesis (Kidney) Basins or Bags	-	1	-	1
119	Urinal	-	1	-	1
120	Bedpan	-	1	-	1
121	Sharps Container	-	1	1	1
122	Flashlight with extra batteries or entire extra flashlight	1	1	1	1
123	Drinking water - 1 gallon	-	1	-	1
124	San Francisco County Map or GPS Device	-	1	-	1
125	San Francisco EMS Agency Protocol Manual, current version on Paper or Electronic Format (e.g. Protocol App on Mobile Device)	1	1	1	1
126	Pre-hospital Care Report (paper) **OR** 1 E-PCR Device	20	20	20	20
127	In Supervisor Rig ONLY: Cooler or refrigerator capable of maintaining 4 one-liter IV bags of NS at constant temperature of 4 degrees Celsius (**OR** may substitute line# 75 cold packs)	-	-	-	ALS Supervisor Vehicles and / or ALS Amb
128	Fire Extinguisher, A/B/C rated, w/maintenance tag < 1 year	-	1	-	1
129	Road Flares	4	4	4	4

	MEDICATIONS	BLS First Response	BLS Amb	ALS First Response	ALS Amb
		NOTE: *The quantities (mg/gms) listed below only represent the total amount of a medication STOCK. It does NOT represent medication dosages. Refer to Treatment Protocols for medication dosages.*			
130	Activated Charcoal (Aqueous suspension)	-	-	50 gms	50 gms
131	Adenosine	-	-	18 mgs	18 mgs
132	Albuterol Unit Dose, 2.5mg/3mL solution	-	-	20 mgs	20 mgs
133	Amiodarone	-	-	600 mgs	600 mgs
134	Aspirin (chewable), 81mg tablet	-	-	1620 mgs (20 tabs)	1620 mgs (20 tabs)
135	Atropine Sulfate, 1mg/10mL preload	-	-	3 mgs	3 mgs
136	Atropine Sulfate, 8mg/20ml multi-dose vial	-	-	8 mgs	8 mgs
137	Calcium Chloride (10%), 1g/10mL	-	-	1 gm	1 gm
138	Dextrose 50%, 25 gm	-	-	50 gms	50 gms
139	Diphenhydramine IV	-	-	100 mgs	100 mgs
140	Dopamine 400mg premixed in 250mL D5W **OR** equivalent ***(NOTE:*** *Supply 250 ml D5W in addition to Dopamine vials if you do not stock premix****)***	-	-	800 mg	800 mgs
141	Epinephrine 1:1,000, 1mg/1mL	-	-	6 mgs	6 mgs
142	Epinephrine 1:10,000, 1mg/10mL	-	-	4 mgs	4 mgs
143	(*optional for EMTs*) Adult epinephrine auto-injector	prefilled dose	prefilled dose	-	-
144	*(optional for EMTs*) Pediatric epinephrine auto-injector	prefilled dose	prefilled dose	-	-
145	Glucagon	-	-	1 mg	1 mg
146	Glucose Paste (approx. 30g/tube)	2 tubes	2 tubes	2 tubes	2 tubes
147	Lidocaine 2% in 5 ml vial (for use w/ intraosseus insertion)			1	1
148	Magnesium Sulfate 50%, 5 g/10 mls	-	-	5 gms	5 gms
149	Midazolam	-	-	10 mgs	10 mgs
150	Morphine Sulfate IV	-	-	20 mgs	20 mgs

151	Naloxone IV	-	-	4 mgs	4 mgs
152	Nitroglycerine, 0.4mg/dose metered spray **OR** Tablets (see Line#151)	-	-	1	1
153	Nitroglycerine, 0.4mg/tablet	-	-	25 tabs	25 tabs
154	Ondansetron 4mg ODT **OR** 4mg/2ml vial	-	-	12 mgs	12mgs
155	Sodium Bicarbonate, 50 mEq/50 ml	-	-	100 mEq	100 mEq
156	Sterile Water for Injection, 20 ml vials	-	-	2 vials	2 vials
IV SUPPLIES		**BLS First Response**	**BLS Amb**	**ALS First Response**	**ALS Amb**
157	Normal Saline 0.9% 1000 ml bag	-	-	4	4
158	D5W 100 ml bag	-	-	2	2
159	IV Administration Set 10 or 15 drops/mL	-	-	4	4
160	IV Administration Set 60 drops/mL	-	-	2	2
161	(Optional) IV Extension Tubing	-	-	2	2
162	IV Catheter (Safety type), 14G	-	-	2	2
163	IV Catheter (Safety type), 16G	-	-	2	2
164	IV Catheter (Safety type), 18G	-	-	2	2
165	IV Catheter (Safety type), 20G	-	-	2	2
166	IV Catheter (Safety type), 22G	-	-	2	2
167	Syringes, 1mL	-	-	2 each	2 each
168	Syringes, 3mL	-	-	2 each	2 each
169	Syringes, 5 or 6mL	-	-	2 each	2 each
170	Syringes, 10 or 12mL	-	-	2 each	2 each
171	Syringes, 30 or 35mL	-	-	2 each	2 each
172	Needles (Safety type), 18G, 20/21G, 25G (**OR** equivalent)	-	-	2 each	2 each
173	3 way stopcock	-	-	2	2
174	Manual Intra-Osseous needle 16G **OR** (See Line# 173)	-	-	1	1
175	EZ-IO Needles, small, medium, & large (or other approved mechanical insertion needles) with	-	-	1	1

176	EZ-IO Driver (or other approved insertion device)	-	-	1	1
177	Pressure Bag Infuser	-	-	1	1
178	Alcohol prep pads or swabs	-	-	10	10
179	Povidone Iodine prep pads or swabs	-	-	10	10
180	Blood Glucose Monitor	-	-	1	1
181	Blood Glucose Monitor Test Strips	-	-	10	10
182	Lancets (safety type)	-	-	10	10
183	Mucosal Atomizing Device (MAD)	-	-	1	1
184	Needle Thoracostomy Kit (e.g. Cook Emergency Pneumothorax Set or equivalent)	-	-	1	1
MCI KIT		**BLS First Response**	**BLS Amb**	**ALS First Response**	**ALS Amb**
185	Bag or Case to hold MCI Equipment	-	1	-	1
186	Mylar Blankets (Space Blankets)	-	12	-	12
187	Bullhorn or Battery Powered Megaphone	-	1	-	1
188	Combat Application Tourniquets or approved equivalent*	-	4	-	4
189	Compression Bandage with ties (e.g. Bloodstopper Dressings)	-	7	-	7
190	Cone masks	-	50	-	50
191	Felt tip markers	-	2	-	2
192	Glasses or Goggles	-	2	-	2
193	Heavy Duty Gloves	-	2	-	2
194	Oral Airways, sizes 0, 1, 2, & 3	-	4	-	4
195	Oral Airways, sizes 4, 5, & 6	-	8	-	8
196	Pens	-	3	-	3
197	Pencils (pre-sharpened)	-	6	-	6
198	Pencil Sharpener	-	1	-	1
199	Ruled paper tablet	-	1	-	1
200	Trauma Shears	-	2	-	2

201	Triage Tags	-	50	-	50
202	Vests - Kelly Green or Blue: "EMT-1" or "EMT-P"	-	2	-	2
203	Vests - Orange: "Medical Group Supervisor"	-	1	-	1
204	Vests - Orange: "Medical Supply Officer"	-	1	-	1
205	Vests - Orange: "Staging Officer"	-	1	-	1
206	Vests - Orange: "Transport Officer"	-	1	-	1
207	Vests - Orange: "Treatment Officer"	-	1	-	1
208	Vests - Orange: "Triage Officer"	-	1	-	1
209	Worksheets/Board: Helicopter Operations	-	1	-	1
210	Worksheets/Board: Medical Branch Director	-	1	-	1
211	Worksheets/Board: Medical Group Supervisor	-	1	-	1
212	Worksheets/Board: Transport	-	1	-	1
213	Worksheets/Board: Treatment	-	1	-	1
	***Acceptable equivalent includes Combat Application Tourniquet, Emergency and Military Tourniquet, or Special Operations Forces Tactical Tourniquet*				

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4002
Effective Date: September 9, 2013
Supersedes: August 1, 2008

CONTROLLED SUBSTANCES

I. PURPOSE

Define the responsibilities of ALS providers for the procurement, storage, use, and tracking of controlled substances and the training of personnel in these standards.

II. POLICY

A. Each ALS provider shall develop a policies and procedures for obtaining, storing, and tracking controlled substances that meet all Federal, State, and local laws. The policies and procedures shall include, at a minimum identify:
   1. Methods of procurement, inventory control, and distribution to field units;
   2. Person(s) directly responsible for the maintaining the controlled substance supply;
   3. Tracking methods for all controlled substances so that each milligram is followed from the time obtained through administration to a patient or waste;
   4. Plan for investigation of discrepancies;
   5. Disciplinary sanctions for failure to comply with the policy;
   6. ALS provider medical director as responsible for obtaining the required controlled substances for use by the provider.
   7. Training program for all personnel on the controlled substance standards.

III. PERSONNEL

A. Unlicensed personnel shall not have access to or custody of controlled substances at any time.

B. Licensed personnel who are in possession of controlled substances are directly and individually responsible to ensure the security of those substances. Possession includes the physical possession of the substances as well as the presence of the substances on any vehicle or stored in equipment to which that person is assigned. Responsibility for the security of the controlled substances may relinquished only when the controlled substances are transferred to another licensed individual (i.e. new crew) or secured in the main inventory safe.

C. Licensed personnel shall only administer controlled substances when indicated by ALS protocol or ordered by a Base Hospital Physician.

IV. STORAGE

A. Controlled substances are stored in their original packaging. If the packaging is such that it must be opened to distribute individual units, then the individual units will be repackaged in a tamper evident container that is resistant to needle punctures, disassembly, or other methods of obtaining the contents without breaking the seal.

B. On-site storage in a safe of heavy gauge metal that is locked and secured in such a way as to prevent it from being removed without being unlocked. Surveillance of the main inventory at all times, either through direct custody or surveillance cameras with a recording device;

C. Storage of the ambulance inventory in a double-locked metal (or other durable material) box that can be sealed or locked in such a way as to prevent unauthorized access without obvious destruction or damage to the container;

D. Controlled substances shall be removed from out of service vehicles and returned to the main inventory safe.

V. REQUIRED RECORDS

A. A record of all requisitions, the supplier, and the amount received with a date.
B. A daily inventory of all controlled substances on all 24-hour units.
C. A record of all controlled substances issued to field units and returned to the main inventory safe.
D. A record of all administration, and/or waste that includes patient name, amount administered/wasted, incident identifier, identity of person administering the drug, and the identity of the person witnessing waste.
E. Periodic audits of all controlled substances.

VI. AUTHORITY

United States Code, Title 21, Controlled Substance Act
Code of Federal Regulation, Title 21, Parts 1300 – 1399
California Health and Safety Code, Sections 11000 et seq. California Uniform Controlled Substance Act
California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.220, and 1798
California Code of Regulations, Title 22, Sections 100172, 100174, and 100175

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4010
Effective Date: August 1, 2008
Review Date: January 1, 2011
Supersedes: August 1, 2007

INTEGRATED RESPONSE PLAN

I. PURPOSE

A. Establish a mechanism by which permitted private ALS providers may participate in the 911 system in order to augment system resources.
B. To provide a uniform method of contacting private ALS ambulances during normal and disaster operations.
C. To provide a method to incorporate permitted BLS ambulances into EMS Operations during a disaster when authorized by the EMSA Medical Director.

II. AUTHORITY

A. California Health & Safety Code, Division 2.5, Sections 1797.204, 1797.206, 1797.220, 1797.224, 1797.250, and 1797.252
B. Title 22, California Code of Regulations Sections 100147, 1001473, and 100175
C. City and County of San Francisco Health Code, Article 14

III. POLICY

A. The Division of Emergency Communications (DEC) shall dispatch the closest properly staffed and permitted ALS ambulance regardless of agency affiliation as indicated by the AVL system to all code 3 requests for EMS service.
B. The EMS Agency will initially equip all ALS units with a GPS transmitter capable of communicating a unit's identifier and location to DEC. Any upgrades or changes to this system will be provided to the private field Providers by DEC.
C. The transmitter will be enabled when available for assignment by DEC.

1. It is the responsibility of the private ALS unit to notify the private provider's dispatch when assigned to a call by DEC.

D. Private ALS units will communicate directly with DEC using the 800MHz radios on the currently assigned channels and/or the MDT.
E. All calls with an AMPDS determinant of Echo, Delta and Charlie will be dispatched to the closest ALS transport unit, regardless of receiving provider or caller origin.
F. Calls with AMPDS determinants of Bravo or Alpha will be assigned to a unit capable of meeting the current response time requirements. Preference may be given to a provider's own unit if the unit is capable of

meeting the response time requirement, otherwise a closer unit, without preference to a provider, must be sent.

G. During a declared MCI, Private ALS providers will suspend using ALS units on non-urgent calls, making those units available for assignment using the standard methods described below.

1. If the MCI is isolated and/or the Private ALS providers will not be needed to manage incident or system calls while the MCI is ongoing, the EMS Agency may allow the Private ALS providers to resume normal operations while the incident is ongoing.

H. During a MCI or disaster in which public and private ALS resources are likely to be overwhelmed and medical mutual aid is unavailable or insufficient, the EMS Agency Medical Director may require that permitted BLS providers suspend non-urgent calls and make those units available to the EMS System.

1. Direct communication with DEC will be enabled and conducted via the 800MHz radio.
2. It will be the responsibility of the BLS ambulance to communicate assignments received from DEC to the provider dispatcher.
3. Utilization of BLS units will be only for the duration of the declared incident and assigned duties that are directly related to the declared incident.
    a) BLS units will not be utilized to respond to EMS calls that are received through normal channels and are otherwise considered part of the normal daily activities of the EMS System.

IV. PROCEDURE

A. When available to DEC, the unit will enable the transmitter and begin sending location and identifier.

B. When not available to DEC, the unit will disable the transmitter to avoid erroneous recommendation by the CAD.

C. If an ALS unit receives simultaneous assignments from the Provider dispatch and the DEC, or if a unit does not disable the transmitter when enroute to a private call and is subsequently assigned a call by the DEC, the unit will respond to the higher priority call.

1. The ALS unit is responsible for notifying the private dispatch center and DEC of the situation and the call to which they are responding.
2. The crew of the ALS unit is required to file a UO with the EMS Agency within 24 hours.

D. Communications with DEC shall be done using the 800MHz radios on the currently assigned channels, or the MDT.

1. The Private ALS unit will advise DEC of the following:
    a) Acknowledge receipt of assignment;

b) On scene;

c) Call disposition (i.e., transport, refusal, and cancel on scene).

2. In the event of radio failure, the Private ALS unit will communicate with the DEC through the Private ALS unit's dispatch.

E. When approved by the EMS Medical Director or Administrator assigned to a declared MCI or disaster.

1. Once on scene of the declared incident, BLS units will be assigned appropriate duties and roles as determined by the Incident Commander and the Medical Group Supervisor.

a) Duties and roles may include transport of delayed or moderate patients determined as stable by ALS personnel on scene.

V. IMPLEMENTATION

A. Technology issues will be addressed through a joint workgroup that includes the affected providers, the ECD, and the EMS Agency.

B. Until such time as technology is implemented to allow the use of the GPS transmitters and CAD recommendations, the private ALS unit will notify Dispatch of their availability either by the MDT or by 800 MHz radio.

C. All other parts of this policy are effective as written.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4020
Effective Date: February 1, 2015
Supersedes: August 1, 2007

Note: Update on Feb 1, 2015 added Veterans Administration Medical Center and UCSF Mission Bay helipads to Appendix B.

EMERGENCY MEDICAL SERVICES (EMS) AIRCRAFT UTILIZATION

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SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4020
Effective Date: February 1, 2015
Supersedes: August 1, 2007

EMERGENCY MEDICAL SERVICES (EMS) AIRCRAFT UTILIZATION

I. PURPOSE

A. To minimize loss of life, disability, pain and suffering by ensuring the timely availability of air medical resources for the City and County of San Francisco.

B. To define the scope and manner with which the EMS System will use EMS aircraft for emergency transport of critically ill and injured patients.

C. To provide for coordinated air medical operations with ground responders and hospital resources.

II. AUTHORITY

A. Code of Federal Regulations, Title 14, Parts 29, 36, 71, 150, 157
B. California Public Utilities Code, Sections 21001-21019, Sections 21240-21258, and Sections 21661-21669.6
C. California Code of Regulations, Title 21, Division 2.5, Sections 3525-3560
D. California Code of Regulations, Title 22, Division 9, Chapter 8, Sections 100276 – 100306
E. City and County of San Francisco Police Code, Article 31, Sections 3100-3112

III. POLICY

A. Availability of Air Medical Services

1. Primary response of EMS aircraft shall be made available to sick and injured persons in the City and County of San Francisco whenever it is safe, appropriate, and necessary to optimize the care of the patient.

2. The pilot in command of the EMS aircraft shall have the full authority to abort or decline response to any request for service when mechanical, geographic, or flight conditions might endanger the crew or others.

3. For incident scene operations where air response is requested, air ambulances shall be considered to be the air response asset of choice. Rescue aircraft may be used to supplant or extend the availability of air medical transportation.

B. Authorization of EMS Aircraft Service Providers

1. All EMS aircraft operators routinely offering services to or from hospitals located in the City and County of San Francisco shall have a written agreement with the EMS Agency and be authorized to operate by the EMS Agency within the aircraft operator's jurisdiction of origin.

2. A request from a designated dispatch center shall be deemed as authorization of aircraft operated by the California Highway Patrol, Department of Forestry, National Guard, or the Federal Government.

3. All EMS aircraft authorized to operate within the City and County of San Francisco shall be classified. Verification by the San Francisco EMS Agency of classification of an EMS aircraft within the aircraft's jurisdiction of origin shall constitute classification of the EMS aircraft within the City and County of San Francisco. EMS aircraft classification shall be limited to the following categories:
    a) Air Ambulance
    b) ALS Rescue Aircraft
    c) BLS Rescue Aircraft
    d) Auxiliary Rescue Aircraft

4. The San Francisco EMS Agency retains the right to inspect EMS Aircraft Providers, including EMS aircraft, and training, quality improvement, and operations policies, procedures and records, to assure compliance with State law and local policies and procedures.

5. The San Francisco EMS Agency shall maintain an inventory of the number and type of authorized EMS aircraft, the jurisdiction of origin of authorized EMS aircraft, the patient capacity of authorized EMS aircraft, and the level of patient care provided by EMS aircraft personnel, and Receiving Hospitals with landing sites approved by the State Department of Transportation, Aeronautics Division.

6. Authorized EMS aircraft operators and service providers will comply with all EMS Agency Policies, Procedures, and Protocols.

C. Medical Flight Crew Requirements

1. All members of the medical flight crew of an EMS aircraft shall be trained in aeromedical transportation as specified in California Code of Regulations, Title 22, Division 9, Chapter 8, Section 100302.

2. All medical flight crew members shall participate in such continuing education requirements as required by their licensure or certification.

D. Ground Crew Requirements

1. All providers operating in the vicinity of helicopters must be regularly trained in standard helicopter safety operations.

2. The EMS Agency must review and approve helicopter safety training standards used by field providers in San Francisco.

E. Patient Management

1. Medical control for flight crew members shall be supplied by the air ambulance operator's Medical Director.

2. EMS aircraft staffed by registered nurses will utilize the standardized procedures of the Air Ambulance service provider. These standardized procedures will be submitted for review by the San Francisco EMS System Medical Director.

3. In situations where the medical flight crew is less medically qualified than the ground personnel from whom they receive patients, the medical flight crew may assume patient care responsibility only as directed by the Base Hospital Physician.

4. EMS aircraft that do not have a medical flight crew shall not transport patients except under direction of the Base Hospital Physician.

5. Prehospital care records will be submitted to the San Francisco EMS Agency by the EMS Aircraft provider within 2 working days of each operation.

F. EMS Aircraft Space and Equipment

1. All EMS aircraft shall be configured according to specifications in California Code of Regulations, Title 22, Division 9, Chapter 8, Section 100306 (a-c).

G. Representation of Provision of Air Ambulance Services

1. No person or organization shall provide or hold themselves out as providing prehospital Air Ambulance or Air Rescue services unless that person or organization has aircraft which have been classified by the local EMS agency within the jurisdiction of origin, with the exception of State or Federal aircraft.

H. Authorized Landing Sites

1. EMS Aircraft shall only land at landing sites meeting 1 of the following criteria:

    a. Heliports permitted by the California Department of Transportation.

    b. Pre-designated EMS landing sites. The San Francisco Police Department shall pre-designate and permit all EMS landing sites (see Appendix B).

    c. Emergency helispots at or near the scene of a Multi-Casualty Incident (MCI), disaster, or other critical incident. The Incident Commander (IC) shall designate appropriate helispots at emergency scenes.

2. The San Francisco EMS Agency shall maintain an inventory of pre-designated EMS landing sites with specifications of latitude and longitude (see Appendix B).

3. In cases of consequence management planning for future events, EMS drills, and other non-emergent transportation needs, a helicopter landing permit will be filed with the Department of Parks and Recreation by the EMS Agency or the agency responsible for planning the anticipated event.

I. Communication Policy

1. EMS aircraft operators shall adhere to EMS Agency Policy #3010, *EMS System Communications Standards*.

2. EMS Aircraft shall maintain the capacity to communicate with the San Francisco Emergency Communications Department (ECD), Landing Zone Operations, and the Base and Receiving Hospitals on the designated frequencies listed in Section IV.I.

3. The EMS Agency retains the right to inspect EMS aircraft communications equipment to assure compliance with standards set forth in this policy.

IV. PROCEDURE

A. Patient Clinical Conditions Warranting Air Medical Transport

EMS aircraft may be used in the following clinical situations:

1. The patient's condition warrants rapid transport, and transport by land would be hazardous or delayed because of road or traffic conditions (> 20 minutes);

2. The patient meets trauma center destination criteria, but San Francisco General Hospital (SFGH) is unavailable and there is an extended (> 20 minutes) ground transport time interval to a regional designated trauma center;

3. Air transport is recommended for patients who meet trauma center destination criteria if the time from the initial incident to the patient's expected arrival at the trauma center via ground ambulance will exceed 30 minutes, **AND** the length of ground transport would pose additional risk to life or limb;

4. Critical trauma patient interfacility transfers from SFGH to another Level I Adult or Pediatric Trauma Center;

6. Other conditions as deemed warranted by the IC and Medical Group Supervisor (MGS or IC designee) in consultation with the Base Hospital Physician.

B. Field Situations Warranting Air Medical Transport

The following field situations warrant the use of air medical transport:

1. MCIs involving trauma when SFGH trauma center capacity is saturated;

2. Inaccessibility to the scene by ground personnel or equipment;

3. Air ambulance service shall be initiated for MCIs involving one or more of the following:

   a. Five or more patients meeting trauma center physiologic and/or anatomic triage criteria (reference EMS Agency Policy #8000, *EMS MCI Policy*);

   b. Five or more patients with partial thickness burns greater than 10% total body surface area or third-degree burns;

   c. A large number of casualties such that Receiving Hospitals in San Francisco will be saturated and hospital Mutual Aid from other Bay Area counties will be requested by the IC (after consultation with the Base Hospital MD).

C. Initiating EMS Aircraft Response

1. ***Field Emergency Response***

   a. For field emergency responses, the decision to request an EMS aircraft is based on the medical and scene management considerations in Section IV.A and IV.B.

   b. During an MCI, the IC is in charge of all emergency operations on scene.

   c. The decision to request an EMS aircraft for a field emergency response shall be made by the IC or his/her designee, upon:

      1) the advice of on-scene medical personnel; and/or,

      2) the suitability of the scene for helicopter operations; and/or

      3) the decision made by the IC and Medical Group Supervisor in consultation with the Base Hospital Physician/designee.

   d. All requests for an EMS aircraft field response shall be made through the San Francisco Fire (SFFD) Dispatch at the ECD (phone: 415-558-3291 or 415-558-3268). The following information must be provided to the ECD by the IC or his/her designee:
      1) Number of patients;
      2) Type and extent of injuries;
      3) Location of nearest landing site (use Thomas Brothers Map coordinates or Longitude and Latitude, if possible);
      4) Nearest landmarks (e.g., highways, railroad tracks, water towers);
      5) Weather conditions as reported from the landing site (especially high winds, fog or visibility problems);
      6) Radio frequency and call sign of the requesting agency/provider.

   e. The IC will determine the EMS landing site from the list of pre-designated sites or an ad-hoc site based on scene management considerations.

2. ***Out-of-County Field Emergency Response***

   a. For transfer of critical patients from scene calls originating outside of San Francisco to a San Francisco Receiving Hospital:

      1) The EMS aircraft will contact ECD Fire Dispatch (415-558-3291 or 415-558-3268) and identify the EMS landing site to be used.

3. ***Interfacility Transfers***

   a. For interfacility transfers of critical patients from San Francisco to an out-of-county Receiving Hospital, the transferring facility will contact ECD Fire Dispatch (415-558-3291 or 415-558-3268) and identify the EMS landing site to be used for patient pickup in San Francisco. **Critical pediatric trauma patient transfers from SFGH Trauma Center to a regional Pediatric Trauma Center may require use of Rolph Field EMS Landing site if ground transport is extremely delayed. EMS landing sites are reserved as "backup" for ground transport in rare circumstances when ground transport is extremely delayed. Without a hospital helipad, secondary ground transport time intervals to and from an EMS landing site make interfacility air transport a remote fall-back option, if delayed ground transport or non-transfer clearly present a threat to the life of the patient.**

   b. Interfacility transfers from out-of-county to San Francisco will use the San Francisco International Airport (SFO) or other out-of-county heliports. EMS landing sites are reserved for emergency landings only.

   c. Transferring/receiving air ambulance companies or hospitals with incoming patients will arrange for interfacility ground transfers prior to departure from point of origin. San Francisco 911 ambulance service is not available for interfacility transports from SFO or out-of-county heliports.

D. Notification

1. The ECD Fire Dispatch will notify all responding agencies when an EMS aircraft has been requested for response to an EMS landing site/helispot (SFFD, San Francisco Police Department [SFPD], or other first responder agency).

2. Cancellations shall only be made through the IC or designee.

E. Activation

1. ECD Fire Dispatch will contact the "Call First" air ambulance company as noted on the EMSystem view screen. (These numbers are also listed in Appendix A of this policy.)

F. Mobilization

1. The EMS aircraft (on the primary provider list approved by the EMS Agency) that is up for first call (as noted on the EMSystem view screen) will respond within a 15 minute call to arrival time interval. If the 15 minute ETA is not possible for the initial air ambulance company, the company will notify ECD Fire Dispatch (415-558-3291 or 415-558-3268 or transferring facility), and another air ambulance company listed on the EMSystem view screen will be called. (These contact numbers are also listed in Appendix A of this policy.)

G. Deployment of Ground Crews

1. A Battalion Chief and engine company of the SFFD will respond to the designated EMS landing site/helispot for fire suppression support, and to clear the area of people, animals, and any temporary obstructions.

2. A SFFD Rescue Captain (RC) will respond as Landing Site Manager under direction of the Battalion Chief. The RC - Landing Site Manager is responsible for aircraft communications and oversight of ground to air patient transfer.

3. The SFPD will send 1 Sergeant and 4 officers to the designated EMS landing site/helispot to secure the landing site perimeter for safety considerations.

4. Transferring/receiving air ambulance companies or hospitals with incoming patients will arrange interfacility ground transfers from SFO or an out-of-county heliport.

H. Destination

1. During an MCI or disaster, the EMS aircraft crew will determine the destination for patients requiring air medical evacuation. The EMS aircraft and/or its dispatch center will contact ECD Fire Dispatch with the Receiving Hospital information. Enroute the EMS aircraft will relay pertinent patient information to the Receiving Hospital.

2. Determination for destination will be based on the shortest ETA to a facility best suited for definitive care of the patient.

3. The EMS aircraft pilot will have the final decision as to destination based on weather and flight safety considerations.

I. Communication Procedure

1. ***General***

a. For field emergency air response, ECD Fire Dispatch will contact the "Call First" air ambulance company dispatch listed on the EMSystem view screen under "EMS Flight Services". (These contact numbers are also listed in Appendix A of this policy.)

b. For interfacility transfers, EMS aircraft to hospital communications will be via landline for initial notification, and HEARNet (155.34 (PL-156.7) for air to hospital communications enroute to Receiving Hospital. See Appendix D for Hospital "ring-down" codes for the HEARNet radio. ECD can ring-down a hospital if aircraft does not have ring-down capability.

2. Frequency Assignments

a. **Emergency Communications Department to/from EMS Aircraft**

1) All EMS aircraft shall communicate directly with ECD Fire Dispatch using CALCORD (VHF frequency 156.075 transmit; 156.075 receive) (CSQ). (Depending on scene location, ECD may not be able to monitor CALCORD traffic.)
2) Backup channel is Fire White 1 (California Fire White [154.280] on VHF).
3) A third backup frequency is on the 800 MHz radio system: Channel C9 (Charley 9) (Mutual Aid Channel 9, low level Firemars 821.9125 CCTSS 156.7 transmit; 866.9125 CCTSS 156.7 receive)
4) ECD Fire Dispatch landline is 415-558-3291 or 415-558-3268.
5) The EMS aircraft responding to field emergencies will contact ECD Fire Dispatch on landline or radio while enroute to the scene to confirm radio frequency and ground contact/incident identifier.

b. **Landing Zone Operations to/from EMS Aircraft**

1) All EMS aircraft shall communicate directly with EMS System prehospital ground crews using VHF radios on CALCORD channel: 156.075 transmit; 156.075 receive (CSQ). (Depending on scene location, ECD may not be able to monitor CALCORD traffic.)
2) Backup channel is Fire White 1 (California fire White [154.280]) on VHF radios.
3) A third backup frequency is on the 800 MHz radio system: channel C9 (Charley 9), 821.9125 CCTSS 156.7 transmit; 866.9125 CCTSS 156.7 receive.
4) The ground crew will be referred to as _____LZ (call name determined by specific location of landing site).

c. **Base Hospital and Receiving Hospitals to/from EMS Aircraft**

1) All EMS aircraft shall communicate directly with Receiving Hospitals using the HEARNet, 155.34 (PL-156.7). The "ring down" name for SFGH is "Mission Base". Hospital-specific "ring down" codes are listed in Appendix D. ECD Fire Dispatch can ring down hospitals if aircraft do not have DTMF capabilities. SFGH triage desk telephone is 415-206-8901. Telephone to Base Hospital Physician is 415-647-4747.
2) If HEARNET is unsuccessful, a backup channel for EMS Aircraft to Base Hospital is UHF Med-9, 462.95 (PL-167.9) *467.9500 transmit / 467.9500 receive (CTCSS – 167.9)*.

d. **Air to Air**

1) The air-to-air channel among EMS aircraft is VHF 123.025.

J. Quality Assurance

1. Activation of Emergency Air Ambulance Service is a sentinel event and will be reviewed by the San Francisco Trauma System Audit Committee.

Appendix A1: AIR AMBULANCE PROVIDERS CONTACT INFORMATION

Air Ambulance Dispatch phone numbers are listed below and on the EMSystem view screen. The company up for "Call First" is also identified on the EMSystem view screen.

AIR AMBULANCE PROVIDERS:

CALSTAR
1. Concord (CALSTAR I)
2. Gilroy (CALSTAR II)
3. Auburn (CALSTAR III)
4. Ukiah (CALSTAR IV)
5. Salinas (CALSTAR V)
6. Lake Tahoe (CALSTAR VI)
7. Santa Maria (CALSTAR VII)
8. Hayward (main office, maintenance)

Dispatch number: 831-335-0341

REACH
1. Santa Rosa (REACH I)
2. Concord (REACH III)
3. Acampo (REACH II)
4. Redding (REACH V)
5. Lakeport (REACH VI)
6. Marysville (REACH VII)
7. Corevalis, Oregon (REACH VIII)

Dispatch number: 800-338-4045

Life Flight of Stanford Health Care
Stanford Health Care, Palo Alto
Dispatch number: 800-321-7828

Appendix A2: BAY AREA AIR AMBULANCE and AIR RESCUE PROVIDERS

Air Ambulances

COMPANY	DISPATCH PHONE	CLASS	STAFF	RESCUE CAPABILITIES	HOURS OF OPERATION
CALSTAR (based in Concord, Gilroy, Vacaville)	1-831-335-0341	Air Ambulance	RN (ALS)	None	24/7
REACH (based in Concord, Santa Rosa, Sacramento)	1-800-338-4045	Air Ambulance	RN (ALS)	None	24/7
Stanford Lifeflight (based at Stanford Hospital)	1-800-321-7828	Air Ambulance	RN (ALS)	None	24/7

Air Rescue Units

COMPANY	DISPATCH PHONE	CLASS	STAFF	RESCUE CAPABILITIES	HOURS OF OPERATION
CHP (ALS and BLS units based in Napa.	(Confidential allied agency line published at dispatch)	ALS Rescue (Napa); BLS Rescue (Napa)	EMT-P (ALS) EMT (BLS)	Hoists baskets, people—cable that runs down and back up to helicopter, vertical line up to 150 ft.; can carry 1 patient only; can do cliff/boat/water rescue (have to pick up a rescue swimmer in San Francisco to do water rescue) Hover and 1-skid operations	Medical missions: 10am – 4am, 7 days per week. Non-medical missions: 24/7

Air Rescue Units (cont'd.)

COMPANY	DISPATCH PHONE	CLASS	STAFF	RESCUE CAPABILITIES	HOURS OF OPERATION
Coast Guard Air Station (based at SFO)	(published at Dispatch) Water rescue missions OK to request directly; All other requests must have a mission number issued by State OES through SF OES and Homeland Security.	Rescue (mission specific; can get EMT rescue swimmer, otherwise crew is not medical capable)	EMT rescue swimmer (must be requested at time of dispatch—mission specific)	Hoist baskets, people; designed to pull people off water or off boats; HH-65 Dolphin aircraft	24/7
EAST BAY REGIONAL PARK FIRE	510-881-1833	ALS/BLS Rescue (Do not always have a paramedic—volunteer flight paramedic program; can take ground paramedic from scene)	EMT-1 or EMT-P	Do search; do not do short haul (with a line attached to the helicopter); no hoist; can land, get out and try to help. Can transport 1 patient at a time.	Day only; on-call at night but need some ambient light for operations
SONOMA COUNTY SHERIFF'S DEPT	707-565-2121	ALS Rescue	EMT and Paramedic (ALS)	Vertical long-line—up to 200 ft.	10 hours per day; nocs on-call
California AIR NATIONAL GUARD (stationed at Moffett Field)	(published at Dispatch) Request must have a mission number issued by State OES through SF OES& Homeland Security.	Auxiliary Rescue	No medical staff	Do not search, but will rescue; can transport rescue teams on Hueys, Blackhawk, Pavehawk (goes 1000 miles; carries more than 20,000 lbs.)	24/7

Appendix B: EMS LANDING SITES *(page 1 of 2)*

ID	SFFD BATT.	LOCATION	STREET	CROSS STREET	LATITUDE	LONGITUDE	NEAREST HOSPITAL
SF 1	1	Galileo High School football field	Polk	Bay	37° 48’	122° 25’	Chinese, St. Francis, CPMC
SF 2	1	Nob Hill (stop traffic on California St.)	1000 block California	Taylor & Mason	37° 47’	122° 25’	Chinese, St. Francis
SF 3	1	Ferry Park	Drumm	Washington	37° 47’	122° 23’	Chinese, St. Francis
SF 4	1	Washington Square	Union	Stockton	37° 48’	122° 24’	Chinese, St. Francis
SF 5	2	James Lang Playground	Turk Street	Octavia Street	37° 46.897’	122° 25.527’	ST FRANCIS
SF 6	3	Jackson Playground	17th Street	Arkansas Street	37° 45.903’	122° 23.926’	SF GENERAL
SF 7	NONE IDENTIFIED						
SF 8	3	Treasure Island—Soccer Field/asphalt parking lot	9th Street	Avenue “D”	37° 49.411’	122° 22.410’	ST FRANCIS; SF GENERAL
SF 9	3	Yerba Buena Gardens	Mission	3rd & 4th Streets	37° 47’	122° 24’	St. Francis, SFGH
SF 10	4	Kimball Playground	Pierce Street	O’Farrell Street	37° 46.995’	122° 25.527’	CPMC-PACIFIC; KAISER SF
SF 11	4	Lafayette Park: grass clearing at the Southeast corner of Washington & Laguna	Laguna	Washington	37° 47’	122° 25’	CPMC, St. Francis
SF 12	4	Moscone Playground	Chestnut Street	Buchanan Street	37° 48.079’	122° 25.995’	CPMC-PACIFIC
SF 13	7	Big Rec—Golden Gate Park	Near Lincoln Way	Between 5th & 8th Ave.	37° 46.002’	122° 27.760’	UCSF
SF 14	7	Kezar Stadium—Golden Gate Park	Near Frederick	Willard	37° 46.042’	122° 27.296’	UCSF
SF 15	7	Polo Field—Golden Gate Park	Near Lincoln Way	Between 31st & 36th Avenues	37° 45.932’	122° 29.652’	VA Med Cntr; UCSF
SF 16	7	Rossi Playground	Arguello Blvd.	Edward Street	37° 46.702’	122° 27.499’	ST. MARY’S
SF 17	NONE IDENTIFIED						
SF 18	8	South Sunset	40th Avenue	Wawona Street	37° 44.184’	122° 29.840’	VA Med Cntr, UCSF
SF 19	8	West Sunset #3 Playground	39th Avenue	Ortega Street	37° 44.967’	122° 29.981’	VA Med Cntr, UCSF
SF20	8	West Sunset #2 Playground	41st Avenue	Pacheco Street	37° 45.069’	122° 29.867’	VA Med Cntr, UCSF

Appendix B: EMS LANDING SITES *(page 2 of 2)*

ID	SFFD BATT. STN.	LOCATION	STREET	CROSS STREET	LATITUDE	LONGITUDE	NEAREST HOSPITAL
SF 21	9	Balboa Playground	Ocean Avenue	San Jose Avenue	37° 43.355'	122° 26.725'	ST LUKES
SF 22	9	Crocker Amazon Field	Geneva Street	Moscow Street	37° 42.777'	122° 26.004'	ST LUKES
SF 23	10	Candlestick Park Parking Lot—K-railed area between gates "E" & "F"	North of traffic control tower	Across from R.V. Park	37° 42.83'	122° 23.12'	SF GENERAL
SF 24	NONE IDENTIFIED						
SF 25	6, 10	Rolph Playground	Cesar Chavez (Army)	Potrero Avenue	37° 44.979'	122° 24.362'	SF GENERAL; ST. LUKES
SF 26	NPS*	Crissy Field (NPS* LZ# 63)	Marine Drive	Access through Marina Gate, W on Marine Dr.	37° 48.15'	122° 28.01'	VA Med Cntr
SF 27	NPS*	Presidio Main Parade Grounds (#65)*	Montgomery	Lincoln	37° 48.02'	122° 27.29'	VA Med Cntr
SF 28	NPS*	Fort Scott Parade Grounds (#66)*	Ralston	Stone	37° 48.04'	122° 28.28'	VA Med Cntr
SF 29	NPS*	Baker Beach Parking Lot (#67)*	Battery Chamberlin	Bowley	37° 47.34'	122° 28.60'	VA Med Cntr
SF 30		VA Med Center Helipad	Clement Street	42nd Ave.	37° .78.22	122°.50.42	VA Med Cntr
SF 31		UCSF Mission Bay Helipad	16Th Street	3rd Street	37°.76.69	122°.39.08	UCSF Mission Bay

* NPS = National Park Service; Presidio Fire Department

Appendix C: REGIONAL TRAUMA CENTERS
Contact Information and Flight Time Intervals

TRAUMA CENTER	PHONE CONTACT	FLIGHT TIME INTERVAL from central San Francisco
San Francisco General Hospital (air transport to/from Rolph Field EMS Landing site)	ED CHARGE NURSE: 206-8111	3 minute air time (to Rolph Field @ C Chavez and Potrero [addnt'l 3 minute ground transport interval]
Oakland Children's (Level II pediatric)	ED: 510-428-3240	5 min.
Eden Hospital (Level II) (Castro Valley)	ED: 510-889-5015	10 min.
John Muir Hospital (Level II) (Walnut Creek)	ED: 925-939-5800	10 min.
Stanford Medical Center (Level I adult & Level I pediatric)	ED: 650-723-7337	12 min.
Regional Medical Center (Level II adult)	ED: 408-729-2841	20 min.
Santa Clara Valley Medical Center (San Jose) (Level I)	ED: 408-885-6912	20 min.
Santa Rosa Memorial (Level II)	ED: 707-525-5207	25 min.
UC Davis (Level I adult & pediatric)	ED: 916-734-3790	35 min.

Appendix D: HEARNet RADIO
HOSPITAL "RING DOWN" CODES

All Call	999	
CHINESE	246	
CPMC	272	
R K DAVIES	382	
KAISER	573	
SETON	738	
SFGH	734	727cp
ST FRANCIS	783	
ST LUKES	785	
ST MARYS	786	
UCSF	827	
VA	826	
EMS Section	367	
	368	
	277	
NPS - GGNRA	677	
LHH	544	
SSF KAISER	547	
	681	
IRWIN	462	
OES	637	

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

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INTERCOUNTY AND BRIDGE RESPONSE

I. PURPOSE

A. Establish guidelines for ambulances that are on scene of medical emergencies outside of San Francisco.
B. Establish transport guidelines for situations in which access to San Francisco hospitals may be limited or impossible.
C. Define responsibilities for the Golden Gate and Bay Bridges.

II. AUTHORITY

A. California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.220, 1797.222, 1798, and 1798.163
B. California Code of Regulations, Title 22, Sections 100147, 100175, and 1000258

III. POLICY

A. Whenever possible calls of a known origin outside of San Francisco will be referred to the local PSAP by the DEC.
B. San Francisco paramedics shall always operate under San Francisco EMSS policies and protocols while on duty with a San Francisco ALS Provider, regardless of incident location.
C. When operating as part of a medical mutual aid response, the Incident Command team will make destination decisions and decisions regarding unusual circumstances. San Francisco paramedics shall follow the directions of the Incident Command team while assigned to the incident.
    1. San Francisco paramedics are not authorized to exceed their scope of practice as defined in EMSS Policies.
D. Golden Gate Bridge Response
    1. The National Park Service is responsible for primary response to the Golden Gate Bridge.
    2. When the DEC receives calls in the National Park Service jurisdiction shall be transferred to the National Park Service dispatch center.
    3. Additional resources may be dispatched from either Marin or San Francisco depending on bridge access and unit availability.
E. Bay Bridge Response
    1. Requests for response on the Bay Bridge will be processed and assigned using standard dispatch procedure.
    2. Additional resources shall be requested from Alameda County if the scene is in Alameda County, or if conditions are such that a unit

responding from Oakland will arrive sooner than a unit from San Francisco's jurisdiction.

IV. PROCEDURE

A. San Francisco paramedics on calls outside of San Francisco remain under the medical control of San Francisco and shall utilize EMSS Protocols.

1. If dispatched to a call that is found to be outside San Francisco, the unit will provide care and transportation in accordance with EMSS policies.
    a) If multiple ALS units arrive on scene, the first arriving ALS transport unit will maintain medical control and transport the patient unless a compelling reason exists to turn patient care over to another unit.
2. On views:
    a) If possible, stop at the scene
    b) Request local ALS response to the incident
    c) Render aid
    d) Turn patient care over to local ALS personnel

B. Patients meeting trauma triage criteria on bridges shall be taken to the most accessible Level I or Level II trauma center.

1. Bay Bridge: Highland General Hospital in Oakland or San Francisco General Hospital
    a) Pediatric trauma patients being transported to the East Bay from the Bay Bridge must be transported to Oakland Children's Hospital.
2. Golden Gate Bridge: San Francisco General Hospital, or a Regional Level II Trauma Center most accessible by ground or air transport.
3. When transporting to a hospital that does not have 800MHz capabilities, ambulances must notify the intended receiving facility through the DEC or private dispatch center.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

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DOCUMENTATION, EVALUATION AND NON-TRANSPORTS

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DOCUMENTATION, EVALUATION AND NON-TRANSPORTS

I. PURPOSE

A. To define the requirements for evaluation, transport, and non-transport of persons at the scene of a prehospital emergency, or other requested patient contact.
B. To establish performance and documentation standards for non-transport incidents, including the assessment and release of patients who choose to decline transport or refuse services against medical advice. (*Death in the Field* is addressed in EMS Agency Policy # 4050).

II. AUTHORITY

A. California Health and Safety Code, Division 2.5, Sections 1797.204 and 1798 – 1798.6
B. California Code of Regulations, Title 22, Sections 100147, 100172 – 100175
C. California Medical Association, Endorsed Actions for Physicians on Scene with Paramedics

III. POLICY AND PROCEDURES

A. Offer of Transport

1. Unless otherwise provided in EMSA Policy # 4050, *Death in the Field* and Policy # 4051, *DNR Policy*, prehospital personnel shall not refuse to provide care or transport to a patient.

2. If patient has a valid Do Not Resuscitate status as defined in EMSA Policy #4051 *DNR Policy*, that patient is to be offered palliative care up to the point of providing ALS resuscitation.

B. Documentation

1. Prehospital personnel shall complete a PCR for each patient contact (refer to EMSA Policy #6010 *LEMSIS*).

2. Non-transport first responder paramedics handing off care to a transport provider must document assessment findings and interventions using a SF EMS Agency approved "Transfer of Care Report." Prehospital personnel shall complete the transfer of care report, including a signature, clearly and legibly using dark blue or black ink. A copy of this report shall be turned into the receiving hospital along with the transport PCR. Provider Agencies shall retain

the original copy of the Transfer of Care documentation in compliance with medical record regulations.

3. All non-transports must be documented on a PCR (electronic or paper), which must include the following:

    a) Complete assessment findings;
    b) The offer to the patient of medical care and transportation;
    c) Any care given;
    d) Explanation to the patient including potential consequences of the patient's actions;
    e) The potential benefits of prehospital care and transportation;
    f) The patient's own words verbalizing an understanding of the event, the refusal of care, and the potential consequences of the refusal of care;
    g) The patient's competency and criteria of self determination to make the medical care decision (include name, age, and guardian as appropriate);
    h) An assessment of the patient's orientation, speech, gait and if able, other physiologic parameters including vital signs;
    i) The name and relationship of a parent or guardian to the patient, if the patient is released to that person;
    j) The name and badge number of the police officer if the patient is released to that person;
    k) Patient signature acknowledging the availability of ambulance transport and their refusal of services;
    l) Witness signature if available;
    m) If a patient refuses to sign the form after having been determined competent, the release shall be documented on the PCR and signed by both the attending EMT-P and a witness;
    n) The documentation shall include a description of the circumstances surrounding the refusal to sign including direct quotes of statements made by the patient;
    o) Patient refusals (*not AMA*) require a paramedic signature and a crew member signature; and
    p) Against Medical Advice refusals require two paramedic signatures and Base Physician contact.

4. A patient care report must be completed for all patients during MCI (refer to EMSA Policy #6010 *LEMSIS*).

5. Prehospital personnel and Provider Agencies shall maintain confidentiality of the verbal and documented patient and medical information in compliance with applicable state and federal law on patient confidentiality at all times.

C. Patient Evaluation

1. Minimum evaluation and documentation standards for ALL patients (both transport and refusal) are described in EMS Agency Treatment Protocols *P-001* and *P-002*.

2. Specific evaluation and documentation requirements are identified under individual protocols, including "documentation for adherence to protocol."

3. No patient shall be released before being assessed and advised by a Paramedic in accordance with the procedures detailed in this policy.

D. Patient Competence

1. All persons at the scene of a prehospital emergency, who meet the criteria for allowing self-determination, shall be allowed to make such decisions regarding their medical care, including the refusal of evaluation, treatment and/or transport.

   The criteria for allowing self-determination of medical care include:
   a) Competence is defined as alert, oriented, able to understand and verbalize an understanding of the nature and consequences of their medical care decision; and
   b) Adult is defined as:
      (1) Eighteen years of age or greater
      (2) Legally emancipated minor
      (3) Legally married minor
      (4) On-duty with the armed forces
      (5) Self-sufficient minor at least 15 years of age, living apart from parents, and managing own financial affairs.

2. Any person at the scene of a prehospital emergency who requested an EMS response, or for whom an EMS response was requested and who presents with one or more of the following conditions shall be considered incapable of making a competent decision regarding medical care and shall be transported to the closest appropriate medical facility for further evaluation:
   a) Altered mental status, from any cause including altered vital signs, influence of drugs and/or alcohol, psychiatric illness, metabolic causes (e.g., CNS infection or hypoglycemia), dementia or head trauma;
   b) Attempted suicide, danger to self or others, or verbalizing a suicidal intent, or on a 5150 hold;
   c) Acting in an irrational manner to the extent that a reasonable person would believe that the ability to make a competent decision is hindered;
   d) Severe injury or illness to the extent that a reasonable and competent person would seek further medical care; and
   e) Patient consent in these circumstances is implied, meaning that a reasonable and competent adult would allow the appropriate medical treatment under similar circumstances.

E. Procedure for Patient Release and Non-Transport

1. All non-transport patients shall receive an ALS level assessment, which shall include, at minimum:
    a) Determination of competence, to include determination of mental status;
    b) Determination if the patient is under the influence of any intoxicants;
    c) Detailed assessment of patient's stated complaints;
    d) Complete physical exam;
    e) Complete vital signs. At least one blood pressure must be auscultated;
    f) ECG;
    g) Blood glucose determination if indicated; and
    h) Provide documentation on the PCR that demonstrates adherence to applicable policy and protocol requirements.

2. Patient Refusals

    a) Patients who meet self-determination criteria who have been evaluated by an EMT-P and determined to have a minor medical condition that requires prehospital care and/or transportation to an Emergency Department shall be allowed to refuse only after being advised of the following:
        (1) That ambulance transportation to an Emergency Department and prehospital care are available and being offered;
        (2) The nature of the condition and the risks associated with refusal of prehospital care and transportation to an Emergency Department;
        (3) The benefits of prehospital care and transportation to an Emergency Department;
        (4) The patient should seek medical attention from a private physician or clinic as indicated; and
        (5) That EMS may be reactivated if they should change their mind.
    b) The attending EMT-P will review the form with the patient and ensure that they understand its content.

3. Against Medical Advice
    a) Competent adult patients who have been evaluated by an EMT-P and determined to have a significant or potentially life-threatening medical condition may request a release from further treatment and transport to an Emergency Department. For those patients, the EMT-P must contact the Base Hospital Physician prior to releasing the patient. Significant or potentially life-threatening medical conditions include the following:
        (1) Chest pain
        (2) SOB/Dyspnea
        (3) Syncope
        (4) Seizure (new onset)
        (5) Severe headache
        (6) Pregnancy related complaints
        (7) Patients meeting Trauma Center Criteria (including mechanism, see EMSA Policy #5001 *Trauma Triage Criteria*)

(8) Suspected GI bleed
(9) Markedly abnormal vital signs
(10) Signs and symptoms of CVA/TIA
(11) Any patient where an ALS intervention has been performed.

4. Every effort should be made to convince the patient to accept treatment and/or transport. Be persuasive and use family members or friends if available.

F. Base Physician Contact

1. All patients who are refusing transport and who meet any of the following criteria require base hospital physician contact:
   a) The patient is an Against Medical Advice refusal;
   b) The EMT-P disagrees with the patient's decision to refuse transport due to unstable vital signs or other clinical factors and is concerned that the patient is at risk of a poor outcome if not transported; and
   c) The patient is in police custody and refusing care AMA.

2. If the treating EMT-P is fulfilling CQI requirements or is doing their first 5 non-transport EMS calls in the San Francisco EMS System, Base Hospital Physician contact must be obtained for all patients who are not transported.

3. Base Hospital contact must be made prior to leaving the patient.

4. Base Hospital Physician report should use this format:
   a) Paramedic ID and 8 digit incident number
   b) Patient age and gender
   c) Location found
   d) Patient chief complaint
   e) Pertinent past medical history
   f) Vital signs
   g) Patient assessment, pertinent physical exam
   h) Competency assessment
   i) Patient wishes
   j) EMT-P opinion and disposition plan.

5. The Base Hospital Physician is responsible for completing the following activities for ALL prehospital patients seeking a release Against Medical Advice:
   a) Taking the EMT-P report
   b) Confirm the patient understands the risks of refusal
   c) Understands transport and/or treatment is available
   d) Is refusing all services
   e) Encourage the patient to accept treatment and/or transport.
6. After speaking with the patient
   a) Confirm with the paramedic the patient is refusing against medical advice
   b) Confirm the paramedic has physicians name to document on the patient care record.

G. Police Custody

1. Patients who are in police custody (defined as "under arrest"), for whom prehospital personnel are called to the scene to evaluate, must be evaluated for potential medical care needs.

2. A patient in police custody maintains the right of self-determination for medical care decisions, including refusals and AMA refusals, and must be treated in accordance with this policy and applicable EMS Agency treatment procedures.

3. ALL patients who are in custody and refusing treatment and/or transport must have a Base Physician contact prior to release to the San Francisco Police Department. The EMT-P and Base Physicians shall follow all procedures as outlined in Section III, A-F.

H. Situations Where Pre-Hospital Personnel Safety is Threatened

1. In instances where the safety of the prehospital personnel is in jeopardy and all reasonable and prudent attempts to mitigate the threat, including law enforcement involvement, have failed, paramedics may depart the scene prior to evaluating a patient. In all cases where this provision is implemented:
    a) The Paramedic supervisor shall be notified immediately and shall conduct an investigation to determine the appropriateness of the decision; and
    b) The EMS Agency Duty Officer shall be notified within 60 minutes of the incident; and
    c) A written report detailing the event and findings of the Paramedic supervisor shall be submitted to the EMS Agency within 24 hours; and
    d) The EMS Agency shall treat all such incidents as a Sentinel Event.
    e) The other exception to section C, paragraph 1 of this policy is during declared states of emergency or disasters as defined in EMS Agency Policy.
2. At no time are field personnel to put themselves in danger by attempting to transport or treat a patient who refuses or resists (see section E of this policy and EMSA Policy #4043 *EMS Use of Restraints*).

APPENDIX 1
APPROVED FORM FOR PATIENT DECLINING TRANSPORT

Patient Declines Transport

I acknowledge that I have a medical problem, which requires additional medical attention, and that an ambulance is available to transport me to the hospital. Instead, I elect to seek alternative medical care and refuse further treatment and/or transport.

Patient Name (Print):	Patient Signature:	Date:
Paramedic Name (Print):	Paramedic Signature:	Date:
Witness Name (Print):	Witness Signature:	Date:
Circumstances/Reasons for Declining Transport:		
Advice given/Alternatives discussed:		

APPENDIX 2
APPROVED FORM FOR REFUSALS AGAINST MEDICAL ADVICE

Against Medical Advice (AMA)

I, the undersigned, have been advised that medical assistance on my behalf is necessary, and that refusal of said assistance and transport may result in my death, or imperil my health. Nevertheless, I refuse to accept treatment or transport and assume all risks and consequences of my decision and release the provider of the ambulance service from any liability arising from my refusal.

Patient Name (Print):	Patient Signature:	Date:
Paramedic Name (Print):	Paramedic Signature:	Date:
Witness Name (Print):	Witness Signature:	Date:

Risks of Refusal Discussed with Patient:	Reasons stated by patient for refusing care:
Benefits of Care/Transport Discussed with Patient:	

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4041
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SCENE MANAGEMENT, PHYSICIAN ON SCENE and MASS GATHERINGS

I. PURPOSE

A. To define roles and responsibilities and establish hierarchy of each level and type of responder at the scene of a medical emergency, mass gathering, and/or special event. This policy applies to the following roles:
   1. First Responders, Basic Life Support (BLS),
   2. Emergency Medical Technician-I (EMT-1),
   3. Advanced Life Support (ALS) prehospital providers,
   4. Emergency Medical Technician-Paramedic (EMT-P), and
   5. Physicians on scene of medical emergencies.

II. AUTHORITY

A. California Health and Safety Code, Division 2.5, Sections 1797.202, 1797.204, 1797.220 and 1798-1798.6
B. California Code of Regulations, Title 22, Sections 100063, 100144, 100147, 100144, 100167)a) and 100169100172 – 100175
C. California Medical Association, Endorsed Actions for Physicians on Scene with Paramedics
D. City and County of San Francisco Traffic Code sections 8000, 801, 802, 804 and Administrative Code Section 90.4

III. POLICY AND PROCEDURES

A. Scene Management

1. <u>Scope of Practice</u>

a) While on the scene of an emergency, prehospital personnel shall manage the medical care of patients within their scope of practice and in coordination with all other personnel on scene.
b) Prehospital personnel shall provide care in accordance with EMS Agency Treatment Protocols appropriate to the level of certification or licensure of the individual providing care.
c) Prehospital personnel shall not deviate from EMS Agency Treatment Protocols or policies without specific permission to do so from the EMS Agency Medical Director or his/her designee.

2. Medical Authority

a) Paramedics have medical authority over EMT-1s, First Responders, and law enforcement personnel.
b) All personnel have a duty to act and must continue to provide appropriate care to the patient within the scope of their certification or licensure.
c) Transporting Paramedics shall assume medical authority upon arrival after receiving a verbal report from a non-transport Paramedic on scene.
d) If there is a disagreement between medical personnel on scene about the medical management of patients, the Base Hospital Physician will be contacted immediately and the most conservative patient-based decision shall prevail until consultation with the Base Hospital Physician is completed and further instruction conveyed.
    (1) If the disagreement occurs between providers of different agencies, all providers will remain on scene and continue to care for the patient(s) up to and including providing transport with another agency's personnel in charge if so directed by the Base Hospital Physician.
e) First Responders and BLS personnel may allow properly identified medical personnel to assist with the care of the patient, but shall maintain medical authority prior to the arrival of a Paramedic.

3. Procedure for Scene Management

a) Coordination of Medical Care
    (1) Prehospital personnel shall enter a scene and begin providing care only if a scene is determined to be safe.
        (a) Law enforcement or other assistance to mitigate identified hazards will be requested as needed to secure a scene.
        (b) If necessary, EMS personnel shall withdraw from any scene where an immediate hazard is identified and wait for appropriate assistance to arrive before entering.
    (2) Upon arrival, the most medically qualified personnel shall assume responsibility for the medical care of the patient.
    (3) First responder personnel, both ALS and BLS, shall initiate and continue care for patients until the arrival of transport personnel.
        (a) On arrival of transport personnel, BLS first responders will immediately provide a verbal report to the most medically qualified person.

(b) ALS first responders will provide a verbal report to ALS transport personnel as soon as possible.

(c) First response personnel shall remain on scene and assist transport personnel with patient care until the primary patient care person on the transport crew releases the first responders.

(d) When first response and transport ALS personnel arrive simultaneously, the transport Paramedic will assume responsibility for, and direct, patient care.

(4) In cases where conflict regarding patient care exists between Paramedics on-scene and there is a belief that a negligent act or policy deviation that will harm the patient is about to, or has occurred, then the Paramedic with that belief shall initiate the following actions:

(a) The Base Hospital Physician will be contacted immediately and have final authority over patient care decisions;

(b) All parties will remain on scene and work under the direction of the Base Hospital Physician to effect care and transport of the patient;

(i) If directed by the Base Hospital Physician, the initiating Paramedic will assume responsibility for patient care and accompany the patient during transport, which may be done in an on-scene ambulance, regardless of agency affiliations.

(c) Incident shall be reported to the on-duty Paramedic Field Supervisors or all agencies involved, and

(d) The initiating Paramedic will file a Sentinel Event report with the EMS Agency within 24 hours of the incident.

b) Change in the Code of Responding Units

(1) Cancellation of responding units

(a) First arriving ALS and BLS personnel shall cancel other responding units when:

(i) it is determined that the patient is not at the scene; or

(ii) the patient is determined dead and cardiopulmonary resuscitation (CPR) is withheld or terminated in accordance with EMS Agency Policy #4050, *Death in the Field*; or

(iii) transport personnel arrive first and determine that no assistance is necessary from other responders.

(b) After completing the primary and secondary patient exam and establishing the chief complaint, an ALS first responder may cancel the responding transport unit if it is determined that the patient will not be transported by ambulance.

(2) Upgrading or downgrading responding units

(a) Prehospital personnel on-scene of a prehospital emergency incident may request a change in the response of responding units. All such requests will be routed through the provider's dispatch or the Emergency Communications Department (ECD), whichever is most appropriate.

(b) Prehospital personnel on-scene with a patient may request a downgraded response of an ambulance after determining that no life threatening condition exists and that the time saved from lights and siren use would not likely impact patient outcome.

(c) Prehospital personnel on scene with a patient shall request an upgraded response upon determination that a life threatening condition exists, or that any delay in transport or arrival of ALS may impact patient outcome.

c) Patient transport

(1) A second Paramedic shall accompany the patient in the ambulance to the hospital under the following situations:

(a) Cardiopulmonary arrest
(b) Patients in cardiac arrest or those who are post-arrest with return of spontaneous circulation in the field
(c) Airway obstruction or respiratory insufficiency with inadequate ventilation
(d) Hypotension with shock
(e) Status epilepticus
(f) Acute deteriorating level of consciousness
(g) The transport Paramedic requests assistance during transport due to the patient's condition
(h) The First Response Paramedic believes it is necessary for patient care
(i) A Paramedic field supervisor determines it is necessary.

(2) A first response Paramedic should strongly be considered as a necessity with any patient requiring a lights and siren transport.

d) "On-Viewed" Incidents

(1) On-view refers to a situation in which a provider, during the normal course of business, arrives first on scene of an EMS incident without being dispatched or otherwise assigned to it.

(a) This section also applies to situations in which a transport-capable ALS vehicle is dispatched as a first responder.

(2) ALS units

(a) Report the location of the incident to the ECD and ascertain if a unit is responding.

(b) If no unit is responding, and the unit on scene is available, that unit will establish patient contact and manage the incident in accordance with EMS Agency Policy to include transport, if indicated.

(c) If a unit is responding, establish patient contact and render aid until such time as the responding unit arrives.

(i) If the patient is unstable and the ETA to definitive care is shorter than the ETA of the assigned unit, the patient should be transported without delay.

(ii) In all cases where this option is selected, the transporting provider's Medical Director will complete a clinical review of the situation and determine if immediate transport was indicated and forward that review to the responding provider.

(a) If a disagreement exists as to the necessity of immediate transport, an Exception Report along with all supporting documentation should be filed with the EMS Agency.

(3) BLS Units

(a) Report the location of the incident to the ECD and request an ALS unit be assigned.

(b) Establish patient contact and render aid until the ALS unit arrives.

e) BLS Units on Scene of ALS Acuity Patients
   (1) This procedure applies to patients encountered by BLS units outside of acute care facilities. If, during an interfacility transfer, a BLS unit encounters a patient that may require a level of care they are unable to provide, the BLS personnel should consult with the transferring physician and their supervisor.
      (a) An acute care facility is defined as a facility recognized as a general or critical care hospital.
   (2) BLS units on scene of the following shall immediately request an ALS unit to respond:
      (a) Acute abnormalities of airway, breathing, or circulation that are changes from the patient's baseline status
      (b) ALOC that is an acute change from the patient's baseline
      (c) Chest pain
      (d) Cardiac arrest
      (e) Motor vehicle accidents
      (f) Obstetric emergencies
      (g) Pediatric patients
      (h) Seizures
      (i) Specialty care patients (i.e., burns)
      (j) Trauma patients requiring the trauma center and
      (k) Any patient who, in the judgment of the attending EMT-1, would benefit from evaluation or treatment by a Paramedic.
   (3) BLS units on scene of unstable patients shall ascertain the ETA of the closest ALS unit and determine the ETA, including patient packaging and extrication, to the closest Receiving Hospital.
      (a) If the ETA of the ALS unit is shorter, BLS units shall stay on scene and render aid, turning over care when the ALS unit arrives.
      (b) If the ETA including patient packaging and extrication to the closest Receiving Hospital is shorter, the BLS shall transport the patient Code 3 to that hospital.

f) Documentation
   (1) An EMS Agency approved Prehospital Care Record (PCR) shall be completed for each patient contact.

(2) The person primarily responsible for directing patient care on scene and during transport will complete the report.

(3) All procedures noted on the PCR shall be accompanied by the identification (Paramedic number) of the Paramedic who performed the procedure.

B. Physician On-Scene

1. A Paramedic may not accept direction from any source except the Base Hospital Physician, except under the following circumstances:
   a) a qualified physician on scene agrees to direct patient care and accompany the patient to the hospital; and
   b) Physician direction is within the Paramedic Scope of Practice.
2. A qualified physician is any physician licensed in the State of California.
3. Do Not Resuscitate (DNR) Decisions
   a) An on-scene physician, after identifying himself/herself as the patient's physician, may issue a written DNR order which emergency medical services (EMS) personnel may follow. This order should preferably be written directly on the PCR and followed by Base Hospital Physician consultation for approval (reference EMS Agency Policy # 4051, *DNR Policy*, Section V.A.4.).
      (1) In this circumstance, the Base Hospital physician may waive the requirement for the physician to accompany the patient during ambulance transport.
4. Procedure for Physician On-Scene of a Prehospital Call
   a) The Paramedic shall:
      (1) Verify identity and credentials of the on-scene physician. A physician must produce a current California medical license, and show it to the Paramedic with a valid photo ID demonstrating that he/she is the person whose name is on the medical license.
      (2) Advise the physician of the options as described below;
      (3) Contact the Base Hospital Physician for consultation or conflict resolution as needed.
   b) Physician Options:
      (1) Assist and offer advice regarding patient care, but allow the Paramedics to remain in control of the scene and transport the patient according to EMS Agency Policy; or
      (2) Consult with the Base Hospital Physician and offer advice on the care of the patient, allowing the Base Hospital Physician to direct care and transport; or

(3) Accompany the patient to the hospital and assume total responsibility for patient care until this responsibility is assumed by the receiving physician.

(a) In this case, the Paramedics will assist the physician as requested provided they operate within the standard of care and the Scope of Practice.

(b) Paramedics will advise the Base Hospital Physician of the situation.

(c) All orders given by the on-scene physician shall be documented on the PCR and signed by the physician.

(d) The physician's name and contact information will be documented on the PCR.

C. Mass Gathering and/or Special Events

1. In mass gatherings where physicians are present as part of an organized system of providing care on site, Paramedics may provide care with these physicians according to site-specific scene protocols.
   a) Patients at these sites who are physically seen and assessed by the designated mass-gathering physician are the responsibility of that physician and should be treated accordingly.
      (1) Paramedics may assist in treatments that do not exceed their Scope of Practice under the direct supervision of the designated mass-gathering physician on site.
      (2) Paramedics may transfer care of stable patients who were injured or became ill on-site and were cared for by Paramedics assigned to the event, to the on-site physician provided that:
         (a) The on-site physician accepts the transfer of care; and
         (b) There are adequate resources (facility, equipment, etc.) on-site to care for the patient.
   b) Once 9-1-1 is activated and Paramedics not assigned to the event arrive at the scene, the arriving Paramedics will follow the guidelines in Section III.A. and B. of this policy.
2. Patients who are **not physically seen** and assessed by the designated mass-gathering physician but who are assessed by Paramedics, are the responsibility of those Paramedics who must follow relevant Standard Treatment Protocols and EMS system policies, including releases Against Medical Advice (AMA).
   a) Conflict resolution: In the event conflict arises regarding a patient care issue, the Paramedics and mass-gathering physician will attempt to resolve it. In cases where resolution is not forthcoming, the Base Hospital Physician will be contacted and will have final authority over medical care to be provided by responding Paramedics.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4043
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Supersedes August 1, 2008

EMS USE OF PHYSICAL RESTRAINTS

I) PURPOSE

A. Establish the circumstances under which restraints may be applied by EMS personnel
B. Identify the types of restraints and adjuncts that may be used
C. Establish the requirements for monitoring restrained patients and documentation

II) AUTHORITY

A. California Health and Safety Code, Division 2.5, Section 1798.6
B. California Welfare and Institutions Code, Section 5150
C. California Code of Regulations, Title 13, Section 1103.2
D. California Code of Regulations, Title 22, Sections 1000063, 100147, and 100175

III) POLICY

A. The need for EMS personnel to maintain his/her personal safety comes first and foremost in their duties.
B. Physical restraints are permitted for patients who are at immediate risk for harming themselves or others because of impaired judgment due to but not limited to any combination of the following:

1. Drugs and/or alcohol
2. Psychiatric illness
3. Head injury
4. Metabolic causes (CNS infection, hypoglycemia, etc.)
5. Dementia
6. Hypoxic patients requiring intubation and at risk for self-extubation

C. If appropriate, EMS personnel shall follow EMS Agency Treatment Protocol #P-006, *Altered Mental Status* (or other appropriate protocols) after the patient is physically restrained.
D. EMS personnel, understanding the impact of restraints upon one's dignity, shall apply the restraints in a professional manner and conduct themselves in such a way as to not appear disrespectful when treating the patient.
E. EMS personnel shall restrain patients in such a way as to protect the patient's airway, breathing, and circulation, and to facilitate evaluation and treatment of the patient's medical condition.

1. EMS personnel shall frequently assess the patient to ensure that the restrained patient's airway is patent, distal limb circulation is adequate,

and that restraints can be released quickly should the patient require cardiopulmonary resuscitation.

2. Airway and suction equipment shall always be available for the restrained patient. EMS personnel shall never leave the restrained patient unattended.

F. EMS personnel shall always seek assistance from the appropriate public safety agency to assist with securing the scene as delineated in EMS Agency Policy #4041, *Scene Management*.

G. If a combative patient aggressively breaks away (escapes) from EMS personnel, the patient shall not be pursued or subdued if they do not represent an immediate threat to the EMS provider.

H. Law Enforcement is the appropriate public safety agency to secure the scene and assure safety in the field. (Refer to EMS Agency Policy #4041, *Scene Management*).

I. All EMS personnel shall receive training by their individual employer in the use of the restraint devices listed in this policy.

J. Approved Restraints:

1. Soft restraints: The primary physical restraint device used in the prehospital setting. Following FDA recommendations.
2. Gurney or spine board straps (Velcro, Buckle): Should be used to supplement the soft restraints. The strap across the chest shall never be over tightened. This allows adequate ventilatory motion of the chest wall muscles and diaphragm.
3. Long back board or flat: The patient should never be cuffed or tied to the gurney. Instead, the patient should be secured to a long back board or flat then placed on a gurney for transport.
4. Spit sock: If the patient is spitting,
5. C-collar: To maintain c-spine protection and minimizes flexion of the neck to prevent a patient from biting an EMS provider.
6. Any method of restraint used must allow for monitoring of the patient's vital signs and airway control.

K. EMS personnel are not authorized to place a patient in hard plastic ties (temporary or riot handcuffs) or any form of restraint requiring a key to remove.

1. Restraint equipment placed by law enforcement (handcuffs, plastic ties, or "hobble" restraints) on an individual in an Extremely Agitated State that requires Advanced Life Support transport should be packaged to maximize IV and airway access and transported without delay. See Restraint Procedure below.
    a) Law enforcement's continued presence is required if the patient must remain in restraints not authorized for use by EMS personnel.
    b) Law enforcement officers should accompany the patient to the hospital in the ambulance.

2. 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.
3. EMS personnel are not authorized to use any other form of restraint not specifically authorized by this policy.

IV) PROCEDURE

A. All combative patients requiring EMS transport to the Receiving Hospital shall have all four of their extremities placed in approved soft restraints and secured to a long back board by an appropriate number of qualified personnel.
B. When the extremities have been secured to a long back board, there will be at least three straps with quick release buckles placed approximately at the patient's torso, hips and knees.
C. Additional adjuncts listed above may be used if the patient is spitting and/or biting.
D. One EMS provider will be assigned to maintain control of the patients' head preventing movement and/or biting. This EMS provider will also attempt verbal de-escalation and monitor the patient's airway and level of consciousness.

1) EMS personnel shall document the following information on the PCR:
    1) The patient's behavior that necessitated restraint usage;
    2) Restraints and adjuncts used;
    3) The time the restraint was applied;
    4) Assessment of the patient's condition after restraints were applied (e.g., airway patency, distal extremity circulation) and every **3** minutes after the initial application.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4050
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Supersedes: February 1, 2009

DEATH IN THE FIELD

I. PURPOSE

To delineate the role of the ALS and BLS provider for patients in cardiac arrest and identify conditions where Cardiopulmonary Resuscitation (CPR) is withheld or discontinued.

II. POLICY

A. A patient may be determined dead without Base Hospital contact when one of the following conditions exist:

1. Obvious Deaths
    a) Decapitation;
    b) Total incineration;
    c) Decomposition;
    d) Separation from the body of either the brain, liver, or heart, or;
    e) Rigor mortis (NOTE: Must apply EKG leads and confirm asystole in 2 leads).

2. Medical Indications
    a) Unwitnessed arrest with a reasonable suspicion of down time of 15 minutes or greater **AND** the patient is pulseless and apneic (no shock indicated on AED for BLS or asystole in 2 leads for ALS) **AND** no evidence of hypothermia, drug ingestion or poisoning.
    b) Patient has had at least 40 minutes of ALS intervention, initial resuscitation efforts have been unsuccessful, and treatment protocols have been exhausted. Patient intubated or supraglottic airway inserted and End Tidal CO2 monitor shows good waveform (for placement confirmation) and persistent low ETCO2 reading (less than 5 mmHg).

3. Medical Directives
    a) Presence of a valid Pre-Hospital Do Not Resuscitate (DNR) or Physician Orders for Life-Sustaining Treatment (POLST) form, medallion/bracelet Form (see Policy 4051 Do Not Resuscitate & Physician Orders for Life-Sustaining Treatment).

4. Trauma
    a) MCI incident where triage principles preclude initiation of CPR.
    b) Blunt, penetrating or profound multi-system trauma with wide complex PEA < 40 or asystole.

5. Environmental
    a) Drowning victims where it is reasonably determined that submersion has been 30 minutes or greater.

B. **NOTE**: If CPR was initiated by non-EMS personnel for the above mentioned conditions listed in II.A. 1-5, DISCONTINUE CPR.

C. The Base Hospital Physician must be contacted to determine death in the field in the following situations:
   1. CPR is started on a patient with NO valid DNR/POLST form and the spouse, immediate family member(s) or guardian who are present disagree on the patient's last wishes for CPR.
   2. Any situation in which the paramedics response warrants clarification or direction.

III. PROCEDURE

A. Maintain the integrity of the death scene.

B. The deceased patient may be removed immediately from the scene in the following situations:
   1. A life threatening or hazardous situation for the field crews exists;
   2. The death occurs in public view and it appears to be from natural causes.

C. The Medical Examiner and the SFPD shall be notified of a death in the field by the highest medical authority at the scene per provider agency protocol.

D. Provide grief support for bystanders and family members as appropriate.

E. Complete a Pre-hospital Care Record with the following information:
   1. Position of patient on arrival,
   2. Description of the environment where the patient was found,
   3. Known or reported circumstances surrounding death,
   4. Actions taken by responding personnel,
   5. Identity of all personnel on scene,
   6. Identity of Base Physician consulted, and
   7. Time of death.

F. Obtain EKG strip unless signs of obvious death as listed in II. A. 1 of this policy.

G. Complete early defibrillation documentation if appropriate.

H. Document if valid DNR/POLST directive present.

I. EMS personnel may leave the scene if SFPD, building security and/ or family members are present to preserve the scene and documentation is completed and left for the Medical Examiner.

IV. AUTHORITY

California Health and Safety Code Section 1797.220 and 1798
California Probate Code Section 4780

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4051
Effective Date: January 30, 2017
Supersedes: January 1, 2011

DO NOT RESUSCITATE & PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT

I. PURPOSE

To establish procedures for San Francisco EMS personnel to recognize and follow valid Do Not Resuscitate (DNR) and Physician Orders for Life-Sustaining Treatment (POLST) directives and to ensure that a patient's decision for end of life care are honored.

II. DEFINITION

Prehospital Do Not Resuscitate (DNR) Form: An official document from the California EMS Authority and the California Medical Association to provide a standardized form for EMS personnel regarding a patient's decision to forgo resuscitative measures in the event of cardiopulmonary arrest.

Physician Orders for Life-Sustaining Treatment (POLST) Form: An official document from the California EMS Authority and the Coalition for Compassionate Care of California is a medical order that gives seriously ill patients more control over their final care by specifying the type of medical treatment they wish to receive at the end of life.

III. POLICY

A. This policy applies to San Francisco EMS personnel (First Responders, EMTs and paramedics) while responding to 911 or private emergency medical calls, non-emergency medical calls, and inter-facility transports for adult patients 18 years or greater, including those in long-term care and hospice programs.

B. All cardiac arrest patients in a prehospital setting shall have cardio-pulmonary resuscitation (CPR) initiated by San Francisco EMS personnel unless a valid DNR directive is present and the procedures outlined in this policy are followed OR the patient is otherwise determined dead according to EMS Agency Policy #4050, *Death in the Field*. If patient has a valid Do Not Resuscitate status as defined in this policy, that patient must to be offered palliative care up to the point of providing ALS resuscitation.

IV. APPROVED FORMS

A. **Statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form** (Appendix A) Must be signed and dated by the patient's physician, the patient or by the patient's legally recognized health care decision maker if the patient is unable to communicate informed health care decisions. Photocopies and faxes are acceptable.

B. **Physician Orders for Life Sustaining Treatment (POLST) Form** (Appendix B) Must be signed and dated by the patient's physician, the patient or by the patient's legally recognized health care decision maker if the patient is unable to communicate informed health care decisions. The form on any color paper is valid (printing the original form on pink-colored paper is recommended to make it standout). Copies and faxes are acceptable.

C. **California EMS Authority approved DNR/POLST medallion or bracele**t (Appendix C): Approved medallions or bracelets must include:
   1. 24/7 toll free telephone number,
   2. Inscribed on the medallion/bracelet" "CALIFORNIA DO NOT RESUSCITATE – EMS", or; "CALIFORNIA DNR – EMS", or "POLST"
   3. An individual specific identification number used to identify the enrollee's medical information on file.

There are two approved California approved medallion providers for the prehospital DNR/POLST medallions:

MedicAlert Foundation	Caring Advocates
www.medicalert.org	www.caringadvocate.org
(888) 633-4298	(800) 647-3223
2323 Colorado Ave.	2730 Argonauta St.
Turlock, CA 95382	Carlsbad, CA 92009

V. PROCEDURES WHEN VALID DNR / POLST DIRECTIVE PRESENT

A. Identify that the patient is the person named in the DNR directive through a reliable witness or the presence of a picture identification or band/tag.

B. Supportive palliative care and transport shall be provided to all patients with a DNR directive who are not in need of immediate resuscitation.

C. EMS personnel shall ignore the DNR directive and provide care according to protocol and need if the patient is conscious and states he/she want resuscitative measures.

D. CPR may be withheld or discontinued when responding to a pulseless and apneic patient with the following approved valid DNR /POLST directives:
   1. Statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form

   2. Physician Orders for Life Sustaining Treatment (POLST) Form.

   3. An approved DNR/POLST medallion/bracelet worn by the patient inscribed with the words: "Do Not Resuscitate." The inscribed toll-free telephone number may be called to access the advance directives. EMS personnel should follow the DNR/POLST medallion/bracelet whether the patient is conscious or not conscious, unless

circumstances indicate that it does not belong to the patient or does not represent the patient's wishes. The same procedures as outlined for the paper forms should be followed for a DNR/POLST medallion or bracelet.

4. When responding to a licensed health facility, a written DNR order signed by a physician in the patient's medical record. Document in the field PCR the presence of a physician signed DNR from the facility records along with date of the order, and the physician's name.

5. EMS personnel may accept only a written DNR order from a physician present on-scene in a non-health care setting and who reasonably identifies himself/herself as the patient's physician. This order should preferably be written directly on the PCR and followed by Base Physician consultation for approval.

E. CPR may be discontinued without Base Hospital contact if a valid DNR/POLST directive is located by EMS personnel after CPR has commenced.

F. If any question exists regarding the validity of the DNR directive or other advanced directives, or if there is any disagreement by the patient's family members or caretakers as to honoring the DNR/POLST directive. EMS personnel should initiate BLS, treat the patient in accordance with applicable treatment guidelines, and immediately contact the Base Hospital physician for further instructions.

G. DNR directives are honored during an inter-facility transport. If a patient dies while en route, transport of the body should continue to the designated receiving facility.

H. EMS personnel shall document the presence of a DNR/POLST directive or medallion/bracelet on the prehospital care record.

I. Copies of the DNR/POLST directive should be attached to the field PCR. If the patient is transported, a copy of the form should be taken with the patient to the receiving facility and given to the facility staff.

J. If an ambulance provider dispatch center is informed about a DNR/POLST directive, the dispatcher shall instruct the caller to get the directive and present it to the emergency responders when they arrive. Caller information that a patient has a DNR directive does not change the ambulance or fire department response code.

J. First responders may cancel or downgrade the ambulance response if the patient is pulseless and apneic and there is a DNR directive. Otherwise, the ambulance shall respond as dispatched.

VI. PROCEDURES WHEN NO DNR / POLST DIRECTIVE OR OTHER DIRECTIVES PRESENT

A. Resuscitation may be withheld or stopped if it has already been initiated if a DNR directive is not present at the scene, but a person who is present and who can be identified as a spouse, immediate family member(s) or guardian requests no resuscitation and has the full agreement of any other family members present on scene. Contact the Base Hospital Physician if there is any disagreement between the spouse, immediate family member(s) or guardian.

B . Other advance directives such as "Living Wills," or directives from other sources (e.g. California Natural Death Act/Declaration or Physician Documentation of Preferred Intensity of Treatment) form are not valid for prehospital personnel. Contact the Base Hospital to determine whether these may be used to guide patient therapy.

C. Durable Power of Attorney for Health Care (DPAHC): EMS personnel encountering a person claiming to be the designated "Attorney In Fact" for the patient at the scene of an emergency, must first verify that person's identification and then ask to see the written power of attorney form to verify that the person is the "Attorney In Fact." Verify that the DPAHC document authorizes the "Attorney In Fact" to make a DNR directive for the patient.

VII. AUTHORITY

California Health and Safety Code Section 1797.220 and 1798
California Probate Code Section 4780

VIII. REFERENCES

- California EMS Authority Guidelines #111 - 5th Revision," Do Not Resuscitate and Other Patient Designated Directives," January 2016.
- Coalition for Compassionate Care of California. www.coalitionccc.org
- POLST California. http://capolst.org

Policy Reference No.: 4051
Effective Date: January 30, 2017
Supersedes: January 1, 2011

APPENDIX A- EMSA/CMA APPROVED PREHOSPITAL DNR FORM

CMA PUBLICATIONS 1(800) 882-1262 WWW.CMANET.ORG

EMERGENCY MEDICAL SERVICES PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

California Medical Association

PURPOSE

The Prehospital Do Not Resuscitate (DNR) Form has been developed by the California Emergency Medical Services Authority, in concert with the California Medical Association and emergency medical services (EMS) providers, for the purpose of instructing EMS personnel regarding a patient's decision to forego resuscitative measures in the event of cardiopulmonary arrest. Resuscitative measures to be withheld include chest compressions, assisted ventilation, endotracheal intubation, defibrillation, and cardiotonic drugs. This form does **not** affect the provision of life sustaining measures such as artificial nutrition or hydration or the provision of other emergency medical care, such as palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions.

APPLICABILITY

This form was designed for use in **prehospital settings** --i.e., in a patient's home, in a long-term care facility, during transport to or from a health care facility, and in other locations outside acute care hospitals. However, hospitals are encouraged to honor the form when a patient is transported to an emergency room. California law protects any health care provider (including emergency response personnel) who honors a properly completed request regarding resuscitative measures, including a Prehospital Do Not Resuscitate Form (or an approved wrist or neck medallion), from criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the provider believes in good faith that the action or decision is consistent with the law and the provider has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under like circumstances. This form does not replace other DNR orders that may be required pursuant to a health care facility's own policies and procedures governing resuscitation attempts by facility personnel. Patients should be advised that their prehospital DNR instruction may not be honored in other states or jurisdictions.

INSTRUCTIONS

The Prehospital Do Not Resuscitate (DNR) Form **must** be signed by the patient or by the patient's legally recognized health care decisionmaker if the patient is unable to make or communicate informed health care decisions. The legally recognized health care decisionmaker should be the patient's legal representative, such as a health care agent as designated in a power of attorney for health care, a court-appointed conservator, or a spouse or other family member if one exists. The patient's physician **must** also sign the form, affirming that the patient/legally recognized health care decisionmaker has given informed consent to the DNR instruction.

The **white copy** of the form should be retained by the patient. *The completed form (or the approved wrist or neck medallion—see below) must be readily available to EMS personnel in order for the DNR instruction to be honored.* Resuscitation attempts may be initiated until the form (or medallion) is presented and the identity of the patient is confirmed.

The **goldenrod** copy of the form should be retained by the physician and made part of the patient's permanent medical record.

The **pink** copy of the form may be used by the patient to order an optional wrist or neck medallion inscribed with the words "DO NOT RESUSCITATE-EMS." The Medic Alert Foundation (1(888)755-1448, 2323 Colorado Avenue, Turlock, CA 95381) is an EMS Authority-approved supplier of the medallions, which will be issued only upon receipt of a properly completed Prehospital Do Not Resuscitate (DNR) Form (together with an enrollment form and the appropriate fee). Although optional, use of a wrist or neck medallion facilitates prompt identification of the patient, avoids the problem of lost or misplaced forms, and is strongly encouraged.

REVOCATION

In the absence of knowledge to the contrary, a health care provider may presume that a request regarding resuscitative measures is valid and unrevoked. Thus, if a decision is made to revoke the DNR instruction, the patient's physician should be notified immediately and all copies of the form should be destroyed, including any copies on file with the Medic Alert Foundation or other EMS Authority-approved supplier. Medallions and associated wallet cards should also be destroyed or returned to the supplier.

Questions about implementation of the Prehospital Do Not Resuscitate (DNR) Form should be directed to the local EMS agency.

CMA PUBLICATIONS 1(800) 882-1262 WWW.CMANET.ORG

EMERGENCY MEDICAL SERVICES PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

An Advance Request to Limit the Scope of Emergency Medical Care

California Medical Association

I, _____, request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will **not** prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

_____ _____
Patient/Legally Recognized Health Care Decisionmaker Signature Date

_____
Legally Recognized Health Care Decisionmaker's Relationship to Patient

By signing this form, the legally recognized health care decisionmaker acknowledges that this request to forego resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

I affirm that this patient/legally recognized health care decisionmaker is making an informed decision and that this directive is the expressed wish of the patient/legally recognized health care decisionmaker. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____
Physician Signature Date

_____ _____
Print Name Telephone

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

APPENDIX B- EMSA APPROVED POLST FORM

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 1/1/2016)*

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

Check One

☐ Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)

☐ Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If patient is found with a pulse and/or is breathing.*

Check One

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ *Trial Period of Full Treatment.*

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
☐ *Request transfer to hospital only if comfort needs cannot be met in current location.*

☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Additional Orders: _____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____
☐ Trial period of artificial nutrition, including feeding tubes. _____
☐ No artificial means of nutrition, including feeding tubes. _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____, available and reviewed →
☐ Advance Directive not available
☐ No Advance Directive

Health Care Agent if named in Advance Directive:
Name: _____
Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)
My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #:
Physician/NP/PA Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker
I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*	Date:	**FOR REGISTRY USE ONLY**
Mailing Address (street/city/state/zip):	Phone Number:	

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F

NP/PA's Supervising Physician	Preparer Name (if other than signing Physician/NP/PA)	
Name:	Name/Title:	Phone #:

Additional Contact ☐ None

Name:	Relationship to Patient:	Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

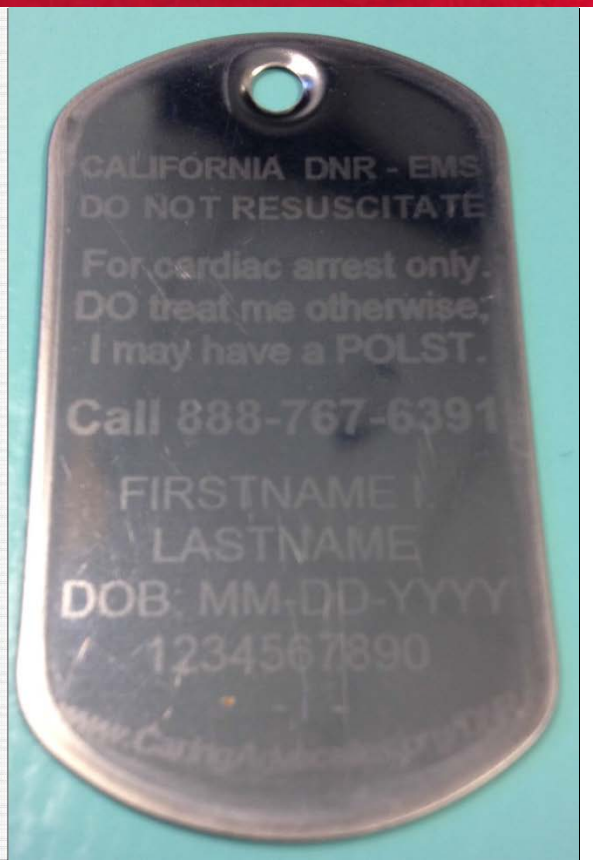
Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.
For more information or a copy of the form, visit **www.caPOLST.org**.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

APPENDIX C – EMSA APPROVED DNR MEDALLIONS



SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4070
Effective Date: August 1, 2008
Review Date: January 1, 2011
Supersedes: New

CRITICAL CARE TRANSPORT BY PARAMEDIC (CCT-P) PROGRAM APPROVAL

I. PURPOSE

1. To establish the criteria and process for gaining approval to provide a Critical Care Transport by Paramedic Optional Scope Program in the City and County of San Francisco.

II. AUTHORITY

1. Health and Safety Code Sections: 1797.107, 1797.172 and 1797.185
2. California Code of Regulations, Title 22, Sections: 100137, 100142, 100145, 100167

III. PROGRAM REQUEST AND APPROVAL

1. Application Process
    a. Permitted ALS providers shall submit a letter of intent including the following material to the EMS Agency for approval:
    b. A copy of the organization's interfacility transport program to include:
        - Name(s) and qualification(s) of the Medical Director. Must be a CCT Registered Nurse or a physician knowledgeable in the subject matter
        - CCT-P Quality Assurance Plan that fulfills the requirements under Policy 6000 Quality Assurance Program
        - Procedure for submission of the data to the EMS Agency for all CCT-P transport
        - Program curriculum
        - CE on going training program curriculum and schedule
        - Draft PCR for approval
        - Draft physician's Order form for approval

2. Upon receipt, application materials will be reviewed for completeness. If any required documentation is missing, the applicant will be notified, in writing, within fourteen (14) business days. The missing information shall be submitted within thirty (30) DAYS. Failure to submit the missing information within thirty (30) days will require the applicant to reapply.
3. The applicant will receive written notification within thirty (30) days of request
4. Approval is valid for four (4) years from the authorization not including periodic monitoring by the EMS Agency. It is the responsibility of the

approved provider to notify the EMS Agency, in writing, of any intent to discontinue the program or any substantial changes in the original application.

IV. STAFFING

A CCT-P Unit is a fully equipped advanced life support ambulance, staffed with a minimum of two (2) authorized staff that includes at least one (1) paramedic and one (1) EMT.

1. Paramedics assigned to CCT-P units shall meet the requirements identified on Policy 4071 CCT-Paramedic Program Description
2. EMTs assigned to CCT-P units shall meet the requirements identified in Policy 2000, Personnel Standards and Scope of Practice in addition to the following
   - Successful completion of an EMS Agency approved and provider-delivered training program specific to the skills used to assist paramedics with patient care during CCT-P transfers
   - Complete at least four (4) continuing education hour's per-year, approved by the EMS Agency and delivered by the provider agency, specific to knowledge and skills used on CCT-P transfers

3. The provider agency shall maintain a list of all staff working on a CCT-P unit and shall see that this list is updated whenever there is a change in personnel
4. The organization shall retain on file, at all times, copies of current and valid credentials for all personnel performing service under this program.
5. The organization must be a San Francisco EMS Agency approved CE provider

V. MEDICAL DIRECTION

Personnel assigned to a CCT-P unit work under the existing medical control system and follows San Francisco EMS prehospital policies and protocols, as approved by the EMS Medical Director.

1. In addition to those optional skills approved for all paramedics in San Francisco, CCT-Ps have an expanded scope that includes the administration of intravenous Nitroglycerine, Potassium Chloride, Lidocaine, Amiodarone Hydrochloride, and Heparin by pump, the use of Automatic Transport Ventilators for ventilator dependent patients, and Midazolam for sedation of ventilator and/or agitated patients
2. The transferring physician specifies standing orders for a patient based on skills and medications included in ht e County CCT-P paramedic basic, optional, and CCT-P expanded scope of practice
3. The EMS Agency Medical Director has overall responsibility for the medical control for all paramedics and EMTs within the City and County of San Francisco.
4. Medical control is exercised through policies, protocols, and training established and approved by the EMS Medical Director

5. Retrospective medical review includes monitoring, quality improvement, incident review and disciplinary processes conducted by the Provider's Medical Advisory and/or by the EMS Agency
6. When a patient's treatment/care is beyond the CCT-P scope of practice, that patient may be transported only in accordance with existing Interfacility Transfer Policy

VI. DOCUMENTATION

Patient Care Report: A written or electronic Patient Care Report (PCR), approved by the EMS Agency, shall be completed for each patient.

1. The PCR shall contain information regarding the call demographics, patient assessment, care rendered and patient response to care
2. A copy of the PCR shall be given to the receiving facility prior to the transfer unit departing the facility.
3. If the patient is turned over to a 9-1-1 system unit, a copy of the PCR shall be sent with the patient is time permits. If the PCR cannot be completed prior to patient transport, the CCT-P paramedic shall complete the PCR and fax it to the Emergency Department of the nearest facility as soon as possible
4. A copy of each PCR, transferring physician orders and related documentation shall be submitted to the EMS Agency upon request

VII. PROGRAM CONTENT

1. The provider shall develop or identify training and orientation programs for CCT-P personnel, which include didactic, clinical and training requirements. The EMS Agency Medical Director shall approve training and orientation programs prior to providing such training
2. The training program shall include a minimum of eighty (80) hours of didactic education and an additional forty hours of clinical education
3. The course shall include the following:
   a. Didactic – Paramedic
      - ♦ Breathing and Airway Management
      - ➢ Pulmonary anatomy and physiology
        - Upper and lower airway anatomy
        - Mechanics of ventilation
        - Gas exchange

      Respiratory Pathophysiology (including signs and symptoms)

      - ♦ Breathing Assessment
      - ♦ Tracheostomies
      - ♦ Endotracheal Intubation – Review Procedure
      - ♦ Esophageal Tracheal Airway Device (combitube) Review Procedure

- Laryngeal Mask Airway Device
- Needle Cricothyrotomy – Review Procedure
- Pharmacological Agents
- Chest Tubes
- Pleural Decompression – Review Procedure
- Portable Ventilators
- Laboratory Values
- Other

b) Pharmacology and Infusion Therapies
c) Infusion Pumps
d) Hemodynamic Monitoring and Invasive lines
e) 12 lead EKG Interpretation
f) Implanted Cardioverter/defibrillators
g) Cardiac Pacemakers
h) Indwelling Tubes (the following should be discussed, described, and preferably demonstrated and/or viewed)
i) Isolation Issues
j) Shock and Multi-system Organ Failure
k) Special Population Considerations
l) Role of the CCT-P
m) Medical-legal Issues
n) Operational Procedures
o) Documentation
p) Pass a written examination with a passing grade of 80% (exam must be approved by the EMS Agency)
q) Skills Examination (exam must be approved by the EMS Agency)
r) Clinical – Paramedic

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4071
Effective Date: August 1, 2008
Review Date: January 1, 2011
Supersedes: New

CCT-PARAMEDIC OPTIONAL SCOPE OF PRACTICE

I. PURPOSE

A. To provide interested San Francisco permitted ALS providers with direction on becoming a Critical Care-Paramedic (CCT-P) Provider with The City and County of San Francisco.

II. AUTHORITY

1. Health and Safety Code Sections: 1797.107, 1797.172 and 1797.185
2. California Code of Regulations, Title 22, Sections: 100137, 100142, 100145, 100167

III. DEFINITION

1. In addition to the basic scope of practice skills, CCT-Ps have completed specialized training to include expanded practice skills authorized for use under local optional scope of practice.
2. These include monitoring/care of the following:
    1. Intravenous Nitroglycerine
    2. Intravenous Potassium Chloride
    3. Intravenous Lidocaine
    4. Intravenous Amiodarone Hydrochloride
    5. Intravenous Heparin
    6. Intravenous Midazolam
    7. Intravenous Morphine Sulfate
    8. Intravenous Blood/Blood Products
    9. Intravenous Glycoprotein IIb/IIIa Receptor Inhibitors
    10. Intravenous Total Parental Nutrition
    11. Automatic Transport Ventilators
    12. Intravenous (IV) Pumps
    13. Tracheostomy and Stoma care
    14. Thoracostomy care
3. This program provides an additional level of critical care service between the ALS paramedic level transfer and the nurse-staffed critical care transfer.

IV. PROGRAM REQUIREMENTS

Paramedic Critical Care Transport Program requirements are outlined in Policy 4070 Critical Care Transport – Paramedic Program Provider Approval. Provider's seeking approval will need to submit the following documentation:

1. A letter of intent CCT-Paramedic Program Director Application with the applicant's Curriculum Vitae and copies of his/hers professional credentials

2. CCT-P Quality Assurance and Improvement Plan
3. Procedures for submission of data the EMS Agency
4. CCT-P Program curriculum
5. CE / Ongoing training program curriculum and schedule
6. Draft of Patient Care Report for approval
7. Draft of Physician's Orders for approval

In addition to these requirements, the applicant must also be permitted to operate as an ALS provider in the City and County of San Francisco.

V. APPLICATION PROCESS

1. Applications are submitted to the San Francisco EMS Agency.
2. Upon receipt of the applications materials, a review will be done for completeness. If any required application documentation is missing, the application will be notified, in writing, within fourteen (14) days, the missing information shall be submitted within thirty (30) days, Failure to submit the missing information within thirty (30) days will require the applicant to reapply.
3. The Agency will insure permit and policy compliance. An inspection of the applicant's ambulance will be conducted to ensure that the vehicle is equipped to the minimum standards outlines in Policy 4001 Vehicle Equipment and Supply List.
4. The applicant will receive written notification within thirty (30) days of receipt of all required materials regarding the decision to approve. If an application is not approved, the reason(s) will be clearly stated in writing. An applicant may reapply if reason(s) for disapproval are corrected.
5. Approval is valid for four (4) years from authorization not including monitoring by the EMS Agency. It is the responsibility of the approved provider to notify the EMS Agency, in writing, of any intent to discontinue the program or any substantial changes to the original application.

VI. PERSONNEL REQUIREMENTS

Paramedic Critical Care Transport Program requirements are outlined in Policy 4070 Critical Care Transport – Paramedic Program Approval). Requirements and applications processes are applicable to both the individual applicant and sponsoring provider agency. Paramedics will need to meet or exceed the following requirements:

1. City and County of San Francisco Paramedic Accreditation
2. Minimum of two (2) years full time field experience, as a paramedic, in an Advanced Life Support system within the last five (5) years
3. Current and continuously renewed provider status in BCLS, ACLS, PALS, or PEPP, and PHTLS or BTLS
4. Successful completion of an Agency approved training and orientation program specific to the skills and procedure used on critical care interfacility transfers

5. Not to be the subject of any outstanding formal prehospital investigation or have any censures including performance improvement plan, suspensions, etc. within the past two (2) years.
6. Be sponsored by an authorized CCT-P provider agency
7. Submit a completed CCT-P Authorization Application
8. EMT personnel must meet the requirements as specified in Policy 2000, Personnel Standards and Scope of Practice. Initially, EMT personnel will need to successfully complete an Agency approve and provider delivered training program specific to the skills used to assist paramedics with patients care during CCT-P transports. Annually, those EMTs authorized to work on a CCT-P ambulance will need to complete a minimum of four (4) hours of Agency approved, continuing education specific to the knowledge and skills used on a CCT-P transfer.

VII. UTILIZATION ORDERS AND TREATMENT PROTOCOLS

1. Critical Care Transports by Paramedic shall be conducted in accordance to the guidelines outlined in Policy 5030, Interfacility Transfers
2. Paramedics and EMTs assigned to a CCT-P ambulance will provide care in accordance with standards established by the EMS Medical Director.

VIII. AMBULANCE INVENTORY REQUIRMENTS

CCT-P ambulance equipment and supply requirements are specified in Policy 4001, Vehicle Equipment and Supply List.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 4072
Effective Date: 10/1/11
Review Date: 1/1/14
Supersedes: New

BARIATRIC PATIENT TRANSPORTS

I. PURPOSE

A. To establish standards for the transport of bariatric patients that assures their comfort, safety and dignity.

B. To authorize the temporary use of non-permitted bariatric ambulances to operate in the San Francisco EMS system for the transport of bariatric patients.

II. AUTHORITY

A. California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.206, 1797.222, 1798.170, and 1798.172

B. California Code of Regulations, Title 22, Sections 100063, 100145, 100147, 100172, 100175, and 100266

III. DEFINITIONS

A. Bariatric Patient: A patient weighing > 350 pounds and/or has a body habitus that exceeds the capacity standards for a normal ambulance gurney in either height, width or both.

B. Bariatric Ambulance: Specially equipped ambulances specifically designed for the transport of bariatric patients.

IV. POLICY

A. Bariatric ambulances not permitted by the City and County of San Francisco, which are operated by a company possessing an ALS or BLS permit from the San Francisco EMS Agency, are authorized to temporarily operate within the San Francisco EMS system for the purposes of transporting bariatric patients when it is determined by either an ambulance provider, hospital or other health institution provider to be in the best interest of patient safety.

B. zNon-San Francisco permitted bariatric ambulances must be permitted by the California Highway Patrol, and if applicable, by the local EMS agency from which the ambulance originates.

C. Ambulance personnel must be knowledgeable about the extrication and transport needs for bariatric patients that assures for their comfort, safety and dignity.

D. Bariatric patients meeting the critical patient triage criteria as defined in Policies 5000 Destination or 5001 Critical Trauma Criteria should be transported to an appropriate receiving hospital as rapidly as possible whether or not a bariatric ambulance is available. Ambulance crews may request assistance from SFFD.

E. Medically stable bariatric patients may be held at the scene until a bariatric transport ambulance becomes available. Required transport times from the scene to a hospital as identified in EMS Agency Policy 4000 Pre-hospital Provider Standards are waived as long as the bariatric patient remains medically stable. At no time should the patient be unattended by medical personnel. If necessary, additional staff should be arranged to attend to the patient. At a minimum, this shall be an EMT with a defibrillator and an 800 MHz radio.

IV. PROCEDURES

A. Any field crew may request a bariatric ambulance through the Division of Emergency Communications (DEC). DEC will contact the private ambulance providers for an available bariatric ambulance.

B. If necessary during 9-1-1 calls, the transporting unit may request additional assistance from the SFFD in order to safely extricate and load a patient.

C. Private ambulance company crews for inter-facility transports will request a bariatric-equipped ambulance through their respective dispatch centers. Proper equipment and the proper number of personnel necessary to handle the patient safely must be assured. If an extraordinary situation arises with little or no advance notice, and with the approval of a Paramedic Captain, the SFFD may be asked to assist.

V. QUALITY IMPROVEMENT

A. Ambulance provider companies shall report scene transports of bariatric patients to the EMS Agency within 24 hours by completing and submitting a "Confidential Exception Report Form." This includes transports without a bariatric-equipped ambulance for critical calls by either the SFFD or a private provider. The EMS Agency shall cumulate and analyze this data annually.

B. Continuing education of all EMS personnel shall address new findings on providing emergency medical care to the bariatric patient in both emergency and non-emergency situations.

Section 5:
Hospitals and
Critical Care Centers

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5000
Effective Date: January 30, 2017
Supersedes: February 1, 2015

DESTINATION POLICY

I. PURPOSE

A. To identify the approved ambulance-transport destinations for the San Francisco EMS System.

B. To delineate clinical criteria for when patients should be transported to a general or specialty care hospitals or other alternate destinations.

II. POLICY

A. The Emergency Medical Services (EMS) Agency designates hospitals approved to receive ambulances according to EMS Agency Policy # 5010 *Receiving Hospital Standards*. The EMS Agency Medical Director may approve Specialty Care Facilities or alternate destinations that support the mission of the EMS System to receive ambulance patients as either temporary or permanent additions to the EMS System.

B. Ambulances may only transport patients to the approved destinations listed in this policy. Prearranged inter-facility transports, as defined in *Policy # 5030 Inter-facility Transfers* are exempt from this policy.

C. When a patient is in need of specialty treatment (e.g. OB/GYN, STEMI, etc), the ambulance crew may bring the patient directly to that hospital's specialty care department if directed to do so by hospital staff.

III. DESTINATION DECISION

A. Hospital destination decisions for EMS patients shall be prioritized based on the following:
   1. Patient medical need;
   2. Hospital ambulance diversion status;
   3. Patient preference;
   4. Family or private physician preference (if patient unable to provide information);
   5. Patients without a preference who require no specialty care shall be transported to the closest open general medical designated hospital.

B. All patients who are incarcerated or under arrest must be taken to Zuckerberg San Francisco General Hospital for evaluation.

C. Patients with medical needs meeting any of the Clinical Field Triage Criteria listed in Section IV below will be transported to the most appropriate specialty care facility. Specialty care designations includes:
    1. Pediatric Medical
    2. Pediatrics Critical Medical
    3. STAR (STEMI and/or Post Arrest with ROSC)
    4. Reimplantation (Microvascular Surgery)
    5. Burns
    6. Obstetrics
    7. Stroke
    8. Trauma
    9. LVAD
    10. Post-Sexual Assault
    11. Sobering

D. Destinations other than those listed in this policy require approval from the Base Hospital Physician prior to transport.

E. In the event of a Multi-Casualty Incident (MCI), destinations will be determined in accordance with EMS Agency Policy # 8000 Multi-Casualty Incident.

IV. CLINICAL FIELD TRIAGE CRITERIA

A. **Critical Airway** Patients in whom EMS personnel cannot obtain adequate airway control should be transported to the closest Receiving Hospital regardless of diversion status. For patients under age 14, the preference is for a critical pediatric medical hospital (CPMC-Cal Campus or UCSF Mission Bay) if ETA is equal to or less than any other receiving facility.

B. **Adult Critical Medical:** Patients with one (1) or more of the following conditions should be transported to the closest full Receiving Hospital:
    1. Airway obstruction or respiratory insufficiency with inadequate ventilation;
    2. Hypotension with shock;
    3. Status epilepticus;
    4. Acute deteriorating level of consciousness without trauma.

C. **Adult Medical:** Patients who do not meet any of the following critical airway, critical medical adult or specialty criteria may be transported to any full Receiving Hospital or Standby Receiving Hospital.

D. **Pediatric Critical Medical:**
    1. Patients under age 14 with 1 or more of the following conditions should be transported to the a Pediatric Critical Medical receiving hospital (CPMC-Cal Campus or UCSF Mission Bay) :

a) Cardiopulmonary arrest or post-arrest;
b) Hypotension with shock;
c) Status epilepticus;
d) Acute deteriorating level of consciousness without trauma

E. **Pediatric Medical:** Patients under age 14 years not meeting the criteria for Emergent Medical Pediatric may be transported to any Receiving Hospital noted as "pediatric medical."

F. **ST Elevation Myocardial Infarction / Post Arrest with ROSC (STAR):** Patients are considered to be STEMI patient if they meet the STEMI criteria as defined in *EMS Agency Protocol 2.06 Chest Pain / Acute Coronary Syndrome*. Patients experiencing a STEMI shall be transported to a designated **ST** Elevation Myocardial Infarction / Post **A**rrest with **R**OSC (**STAR**) Center according to the following hierarchy:
   1. Cardiopulmonary arrest - Patients who are age 14 or over and are in cardiac arrest or those who are post-arrest with return of spontaneous circulation in the field;
   2. Patients who are unstable and would experience a significant delay in their care by transport to a preferred STAR Center shall be transported to the closest, designated STAR Center;
   3. Patient preference for transport to a specific Receiving Hospital that is designated as a STAR Center;
   4. Family or private physician preference (if patient unable to provide information) for transport to a specific Receiving Hospital that is designated as a STAR Center;
   5. Patients without a preference shall be transported to the closest Receiving Hospital that is designated as a STAR Center.

G. **Stroke:** Patients who are age 14 or over and are experiencing the symptoms of acute stroke (onset 4.5 hours or less prior to 911 call) and exhibiting an "abnormal" result on the Cincinnati Prehospital Stroke Scale (see *EMS Agency Protocol 2.14 Stroke*) shall be transported to a designated Stroke Center according to the following hierarchy:
   1. Patients who are unstable and would experience a significant delay in their care by transport to a preferred Stroke Center shall be transported to the closest designated Stroke Center;
   2. Patient preference for transport to a specific Receiving Hospital that is designated as a Stroke Center;
   3. Family or private physician preference (if patient unable to provide information) for transport to a specific Receiving Hospital that is designated as a Stroke Center;
   4. Patients without a preference shall be transported to the closest Receiving Hospital that is designated as a Stroke Center.

H. **Reimplantation :** If the patient has any of the following amputations or devascularization injuries, they may be taken to the Reimplantation

(Microsurgical)Facility of their choice or to the closest Reimplantation Center if the patient has no preference:

1. Isolated amputation or partial amputation distal to the ankle or wrist;
2. Extensive facial, lip, or ear avulsion;
3. Penile amputation;
4. If the patient meets trauma triage criteria, transport to a Trauma Center;
5. Simple avulsion lacerations of the distal phalanx will be transported to any open Receiving Hospital or the closest open Receiving Hospital if the patient has no preference.

I. **Burns:** Patients with the following criteria shall be transported to the St Francis Hospital Burn Center:

1. Partial thickness burns **>** 10% of the total body surface area (TBSA);
2. Burns involving the face, eyes, ears, hands, feet, perineum or major joints;
3. Full thickness or 3rd degree burns in any age group;
4. Serious electrical burns;
5. Serious chemical burns;
6. Inhalation injuries (including burns sustained in a closed space for purposes of facial burns);
7. Pediatric burn patients who do not meet trauma triage criteria shall be transported to St. Francis Memorial Hospital;
8. Transport to Zuckerberg San Francisco General Hospital Trauma Center if the burned patient meets trauma triage criteria.

J. **Obstetrics:** Pregnant patients who are over 20 weeks gestation (by patient history) with any condition that does not fall under other specialty center should be transported to the Obstetrics Specialty Care Facility of their choice or the closest open Obstetrics Specialty Care Facility if the patient has no preference.

K. **Psychiatric:** Psychiatric patients with co-existing medical complaints, alterations in mental status, abnormal vital signs, or history of overdose of medication shall be transported to the appropriate Receiving Hospital or Specialty Care facility based on their clinical needs:

1. Psychiatric patients without co-existing medical complaints may be transported for evaluation (medical clearance) to the open Receiving Hospital of their choice or the closest open Receiving Hospital;
2. All patients who have been placed on a 5150 hold require an evaluation (medical clearance), which may be performed at any Receiving Hospital. These patients should be transported to the hospital identified by the custodian placing the hold, provided that the hospital is open and receiving patients or arrangements have been made for direct admissions;
3. All full Receiving Hospitals in San Francisco are appropriate destinations for medical clearance of involuntary patients. Psychiatric patients in police or sheriff

custody (those patients who are incarcerated or under arrest) must be taken to Zuckerberg San Francisco General Hospital for evaluation.

L. **Trauma:** Patient meeting the criteria described in *Policy # 5001, Trauma Destination*, will be transported to a Trauma Center.

M. **LVAD** (Left Ventricular Assist Device): Any patient with a (left) ventricular assist device (LVAD) should be transport the patient to the LVAD Center that implanted the device (UCSF or CPMC-Pac). You are authorized to BYPASS the closest San Francisco LVAD Center to get the patient to the LVAD Center that implanted their device no matter the patient's condition. If the LVAD Center that implanted the device is not in San Francisco, take the patient to the closest San Francisco based LVAD Center.

N. **Post-Sexual Assault:** Any patient who self-identifies as a victim of sexual assault or abuse within the 72 hours prior to their activation of 911 services AND does not have an overriding medical complaint or meet any special care criteria listed in this policy should go to Zuckerber San Francisco General Hospital. This also applies to pediatric patients who are identified as being victims of sexual assault or abuse.

O. **Sobering Services:** Intoxicated patients with no acute medical condition(s) or co-existing medical complaints may be transported to the San Francisco Sobering Center, if the patient meets the following criteria:
    1. Be at least 18 years or older;
    2. Found on street / in a shelter or in Police Department custody;
    3. Voluntarily consent or have presumed consent (when not oriented enough to give verbal consent) to go to the Sobering Center;
    4. Not be on the San Francisco Sobering Center "Exclusion List."
    5. Be medically appropriate by meeting **ALL of the following criteria:**
        a) Indication of alcohol intoxication (odor of alcoholic beverages on breath, bottle found on person);
        b) Glasgow Coma Score of 13 or greater;
        c) Pulse rate greater than 60 and less than 120~~;~~
        d) Systolic blood pressure greater than 90;
        e) Diastolic blood pressure less than 110;
        f) Respiratory rate greater than 12 and less than 24;
        g) Oxygen saturation greater than 89%;
        h) Blood glucose level greater than 60 and less than 250;
        i) No active bleeding;
        j) No bruising or hematoma above clavicles ;
        k) No active seizure; and
        l) No laceration that has not been treated.

V. AUTHORITY

California Health and Safety Code, Division 2.5, Sections 1798 and 1798.163

SAN FRANCISCO HOSPITAL DESIGNATIONS

	Critical Airway	Medical Adult	Critical Medical Adult	Medical Peds	Critical Medical Peds	Psych	Stroke	STAR	Trauma	OB	Reimplan-tation	Burns	LVAD	Post Sexual Assault	Sobering
ZFGH	X	X	X	X		X	X	X	X	X	X	X [1]		X	
CPMC - PAC	X	X	X	X		X	X	X					X		
Davies	X	X	X	X		X	X				X [1]				
St Francis	X	X	X	X		X	X					X [2]			
Kaiser	X	X	X	X		X	X	X		X					
St Mary	X	X	X	X		X	X	X							
St Lukes	X	X	X	X		X				X					
UCSF-Parn	X	X	X	X		X	X	X			X [1]		X		
Seton	X	X	X	X			X								
South Kaiser	X	X	X	X			X								
Chinese (standby)		X													
VA Medical (standby)		X													
CPMC Peds Calif Campus	X		X	X	X					X					
UCSF Peds Mission Bay	X		X	X	X					X					
Sobering Center															X

1. Burns and reimplatation patients WITH associated major trauma must be taken to SFGH Trauma Center.
2. Burns (adult + pediatric) who do NOT meet major trauma criteria must be transported to St Francis Memorial Hospital.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No: 5001
Effective Date: January 7, 2013
Supersedes: August 1, 2008

TRAUMA TRIAGE CRITERIA

I. PURPOSE

To identify patients meeting trauma criteria including those requiring base hospital contact before transport to the San Francisco General Hospital.

II. AUTHORITY

California Health and Safety Code, 1797.67, 1797.198, and 1797.204, 1798.160, 1798.161.
California Code of Regulations Title 22, §100248,100252, 100255.
Committee on Trauma, American College of Surgeons, *Resources for Optimal Care of the Injured Patient:* 2006, Chapter 3.

III. CRITERIA FOR TRANSPORT TO A TRAUMA CENTER

Patients meeting one or more of the following in any category shall be transported to the trauma center:

A. Physiologic Criteria
1. Glascow Coma Score < 13
2. Systolic Blood Pressure < 90
3. Respiratory Rate for adult < 10 or > 29 per minute
4. Respiratory Rate for infants less than 1year, < 20 per minute.

B. Anatomic Criteria
1. All gunshot wounds.
2. All penetrating injuries to head, neck, torso and extremities proximal to elbow and knee.
3. All blunt trauma with suspected significant chest, abdominal or pelvic injury.
4. Flail chest.
5. All burns or inhalation injuries associated with trauma.
6. Two or more proximal long bone injuries
7. Pelvic fractures.
8. Limb paralysis.
9. Amputation proximal to wrist and ankle.
10. Crushed, degloved, or mangled extremity.
11. Open or depressed skull fracture.
12. Multi-system trauma.

C. Mechanism of Injury
1. Adult falls > 20 feet (1 story = 10 ft.)
2. Pediatric falls > 10 feet (2 to 3 times the height of the child)
3. High risk auto crash:

a. Intrusion into passenger compartment > 12 inches or > 18 inches on any site
b. Ejection from vehicle (partial or complete)
c. Death of another passenger in same compartment
d. Extrication time > 20 minutes

7. Motorcycle accident:
   a. Initial speed > 20 mph
   b. Separation of rider from bike while in motion
8. Auto-pedestrian or bicycle injury:
   a. Impact > 5 mph
   b. Thrown or run over

IV. ☎ BASE HOSPITAL CONTACT

Contact the Base Hospital to determine whether patients who have not met physiological, anatomic, or mechanism of injury criteria, but have underlying conditions or comorbid factors that place them at a higher risk for injury. These include:

1. Patients < 5 years and > 55
2. Anticoagulants and bleeding disorders
3. Time sensitive extremity injury
4. End-stage renal disease requiring dialysis
5. Abdominal injuries and restraint use in children
6. Pregnancy > 20 weeks
7. EMT-P concerns or judgment.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5010
Effective Date: September 1, 2009
Review Date: January 1, 2011
Supersedes: August 1, 2007

RECEIVING HOSPITAL STANDARDS

I. PURPOSE

A. Establish minimum standards for all San Francisco EMS approved receiving hospitals.
B. Integrate receiving hospitals into the EMS system as stakeholders in the planning, design, and delivery of Emergency Medical Services.
C. Provide a mechanism for receiving hospitals to communicate with the EMS Agency and other system participants.

II. AUTHORITY

A. Code of Federal Regulations, Title 45, Section 164.512 (b) (l) (i)
B. California Health and Safety Code, Division 2.5, Sections 1797.67, 1797.204, 1797.222, 1797.250, 1797.252, 1798, 1798.150, and 1799.205.
C. California Code of Regulations, Title 22, Sections 100172, 100175, 70411-70419, and 70451 – 70459.
D. Joint Commission on Accreditation of Health Care Organizations, Emergency Department Standards

III. POLICY

A. General Requirements
    1. All receiving hospitals must have a written agreement with the San Francisco EMS Agency to be recognized as an approved destination for ambulances transporting prehospital patients.
    2. All receiving hospitals shall meet all Federal, State, and local requirements to be recognized as a Comprehensive Emergency Department, Basic Emergency Department, or Standby Emergency Department.
    3. Receiving Hospitals shall be accredited by the Joint Commission on Accreditation of Health Care Organizations.
    4. Medical Control of Advanced Life Support personnel shall be the sole responsibility of the Base Hospital.
    5. Receiving hospitals shall comply with all EMS Agency Policies and develop internal policies compelling hospital personnel to comply with EMS Agency policies when their work relates to the EMS system.
    6. Receiving Hospitals that are not designated Specialty Receiving Centers, e.g. STEMI Receiving Centers, Stroke Centers, Trauma Centers or Pediatric Critical Care Centers, shall have in place rapid transfer

protocols, policies or procedures so that patients who need theses specialty receiving centers can access them rapidly.

B. Personnel
   1. Medical Director
      a) The ED Medical Director shall be a physician certified or qualified by training and experience for examination by the American Board of Emergency Medicine.
   2. ED Physicians with direct patient care responsibilities
      a) Must be Board Eligible, Board Prepared, or Board Certified in Emergency Medicine, Internal Medicine, Surgery, or Family Practice and maintain current recognition in the following curricula:
         (1) Advanced Cardiac Life Support (or equivalent)
         (2) Pediatric Advanced Life Support (or equivalent)
         (3) Current certification in Emergency Medicine may be held in lieu of III, B, 2, a, 1 – 2.
   3. Direct Supervision of Nursing and Medical Support Personnel
      a) A Registered Nurse qualified by training and experience in emergency room nursing care shall be responsible for nursing care within the ED at all times.
   4. Nursing
      a) All regularly scheduled nurses in the ED shall maintain recognition in the following curricula:
         (1) Basic Life Support, Health Care Provider
         (2) Advanced Cardiac Life Support (or equivalent)
         (3) Pediatric Advanced Life Support (or equivalent)
      b) Nurses newly hired or assigned to the ED shall have current recognition in the above curricula within 6 months of hire or assignment.
   5. At least one person trained to operate all EMS communications equipment shall be on duty at all times.
   6. Each facility shall designate a person or person(s) to represent the hospital at EMS System Advisory Committee meetings, Trauma System Audit Committee meetings, act as a liaison to the EMS System, and disseminate information regarding EMS within the facility.

C. EMS Specific Training
   1. All regularly scheduled full time employees, to include physicians, nurses, and support staff with patient care or ambulance interface duties, shall complete training in the following areas:
      a) EMS Agency Policies
      b) EMS Agency Exception Reporting
      c) Diversion, EMS Agency and internal hospital policy
      d) Operation of all communication and diversion monitoring equipment
      e) San Francisco Department of Public Health Emergency Operations Plan

f) Internal disaster plans

2. All receiving hospitals will work cooperatively with the EMS Agency and the Base Hospital to provide Continuing Education for prehospital and ED personnel.

IV. SPECIFIC SERVICES AND EQUIPMENT REQUIREMENTS

A. Data Collection and Sharing

1. Record keeping

a) The Emergency Department shall maintain a medical record for each patient in accordance with JCAHO standards.

(1) The record will include the Prehospital Care Report, if applicable;

(2) The records shall be immediately available to ED staff.

b) The Emergency Department shall maintain a register that includes all data elements defined by JCAHO, Title 22, and will also include the name and unit number of the transporting ambulance, when applicable.

2. Hospitals will collect and report such information as determined necessary by the EMS Medical Director for the purposes of public health surveillance and injury prevention activities.

3. Hospitals shall comply with the data reporting components of the EMS Agency Quality Improvement plan.

B. Referrals and Resources

1. In addition to the required referrals listed in State law, receiving hospitals shall maintain names, addresses, and telephone numbers for the following:

a) Sexual assault victim referral
b) Elder, dependent adult, or child abuse
c) Battered intimate partner or spouse referral
d) Detoxification unit
e) Drug and Alcohol abuse counseling and support services
f) Psychiatric services
g) Hyperbaric chamber
h) Physician referral
i) Outpatient medical services
j) Resources for the homeless
k) Other city and county designated specialty care centers
l) Regional poison control center

2. All receiving hospitals shall maintain a current copy of the EMS Agency Policy Manual in the Emergency Department.

3. Contact information for the following shall be available in the ED:

a) EMS Agency Duty Officer

b) Department of Emergency Management Division of Emergency Communications (DEC) supervisor

c) Ambulance providers supervisor and/or communications center

4. All hospitals shall have transfer agreements with EMSA designated specialty receiving centers (if such services are not available internally) including, but not limited to the following facilities:
    a) Trauma Center
    b) Pediatric Critical Care Center
    c) Burn Center
    d) Stroke Center

C. Pediatric Services

1. All receiving hospitals shall have the capability to resuscitate and provide immediate, short-term post resuscitation care for pediatric patients (< 14 years of age) in the Emergency Department.
2. Appropriately sized and specialized equipment and pharmacological agents necessary to resuscitate and care for pediatric patients in accordance with current recommendations by the National Emergency Medical Services for Children Resource Alliance shall be immediately available in the Emergency Department.

V. STANDARDS COMPLIANCE

A. Each receiving hospital will complete a self-assessment at least once every 3 years to ensure compliance with EMS Agency requirements.

1. The self assessment may be performed concurrent with JCAHO review.
2. Results of the self-assessment must be sent to the EMS Agency.

B. Receiving hospitals shall permit announced and unannounced visits by EMS Agency staff for the purposes of monitoring compliance.

C. Suspension/Revocation

1. The EMS Medical Director may suspend or revoke approval of any given receiving hospital for cause.
2. The EMS Agency shall notify the hospital administration in writing of its intent to deny, revoke, or suspend approval and give the hospital sixty (60) days to submit a corrective action plan.
3. The EMS Agency shall respond to the corrective action plan within thirty (30) days.
    a) If the EMS Agency requests any modifications to the Corrective Action Plan, the hospital shall have thirty (30) days to respond to those requests.
4. The EMS Agency will monitor the hospital's compliance with the Corrective Action Plan and take action as indicated.
5. If, in the opinion of the EMS Medical Director, non-compliance or failures on the part of a hospital constitute an immediate and substantial hazard to the health, safety, or welfare of the public, the EMS Agency may immediately suspend approval of that hospital.
    a) The hospital may appeal such a decision to the Director of Public Health.
    b) The EMS Agency may continue a suspension pursuant to this section until the noted deficiencies are corrected.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5011
Effective Date: August 1, 2008
Review Date: January 1, 2011
Supersedes: September 1, 2005

BASE HOSPITAL STANDARDS

I. PURPOSE

A. To define the role of the Base Hospital within the EMS system.
B. To establish operational, medical, and personnel standards for the Base Hospital.
C. To provide procedures by which Base Hospital Physicians are approved by the Base Hospital Medical Director

II. AUTHORITY

A. California Health & Safety Code, Division 2.5, Sections 1797.58, 1798.59, 1797.220, 1798 – 1798.3, 1798.100 – 1798.105
B. California Code of Regulations, Title 22, Sections 100144 and 100169.

III. POLICY

A. Base Hospital General Requirements:
   1. Comply with all applicable Federal, State, and local codes, statutes, ordinances, and rules with regards to hospitals, Base hospitals, and radio communications.
   2. Comply with all applicable EMS Agency policies and standards including Policy #5010 Receiving Hospital Standards and the requirements described in this policy.
   3. Have a written agreement with the EMS Agency identifying the hospital as an approved Base Hospital.
   4. Have a designated area within the Emergency Department for Base Hospital telecommunications equipment.
   5. Permit periodic announced and unannounced visits by EMS Agency staff to monitor compliance with any of the above.
B. Roles and Responsibilities
   1. Provide on-line medical direction and consultation to prehospital personnel in accordance with EMS Agency Policies and Patient Treatment Protocols.
      a) Medical direction shall include, but is not limited to, ordering interventions based upon patient presentation per EMS Agency Patient Treatment Protocols and medical consultation as requested by a prehospital provider.
   2. Collect data and keep records in accordance with the Base Hospital and EMS Agency Quality Improvement plans.
   3. Act as an educational resource for prehospital providers.

a) Provide a collection of texts, journals, policies, and procedures along with an opportunity for educational consultation with prehospital personnel.

b) Periodically offer Continuing Education courses.

c) Develop and present any local policy or educational updates as required by the EMS Agency Medical Director for continued EMT-P accreditation in San Francisco.

4. Participate in the EMS system planning through:

a) Base Hospital personnel representation at all stakeholder meetings including, but not limited to the EMS Advisory Committee and the Trauma System Audit Committee.

b) Prehospital research as approved by the EMS Agency.

C. Personnel Requirements

1. Clerical Support

a) The Base Hospital shall employ such clerical support as necessary to meet the requirements of the Base Hospital.

2. Base Hospital Coordinator

a) Minimum requirements:

(1) Experienced ED RN regularly assigned to the ED with patient care responsibilities.

(2) Thoroughly familiar with prehospital policies, procedures, and practices and a minimum of 1 year experience working directly with prehospital personnel in San Francisco.

b) Participate in a minimum of 24 hours direct observation of prehospital care each year, at least 12 hours of which must be on an Advanced Life Support Provider.

c) Collaborate with the Base Hospital Physicians and Medical Director to meet the requirements of the Base Hospital.

3. Base Hospital Physician

a) Minimum requirements and orientation

(1) Current licensure to practice medicine in California.

(2) Current practice at the Base Hospital.

(3) Current participation in an Emergency Medicine Residency, or be Board Eligible or be Board Certified in Emergency Medicine.

(4) Completion of an approved orientation course that, at a minimum, includes the following:

(a) Orientation to system issues relevant to Base Hospital Physician Medical Direction.

(b) Radio communications.

(c) Written examination testing knowledge of Advanced Life Support protocols and EMS Agency policy.

(d) Direct observation of prehospital care (required for initial approval only)

(i) 8 hours and 4 ALS patient contacts, at least half of the experience must on a San Francisco Advanced Life Support Ambulance.

b) New Base Hospital Physicians shall have the first (3) three consultations reviewed by the Base Hospital Medical Director, who will provide written feedback to the physician.

(1) The Base Hospital Medical Director or their designee shall perform ongoing review of consultations until the first (6) six consultations have been completed.

c) Maintenance of approval

(1) Full time physicians (0.5 FTE or greater):

(a) Complete the didactic and exam portion of the orientation course every 4 years.

(b) Eight hours of involvement in prehospital care each year. This may include direct observation at the 911 medical dispatches or via a ride along with an ALS ambulance crew.

(c) Attend 2 hours of organized prehospital continuing education each year (field care audit, journal club, local EMS conference, etc.).

(d) Educate prehospital personnel by one of the following methods:

(i) Facilitate formal field care audit session.

(ii) Perform clinical rounds/clinical preceptor.

(iii)Lecture on prehospital care at an educational seminar for ALS providers or at a locally approved paramedic training program.

(e) Perform or assist with prehospital research.

(f) Participate in medical disaster exercises.

(g) Serve in a position of leadership on a state or local EMS advisory committee.

(h) Perform special projects approved by the Base Hospital Medical Director.

(2) Part time physicians (0.5 FTE or less)

(a) Meet the same requirements listed above for full-time physician except for 1(a) and 1(b).

4. Base Hospital Medical Director

a) Minimum requirements:

(1) Maintain all requirements for Base Hospital Physician.

(2) Maintain current Board Certification in Emergency Medicine.

(3) Participate in an additional 16 hours of direct prehospital care observation per year, 8 hours of which must take place on an ALS ambulance.

b) Roles and responsibilities

(1) Oversight of Base Hospital Physicians:

(a) Perform reviews and audits as required or necessary.

(b) Be available, or designate an alternate of equal qualifications, at all times to provide direction and supervision.

(c) Represent EMS Issues to the Base Hospital Disaster Committee,

(d) Ensure Base Hospital Physicians comply with all requirements.

(2) Oversight of Base Hospital Quality Improvement and administrative activities.

(3) Liaison to the EMS Agency and ambulance provider Medical Directors.

D. Quality Improvement

1. The Base Hospital shall develop a Quality Improvement plan approved by the EMS Agency.

a) Plan will meet the requirements of EMS Agency Policy #6000, Quality Improvement Program.

b) Plan will work to support EMS System Quality Improvement Plan.

c) Must contain the following:

(1) Prospective educational component.

(2) Concurrent observation and evaluation component.

(3) Retrospective examination of identified Quality Indicators.

(4) Clearly designed method of using knowledge gained to influence ongoing education of Base Hospital staff and prehospital personnel.

(5) Remediation contingencies for individuals who consistently fail to meet expectations.

2. Base Hospital policies and procedures shall support the plan and require personnel to participate in Quality Improvement.
3. Plan must be reviewed and revised as necessary at least every 2 years.
4. Data and patient information, as determined necessary by the EMS Agency Medical Director, shall be provided in a form determined by the EMS Agency for the purposes of system wide quality improvement, case review, or individual case investigation:
    a) Whenever possible data will be requested without patient identifying information and shall be the minimum amount of information necessary to achieve the goals of a given project.
5. Base Hospital report:
    a) Bi-annual preparation to coincide with fiscal year of City and County of San Francisco.
    b) Due no later than 60 days following close of every second fiscal year.
    c) Will detail the previous 24 month's activities.
6. All deficiencies in prehospital care shall be forwarded, in a timely fashion, to the provider's Medical Director or QI representative for investigation:
    a) Situations that remain unresolved after contacting the provider shall be reported to the EMS Agency using the reporting procedures outlined in EMS Agency Policy #6020, Incident Reporting.
    b) Incidents that, in the opinion of Base Hospital personnel, represent an act of gross negligence or an ongoing threat to public health and safety shall also be reported to the provider field supervisor and the EMS Agency.

E. Prehospital Education:
1. The Base Hospital shall develop and present Continuing Education programs with a specific goal of improving the quality of care and knowledge of prehospital and Base Hospital personnel.
2. Offer programs of structured clinical experience with Continuing Education credit to prehospital providers
3. Provide resources for supervised remediation of prehospital personnel.
4. The Base Hospital may act as a clinical site for paramedic training programs, subject to hospital and school policies.

F. Base Hospital Communications:
1. The Base Hospital will maintain a dedicated radio and telephone line for prehospital personnel to consult with the Base Hospital Physician.
2. All voice communications between the Base Hospital Physician and prehospital personnel shall be recorded:
    a) Recorded consultations are not considered part of the patient record.
    b) Confidentiality shall be maintained during all communications.
    c) Recorded consultations shall be made available to the EMS Agency within 10 days of request.

d) Recorded consultations shall be kept on file, protected from accidental erasure, and unaltered for a minimum of 100 days:

(1) Copies of recordings used for public presentation may be edited to remove patient and personnel identifying information.

e) Recordings may be used for educational and investigative purposes.

3. The Base Hospital will maintain a dedicated telephone line to the Emergency Communications Department.

IV. PROCEDURE

A. Radio communications and consultations shall be conducted in accordance with EMS Agency Policy #3020, Field to Hospital Communications.

B. The Base Hospital will maintain a record of all calls that includes:

1. EMT-P and physician identities.
2. Prehospital assessment.
3. Interventions prior to contact.
4. Medical direction given.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5012
Effective Date: August 1, 2007
Review Date: January 1, 2011
Supersedes: February 1, 2004

PEDIATRIC CRITICAL CARE STANDARDS

I. PURPOSE

A. Establish the minimum standards for receiving hospitals who wish to accept emergent pediatric patients from approved ALS and BLS providers within the San Francisco EMS System.

II. AUTHORITY

A. California Health and Safety Code, Sections 1255, 1255.5, 1256, 1797.220, 1797.222, 1798, 1798.150, 1798.163, 1799.202 et seq.
B. California Code of Regulations, Title 22, Sections 10727, 10728, 42400 et seq., 100147, 100172, 100175
C. California Children's Services Procedure Manual, Chapter 3, Standards for Pediatric Intensive Care Units (PICUs)

III. POLICY

A. Pediatric Critical Care Centers shall be receiving hospitals as defined by EMS Agency Policy and will comply with all Federal, State, and local laws, as well as all EMS Agency Policies.

A. A freestanding, DHS accredited Children's Hospital may, with the approval of the EMS Medical Director, limit acceptance of patients from the EMS System to pediatric patients only if:

a) that facility normally restricts their capabilities to pediatrics, and

b) does not possess the equipment or personnel necessary to care for adult patients.

B. DHS accredited Children's Hospitals, whether freestanding or incorporated as part of a larger medical center compliant with the Receiving Hospital Standards, are considered to have met the specialty equipment and personnel requirements of this policy, provided those personnel and services are immediately available to the Emergency Department.

A. Hospitals approved under this provision shall have transfer agreements with the following facilities:

a) An EMS designated Pediatric Trauma Center

b) An EMS designated Burn Center that accepts pediatric patients

C. Application Process:

1. A Receiving Hospital that wishes to become a Pediatric Critical Care Center must submit a request in writing no later than 60 days prior to desired date of designation as A PCCC by the EMS Agency

2. The request must include the name and contact information for the Medical Director of the Pediatric Intensive Care Unit (PICU) and the date of certification of the PICU

3. The request must be signed by both the PICU Medical Director and the hospital Chief Executive Officer or Chief Operations Officer

4. Current designated PCCC's must submit this information within 60 days of the effective date of this policy revision (August 1. 2007)

D. Approval:

1. Approved Receiving Hospitals that have a Pediatric Intensive Care Unit (PICU) certified by California Children's Services (CCS) are considered to have met the specialty equipment and personnel requirements of this policy, provided those personnel and services are immediately available to the Emergency Department.

A. Hospitals approved under this provision will have transfer agreements with the following facilities:

a) A DHS accredited Children's Hospital
b) An EMS designated Pediatric Trauma Center
c) An EMS designated Burn Center that accepts pediatric patients

2. The PCCC will be approved after satisfactory review of application documentation and a site survey, when deemed necessary, by the EMS Agency Medical Director or his/her designee

3. The PCCC will be re-approved after a satisfactory San Francisco EMS Agency review every (2) two years.

4 The PICU Medical Director shall notify the EMS Agency of subsequent changes in their status

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5013
Effective Date: February 1, 2004
Review Date: January 1, 2011
Supersedes: New

TRAUMA CENTER DESIGNATION

I. PURPOSE

To establish the process and criteria by which the EMS Agency designates a Trauma Center(s) in the City and County of San Francisco

II. AUTHORITY

A. Division 2.5, California Health and Safety Code, Sections 1797.198, 1798.160, 1798.162 (a), 1798.163, 1798.165
B. California Code of Regulations, Sections 100255, 100257, 100259, 100260, 100265
C. City and County of San Francisco (CCSF) 2001 Trauma Care System Plan, Section IX
D. *Resources for the Optimal Care of the Injured Patient* published by the American College of Surgeons Committee on Trauma (ACSCOT)

III. POLICY

A. The EMS Agency Medical Director shall designate a Trauma Center(s) based on the needs assessment, trauma care system design and standards set forth in the CCSF Trauma Care System Plan.
B. Initial designation for a trauma center may be conducted through a competitive procurement/selection process in accordance with all applicable local, state and federal laws and regulations.
C. Designated Trauma Centers shall
    1. Maintain verification of Trauma Care services through the Trauma Center verification program of the ACSCOT
    2. Execute a written agreement for provision of trauma care services with the EMS Agency
    3. Participate in the EMS Agency trauma data collection system
    4. Participate in the EMS Agency trauma performance improvement program
    5. Comply with all applicable EMS Agency policies and procedures
D. The EMS Agency Medical Director shall evaluate designated Trauma Centers' status every three years, in consultation with the ACSCOT.
E. In the event a designated Trauma Center fails to meet EMS Agency Trauma Center criteria and standards as set forth in this policy
    1. The EMS Agency Medical Director may elect to issue a conditional designation that will be followed within six to twelve months by another evaluation of the deficient area(s).

2. Upon satisfactory completion of a second evaluation, the EMS Medical Director will restore the hospital's status as a designated Trauma Center.
3. If the second evaluation is unsatisfactory, the EMS Agency Medical Director, in consultation with the Director of Health, may elect to either continue the conditional designation upon correction of the areas of deficiency or solicit a Request for Proposals from other hospitals within the City and County of San Francisco.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5014
Effective Date: September 1, 2005
Review Date: January 1, 2011
Supersedes: New

LEVEL I TRAUMA CARE STANDARDS

I. Purpose

To define standards for Level I Trauma Care facilities. Level I Trauma Care Standards are adapted from California Code of Regulations Title 22 Trauma Care System Standards (§100236 – 100266).

II. Authority

A. California Health and Safety Code 1797.198, 1797.204, 1797.224, 1798.160 – 165.
B. CCR Title 22 100236 – 100266.

III. Trauma Center Requirements: Level I Trauma Centers

a. A Level I or II trauma center is a licensed hospital which has been designated as a Level I or II trauma center by the EMS Agency. While both Level I and II trauma centers are similar, a Level I trauma center is required to have staff and resources not required of a Level II trauma center. The additional Level I requirements are located in Section III of these standards. Level I and II trauma centers shall have appropriate pediatric equipment and supplies and be capable of initial evaluation and treatment of pediatric trauma patients. Trauma centers without a pediatric intensive care unit, as outlined in Section III.e.1. of these standards, shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care. A Level I or Level II trauma center shall have at least the following:

1. A trauma program medical director who is a board-certified surgeon, whose responsibilities include, but are not limited to, factors that affect all aspects of trauma care such as:
    a) recommending trauma team physician privileges;
    b) working with nursing and administration to support the needs of trauma patients;
    c) developing trauma treatment protocols;
    d) determining appropriate equipment and supplies for trauma care;
    e) ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
    f) having authority and accountability for the quality improvement peer review process;
    g) correcting deficiencies in trauma care or excluding from trauma call those trauma team members who no longer meet standards;

   h) coordinating pediatric trauma care with other hospital and professional services;
   i) coordinating with local and State EMS agencies;
   j) assisting in the coordination of the budgetary process for the trauma program; and
   k) identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics, and other appropriate disciplines to assist in identifying physicians from their disciplines who are qualified to be members of the trauma program.
2. A trauma nurse coordinator/manager who is a registered nurse with qualifications including evidence of educational preparation and clinical experience in the care of the adult and/or pediatric trauma patient, administrative ability, and responsibilities that include, but are not limited to:
   a) organizing services and systems necessary for the multi-disciplinary approach to the care of the injured patient;
   b) coordinating day-to-day clinical process and performance improvement as it pertains to nursing and ancillary personnel; and
   c) collaborating with the trauma program medical director in carrying out the educational, clinical, research, administrative, and outreach activities of the trauma program.
3. A trauma service which can provide for the implementation of the requirements specified in these standards and provide for coordination with the EMS Agency.
4. A trauma team, which is a multi-disciplinary team responsible for the initial resuscitation and management of the trauma patient.
5. Department(s), division(s), service(s) or section(s) that include, at least the following surgical specialties, which are staffed by qualified specialists:
   a) general;
   b) neurologic;
   c) obstetric/gynecologic;
   d) ophthalmologic;
   e) oral or maxillofacial or head and neck;
   f) orthopaedic;
   g) plastic; and
   h) urologic
6. Department(s), division(s), service(s) or section(s) that include, at least the following non-surgical specialties, which are staffed by qualified specialists:
   a) anesthesiology;
   b) internal medicine;
   c) pathology;

d) psychiatry; and
e) radiology;

7. An emergency department, division, service or section staffed with qualified specialists in emergency medicine who are immediately available.
8. Qualified surgical specialist(s) or specialty availability, which shall be available as follows:
    a) general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be immediately available for trauma team activation and promptly available for consultation;
    b) On-call and promptly available:
        i. neurologic;
        ii. obstetric/gynecologic;
        iii. ophthalmologic;
        iv. oral or maxillofacial or head and neck;
        v. orthopaedic;
        vi. plastic;
        vii. reimplantation/microsurgery capability. This surgical service may be provided through a written transfer agreement; and
        viii. urologic.
    c) Requirements may be fulfilled by supervised senior residents as defined in EMS Agency Policy #1020, *Glossary*, who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:
        i. the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;
        ii. a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available;
        iii. a staff trauma surgeon or a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.
    d) Available for consultation or consultation and transfer agreements for adult and pediatric trauma patients requiring the following surgical services;
        i. burns;
        ii. cardiothoracic;
        iii. pediatric;

iv. reimplantation/microsurgery; and
v. spinal cord injury.

9. Qualified non-surgical specialist(s) or specialty availability, which shall be available as follows:
    a) Emergency medicine, in-house and immediately available at all times. This requirement may be fulfilled by supervised senior residents, as defined in EMS Agency Policy #1020, *Glossary*, in emergency medicine, who are assigned to the emergency department and are serving in the same capacity. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialists in emergency medicine and are board certified in emergency medicine shall not be required by the EMS Agency to complete an advanced trauma life support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine.
    b) Anesthesiology. Level II shall be promptly available with a mechanism established to ensure that the anesthesiologist is in the operating room when the patient arrives. This requirement may be fulfilled by senior residents or certified registered nurse anesthetists who are capable of assessing emergent situations in trauma patients and of providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist on-call shall be advised about the patient, be promptly available at all times, and be present for all operations.
    c) Radiology, promptly available; and
    d) Available for consultation:
        i. cardiology;
        ii. gastroenterology;
        iii. hematology;
        iv. infectious diseases;
        v. internal medicine:
        vi. nephrology;
        vii. neurology;
        viii. pathology; and
        ix. pulmonary medicine.

b. In addition to licensure requirements, trauma centers shall have the following service capabilities:
    1. Radiological service. The radiological service shall have immediately available a radiological technician capable of performing plain film and computed tomography imaging. A

radiological service shall have the following additional services promptly available:
   a) angiography; and
   b) ultrasound.
2. Clinical laboratory service. A clinical laboratory service shall have:
   a) a comprehensive blood bank or access to a community central blood bank; and
   b) clinical laboratory services immediately available.
3. Surgical service. A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:
   a) Operating staff who are promptly available unless operating on trauma patients and back-up personnel who are promptly available; and
   b) appropriate surgical equipment and supplies as determined by the trauma program medical director.

c. A Level I and II trauma center shall have a basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:
1. designate an emergency physician to be a member of the trauma team;
2. provide emergency medical services to adult and pediatric patients; and
3. have appropriate adult and pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director.

d. In addition to the special permit licensing services, a trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following approved supplemental services:
1. Intensive Care Service:
   a) the ICU shall have appropriate equipment and supplies as determined by the physician responsible for the intensive care service and the trauma program medical director;
   b) The ICU shall have a qualified specialist promptly available to care for trauma patients in the intensive care unit. The qualified specialist may be a resident with two (2) years of training who is supervised by the staff intensivist or attending surgeon who participates in all critical decision making; and
   c) the qualified specialist in b) above shall be a member of the trauma team.
2. Burn Center. This service may be provided through a written transfer agreement with a Burn Center.
3. Physical Therapy Service. Physical therapy services to include personnel trained in physical therapy and equipped for acute care of the critically injured patient.

4. Rehabilitation Center. Rehabilitation services to include personnel trained in rehabilitation care and equipped for acute care of the critically injured patient. These services may be provided through a written transfer agreement with a rehabilitation center.
5. Respiratory Care Service. Respiratory care services to include personnel trained in respiratory therapy and equipped for acute care of the critically injured patient.
6. Acute hemodialysis capability.
7. Occupational therapy service. Occupational therapy services to include personnel trained in occupational therapy and equipped for acute care of the critically injured patient.
8. Speech therapy service. Speech therapy services to include personnel trained in speech therapy and equipped for acute care of the critically injured patient.
9. Social Service.

e. A trauma center shall have the following services or programs that do not require a license or special permit.

1. Pediatric Service. In addition to the requirements in Division 5 of Title 22 of the California Code of Regulations, the pediatric service providing in-house pediatric trauma care shall have:
   a) a pediatric intensive care unit approved by the California State Department of Health Services' California Children Services (CCS); or a written transfer agreement with an approved pediatric intensive care unit. Hospitals without pediatric intensive care units shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care; and
   b) a multidisciplinary team to manage child abuse and neglect.
2. Acute spinal cord injury management capability. This service may be provided through a written transfer agreement with a Rehabilitation Center;
3. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code;
4. An outreach program, to include:
   a) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
   b) trauma prevention for the general public;
5. Written interfacility transfer agreements with referring and specialty hospitals;
6. Continuing education. Continuing education in trauma care shall be provided for:
   a) staff physicians;
   b) staff nurses;
   c) staff allied health personnel;
   d) EMS personnel; and

e) other community physicians and health care personnel.

IV. Additional Level I Criteria

In addition to the above requirements, a Level I trauma center shall have:

a. One of the following patient volumes annually:
   1. a minimum of 1200 trauma program hospital admissions, or
   2. a minimum of 240 trauma patients per year whose Injury Severity Score (ISS) is greater than 15, or
   3. an average of 35 trauma patients (with an ISS score greater than 15) per trauma program surgeon per year.

b. Additional qualified surgical specialists or specialty availability on-call and promptly available:
   1. cardiothoracic; and
   2. pediatrics;

c. A surgical service that has at least the following:
   1. operating staff who are immediately available unless operating on trauma patients and back-up personnel who are promptly available.
   2. cardiopulmonary bypass equipment; and
   3. operating microscope.

d. Anesthesiology immediately available. This requirement may be fulfilled by senior residents or certified registered nurse anesthetists who are capable of assessing emergent situations in trauma patients and of providing treatment and are supervised by the staff anesthesiologist.

e. An intensive care unit with a qualified specialist in-house and immediately available to care for trauma patients in the intensive care unit. The qualified specialist may be a resident with 2 years of training who is supervised by the staff intensivist or attending surgeon who participates in all critical decision making.

f. A Trauma research program; and

g. An ACGME approved surgical residency program.

V. Quality Improvement

Trauma centers of all levels shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition, the process shall include:

- **a.** A detailed audit of all trauma-related deaths, major complications and transfers (including interfacility transfer);
- **b.** A multi-disciplinary trauma peer review committee that includes all members of the trauma team;
- **c.** Participation in the trauma system data management system;
- **d.** Participation in the EMS Agency Trauma System Audit Committee; and
- **e.** Each trauma center shall have a written system in place for patients, parents of minor children who are patients, legal guardian(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child.
- **f.** Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5015
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Supersedes: September 1, 2006

STROKE CENTER STANDARDS

I. PURPOSE

Establish the minimum standards for Receiving Hospitals who wish to accept acute stroke patients from approved ALS and BLS providers within the San Francisco EMS System.

II. AUTHORITY

A. California Health and Safety Code, Sections 1255, 1255.5, 1256, 1797.220, 1797.222, 1798, 1798.150, 1798.163, 1799.202 et seq.
B. California Code of Regulations, Title 22, Sections 10727, 10728, 42400 et seq., 100147, 100172, 100175.
C. Joint Committee on the Accreditation of Hospitals and Health Care Organizations (JCAHO) Primary Stroke Center.

III. POLICY

A. Stroke Centers shall be Receiving Hospitals as defined by San Francisco (SF) Emergency Medical Services (EMS) Agency Policy and will comply with all Federal, State, and local laws as well as all EMS Agency Policies.

1. JCAHO accredited Primary Stroke Centers are considered to have met the specialty equipment and personnel requirements of this policy. Hospitals approved under this provision will have transfer agreements with other Receiving Hospitals for stroke patients and will participate in the Local EMS Information System (LEMSIS) and EMS quality improvement programs per EMS Agency Policy #5010, *Receiving Hospital Standards*.

B. Application Process:

1. A Receiving Hospital that wishes to become a Stroke Center must submit a request in writing no later than 60 days prior to the desired date of designation as a Stroke Center by the EMS Agency.
2. The request must include the date of achievement of JACHO accreditation as Primary Stroke Center and the name and contact information for the Primary Stroke Center Program Manager

3. The request must be signed by the program Manager and the hospital Chief Executive or Chief Operations Officer
4. Currently designated Stroke Centers must submit this information with 60 days of the effective date of the policy revision (August 1, 2007)

B. Approval:

1. The Stroke Center will be approved after satisfactory review of application documentation and a sire survey, when deemed necessary, by the EMS Agency Medical Director or his/her designee.
2 The Stroke Center will be re-approved after satisfactory San Francisco EMS Agency review every two (2) years
3. The Stroke Center Program Manager shall notify the EMS Agency of subsequent changes in their status.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No: 5016
Effective Date: January 7, 2013
Supersedes: New

STEMI AND ROSC ("STAR") RECEIVING CENTER STANDARDS

I. PURPOSE

To establish standards for the designation of hospitals as approved receiving centers for STEMI and post-cardiac **a**rrest patients with Return of Spontaneous Circulation (ROSC) called STAR Centers.

II. AUTHORITY

Code of Federal Regulations, Title 45, Section 164.512 (b) (l) (i)
California Health and Safety Code, Division 2.5, Sections 1797.222, 1797.250, 1797.252, 1798, and 1798.150.
California Code of Regulations, Title 22, Sections 100169, 70411-70419, and 70451 – 70459.
Joint Commission on Accreditation of Health Care Organizations, Emergency Department Standards
San Francisco Business and Tax Regulations Code SEC. 249.8 (e)(1-2)

III. DEFINITIONS

STEMI: An acute myocardial infarction that generates a ST segment elevation on a 12-lead electrocardiogram (EKG).

ST Elevation Myocardial Infarction / Post **A**rrest with **R**OSC (**STAR**) Center: A licensed general acute care hospital with a special permit for a cardiac catheterization laboratory and cardiovascular surgery from the California State Department of Health Services, and designated as a STAR center by the County of San Francisco.

Return of Spontaneous Circulation (ROSC) Post-cardiac arrest patients are those with a pulse, blood pressure or have cardiac output directly observed with ultrasound. These patients are eligible for ICU care and specialized treatment, such as therapeutic hypothermia and cardiac catheterization (if found to have a STEMI as the cause of the cardiac arrest).

IV. POLICY

A. The EMS Medical Director shall designate a STAR Receiving Center based on the standards set forth in policy.
B. Designated STAR Receiving Centers shall agree to comply with all applicable EMS Agency Policies and procedures.
C. A hospital must demonstrate all of the following to become a designated STAR Receiving Center for the EMS system:
    1. Written agreements with the San Francisco EMS Agency designating the hospital as:
        a) An approved receiving destination for patients transported by EMS ambulances.

   b) An approved destination for STEMI and post-cardiac arrest patients. STAR receiving centers have two months after obtaining the initial designation to complete this written agreement.
2. Licensure as a Comprehensive or Basic Emergency Department (ED).
3. A special permit for a Cardiac Catheterization Laboratory from the California State Department of Health Services (DHS) as well as a special permit issued by DHS for Cardiovascular Surgery Service.
4. Accreditation by the Joint Commission on Accreditation of Health Care Organizations.
5. STAR program description that includes an organizational chart, programmatic goals and objectives, and a Quality Assurance program for both STEMI and post-cardiac arrest patients.
6. Data reporting procedures for the data elements listed in Appendix A.
7. Assigned Program coordinators:
   a) One interventional cardiologist.
   b) One nursing administrator (selected from Interventional Cardiology or Emergency Department or Intensive Care Unit).
   c) Both program coordinators must actively participate in meetings of a STAR Committee which reports to the EMS Advisory Committee (EMSAC).
8. A single point of contact responsible for reporting the data elements listed in Appendix A to the EMS Agency. (This point of contact may be from a service line or department responsible for quality and/or administration of patients treated by Interventional Cardiology, ED or ICU, and does not need to be either a physician or a nurse administrator).

V. INITIAL APPLICATION FOR STAR DESIGNATION

A. Interested hospitals shall submit a written request for STAR receiving center status along with documentation of their eligibility for the STAR Receiving Center designation by compliance with standards listed in Section IV.
B. STAR Receiving Centers must pay all applicable fees at a time designated by the EMS Agency. The San Francisco Business and Tax Regulations Code SEC. 249.8 (e)(1-2) authorizes the payment of regulatory fees to the City and County of San Francisco for hospitals that receive STEMI patients through EMS ambulance services.
C. Approval or denial of the STAR receiving center designation shall be made in writing by the EMS Agency to the requesting Hospital within one month after receipt of the request and all required documentation.
D. The EMS Agency reserves the right to do an initial site surveys to assure compliance with the standards listed in this policy.

VI. MAINTENANCE OF STAR DESIGNATION

A. Each receiving hospital will complete a self-assessment at least once every two years to ensure compliance with EMS Agency requirements. The self assessment may be performed concurrent with JCAHO review.

B. A STAR Receiving Center shall comply with the data collection, record keeping and quality improvement standards for all receiving hospitals as described in *Policy 5010 Receiving Hospital Standards.* Appendix A lists the current STAR data elements. Data collection shall be reported in periods of time designated by the EMS Agency. Data elements may be revised periodically by the STAR Committee with recommendations made to the EMS Agency Medical Director.
C. Regular participation of the STAR Program coordinators in the STAR Committee meetings.
D. STAR Receiving Centers must pay all applicable fees at a time designated by the EMS Agency. The San Francisco Business and Tax Regulations Code SEC. 249.8 (e)(1-2) authorizes the payment of regulatory fees to the City and County of San Francisco for hospitals that receive STEMI patients through Ambulance Service Providers.
E. The EMS Agency may deny, suspend, or revoke the approval of a STAR Receiving Center for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Medical Director of the EMS Agency. Second requests for review or appeal of the EMS Agency Medical Director decision may be submitted to the San Francisco Director of Health.
F. The EMS Agency reserves the right to do periodic site surveys to assure compliance with the standards listed in this policy.

APPENDIX A: STAR DATA ELEMENTS

Data should be in an Excel spreadsheet showing information for each case.

GENERAL INFORMATION

1. Demographic information *(aggregate data only)*
2. Paramedic run number
3. Time and date of patient arrival
4. Interfacility or 911? If interfacility, ALS or CCT? *(if available)*
5. ED disposition
6. Length of hospital stay
7. Hospital disposition: Discharged? Expired? Transferred?
8. If transferred, times of departure of patient, arrival of patient, and D2B if STEMI
9. ICD code

STEMI DATA ELEMENTS

10. STEMI: 12 lead ECG reading and paramedic interpretation *(completed by EMS Agency, not hospitals)*
11. STEMI: Arrival time at hospital
12. STEMI: First device activation (i.e. "balloon time")
13. STEMI: Arrival time at hospital to first device activation (D2B)
14. STEMI: Prehospital ECG to first device activation (E2B) *(completed by EMS Agency, not hospitals)*
15. STEMI: Did the patient have ROSC after cardiac arrest?

ROSC DATA ELEMENTS

16. ROSC: Survival to ED admit (% of cardiac arrest patients admitted to ED)
17. ROSC: Survival to hospital discharge (% of cardiac arrest patients discharged or transferred as hospital disposition)
18. ROSC: Use of hypothermia
19. ROSC: Cerebral Performance Score

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5020
Effective Date: January 30, 2017
Supersedes: August 1, 2012

DIVERSION POLICY

I. PURPOSE

To establish procedures for hospitals to divert 911 ambulance patients.

II. HOSPITAL STATUS DEFINTIONS

Open: A hospital is able to receive patients transported via 911 ambulances.

Ambulance Diversion: A hospital is temporarily closed to select patients transported via 911 ambulances due to an overload of patients in the Emergency Department.

Internal Disaster: A hospital is completely closed to ALL patients transported via 911 ambulances due to a compromised specialty center function or when an internal disaster status with the Hospital Incident Command System (HICS) is activated.

Diversion Suspension: A temporary halt to the use of ambulance diversion.

III. POLICY

A. *Reddinet* is an internet-based communications system that is used to communicate a hospital's diversion status to the EMS System (911 Dispatch [Division of Emergency Communications (DEC)], hospitals and ambulances). Each EMS organization shall have personnel trained to operate Reddinet on-duty 24 hours a day, seven days a week.

B. EMS personnel shall utilize *EMS Agency Policy #5000 Ambulance Destination* to determine a hospital destination for ambulance transported patients. The Base Hospital Physician is the final authority in determining a destination for a patient during an ambulance transport.

C. **Ambulance Divert / Diversion** may only be declared by a hospital when its Emergency Department has an overload of patients and it cannot safely provide care to any additional 911 ambulance patients. A hospital may NOT declare Diversion due to the lack of staff or in-patient medical/surgical or critical care beds.

D. Ambulance Diversion **ONLY** applies to general medical patients. Diversion does **NOT** apply to:
   1. Critical airway patients
   2. Adult critical medical patients,
   3. Patients meeting the following Specialty Care triage criteria:
      a) Pediatric Medical

b) Pediatrics Critical Medical
c) STAR (STEMI and/or Post Arrest with ROSC)
d) Reimplantation (Microvascular Surgery)
e) Burns
f) Obstetrics
g) Stroke
h) Trauma
i) LVAD
j) Post-Sexual Assault

4. Patients originating from a hospital-based clinic. Such patients shall be considered to have arrived on hospital property and must be transported to that hospital's Emergency Department.
5. Patients who are incarcerated or in police custody that are taken to Zuckerberg San Francisco General Hospital.

E. **Internal Disaster** is the declaration of a complete closure of the Emergency Department to ALL 911 ambulance traffic due to a compromised specialty center function (e.g. cardiac catheterization lab is down and not available for a 911 ambulance patient) OR when an internal disaster status with the Hospital Incident Command System (HICS) is activated.

1. A hospital may not declare an internal disaster due to the lack of staff or in-patient medical/surgical or critical care beds or Emergency Department beds.
2. The following physical plant issues must exist during a declared internal disaster status:
    a) Power outage with a non-functional generator,
    b) Fire,
    c) Flooding,
    d) Hazmat (contamination of patient care areas), or
    e) Safety and security compromised (e.g. imminent threat of violence or active violent incident), and
    f) Hospital Incident Command System (HICS) is activated.
3. A hospital declaring Internal Disaster is REQUIRED to notify the Department of Emergency Management (DEM) Duty Officer. The DEM Duty Officer must be contacted through the 911 Dispatch [DEC].

IV. DIVERSON SUSPENSION

A. Diversion Suspension is a temporary halt in the use of ambulance diversion. Diversion suspension requires Receiving Hospitals to accept all 911 ambulance transported patients. The intent of Diversion Suspension is to "open up" hospitals that are on diversion to allow for the safe and efficient function of the EMS system.

B. Diversion suspension is initiated by 911 Dispatch [DEC] when **four (4)** or more of the following full Receiving Hospitals***** are on Diversion:

1. San Francisco General Hospital
2. CPMC-St Lukes
3. UCSF – Parnassus
4. St Mary's Medical Center
5. Kaiser San Francisco
6. CPMC – Pacific Campus
7. CMPC – Davies Campus
8. St Francis Memorial Hospital

"Full Receiving Hospitals" receive both critical (Code 3 lights and sirens) and non-urgent (Code 2 non-lights and sirens) 911 ambulance traffic.*

C. When diversion suspension is initiated, it shall remain in effect for a **four-hour** time period.

D. If four (4) or more full Receiving Hospitals are on Ambulance Diversion at the end of the four-hour diversion suspension, DEC staff shall continue the diversion suspension for another **four-hour** time period.

E. Diversion suspension does **NOT** apply to:
   1. The pediatric Emergency Departments at UCSF Mission Bay, or CPMC – California Campus.
   2. Hospitals located in other counties (Seton Medical Center and Kaiser South San Francisco in San Mateo County).
   3. When a hospital is on "INTERNAL DISASTER the hospital remains completely closed to all 911 ambulance traffic even during a diversion suspension.

V. ZUCKERBERG TRAUMA OVERRIDE

A. ZSFG is the only Trauma Center for San Francisco. During Diversion Suspension, ZSFG may elect to invoke "Trauma Override" which continues the diversion of medical (non-trauma) patients away from ZSFG. The intent of Trauma Override is to preserve the ZSFG Emergency Department capacity for trauma patients.

B. Trauma Override does **NOT** apply to:
   1. Critical airway patients,
   2. Adult critical medical patients,
   3. Patients meeting Specialty Care criteria listed in III.D.
   4. Patients originating from a hospital-based clinic. Such patients shall be considered to have arrived on hospital property and shall be transported to the ZSFG Emergency Department.
   6. Patients who are incarcerated or in police custody.
   7. ZSFG will follow *Policy 5021 Trauma Bypass* for any internal disaster situation that closes it to trauma patients.

VI. HOSPITAL PROCEDURES

A. A hospital is considered OPEN for receiving 911 ambulance patients if the diversion status is not displayed on the Reddinet status screen. "OPEN" status is indicated when the Reddinet status page displays the facility as a hyphen (**-**).

B. A hospital is on AMBULANCE DIVERT when the Reddinet status page displays their facility as "DIVERT."

C. ZSFG is on TRAUMA OVERRIDE when the Reddinet status page displays their facility as "OVERRIDE."

D. A specialty center designated receiving hospital or receiving hospital is on INTERNAL DISASTER when Reddinet status page displays their facility as "INT DISASTER."

E. Hospitals shall change their diversion status to OPEN on the Reddinet screen immediately upon relieving the situation that necessitated the use of any divert status. **Diversion status updates on Reddinet should be made even during periods of diversion suspension.**

VII. 911 DISPATCH DEC PROCEDURES

A. DEC shall announce by radio and mobile data terminals to all ambulance personnel any time there is a change in diversion status on the Reddinet screen or when diversion suspension starts or ends. Routine diversion status and diversion suspension announcements must also be done every two hours.

B. DEC shall follow the same procedures for communication of ZSFG Trauma Override or hospital Internal Disaster to EMS System participants.

VIII. AMBULANCE PROCEDURES

A. When hospital is on "AMBULANCE DIVERT," no general medical patients may be transported to that hospital. Ambulance Diversion does **NOT** apply to:
   1. Critical airway patients
   2. Critical medical adult patients, or
   3. Patients meeting Specialty Care triage criteria.
   4. Patients originating from a hospital-based clinic.

B. When a hospital is on "INTERNAL DISASTER," NO patient will be transported via 911 ambulance to that hospital. The hospital is completely closed to ALL 911 ambulance traffic even during a diversion suspension.

C. Zuckerberg San Francisco General Hospital is always open to incarcerated or in-custody patients except when an "INTERNAL DISASTER and TRAUMA BYPASS" are declared.

D. Ambulances that are en route to any hospital or have arrived on hospital property must complete the patient transport to that facility when its Emergency Department goes on Diversion except when a "INTERNAL DISASTER is declared.

E. Ambulances may go to hospital during a declared INTERNAL DISASTER if they are needed for the evacuation of patients in that facility.

IX. BACK UP TELEPHONE COMMUNICATIONS IF REDDINET FAILS

A. Hospitals must notify DEC via telephone of any diversion status changes.

B. DEC may enter the hospital status into the Reddinet if the hospital is unable to access the web site.

C. All Reddinet users (hospitals/911 dispatch) must contact their IT staff and / or the Reddinet Technical Support line for assistance in getting the website back up.

X. QUALITY ASSURANCE

A. The EMS Agency shall report monthly diversion activity for all San Francisco Receiving Hospitals.

B. Problems related to the implementation of this policy shall be reported to the EMS Agency through the Exception and Sentinel Events Report System.

XI. AUTHORITY

California Health and Safety Code, Section 1798

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No: 5021
Effective: February 1, 2009
Review Date: February 1, 2011
Supersedes: August 1, 2008

TRAUMA CENTER BYPASS POLICY

I. PURPOSE

To describe Trauma Center bypass procedure for the optimal care of trauma patients if San Francisco General Hospital (SFGH) Trauma services are not available.

II. AUTHORITY

- Division 2.5, California Health and Safety Code, Sections 1797.198, 1798.160, 1798.162 (a), 1798.163, 1798.165
- California Code of Regulations, Title 22, Division 9, Chapter 7: Trauma Care Systems, Sections 100255 (a-c)
- City and County of San Francisco Trauma Care System Plan, Section VII, Objective III.A.

III. POLICY

- **Conditions under which the Trauma Center Bypass Policy shall be activated:**
  1. The Trauma Center Bypass policy shall be activated if the Trauma Center is incapable of receiving trauma patients as defined in the Trauma Triage Criteria # 5001.

  - The Trauma Center will notify EMS Agency to activate either ***"partial"*** or ***"total"*** bypass.

    - ***"Partial bypass"*** means that the Trauma Center can only receive trauma patients approved for transport to SFGH by Base Hospital MD (for example, CT scan is unavailable, but all other equipment and services are functioning normally).

    - ***"Total bypass"*** means that the SFGH Trauma Center cannot receive any trauma patients (for example, a disruption in building structural integrity renders all the operating rooms non-functional).

- **SFGH Policy Development**
  - By August 1, 2009 SFGH shall develop and implement an internal policy and procedure to initiate the Trauma Center Bypass policy.
    - The SFGH internal policy and procedure will include a mechanism that is approved by the EMS Agency Medical Director for notifying the EMS Agency Duty Officer and the Department of Emergency Management, Division of Emergency Communication (DEC).

Policy Reference No: 5021
Effective: February 1, 2009
Review Date: February 1, 2011
Supersedes: August 1, 2008

IV. PROCEDURE

- **Initiation of Trauma Center Bypass Policy**
  - Prior to initiation of the Trauma Center Bypass policy, the SFGH hospital internal disaster plan shall be activated.

- **Notification of the EMS Agency Section Duty Officer**
  - SFGH Administrator on Duty (AOD) shall contact the EMS Duty Officer to consider activation of the Trauma Center Bypass Policy.
    - EMS Duty Officer pager # is 327-9114.

- **Activation of Trauma Center Bypass Policy**
  - The EMS Duty Officer shall verify that:
    - SFGH Trauma Center has a partial or total incapacity to receive trauma patients as defined in the Critical Trauma Patient Criteria and Triage Decision Scheme Policy # 5001.

    - SFGH has made every attempt to ensure that trauma services are available and has initiated the hospital internal disaster plan.

  - The EMS Duty Officer, in consultation with the SFGH AOD shall determine that the Trauma Center is on ***partial*** or ***total*** bypass, and shall activate the Trauma Center Bypass Policy.

  - The EMS Duty Officer shall advise DEC and contact the San Mateo Public Safety Communications at 650-363-4981 and request the EMS on call Administrator and the AMR Field Supervisor be notified. Communication shall include reference to the EMS Aircraft Utilization Policy # 4020 for consideration of direct transport of the trauma patients by air from field to regional trauma centers. The DEC shall notify regional Trauma Centers of policy activation.

  - DEC shall alert all hospital and pre-hospital providers of activation of the Trauma Center Bypass Policy via:

    - SFFD EMS 800 MHz radio
    - Hospital roll call on 800 MHz radio
    - EMResource and
    - Private ambulance dispatch center

  - SFGH shall indicate the beginning and end of Trauma Center Bypass on the EMResource screen.

- During periods of activation of this policy, SFGH shall provide a Trauma Center status update to the DEC and the EMS Duty Officer 2 hours after activation, then on a regular 4-hour schedule until Trauma Center Bypass is ended.

- The EMS Agency Duty Officer may ask for a status update from SFGH at any time during periods of policy activation.

- When Trauma Center Bypass is no longer required, SFGH shall consult with EMS Duty officer, who will verify and notify the DEC and San Mateo Public Safety Communications.

- **Destination**
  - While this policy is activated, patients who meet Trauma Triage Criteria Policy # 5001 will be diverted from SFGH Trauma Center to local and regional hospitals. Whenever possible, transport will be by air. Destination decision will be based on the following:

    - During ***partial*** Trauma Center Bypass, Field providers will consult with the Base Hospital Physician to determine if SFGH can take a critical trauma patient. If SFGH cannot receive the patient, the patient will be transported to the most accessible regional trauma center.
      - In cases of airway compromise, impending arrest, cardiac resuscitation, or post resuscitation, patient will be transported to the nearest Receiving Hospital, which may include SFGH.

    - During ***total*** Trauma Center Bypass, the Trauma Triage Criteria Policy #5001 will be utilized as follows:

      - Patients meeting Mechanism-only trauma center transport criteria shall be transported by ground ambulance to the nearest open receiving hospital.

      - Patients meeting Anatomical and/or Physiologic trauma center transport criteria shall be transported by air or ground ambulance to the most accessible regional Trauma Center. Pediatric patients will be transported to Oakland Children's Hospital.

      - Air ambulances will transport to the most accessible regional Level I or II Trauma Center with air access, in accordance with EMS Aircraft Policy # 4020.

- In cases of airway compromise, impending arrest, cardiac resuscitation, or post resuscitation, patient will be transported to the nearest Receiving Hospital.

- If transporting by ground to a regional trauma center, San Francisco paramedics will notify the intended destination of their ETA and patient status through the DEC. DEC will use the standard "Field Report" form in Attachment C and fax this to regional trauma center receiving the patient, as well as to the EMS Agency.

- During periods of activation of this policy, the Trauma Center will not invoke "Trauma Center Override".

- **Quality Assurance**
  - Within 3 working days of any activation of the Trauma Center Bypass Policy, SFGH Trauma Center will issue a report to the EMS Agency(see Attachment A).

  - Activation of the Trauma Center Bypass Policy is a sentinel event and will be reviewed by the San Francisco Trauma System Audit Committee.

  - Activation of the Trauma Center Bypass Policy is a standard reporting item for Health Commission review.

ATTACHMENT A
TRAUMA CENTER BYPASS POLICY
ACTIVATION REPORT

To be completed by the SFGH Trauma Center within 3 working days of an incident that results in activation of the Trauma Center Bypass Policy. Please fax to EMS Agency # 415-552-0194.

Please provide the following information:

Date and Time Bypass Activated: Date_____ Time: _____
Date and Time Bypass Terminated: Date_____ Time: _____

What was the nature of the incident that prompted activation? Please describe the circumstances (example: what equipment/physical plant failure?)

How was the problem resolved?

- Did SFGH initiate internal disaster plan prior to Trauma Bypass activation? ___yes ____no
- Was SFGH on Diversion at the time of the Trauma Bypass activation? ____yes ____no
- Date and Time Diversion had been activated: Date:_____ Time: _____
- Was SFGH on Trauma Override at the time of Trauma Bypass activation? ___yes ____no
- Date and Time Trauma Override had been activated: Date:_____ Time:_____

Number of patients triaged to alternate destinations:

Name of Hospital_____ Number of patients_____

Name of Hospital_____ Number of patients_____

Your recommendations/comments about this policy: did the Trauma Bypass procedure work? Did the notification and triage procedures facilitate optimal patient care? Please include additional pages if needed.

Completed by:
Name: _____ phone#_____

SFGH Title: _____ date: _____

ATTACHMENT B

REGIONAL TRAUMA CENTERS
Contact Information and Flight Time Intervals

TRAUMA CENTER	PHONE CONTACT	FLIGHT TIME INTERVAL from central San Francisco
Highland Alameda County Hospital	ED: 510-437-4559	NO HELIPAD; GROUND TRANSPORT ONLY
Oakland Childrens (Level II pediatric)	ED: 510-428-3240	5 min.
Eden Hospital (Level II) (Castro Valley)	ED: 510-889-5015	10 min.
John Muir Hospital (Level II) (Walnut Creek)	ED: 925-939-5800	10 min.
Stanford Health Care (Level I)	ED: 650-723-7337	12 min.
San Jose Hospital (Level II)	ED: 408-977-4684	20 min.
Santa Clara Valley Medical Center (San Jose) (Level I)	ED: 408-885-6912	20 min.
Santa Rosa Memorial (Level II)	ED: 707-525-5207	25 min.
UC Davis (Level I adult & pediatric)	ED: 916-734-3790	35 min.

ATTACHMENT C
FIELD REPORT FORM

To be used by DEC to report patient information to destination Trauma Centers.

Date_____ Time_____ Ambulance Unit_____

DEC Call Taker_____ Run Number_____

Chief Complaint_____ AMPDS code_____

PATIENT INFORMATION

AGE_____ SEX_____

MECHANISM OF INJURY_____

TYPE OF INJURY/INJURIES_____
_____
_____

VITAL SIGNS:

BLOOD PRESSURE_____ PULSE_____ RESPIRATORY RATE_____

TREATMENT: ❑ **c-spine** ❑ **IV** ❑ **intubated (nasal/oral)**
_____❑ **medications (if applicable)**
_____
_____
_____

DESTINATION TRAUMA CENTER_____

ETA_____

Hospital Notification:

TIME: _____HOSPITAL CALL TAKER: _____

Please fax completed form to EMS Agency # 415-552-0194 and to Regional Trauma Centers.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5030
Effective Date: August 1, 2008
Review Date: January 1, 2011
Supersedes: February 1, 2005

INTERFACILITY TRANSFERS

I. PURPOSE

A. Define the San Francisco EMS Agency requirements pertaining to interfacility transfers by ambulances
B. Establish procedures to arrange, facilitate, and track interfacility transfers
C. Identify appropriate level of care and method of transport within the San Francisco EMS System

II. AUTHORITY

A. California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.206, 1797.222, 1798.170, and 1798.172
B. California Code of Regulations, Title 22, Sections 100063, 100145, 100147, 100172, 100175, and 100266

III. POLICY

A. Hospitals shall comply with all applicable Federal, State, and Local laws, regulations, and policies governing the access, treatment, and transfer of patients.
B. Hospitals shall develop written policies governing patient transfers and ensuring compliance with all applicable laws, regulations, and policies.
C. Hospitals shall develop written transfer agreements with facilities offering specialty care services not available internally.
    1. All hospitals within the City and County of San Francisco will develop a written transfer agreement with a local EMS designated Trauma Center and an EMS designated Pediatric Trauma Center to facilitate the rapid transfer of critical trauma patients to a local Trauma Center.
    2. All hospitals within the City and County of San Francisco shall develop a written transfer agreement with a hospital that has a California Children's Services certified Pediatric Intensive Care Unit if such services are not available internally.
    3. All hospitals within the City and County of San Francisco shall develop a written transfer agreement with an EMS designated Burn Center if such services are not available internally.
D. No transfer will take place without the transferring physician ensuring that:
    1. The patient received an appropriate medical screening examination and medical treatment within the transferring facility's capacity that minimizes the risks to the patient's health;
    2. There is an accepting physician;

3. The accepting facility has the capacity to care for the patient and has consented to receive the patient;
4. All available medical records regarding the patient's diagnosis and care have been made available to the accepting facility;
5. The patient has no emergency medical condition or has a stabilized emergency medical condition;
6. An appropriate method of transport is arranged;
7. There will be attendance by appropriately licensed or certified personnel with the essential equipment and medications needed to ensure appropriate treatment during transport.

E. The transferring physician is responsible for approving the category of qualifications of transporting personnel

1. Determining level of care necessary for transport will be done in accordance with IV, E.
2. When determining the necessary qualifications, consideration must be given to the length of time the patient is expected to be in the care of the transporting personnel, the patient's condition at the time of transfer, and the likelihood of the patient's condition deteriorating during the transport
3. When a reasonable possibility exists that a patient may deteriorate during the transport, the transferring physician will require the attendance of personnel capable of caring for the patient in the event of such deterioration.

F. The transferring physician remains responsible for the patient until such time as the patient arrives at and is accepted by the intended receiving facility and receiving physician.

1. Medical control of prehospital personnel remains with the EMS Agency Medical Director and the Base Hospital Physician.
2. Prehospital personnel will not exceed their scope of practice while caring for patients during interfacility transfers.
3. Registered Nurses accompanying patients on transports will operate under the medical control of the transferring physician.

G. The primary provider of emergency response to 911 requests in San Francisco shall not do interfacility transport except when:

1. A helicopter has landed and has an unstable patient requiring emergent transport to a hospital and the pre-arranged ground transport has failed to provide service.
    a) Helicopters shall not leave the sending facility without pre-arranged ground transport from the landing site to the intended receiving hospital.
2. A critical trauma patient requires emergent transport to a local Trauma Center in accordance with a written transfer agreement.
3. An unstable patient requires emergent transport from an Emergency Department to another facility that can provide specialty care the sending hospital cannot, and delay in receiving such care poses an imminent threat to the patient's health.

H. All incidents under section G require an Unusual Occurrence report be filed with the EMS Agency within 24 hours of the incident.

1. Responsibility for filing the report rests with the sending physician except in the case of helicopters, in which case the helicopter crew is responsible.

IV. PROCEDURE

A. Sending hospital, under the direction of the transferring physician, shall arrange for appropriate method of transportation.

1. Basic Life Support ambulance (BLS) – to transfer stable patients between acute care facilities or to sub-acute care facilities (including home).
2. Advanced Life Support ambulances (ALS) – to transfer stable patients that require cardiac monitoring or may require intervention that is within the paramedic scope of practice and for non-life threatening conditions.
    a) In the event of sudden, unexpected patient deterioration the paramedic in attendance will treat the patient according to existing ALS protocols and/or Base Physician direction.
3. Critical Care Transport (RN) – for transferring stable patients requiring continuous therapy not included in the paramedic scope of practice, patients who have a reasonable expectation of deterioration during the transport, or unstable patients requiring transfer for specialty care.
4. Critical Care Transport-Paramedic (CCT-P) - for transferring stable patients requiring continuous therapy not included in the paramedic basic scope of practice, patients who have a reasonable expectation of deterioration during the transport, or unstable patients requiring transfer for specialty care.
5. In the event an unstable patient or a patient requiring CCT level care requires immediate transport and the only available ambulance is either BLS or ALS, the transferring physician must accompany the patient (or designate a qualified individual to accompany the patient) with all essential equipment and medications.

B. Sending hospital will transfer care to the transport personnel and provide all documentation needed to continue care of the patient at the receiving facility.

1. Transfer of care includes a verbal report to the transporting personnel from the transferring physician or nurse caring for the patient at the time of transport.
2. Transporting personnel will be provided with patient information necessary to continue care of the patient and complete any required patient care reports.

C. Transporting personnel will assume and continue care of patient until such time as patient care is transferred to the receiving facility staff along with all documents necessary to continue care of the patient.

1. Transporting personnel will provide advanced notification via radio while enroute to the receiving facility if:
    a) The patient is a transfer for higher level of care; and
    b) The patient's destination is the receiving facility's Emergency Department.
2. Transfer of care includes a verbal report to the receiving facility staff assigned to care for the patient.

D. Patient belongings, supplies, and equipment shall only be transported with the patient in such amounts that can be safely secured in the ambulance.

1. Transport personnel will not assume responsibility for controlled substances or medications in unsealed packages.

E. Guidelines for determining level of care

1. The following table identifies the minimum level of care required for the type of care needed or equipment required during transport.

Equipment or Care Required	BLS	ALS	CCT - RN	CCT-P
Stable patient requires no special care, may have NG tube, Foley catheter, gastrostomy tube, or patient controlled device that requires no intervention from transporting personnel	♦			
Stable patient requires cardiac monitoring or may need paramedic level intervention, with no reasonable expectation that patient condition will deteriorate		♦		
Stable patient requiring care outside paramedic scope of practice, patient whose condition has a reasonable expectation of deteriorating, or an unstable patient			♦	♦
Oxygen by mask or cannula	♦			
Continuous ventilatory assistance required			♦	♦
Accompanied by RT or RN from hospital		♦		
Peripheral IV (or heparin/saline lock) without additives	♦			
D10 (as substitute for TPN)	♦			
Potassium Chloride <40 mEq/L		♦		
Peripheral IV with any drug listed in paramedic scope of practice being administered to a stable patient, infused without an IV pump		♦		
IV infusion of any drug requiring an IV pump, outside paramedic scope of practice, or to unstable patient			♦	♦
Central venous access device (capped)	♦			
Central venous access device with fluids running	♦			
Arterial access device			♦	
Pulmonary artery line in place			♦	
Intra-Aortic Balloon Pump			♦	
Intracranial pressure line in place			♦	
Temporary pacemaker			♦	
Chest tube w/o suction		♦		
w/ suction			♦	♦

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 5040
Effective Date: August 1, 2007
Review Date: January 1, 2011
Supersedes: June 1, 1999

EMERGENCY DEPARTMENT DOWNGRADE OR CLOSURE IMPACT EVALUATION POLICY

I. PURPOSE

A. To establish EMS Agency policy and procedures for evaluating the community impact of an Emergency Department downgrade or closure.

B. To establish Receiving Hospital procedures for the communication to the EMS Agency and the local community regarding a planned reduction or elimination in the level of emergency department services.

II. AUTHORITY

A. Health & Safety Code, Division 2.5, Section 1255.1 – 1255.3, 1300 (b), 1300 (c) and 1364.1.

B. The City & County of San Francisco Charter Appendix Q, Section II.

III. POLICY

A. Hospitals shall provide public notice at least 90 days prior to closing, eliminating or reducing the level of services provided by their Emergency Department. This public notice shall include one public hearing with the San Francisco Health Commission in compliance with all the requirements of San Francisco Charter Appendix Q Section II. The hospital is required to notify the Secretary of the Health Commission at least 90 days prior to the downgrade or closure of the Emergency Department. The public hearing shall be held within 60 days of notice receiving notification from the hospital.

B. Hospitals shall also notify in writing the EMS Agency of the Department of Public Health at least 90 days before the intended date of the closing, eliminating or reducing the level of services provided by their Emergency Department.

C. Upon receiving written notice of a proposed Emergency Department closure or reduction in level of service, the EMS Agency shall complete an Impact Evaluation of the downgrade or closure upon the community within 60 days. The EMS Agency Community Impact Evaluation shall be completed in consultation with San Francisco hospitals and prehospital emergency care providers and shall meet the requirement as outline in Section IV. B. of this policy.

D. The hospital proposing the closure or reduction in services, and other hospitals in the defined service area, shall provide information for the Community Impact Evaluation when requested by the EMS Agency. The requested information shall meet the requirements as outlined in outlined in Section IV.B. of this policy.

E. Upon completion of the EMS Agency Community Impact Evaluation, the EMS Agency shall submit to the state Department of Health Services and the State EMS Authority, the results of that evaluation within three days of its completion.

F. The EMS Agency shall make the Community Impact Evaluation available for public review.

IV. PROCEDURE

A. The Community Impact Evaluation shall include descriptions of current community access to prehospital and hospital emergency care in San Francisco County; and how the Emergency Department downgrade or closure will affect prehospital and hospital emergency services provided by other entities. These descriptions shall include:

1. Defined service area population density.

2. Location of facility proposing the Emergency Department service change.

3. Proximity to other Emergency Departments in the defined service area, including travel time, distance and a map with area hospitals and public transit routes noted.

4. Number of annual Emergency Department patient visits (both 911 transports and walk-ins).

5. Description of the general population and any special need population served by the hospital.

6. Number of Emergency Department treatment spaces (beds) in the defined service area.

7. Net change in the number of Emergency Department beds in the defined service area as a result of the Emergency Department closure or downgrade.

8. Type of specialty services provided and next nearest available alternative providers.

9. Number of patients transported by ambulance to Emergency Departments in the defined service area.

10. Net change in the number of patients transported by ambulance to area Emergency Departments as a result of the Emergency Department closure or downgrade.

11. Current and estimated net change on ambulance and fire response unit time on task in the defined service area.

12. Steps hospitals and community providers have undertaken to accommodate the Emergency Department downgrade/closure.

13. If the Hospital intending to close or downgrade its Emergency Department is a designated Base Hospital, then the impact shall also include:
    a. Annual number of calls.
    b. Impact on patients and field personnel.
    c. Other base hospitals.

14. If the Hospital intending to close or downgrade its Emergency Department is a designated Trauma Center, then the impact shall also include:
    a. Number of trauma patients
    b. Impact on other hospitals' trauma centers and trauma patients

15. The Hospital proposing to close or downgrade its Emergency Department shall provide a description of procedures for handling patients whom self-direct to the downgraded Emergency Department that require emergency medical cares.

16. The Hospital proposing to close or downgrade its Emergency Department shall provide a description of its communication plans to the community at large and to applicable health plans, and health plan members.

Section 6:
Quality Improvement

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 6000
Effective Date: August 1, 2008
Review Date: January 1, 2011
Supersedes: July 1, 2007

QUALITY IMPROVEMENT PROGRAM

I. PURPOSE

A. The purpose of this policy is to maintain an effective method for monitoring and evaluating patient care.
B. To define the local EMS System data collection and utilization.
C. To establish standards of patient care and to resolve identified problems through a systematic quality improvement (QI) program.
D. To define the minimum required elements of provider QI plans.

II. AUTHORITY

A. California Health and Safety Code, Division 2.5, Sections 1797.10, 1797.107, 1797.174, 1797.176, 1797.204, 1797.220, and 1798
B. California Code of Regulations, Title 22, Division 9, Chapter 12, Sections 100147, 100400, 100401, 100402, 1004003, 1004004, and 1004005.

III. REFERENCE

A. EMSA #163 EMS System Quality Improvement Indicators (Appendix M)
B. EMSA #166 EMS System Quality Improvement Guidelines

IV. EMS SYSTEM QI

A. The EMS Agency will develop a Quality Improvement Program in accordance with EMS Authority requirements and EMS QI Program Model Guidelines.
B. The EMS Agency shall use the EMS System Quality Indicators to evaluate quality of prehospital care in the San Francisco EMS System.

1. The EMS System Quality Indicators consist of variables collected in the Local EMS Information System (LEMSIS-Policy 6020).
2. The EMS System providers shall collect, compile and submit LEMSIS data elements pursuant to the LEMSIS policy.
3. The EMS Agency shall manage the LEMSIS data repository and its elements.

C. The EMS Agency shall analyze the EMS System quality indicators based upon the data elements collected in the LEMSIS data repository.

1. The EMS Agency Medical Director shall report the results of the EMS Agency quality indicator analysis to the Emergency Medical Services Advisory Committee.

D. Clinical acts or system issues that constitute a threat to public health and safety or integrity of the EMS System shall be reported through the EMS Agency Incident Reporting process in Policy 6020.
E. When the EMS Agency identifies performance improvement needs, the Agency will develop performance improvement plans in cooperation with appropriate provider agencies.

F. The Medical Director may require prehospital personnel as a condition of reaccredidation or recertification to participate in any prehospital clinical training conducted by the Base Hospital that has been recommended through the EMS System quality indicator analysis.

G. The continuous process of data collection, evaluation and analysis using the LEMSIS data repository and the EMS System quality indicators as described above is the foundation for improving the quality of care in the San Francisco EMS System.

V. BASE HOSPITAL QI PROGRAM

A. The Base Hospital shall be the primary training component of the EMS system QI program as described in Policy 5011, Sections III, D, and E.

VI. PROVIDER QI PROGRAMS

A. Each approved EMS provider shall develop, and submit to the EMS Agency for approval, a comprehensive Quality Improvement Plan meeting the requirements of 22 CCR 100402 and which address but are not limited to the following:

1. Personnel
2. Equipment and Supplies
3. Documentation
4. Clinical Care and Patient Outcome
5. Skills Maintenance/Competency
6. Transportation/Facilities
7. Public Education and Prevention
8. Risk Management
9. Quality indicators defined by EMSA regulation and those indicators unique to San Francisco and defined in the LEMSIS policy.

B. Providers will develop internal policies requiring participation in the QI process, including remediation, with provisions for disciplinary action for non-compliance.

C. Providers will participate in the QI activities of the LEMSIS Steering Group (refer to Policy 6010) for the purpose of conducting audits of prehospital audio communications and patient care records to evaluate outcomes and system performance in order to identify opportunities for improvement.

D. Providers will conduct an annual review of the QI program and revise the written plan for the upcoming year as necessary to meet performance objectives.

E. Providers will submit a report of the annual review and plan for the upcoming year to the EMS Agency detailing: QI and training activity to include analysis of quality indictors, any formal remediation and disciplinary actions taken in accordance with the Incident Reporting policy.

F. Records of QI activity, including individual employee records, must be stored in a secured environment with access limited to QI and management personnel only

1. Records must be available to the EMS Agency for review:
    a) During site evaluations
    b) As part of an investigation
    c) As determined by the EMS Medical Director with advanced notice.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

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LOCAL EMERGENCY MEDICAL SERVICES INFORMATION SYSTEM (LEMSIS)

I. PURPOSE

The Local EMS Information System (LEMSIS) serves as the central repository of EMS data using standardized data elements and indicators for system-wide monitoring and evaluation of patient care in the San Francisco EMS System.

II. AUTHORITY

A. Code of Federal Regulations, Title 45, Section 164.512 (b) (l) (i)
B. California Health and Safety Code, Division 2.5, Section 1797.220
C. California Code of Regulations, Title 22, Section 100172
D. Code of Federal Regulations, Title 45, Section PART 164, Subpart E, Sec. 164.512 (b,i)

III. REFERENCE

A. EMSA #164 California EMS Information System Data Dictionary
B. NEMSIS (National EMS Information System, NHTSA Version 2.2.1 Data Dictionary

IV. POLICY

A. Patient Care Documentation Standards

1. The provider Patient Care Record (PCR) must contain all data fields listed in Appendix A.
2. A SF EMS Agency approved Patient Care Record (may be paper or electronic) shall be completed for all patient contacts, including:
    a) Transported patients
    b) Non-transports
    c) Patients treated and released at special events, including when released to event medical staff (refer to Mass Gathering Policy 7010)
3. For prehospital births, a separate PCR must be completed for the mother and each newborn.
4. PCR's shall be completed immediately after each call whenever possible, and must be completed prior to going off duty.
    a) A copy of the PCR will be provided to the receiving hospital prior to leaving the facility unless the unit is needed for another emergency call.
        (1) If required for another emergency call, the PCR will be provided to the facility prior to going off duty, or within 24 hours, whichever is earlier.
5. PCR's must be completed for all patients during MCI. Triage tags are not considered an acceptable substitute for a PCR. Patient tracking information will be included on the PCR.

B. Data Collection and Reporting

1. Dispatch and Ambulance providers shall collect all data elements as defined by this policy, in Appendix A in a format defined by the EMSA and in accordance with standards established the National EMS Information System (NEMSIS) and California EMS Information System (CEMSIS).
2. Hospital providers shall report hospital outcome data elements from the Hospital data systems.
3. Providers shall train all personnel involved in collecting data on the purpose of the LEMSIS, the LEMSIS data elements definitions (Appendix A), and data sources as defined in this policy.
4. Providers shall collect, organize, and validate the LEMSIS data elements.
   a) Provider QI plans shall include method for validation of data accuracy
   b) Validation method is subject to approval by the EMS Agency Medical Director
5. Providers may use electronic, manual or scanned patient records for data collection; however, data must be in an electronic format meeting EMS Agency requirements for submission.

C. Data Transfer

1. Providers using hard copy PCR's shall transmit all LEMSIS data for each month to the EMS Agency no later than 45 days after the end of that month.
2. Providers using electronic PCR's shall transmit all LEMSIS data and an electronic copy of the PCR to the EMS Agency according to deadlines established by the EMS Agency.
3. Data will be in an electronic form that is importable to the EMS Agency data system.
4. Each provider shall have a HIPAA compliance protocol that addresses data security during transfer to the EMS Agency.
5. The EMS Agency abides by the San Francisco Department of Public Health HIPAA compliance protocol as it pertains to the transfer and receipt of EMS data for LEMSIS.
6. Investigators of EMS research studies who request data from LEMSIS must have approval by an Institutional Review Board prior to submitting their request to the EMS Agency (refer to Research Studies Policy 6030).

D. Retention of Data

1. The EMS Agency shall maintain the LEMSIS data repository and establish procedures for retention and secure storage of LEMSIS data.

E. Data Reporting and Analysis

1. The LEMSIS Steering Group provides technical expertise and oversight of data collection, analysis, and reporting as it relates to quality improvement activities. The LEMSIS Steering Group will be comprised of quality improvement representatives from the EMS Agency, each ambulance provider, the Base Hospital, and the Department of Emergency Management, Division of Emergency Communications. The LEMSIS Steering Group will meet on a quarterly basis and be responsible for the following functions:
   a) Oversee development and implementation of locally and state determined EMS system indicators for evaluation

b) Maintain responsibility for collecting and evaluating data for reporting to the EMS Advisory Committee on state required and optional EMS System indicators
c) Provide recommendations to the EMS Advisory Committee and EMS Agency Medical Director on benchmarking and best practices based upon analysis of EMS System Quality Indicators.

2. EMS System Quality Indicators are determined using LEMSIS data elements, Base Hospital data, Trauma Center data, and EMS Agency certification and accreditation data.

3. The EMS Agency shall produce a quarterly EMS System report of EMS System Quality Indicators for review at the EMS Advisory Committee.

APPENDIX A: LEMSIS DATA ELEMENTS & QUALITY INDICATORS

Data Element	Data Source	Definition/Code sets
EMS Incident Data		
PSAP Identifier	EMS Agency code set	Identity of the dispatch center providing the data
Incident identifier	Dispatch CAD	Unique numeric identifier for each EMS incident
Incident address number	Dispatch CAD	Number of street address of the incident
Incident address street name	Dispatch CAD	Street name of incident
Apartment number	Dispatch CAD	Apartment number if incident is in a building with suite, apartment, office numbers
Incident address cross street	Dispatch CAD	Nearest cross street of incident
Incident City	Dispatch CAD	City of Incident
Location type	Dispatch CAD or PCR	Code set based upon types of locations
Transferring facility identifier	Dispatch CAD	Name of facility transferring patient (for interfacility transfers); may be HIPAA identifier number
Date incident reported	Dispatch CAD	Date of incident
Time incident reported	Dispatch CAD	Time incident first captured in the CAD computer (call pick up time)
Response unit number	Dispatch CAD	Identifier of response unit by locally approved identifier number
Response Agency	Dispatch CAD	Identifier of response agency
Time dispatch notified of EMS call	Dispatch CAD	Time dispatch center first captured call if transferred from a primary PSAP
Date dispatch notified of EMS call	Dispatch CAD	Date dispatch center first captured call if transferred from a primary PSAP
EMS Incident Data		
Time incident entered	Dispatch CAD	Time call taker completed entry of incident information into the computer so that the call is available for dispatch (in the queue)
Date incident entered	Dispatch CAD	Date call taker completed entry of incident information into the computer so that the call is available for dispatch (in the queue)
Time response unit notified	Dispatch CAD	Time response unit dispatched on the incident
Date response unit notified	Dispatch CAD	Date response unit dispatched on the incident

Data Element	Data Source	Definition/Code sets
Time response unit mobile	Dispatch CAD	Time response unit reports enroute to the incident
Date response unit mobile	Dispatch CAD	Date response unit reports enroute to the incident
Lights/sirens to scene	Dispatch CAD or PCR	Code 2 Code 3 Cancelled enroute
Time vehicle stopped at scene	Dispatch CAD	Time unit reports on scene of the incident (wheels stopped)
Service type	Dispatch CAD	Scene response Interfacility transfer
Treatment crew member identifier	Dispatch CAD	Numeric County identifier for each responder
Treatment crew member type	Dispatch CAD	EMT-1 EMT-P Public Safety EMT-P intern Field Supervisor Other
Vehicle type	Dispatch CAD	BLS first responder ALS first responder BLS ambulance ALS ambulance Aeromedical Other
Patient Data		
Patient name	PCR	Patient's name as indicated on driver's license
Patient street address	PCR	Number, street name, and unit number of patient's residence
Patient city of residence	PCR	City of residence
Patient State of residence	PCR	State of residence
Patient zip of residence	PCR	Postal code of residence
Patient social security number	PCR	Last 5 digits of patient's SSN in format N-NNNN
Patient date of birth	PCR	Date of birth in format MMDDYYYY
Patient age	PCR	Numeric entry of patient's age
Patient age units	PCR	Years Months Days
Patient gender	PCR	Female Male Unknown
Patient weight	PCR	Approximate weight in kg. ki

Data Element	Data Source	Definition/Code sets
PCR identifier	PCR	Unique identifier for each PCR (chart number)
Time arrived at patient side	PCR	Time unit documents first contact with the patient
Patient chief complaint	PCR	Free text field of patient's chief complaint
Primary impression	PCR	Code set of Medical and Trauma categories that reflects the provider's clinical impression that was most important in determining care given to the patient
Secondary impression	PCR	Code set of Medical and Trauma categories that reflects the provider's secondary clinical impression that completes the description of the patient
Cause of injury	PCR	Code set of injury mechanism types
Injury Contributing factors	PCR	Code set of factors that may have contributed to the injury severity
Pre-existing condition	PCR	Code set of medical history conditions
Safety factors	PCR	Code set of safety factors that affected the incident
Factors affecting EMS delivery of care	PCR	Code set of factors that affected delivery of care
Suspected ETOH/drug use	PCR	Yes No
Witnessed cardiac arrest	PCR	Yes No
Estimated time of witnessed cardiac arrest	PCR	Time that identifiable witness saw or heard collapse
Initial pulse rate	PCR	Numeric value in beats per minute
Initial cardiac rhythmn	PCR	Code set of cardiac rhythms
Initial respiratory rate	PCR	Numeric value in breaths per minute
Initial respiratory effort	PCR	Normal Labored Absent

Data Element	Data Source	Definition/Code sets
	Patient Data	
Initial lung sounds left side	PCR	Normal Rales Wheezes Rhonchi Diminished
Initial lung sounds right side	PCR	Normal Rales Wheezes Rhonchi Diminished
Initial systolic blood pressure	PCR	Systolic blood pressure in mmHg
Initial diastolic blood pressure	PCR	Diastolic blood pressure in mmHg
Perfusion	PCR	Based upon skin signs: -Normal -Decreased
Initial GCS-eye opening	PCR	1-4 score for eye opening
Initial GCS-verbal	PCR	1-5 score for verbal responsiveness
Initial GCS-motor	PCR	1-6 score for motor response to pain
GCS Total	PCR	1-15 total of E,V,M components
Revised trauma score	PCR	Numeric score calculated from: Respiratory Rate (0-4 scale) Systolic blood pressure (0-4 scale) Neurologic-GCS (0-4)
Base Hospital contact	PCR	Yes No
Estimated time CPR started	PCR	Time CPR first initiated by any provider
Initial provider of CPR	PCR	First responder EMT-1 EMT-P Bystander Other
Time CPR discontinued	PCR	Time CPR
Time of first defibrillatory shock	PCR	Time of first defibrillation performed by any provider

Data Element	Data Source	Definition/Code sets
Patient Data		
Provider of first defibrillatory shock	PCR	First responder EMT-1 EMT-P Bystander Other
Return of Spontaneous Circulation	PCR	Yes or No
Procedure Name	PCR	Code set of approved procedures in local scope of practice
Procedure performed by	PCR	County EMT-P number
Procedure attempts	PCR	Numeric value representing number of attempts made by the EMT-P at the procedure
Procedure result	PCR	Improved No change Deteriorated
Medication Name	PCR	Code set of approved medications in local scope of practice
Medication Dose	PCR	Numeric value
Medication Dose Unit	PCR	mg grams cc mEq units
Medication Route	PCR	IV IM ETT SQ Rectal IO Lingual Sublingual
Medication Administered by	PCR	County EMT-P number
Medication result	PCR	Improved No change Deteriorated
Pain scale prior to treatment	PCR	Item on 1-10 scale assessed prior to treatment
Pain scale after treatment	PCR	Item on 1-10 scale assessed after treatment

Data Element	Data Source	Definition/Code sets
Patient Data		
Incident/Patient disposition	PCR	Transport Nontransport (specify GOA, AMA, refusal, field pronouncement, SFPD, other)
Destination	PCR	Hospital or facility of destination (precoded list of Receiving Hospitals and free text field to enter other options)
Destination Determination	PCR	Reasons for choosing the destination: Patient preference Closest hospital Specialty Care (specify) Diversion
Lights/Sirens from scene	PCR	Code 3, Code 2, or N/A (nontransport)
Scene departure time	PCR and/or Dispatch CAD	Time enroute to hospital
Destination arrival time	PCR and/or Dispatch CAD	Time of arrival at hospital
Patient condition on arrival	PCR	Unchanged, Improved Deteriorated
Destination cardiac rhythm	PCR	Final cardiac rhythm entered on the PCR upon arrival at destination facility
Special Studies	PCR	Yes: free text field to identify research study No
ED disposition	Destination ED	Admitted to Ward Admitted to ICU Discharged from ED AMA from ED Expired in ED Transferred from ED
ED primary diagnosis	Destination ED	ICD-9 code of primary diagnosis made by ED physician
ED secondary diagnosis	Destination ED	ICD-9 code of secondary diagnosis made by ED physician
Hospital disposition	Destination ED	Discharged Transferred Expired in hospital
Length of hospital stay	Destination ED	Number of days patient was admitted to the hospital

V. QUALITY INDICATORS

Name	Source of Variables	Definition
Cardiac Arrest		
Bystander CPR	LEMSIS-PCR data	% of incidents that patients received CPR from a bystander
PAD-AED	LEMSIS-PCR data	% of incidents that patients received initial defibrillation by layperson AED program
BLS-AED	LEMSIS-PCR data	% of incidents that patients received initial defibrillation by BLS or public safety personnel
Time to first shock	LEMSIS-PCR data	Mean +/- sd of time from witnessed arrest to initial defibrillation
Epinephrine Use	LEMSIS-PCR data	% Cardiac arrest patients receiving epinephrine
Antidysrhythmic Use	LEMSIS-PCR data	% Cardiac arrest patients receiving antidysrhythmic drug
ROSC	LEMSIS-ED data	% of total cases with ROSC=yes
Survival to ED admit	LEMSIS-ED data	% of cardiac arrest patients admitted to ED
Survival to hospital discharge	LEMSIS-ED data	% of cardiac arrest patients discharged or transferred as hospital disposition
Chest Pain		
Oxygen administered	LEMSIS-PCR data	% of incidents with primary or secondary impression is chest pain and oxygen administered
Nitroglycerin administered	LEMSIS-PCR data	% of incidents with primary or secondary impression is chest pain and nitroglycerin administered
Morphine administered	LEMSIS-PCR data	% of incidents with primary or secondary impression is chest pain and morphine administered
Aspirin administered	LEMSIS-PCR data	% of incidents with primary or secondary impression is chest pain and aspirin administered
Decrease/Relief of symptoms	LEMSIS-PCR data	% of incidents with primary or secondary impression is chest pain and medication result = improved; may be evaluated also using pain scale prior to treatment and pain scale after treatment if number reduced by at least 1 point on pain scale after treatment; also evaluated with patient condition on arrival = improved

Name	Source of Variables	Definition
Chest Pain		
Prehospital Impression match ED diagnosis	LEMSIS-PCR data, Destination ED data	% of incidents with primary of chest pain-cardiac origin and ED ICD-9 code matches cardiac origin
Survival to hospital discharge	LEMSIS-PCR data, Destination ED data	% of incidents with primary or secondary impression is chest pain and hospital outcome = discharged or transferred
Destination hospital	LEMSIS-PCR data	Hospital transport distribution of incidents with primary or secondary impression of chest pain and
Shortness of Breath		
Signs or symptoms of bronchospasm	LEMSIS-PCR data	% of incidents with lung sounds = wheezes and/or primary or secondary impression is bronchospasm
Signs or symptoms of fluid overload	LEMSIS-PCR data	% of incidents with lung sounds = rales and/or primary or secondary impression is CHF
Oxygen administration	LEMSIS-PCR data	% of incidents with chief complaint shortness of breath and oxygen administered
NTG administration	LEMSIS-PCR data	% of incidents with chief complaint shortness of breath and NTG administered
Morphine administration	LEMSIS-PCR data	% of incidents with chief complaint shortness of breath and morphine administered
Furosemide administration	LEMSIS-PCR data	% of incidents with chief complaint shortness of breath and furosemide administered
Relief of symptoms	LEMSIS-PCR data	% of incidents with chief complaint shortness of breath and medication result = improved; may be evaluated also using pain scale prior to treatment and pain scale after treatment if number reduced by at least one point on pain scale after treatment; also evaluated with patient condition on arrival = improved
Adherence to protocol	LEMSIS-PCR data	% of incidents with primary or secondary impression of CHF or bronchospasm and associated EMS Agency protocol used

Name	Source of Variables	Definition
Shortness of Breath		
Prehospital impression matches ED diagnosis	LEMSIS-PCR data	% of incidents with chief complaint shortness of breath when primary or secondary impression matches ED ICD-9 code
Admission to hospital	LEMSIS-PCR data, Destination ED data	% of incidents chief complaint of shortness of breath and ED disposition is admission to Ward or ICU
Survival to hospital discharge	LEMSIS-PCR data, Destination ED data	% of incidents with primary or secondary impression is congestive heart failure and hospital outcome = discharged or transferred
Critical Trauma		
Frequency blunt	LEMSIS-PCR data	% of incidents with primary or secondary impression = blunt trauma mechanism
Frequency penetrating	LEMSIS-PCR data	% of incidents with primary or secondary impression = penetrating trauma mechanism
Frequency Head	LEMSIS-PCR data	% of incidents with primary or secondary impression = head trauma
Frequency Chest	LEMSIS-PCR data	% of incidents with primary or secondary impression = chest trauma
Frequency Abdomen	LEMSIS-PCR data	% of incidents with primary or secondary impression = abdominal trauma
Critical Trauma		
Frequency Burns	LEMSIS-PCR data	% of incidents with primary or secondary impression = burns
Lapse time on scene > 10 minutes	LEMSIS-PCR data	% of incidents with destination Specialty Care = Trauma Center and scene time >10 minutes (scene time calculated as interval from arrival on scene-wheels stopped to scene departure time)
Triage criteria	LEMSIS-PCR data	% of incidents with Specialty Care = Trauma Center and distribution of trauma triage criteria used to determine specialty care destination
Advanced airway	LEMSIS-PCR data	% of incidents with primary or secondary impression = trauma and patient intubated in field
Oxygen administered	LEMSIS-PCR data	% of incidents with primary or secondary impression = trauma and oxygen administered
Destination for all trauma	LEMSIS-PCR data	% of incidents with primary or secondary impression = trauma and hospital destination distribution to non-Trauma Centers

Name	Source of Variables	Definition
Critical Trauma		
% patients with trauma triage criteria transported to non-Trauma Centers	LEMSIS-PCR data	% of incidents with primary or secondary impression = trauma and trauma triage screen of PCR data elements determines + trauma triage criteria and hospital destination = non-Trauma Center
ALS Skills (Pediatric patient = 16 years and under)		
Adult ET oral	LEMSIS-PCR data	frequency performed per year
Adult ET nasal	LEMSIS-PCR data	frequency performed per year
Adult ET oral success rate	LEMSIS-PCR data	% confirmed placement with auscultation, adequate chest rise and $ETCO_2$ colorimetric change
Adult ET nasal success rate	LEMSIS-PCR data	% confirmed placement with auscultation, adequate chest rise and $ETCO_2$ colorimetric change
Pedi ET oral	LEMSIS-PCR data	frequency performed per year
Pedi ET success rate	LEMSIS-PCR data	% confirmed placement with auscultation, adequate chest rise and $ETCO_2$ colorimetric change
Pedi IV	LEMSIS-PCR data	frequency performed per year
Pedi IO	LEMSIS-PCR data	frequency performed per year
Needle cricothyrotomy	LEMSIS-PCR data	frequency performed per year
Combitube	LEMSIS-PCR data	frequency performed per year
Needle thoracostomy	LEMSIS-PCR data	frequency performed per year
Transcutaneous pacing	LEMSIS-PCR data	frequency performed per year

Data Element	Data Source	Definition/Code sets
Access and Utilization		
PSAP call load	LEMSIS-Dispatch CAD	Number of EMS incidents per month
911 call pick up	LEMSIS-Dispatch CAD	90th percentile lapse time from first ring to call pick up
911 QUEUE-entry	LEMSIS-Dispatch CAD	90th percentile lapse time from call pick up to call entry
911 QUEUE-response	LEMSIS-Dispatch CAD	90th percentile lapse time from call entry to response unit notified
Response		
Response unit QUEUE	LEMSIS-Dispatch CAD	90th percentile Lapse time from unit notified to unit enroute
Response unit ROLL	LEMSIS-Dispatch CAD	90th percentile Lapse time from enroute to onscene
Receiving Facilities		
Transports	LEMSIS-PCR data	Distribution (%) of EMS transports by destination ED
Diversion	LEMSIS-PCR data	% of hours per month total diversion (corrected using suspension times)
Transfers from ED	LEMSIS-PCR data, Destination ED data	% of EMS transports with ED outcome = transferred
Base Hospital		
Caseloads per 24 hours	Base Hospital	Average number of prehospital Medical Control contacts per day
Case loads by Type	Base Hospital	Types of contacts by category
Base Hospital MD pick up time	Base Hospital	Lapse time from initial contact to MD call pick up
Number of hours of prehospital CE provided	Base Hospital	Total hours per year of CE's offered to prehospital personnel per year
Number of locally certified/accredited personnel attending CE programs	Base Hospital	Total number of EMT-1, EMT-P certified/accredited in SF who attended Base Hospital CE programs per year

Data Element	Data Source	Definition/Code sets
Trauma Center		
Trauma caseload	Trauma Center	Average number of Trauma cases received per 24 hours
Prehospital trauma cases per 24 hours	Trauma Center	Average number of Trauma cases from prehospital setting received per 24 hours
Prehospital trauma cases scene times	LEMSIS-PCR data, Dispatch CAD	Average lapse time from on scene to scene departure time
Prehospital trauma cases transport times	LEMSIS-PCR data, Dispatch CAD	Average lapse time from on scene departure time to hospital arrival time
Prehospital trauma cases advanced airway	LEMSIS-PCR data, Trauma Center	% of critical trauma patients with advanced airway management in field
Prehospital trauma cases outcome	LEMSIS-PCR data, Trauma Center	Prehospital critical trauma patients with hospital disposition = discharged or transferred
Public Education and Prevention		
AED	EMS Agency database	Number of layperson AED sites registered with local EMS Agency
EMS Education and Training		
EMT-1 certified	EMS Agency database	Number of EMT-1's certified each year
EMT-P accredited	EMS Agency database	Number of EMT-P's accredited each year
Approved CE Providers	EMS Agency database	Number of approved CE providers
Approved EMS training programs	EMS Agency database	Number of EMT training programs (EMT-1 and EMT-P)
ALS Staffing Levels		
2 EMT-Ps on critical patient contacts	LEMSIS-PCR and Dispatch CAD	% of incidents with Code 3 transport to hospital and 2 EMT-Ps on scene
2 EMT-Ps transporting	LEMSIS-PCR and Dispatch CAD	% of incidents with Code 3 transport to hospital and 2 EMT-Ps in transport ambulance

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

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INCIDENT REPORTING

I. PURPOSE

A. To establish a peer to peer report and response mechanism for resolving issues and incidents that are reportable but are not a threat to public health and safety or pose a threat to the integrity of the EMS system.
B. To establish a mechanism for reporting and investigating issues and incidents which pose a threat to the integrity of the EMS system and/or possibly constitute a violation of California Health and Safety Code Section 1798.200 et seq.
C. To set standards for regular reporting of incidents to the EMS Agency for the purpose of monitoring the EMS system and identification of opportunities for improvement in clinical outcomes and/or system structures and processes.

II. AUTHORITY

A. California Health and Safety Code, Sections 1797.204, 1797.220, and 1798
B. California Code of Regulations, Sections 100147 and 100402

III. POLICY

Overview of Incident Reporting		
Level I **Peer to Peer Reporting**	**Level II** **Exception Reporting**	**Level III** **Mandatory Reporting**
• For minor interpersonal issues, misunderstandings or operational issues not involving patient care. • Resolve as soon as possible after the incident in person or by telephone with supervisors or management representatives. • If unsure whether the issue is Level I or II or if the issue cannot be resolved at this level, an Exception Report should be submitted.	• For patient care issues complete an EMSA Exception Form and fax or mail to provider management. This includes commendations. • For system issues involving patient care, mail or fax report to EMSA. • Reporting party may also call provider management or EMSA to verbally report an incident which will be documented on the Exception Form by the provider.	• Includes, but not limited to: incidents involving: Clinical acts or omissions that may be a threat to public health and safety or considered negligent or contributing to poor patient outcome; Violations of EMS policies and treatment protocols that may result in poor patient outcome; and Use of intoxicants or impaired ability due to alcohol or drugs while on duty. • Report to the EMSA within 24 hrs.

A. Peer to Peer Reporting:
   4. Any incident or event such as minor interpersonal conflicts, misunderstandings and demeanor issues that are unrelated to patient care activities or minor operational issues.

B. Exception Reporting
   4. Any incident or event which the reporting party believes warrants reporting to another EMS system participant shall be documented and forwarded by the reporting party to all other agencies involved.

      e) Reportable incidents or events include, but are not limited to:
         (1) Policy or protocol violations not related to clinical care or patient outcome;

         (2) Deviation from authorized use of supplies or equipment;
         (3) Documentation error or omission not related to patient care;
         (4) Communication errors;
         (5) Destination errors with no impact on patient outcome;
         (6) Near miss incidents; and
         (7) Operational (non-clinical) issues.
      f) Commendations may also be submitted to communicate exceptional care by an individual or group of providers.

   5. Exception will be documented using a form developed by the EMS Agency.
      e) Copies of all supporting documents, such as PCRs, hospital records, dispatch logs, etc. must be included.

   6. The EMS Agency shall log all Exception Reports for the purposes of data collection and analysis.

   7. In the event that a recipient of an Exception Report fails to respond, or provides an inadequate response, the reporting party may inform EMSA of the failure and request follow-up action on closure reporting.

C. Mandatory Reporting
   4. Any event that is actionable pursuant to Health & Safety Code Section 1798.200 shall be reported, within 24 hours, to the EMS Agency Duty Officer (refer to Procedure IV.D.).
      e) Reportable events include, but are not limited to:
         (1) Use of intoxicants or impaired ability due to alcohol or drugs while on duty as an EMS provider.

(2) Clinical acts or omissions that may be considered negligent or possibly contributed to a poor patient outcome.
(3) Deviation from EMS policy or protocol that may result in a poor patient outcome.
(4) Any act or omission that constitutes a threat to public health and safety.
(5) Any event where recurrence would have a significant chance of adverse outcome.

5. Any individual with direct knowledge of a Mandatory Reporting incident is required to complete a written report and submit it directly to the EMS Agency within 72 hours (refer to Procedure IV.D.).
    e) Employers may require concurrent reporting internally, but shall not preclude, inhibit, or delay direct reporting to the EMS Agency.
6. Written reports, using a form developed by the EMS Agency, shall be completed and submitted to the EMS Agency within 72 hours.
    e) The written report must include copies of all pertinent documentation, including but not limited to:
        (1) Patient care records
        (2) Dispatch logs
        (3) Written statements by involved personnel
        (4) Summary of initial investigation and actions taken by agency (when applicable and available).
7. The EMS Agency shall lead Mandatory Reporting Investigations
    e) All providers shall assist the EMS Agency and complete requests in the time frame determined by the EMS Agency investigator.
    f) EMS provider agencies shall make available all personnel involved with or having knowledge of the incident for interviews by the EMS Agency investigator.
    g) Provider agencies shall allow the EMS Agency access to proprietary or confidential information directly pertinent to the investigation.
    h) All Mandatory Reporting investigations shall be completed within 30 days or as soon as reasonably possible.
    i) The EMS Agency shall provide a report of the findings and actions to the reporting party.
        (1) Investigative reports will not disclose confidential or proprietary information collected during the investigation.
        (2) Final reports may be delayed indefinitely if their release will compromise another investigation of the incident or involved personnel being performed by another regulatory or investigative authority.

D. Provider Reporting
    1. All EMS ambulance providers will submit a report, at intervals determined by the EMS Agency, using a standard format developed by the EMS Agency, which includes the following elements:
        a) A summary of all issues received and actions taken related to the delivery of EMS and/or patient care.
        b) A summary of all Exception and Mandatory Reporting incidents received and actions taken.
        c) An analysis of any trends identified in the types of incidents being reported.
        d) The status of all open Exception and Mandatory Reporting investigations, including work and remedial actions in progress.
        e) A summary of quality assurance and performance improvement activities to include:
            (1) Any audits required by the EMS Agency.
            (2) Any education pertaining to clinical care or EMS operations.
            (3) Any internal projects in progress.

IV. PROCEDURE

A. Peer to Peer Reports
    1. When incidents involving minor interpersonal issues, misunderstandings or minor operational issues not involving patient care occur, reporting party shall directly contact supervisor or management representatives of the recipient agency to resolve the issue as soon as possible after the incident by telephone or in person.
    2. Providers will log these reports and document actions to resolve the problems in a timely manner.
    3. If unsure whether the issue is Level I or Level II submit as an Exception Report or contact the EMSA staff for guidance.
    4. If the issue cannot be resolved at Level I or has become a repeated problem submit as an Exception Report.

B. Exception Reporting
    1. Reporting party will complete a written report on a form developed by the EMS Agency or call the provider or EMSA to verbally report an incident which will be documented on the Exception Form by the individual receiving the report.
    2. Reporting party will forward form, along with all supporting documentation to the provider agency's management for individual clinical issues or to the EMSA for system issues.
    3. The provider agency will fax a copy of the report to the EMS Agency within 72 hours of receipt.
    4. To close the incident, the provider or EMSA will issue a report of the investigation and actions taken to the reporting party within 30 days of receipt.

a) This policy shall not require that recipients consult with reporting party regarding any actions taken, only that the reporting party be notified of the findings and actions.
    (1) This policy shall not require any agency to disclose any information of a proprietary or confidential nature to the reporting party.
b) Written closure reports will be made using either the EMSA form or a letter/internal form that addresses the same elements of the EMSA form. The recipient may orally conduct the closure report with the reporting party. At that time, the provider will ask the reporting party if a copy of the written closure report is desired. The provider will log the manner in which the closure was provided to the reporting party and provide a copy of the closure report to the EMS Agency.

C. Mandatory Reporting

1. Any person with direct knowledge of an incident asdefined in III, C,1 shall notify the EMS Agency Duty Officer within 24 hours of the event in writing by faxing the report to the EMSA or by verbal report on the telephone. The Duty Officer can be contacted through the 911 Dispatch Center at the Department of Emergency Management.
    a) In cases with multiple people from the same agency having knowledge of an event, one notification to the EMS Agency Duty Officer may be made, however individual written reports are still required.
    b) The person(s) reporting the incident may, in addition, choose to also directly contact a field supervisor or management representative of the involved provider.

2. Each person with direct knowledge of a Mandatory Reporting Incident shall submit a written report, on a form developed by the EMS Agency, along with supporting documentation within 72 hours.

3. The EMS Agency Duty Officer shall:
    a) Verify that the incident qualifies for Mandatory Reporting , and
    b) Initiate an investigation consistent with the requirements of Policy 2070, or
    c) If an incident does not qualify as Mandatory Reporting, the reporting party shall be notified and the matter will be pursued as an Exception Report, as detailed in IV, B..

4. Upon notification of the incident, management at the involved provider agency will conduct an investigation and submit a report of the findings to the EMS Agency on a form developed by the EMS Agency along with supporting documentation. The report will be due within 30-days or sooner at the discretion of the EMS Agency.

5. EMS Agency shall review all information from EMSA led fact finding and from reports of the involved agencies to determine the outcome of the investigation and any corrective actions. Investigations will be completed within 30-days, or as soon as reasonably possible.
    a) In cases where personnel or information is not available, the investigative period may be extended, with the approval of the EMS Medical Director, as necessary to ensure a comprehensive and equitable investigation.
6. The EMS Agency will prepare a final report that will include the following elements:
    a) Investigation summary
    b) Identified causes, including system or process inadequacies that require correction.
    c) Recommended actions
7. Provider agencies will prepare a corrective action plan that addresses any organizational, mechanical, or process causes and will include method of correction and anticipated completion date.
    a) Corrective action plan shall be submitted to EMS Agency for review and approval no later than 30 days after being notified of deficiencies.

8. EMS Medical Director may take action as determined appropriate pursuant to the California Health and Safety Code Section 1798.200 et seq. and EMS Policy 2070.

9. Provider Reporting
    a) Each EMS provider agency shall compile data as described above and submit it to the EMS Agency by the required deadline..
    b) The data will be submitted in a format developed by the EMS Agency.
    c) All data elements will be defined by the EMS Agency.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 6030
Effective Date: August 1, 2008
Review Date: January 1, 2011
Supersedes: February 1, 2004

RESEARCH STUDIES

I. PURPOSE

A. To ensure that all public and non-profit private entities, scientific institutions, and individuals engaged in the conduct of EMS research in the San Francisco Emergency Medical Services (EMS) system adhere to a standardized procedure and review process.

II. AUTHORITY

A. California Health & Safety Code, Division 2.5, Section 1797.221
B. California Code of Regulations, Title 22, Division 9, Sections 10064.1 and 100146
C. Confidentiality of Medical Information Act, California Civil Code Sections 56-56.16

III. REFERENCE

A. EMSA #125 Guidelines for EMT 797.221 Paramedic Scope of Practice: Request for Additions to the EMT-P Scope of Practice

IV. POLICY

A. Study Protocol

1. The EMS Agency Medical Director must approve the study protocol of any EMS research study in the San Francisco EMS System prior to implementation of the research study.

B. The Principal Investigator of an EMS study shall submit a copy of the study protocol to the EMS Agency Medical Director prior to the initiation of the study. The study protocol shall consist of the following sections:

1. Background/Significance
2. Methods
3. Study Subjects
4. Data Collection and Analysis
5. Consent Process
6. Training and competency testing required to implement the study
7. Recommended policies and procedures to be instituted regarding the use and medical control of the procedures or medication used in the study.
8. Risks/Benefits
9. Confidentiality/Data Security/HIPAA Compliance
10. References, including copies of relevant literature

C. Processing by the EMSA

1. Any studies involving the EMS system are to be submitted to the EMS Agency prior to seeking Institutional Review Board (IRB) approval.
2. For studies limited to record reviews, the EMS Agency will aim to render a decision to approve or disapprove the study within 21 days of receipt.
3. For studies involving changes in paramedic practice or Trial Studies, the EMS Medical Director will appoint a Research Advisory Working Group of qualified persons with experience in research and knowledge of the effect of the proposed research on the EMS system. The committee will assist the Medical Director with the approval of the study and will aim to render a decision to approve or disapprove the study within 45 days of receipt.
4. For Trial Studies requiring State EMS Authority Approval, the Principal Investigator will need to allow an additional 45 days for the entire review process (refer to Section IV, E of this policy).

D. Institutional Review Board Approval

1. The Principal Investigator shall submit a copy of the IRB protocol approval or exemption to the EMS Agency Medical Director prior to the initiation of the study.
2. The protocol of an EMS study in the City and County of San Francisco must comply with the following:
    a) All federal requirements for the protection of human subjects in research (45 CFR 46 and 21 CFR 56).
    b) Procedures for application to and review by the sponsoring institution's IRB.
    c) The requirements set by the State of California EMS Authority (CCR, Title 22, Section 100144 subsection (b) (14), if intending to perform any prehospital emergency medical treatment or procedure which is additional to the Paramedic Scope of Practice (refer to Section IV, E of this policy).

E. EMS Authority Request for Approval of Trial Studies

1. The Principal Investigator shall complete State EMS Authority Form #0391 and submit to the EMS Agency Medical Director for review.
2. The EMS Agency Medical Director will forward the request to the State EMS Authority.

F. Study Implementation

1. For studies that involve patient interventions by prehospital personnel, the Principal Investigator must ensure the following:
    a) A certified EMT and/or licensed and accredited paramedic is either a study investigator, coordinator or liaison to provide input on the study protocol. (EMT and/or paramedic from the local EMS System is preferred);

b) A regular review of study progress with the prehospital personnel through quarterly newsletters, direct feedback and/or meetings.

G. The EMS Agency Medical Director may revoke approval of the project for violations of patient's rights or for activities and procedures not specified in the proposal.

H. Data Collection and Release of Medical Record Information

1. Ambulance Providers
   a) The principal investigator shall develop the mechanism for obtaining data from the ambulance providers.
2. Base Hospital
   a) The principal investigator shall identify a process for collecting data from the Base Hospital.
3. Receiving Hospitals
   a) The study protocol will address the specific mechanisms for obtaining patient consent and for maintaining patient confidentiality.
   b) A copy of the study protocol will be included with the letter to hospitals requesting participation in the research study.
   c) If the hospital consents to participate in an EMS research study, a hospital liaison will facilitate medical records retrieval according to the hospital's internal procedures and policies.

I. Study Results

1. Quarterly written reports will be submitted to the EMS Agency Medical Director. These reports are to include:
   a) Brief summary of project;
   b) Objectives of study;
   c) Results to date;
   d) Adverse events or safety issues
   e) Logistical problems
   f) Work plan for the upcoming quarter, and
   g) Conclusions.
2. Copies of the annual progress report to the IRB will be submitted to the EMS Agency Medical Director.
3. Copy of the annual research renewal notice from the IRB.
4. Copies of reports from any safety monitoring committees involved in oversight of the research study.
5. The EMS Medical Director may request that the Principal Investigator provide a presentation on the progress of the study to EMS Advisory Committee.

J. The Principal Investigator shall submit a final written report to the EMS Agency Medical Director at the conclusion of the study. A copy of any abstracts or manuscripts submitted for publication will be provided, in confidence, at the same time to the EMS Agency Medical Director.

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 6040
Effective Date: August 1, 2008
Review Date: January 1, 2011
Supersedes: February 1, 2005

PILOT PROGRAMS

I. PURPOSE

A. To define the process by which the San Francisco Emergency Medical Services (EMS) Agency plans, develops, implements, and monitors Pilot Programs.

II. AUTHORITY

A. California Health and Safety Code, Section 1797 et seq. and 1798 et seq.; California Code of Regulations, Title 22, Division 9.

III. REFERENCE

A. California Health and Safety Code, Section 1797 et seq. and 1798 et seq.; California Code of Regulations, Title 22, Division 9.

IV. POLICY

A. The EMS Agency Medical Director must review and approve of all Pilot Programs prior to implementation.

B. Pilot Program studies are typically small scale and short term for the purpose of evaluating quality indictors and/or operational improvements for local EMS policies and/or protocols.

C. Projects involving any of the following will be considered as research and require approval according to Research Policy 6030:

A. Changes in the State EMS Authority EMT-P Scope of Practice or untested intervention.
B. The goal of the project is to test a hypothesis.
C. The investigators intend to submit the results for publication in a professional journal.
D. When questions arise as whether a project is quality improvement versus research, the investigator will consult with the Institutional Review Board.

D. The Pilot Program Investigator(s) shall submit a Pilot Program Proposal to the EMS Agency at least three months prior to the planned implementation date in order to allow time for EMS Advisory Committee Review.

1. The EMS Agency shall review the Pilot Program Protocol and solicit EMS Stakeholder input through the Protocol Review Process in Section IV.
2. Investigator(s) must submit the Pilot Program Proposal according to the following structure:

a) Background/Significance: Describe the rationale for the Pilot Program, citing relevant research. Identify what questions remain and how the proposed Pilot Program will address these questions. Specify how the Pilot Program may improve the quality of care in the EMS System.
b) Objectives: List the objectives upon which the outcome of the Pilot Program will be based. Identify the predictor and outcome variables and the expected outcome of the Pilot Program.
c) Design/Methods: Identify the type of study, the outcome variables to be measured and how each is an indicator of quality of care. Describe the methods used to collect the data and avoid bias.
d) Evaluation: Describe the data management and statistical methods that will be used to evaluate the data. Include methods used to minimize bias and standards or benchmarks proposed to accept the conclusions.
e) References: Attach copies of references cited in the protocol.

V. PILOT PROGRAM REVIEW PROCESS

A. The EMS Agency Medical Director shall review the Pilot Program Protocol and will either forward the protocol to the EMS Advisory Committee for review or return to the Investigator for modifications.
B. The EMS Advisory Committee will review the protocol, provide feedback and vote to recommend approval, modifications or disapproval of the proposed Pilot Program.
C. After review of the recommendations by the EMS Advisory Committee, the EMS Agency Medical Director may present the proposed Pilot Program to the Director of Health.
D. The EMS Agency Medical Director will approve or deny the implementation of the Pilot Program. If approved, the data collection period is one year.

VI. REPORTING PROCESS

A. Monthly Reports: The Pilot Program Investigator shall submit monthly reports to the EMS Agency on the 15th day of each month. These reports must summarize the progress of the program and evaluate available outcome data from the previous month. The need for quarterly reports in addition to or instead of monthly reports will be determined by the EMS Agency Medical Director.

B. Final Report: At the end of the one year data collection period, the Investigator must submit a final report to the EMS Agency Medical Director. The final report must include a summary of the Pilot Program including the objectives, methods, data analysis of the outcome variables, the limitations of the study and the conclusions. The final report is due no later than the 15th day of the 3rd month following program completion.

VII. COMPLETION OF PILOT PROGRAM

A. At the completion of the Pilot Program, the EMS Medical Director will assign one of the following designations:

1. Approved
2. The Pilot Program demonstrates improved quality of care. EMS policies and/or treatment protocols may be revised pursuant to EMS Agency Policy 1060.
3. Extended (up to one year)
4. There is insufficient data to evaluate the impact of the Pilot Program on quality of care and the data collection period must be extended.
5. Closed
6. The Pilot Program does not demonstrate an improvement in quality of care.

B. The EMS Agency will present the results of the Pilot Program and the recommendations of the EMS Medical Director to the EMS Advisory Committee.

Section 7:
Community Programs

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 7010
Effective Date: January 30, 2017
Supersedes: May 23, 2013

EMERGENCY MEDICAL SERVICES AT SPECIAL EVENTS

I. PURPOSE

Establish minimum standards for emergency medical services at mass gatherings and special events.

II. POLICY

For brevity, the term "Special Event" is used to refer to either a Mass Gathering or Special Events in this policy.

A. Special Event Medical Plans requiring review by the EMS Agency Medical Director or designee, as mandated by applicable Traffic Code(s), shall meet the minimum standards for the size and type of event, as defined in this policy. These standards are summarized in the Appendices.

B. The EMS Agency Medical Director has the final authority in determining the applicability of any standard and what shall be considered an adequate Event Medical Plan.

III. SPECIAL EVENT MEDICAL PLANS

A. Special Event Medical Plans shall include, but not be limited to, the following considerations:
   1. Event description, including event name, location and expected attendance.
   2. Participant safety (the safety plan for event participants and spectators)
   3. Non-participant safety (the safety plan for individuals not participating in, but affected by the event such as neighboring local residents and on-lookers)
   4. Descriptions of the following medical resources:
      a) Personnel certified in cardio-pulmonary resuscitation, rapid access to automatic external defibrillator(s), and 911 access;
      b) First aid station(s) (if indicated; see Appendix A);
      c) Ambulance(s) (if indicated; see Appendix A);
      d) `Mobile medical resource(s) (if indicated; see Appendix A); and
      e) In addition to first aid supplies, a Multi Casualty Incident Medical Kit with medical equipment for 50 victims (see MCI kit listed in appendix C*).*

B. Special Event Communications Plans, including name(s) and contact information for the event leader and a point of contact on the day of the event, a description of direct routine communications, and a description of disaster communications if cell phones are not available (e.g. two-way radios). A description of communications between the following shall be included:
   1. Venue staff and/or security personnel, event coordinator, and medical personnel;

2. Medical personnel located at a first aid station and mobile resources and/or satellite stations;
3. Medical personnel and the City and County 911 Dispatch Center;
4. Medical personnel and ambulances as applicable, and
5. Medical staff at Receiving Hospitals as applicable.

C. Disaster Plan describing the ability to care for a minimum of 50 event attendees and staff as casualties. The plan must include training of all event medical personnel in the disaster plan, the START disaster triage system, and all appropriate necessary equipment. This may be done at any time prior to the start of the event.

IV. EMT SERVICES AT SPECIAL EVENTS

A. On-site medical personnel shall be minimally certified as an EMT-1 in California and equipped to provide the complete EMT-1 Scope of Practice as defined in California Code of Regulations, Title 22, Section 100163. They shall follow San Francisco EMS Agency Policies and Protocols.

B. Paramedics equipped and used to provide Basic Life Support need only be licensed by the State of California

V. PARAMEDIC SERVICES AT SPECIAL EVENTS

A. Paramedics deployed as part of a Special Events Medical Plan shall be:
   1. Licensed in the state of California;
   2. Accredited in the City and County of San Francisco;
   3. On-duty with an approved Paramedic Service Provider for the duration of the event for which they are deployed; and
   4. Equipped to provide Advanced Life Support care.

B. Paramedics shall follow San Francisco EMS Agency Policies and Protocols. An on-scene physician may provide medical direction only as allowed in EMS Agency Policy #4041 *Physician on Scene*.

VI. AMBULANCE SERVICES AT SPECIAL EVENTS

Ambulances deployed as part of the approved Event Medical Plan shall be permitted for operation in San Francisco by the EMS Agency.

VII. AUTOMATIC EXTERNAL DEFIBRILLATORS

Automatic External Defibrillators (AEDs) should be made accessible to medical personnel and non-medical personnel trained in its use and located throughout the venue in location(s) that will enable the first shock to a person in cardiac arrest within 5 minutes of notification of qualified personnel. The current San Francisco EMS Response Interval Standard for time to defibrillation must be met by the responding agencies.

VIII. PROCEDURES FOR SUBMITTING SPECIAL EVENT MEDICAL PLANS

A. Special Event Medical Plans shall be submitted following guidelines posted on the San Francisco EMS Agency website.
B. The EMS Agency Medical Director or designee shall review the Special Event Medical Plan within 15 days and respond to both the event sponsor and the City permitting agency as follows:
    1. Approved without modification.
    2. Approval pending submission of additional information specified by the reviewer.
    3. Not Approved.
C. Plans not approved will be returned to the event sponsor with an explanation of the decision.

The event sponsor may appeal the decision by resubmitting the plan to the EMS Agency Medical Director. A review will occur within 5 days of receipt. The EMS Agency Medical Director's decision shall be delivered to the event sponsor within 5 business days of the review.

IX. PROCEDURES FOR SUBMITTING POST – EVENT MEDICAL TREATMENT REPORTS

The event sponsor will submit an Event Medical Treatment Report, within two weeks of the conclusion of the event, to the EMS Agency Medical Director or designee. The report will provide a summary of the medical incidents during the event that involved the EMS plan medical resources. This summary will include at a minimum the number of patients seen at the first aid station(s) or other facilities, their age, gender, chief complaint, and disposition.

X. EMS AGENCY STAFF CONTACT

The EMS Agency staff point of contact for questions on this policy or Special Event Medial Plans may be reached via contact information published at the EMS agency website.

XI. AUTHORITY

California Health and Safety Code, Sections 1797.202, 1797.204, 1797.220, 1798
California Code of Regulation, Title 22, Sections 100063, 100144, 100167(a), 100169 City & County of San Francisco Traffic Code sections 800, 801, 802, 804, San Francisco
Transportation Code, Division I, section 9.2 and 9.3, San Francisco Police Code section 366, and Administrative Code section 90.4

Policy Reference No.: 7010
Effective Date: Jan. 30, 2017
Supersedes: May 23, 2013

EMERGENCY MEDICAL SERVICES AT SPECIAL EVENTS

APPENDIX A

GUIDELINES FOR MINIMUM MEDICAL RESOURCE IN SPECIAL EVENTS

EVENT TYPE	Estimated Crowd Size (maximum attendees at peak time)	CPR & 911 Access	1st Aid Station w/ EMT [1]	1st Aid Station w/ Physician, Nurse, or Paramedic [4]	Water-based ALS	ALS Ambulance [3]	Mobile Resources
Concert / Music Festival	< 2,500	Required	Recommended				
	2,500-15,500	Required	Required	Recommended		ALS Required (May need multiple units)	Recommended
	15,500-50,000	Required		Required		ALS Required (May need multiple units)	Required
	>50,000	Required				ALS Required (May need multiple Units)	Required
Athletic / Sporting Event [2]	< 2,500	Required	Recommended	Recommended			
	2,500-15,500	Required		Required		ALS Required	Required
	15,500-50,000	Required				ALS Required (May need multiple Units)	Required
	>50,000	Required				ALS Required (May need multiple Units)	Required
Parade / Block Party / Street Fair / Outside Venue	< 2,500	Required	Recommended				Recommended
	2,500-15,500	Required	Required	Required		ALS Required (May need multiple units)	Required
	15,500-50,000	Required		Required		ALS Required (May need multiple Units)	Required
	>50,000	Required				ALS Required (May need multiple Units)	Required
Conference or Convention	< 2,500	Required	Recommended	Recommended			
	2,500-15,500	Required	Required	Recommended		ALS Required (May need multiple units)	Recommended
	15,500-50,000	Required		Required		ALS Required (May need multiple Units)	Required
	>50,000	Required				ALS Required (May need multiple Units)	Required
Water-based	50 – 100	Required	Required	Recommended	Required	Required	Required

Events (Swim, Triathlon, etc.)	100 – 300	Required		Required	Required (May need multiple Units)	Required (May need multiple Units)	Required (May need multiple Units)
	300 – 1,000	Required			Required (May need multiple Units)	Required (May need multiple Units)	Required (May need multiple Units)
	> 1,000	Required			Required (May need multiple Units)	Required (May need multiple Units)	Required (May need multiple Units)

1 Automatic External Defibrillator required for all events larger than 2,500 attendees.

2 More than 1 first aid station is recommended for parades/ sporting events taking place over 1 mile or more.

3 Multiple ambulances may be required depending on event history and size. Recommend 1 unit per 10,000 participants or spectators (Additional Resources may be necessary for isolated or hard-to-access areas, such as Treasure Island.).

4 If sobering services are required as part of your EMS plan, they must be staffed by a Nurse or Physician per DPH sobering protocols.

Policy Reference No.: 7010
Effective Date: January 30, 2017
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EMERGENCY MEDICAL SERVICES AT SPECIAL EVENTS

APPENDIX B

DEFINITIONS SPECIAL EVENT MEDICAL RESOURCES

CPR & 911 Access: Event staff and/or safety personnel have the capability to notify 911 of any medical emergency and to provide CPR/AED access per San Francisco EMS Agency System Standards [within five (5) minutes in 90% of occurrences].

First Aid Station with Emergency Medical Technician (EMT): A fixed or mobile facility with the ability to provide first aid level care staffed by at least one EMT or higher skill level personnel. First Aid level care is defined as treatment of minor medical conditions and injuries by care providers that have received training in First Aid, at the EMT level. Examples of First Aid care are cleaning, bandaging and treating simple wounds such as scrapes and shallow cuts, providing cold packs for musculo-skeletal strains and bruises, and giving drinking water and a place to rest for patients who are mildly dehydrated. Each Fixed First Aid Station shall have an AED and MCI Kit present at all times. Examples of a First Aid Station are a tent, a clinic, an ambulance or vehicle of some type. The first aid station must have 911 communications capability. EMTs who are employees of locally permitted ambulance provider agencies are recommended due to their familiarity with local policy, procedure and protocol. It is also recommended that any event employing multiple First Aid Stations also have a designated Event Physician Medical Director and establish a liaison with the Emergency Communications Department and the Fire Department to improve coordination with 911.

First Aid Station with Paramedic, Nurse, or Physician: A similar facility to a First Aid Station with an EMT, but staffed by at least one Accredited Paramedic, Registered Nurse or Physician, holding a current California license. It is preferred that the Nurse and Physician be experienced in emergency medical care and triage of seriously ill or injured patients to higher levels of care. Examples would be RN's with Emergency Medicine, Critical Care, or Urgent Care backgrounds, or Nurse Practitoners or other mid-level provider licensees. Examples of appropriate Physicians would be those with Emergency Medicine, Family Practice, Sports Medicine, Internal Medicine or Trauma Care specialization. Physicians and/or Nurses are recommended for larger crowd sizes or events needing sobering services; Paramedics may be substituted for smaller size crowds as outlined in the *Guidelines for Medical Resource in Special Events Matrix* in Appendix A.

BLS (Basic Life Support) Ambulance: An ambulance staffed by two EMTs or Paramedics working at a BLS level. BLS units may be utilized for first response (as a Mobile Team) or to substitute for a fixed First Aid Station with an EMT, but may NOT transport unless the following criteria are met. BLS units, in accordance with the City of San Francisco Ambulance Ordinance, may not

transport the ill or injured from a venue to a receiving hospital unless directed to do so by a designated Event Physician in accordance with EMS Agency Policy 4042. In cases where a patient has a life-threatening condition, a dedicated BLS Ambulance may transport only if the ETA to the closest receiving hospital is less than the ETA of responding ALS resources.

ALS (Advanced Life Support) Ambulance: An ambulance staffed by at least one Paramedic and one EMT (ALS) or two Paramedics. An ALS Ambulance is a dedicated transport unit, and must be available for any patient within the event footprint. ALS Ambulances may NOT be utilized as both transport unit and fixed First Aid Station.

Mobile Resource(s): Mobile or "Roving Medical Resource(s)" are non-ambulance based EMTs and/or paramedics, or higher-level interventionists, that are deployed throughout the footprint of a special event and may be on foot, bicycles, or motorized transport cart/vehicle (Gator, Moped, Motorcycle, etc.). Mobile Resource(s) must be able to provide, AT MINIMUM, First Aid Care at a BLS level, and must have communication capability, by radio, cell phone, or other medium (See Appendix D). Each Mobile Resource must carry at least one AED at all times. EMTs, that are dedicated resources within an approved medical plan, may respond, evaluate, and create Patient Declines Transport (PDT) documentation (NOT AMA), for patients that do not qualify under the guidelines in EMSA Policy 4040, Section E.3.a)(1-11).

Water-Based Resource(s): A medical response resource (BLS or ALS), that is based on a boat, Personal Water Craft (PWC), or other water-based vessel (Kayak, Surf-Ski, etc.), that is capable of providing medical interventions and rendezvous with another vessel of higher-level care, or a ground-based transport unit. Any ALS Resource must be located on a vessel that has an accessible deck, and room/equipment to perform ALS/ACLS interventions (See Appendix D). Each Water-Based Resource(s) must have communication capability, by radio, cell phone, or other medium.

APPENDIX C

Multi Casualty Incident Medical Kit

ITEM	Quantity
Bag or Case to hold MCI Equipment	1
Bullhorn or Battery Powered Megaphone	1
Combat Application Tourniquets or approved equivalent*	4
Compression Bandage with ties (e.g. Bloodstopper Dressings)	7
Sterile gauze pads 4" x 4," 12 per box	1
Nonsterile 4" x 4" gauze pads, 200 per box	1
Abdominal Dressing, 8" x 10" or 5"x9" or similar size	2
Stretch-style Sterile Gauze Rolls 4" or 5"	4
Petroleum Gauze Pads, 4" x 6" or 3" x 9" (or similar size)	4
Triangular Bandages	2
Cloth Tape 1," 2" and 3"	2 each size
Cone masks	50
Felt tip markers	2
Glasses or Goggles	2
Heavy Duty Gloves	2
Oral Airways, sizes 0, 1, 2, & 3	4
Oral Airways, sizes 4, 5, & 6	8
Pens	3
Ruled paper tablet	1
Trauma Shears	2
Triage Tags	50
Vests - Kelly Green or Blue: "EMT-1" or "EMT-P"	2
Worksheet: Patient Tracking (who was treated, for what, where did they go?)	1
***** *Acceptable equivalent includes Combat Application Tourniquet, Emergency and Military Tourniquet, or Special Operations Forces Tactical Tourniquet*	

APPENDIX D

Qty:	Description:	Qty:	Description:
BLS Mobile Resource Inventory:			
Various Equipment:			
Appropriate PPE (for reasonably expected hazards)			
	Stethoscope		Blood Pressure Cuff (Adult)
	Paper PCR (or equivalent handoff report)		P100 Mask
2	Biohazard Bags	1	Sharp Shuttle
1	Automatic External Defibrillator (AED)	1	Oxygen (“A” Cylinder or larger)
Airway:			
	Assorted OPA’s		Assorted NPA’s
1	Nasal Cannula (NC)	1	Non-Rebreather Mask (NRB)
1	Pediatric NRB	1	Bag-Valve Mask (BVM)
5	Water-Based Lubricant		
Trauma Supplies:			
2	Blood Stoppers	1	Petroleum Gauze
1	Triangular Bandage	2	Roller Gauze
5	4X4 Gauze Dressing (Sterile)	2	Abdominal Pad 5X9 (or larger)
10	Band Aids	1	Tourniquet (Combat Style)
1	Quick Clot Bandage (or equivalent)	1	1” or 2” Cloth Tape
1	Trauma Shears	3	Antibiotic Ointment
3	Instant Ice Pack	1	Backboard and/or KED (for Carts Only)
ALS Mobile Resource Inventory:			
All of the above items, PLUS:			
Glucometer (Lancets, Test Strips, ETOH Swabs, BandAids, etc.)			
Airway:			
1 ea	King Tube, Sizes 3,4,5	1	Tube Tamer (or equivalent holding device)
1	Mac 1 Laryngoscope Blade	1	Mac 4 Laryngoscope Blade
1	Laryngoscope Handle (incl. extra batteries)	1	Magill Forceps
1	Nebulizer Mask, Adult	1	Nebulizer Mask, Pediatric
IV Start Kit and Supplies:			
1	16 gauge IV Catheter	2	18 gauge IV Catheter
2	20 gauge IV Catheter	2	22 gauge IV Catheter
2	Tegaderm (or equivalent)	6	Alcohol Swabs
1	1” Transpore Tape	2	Tourniquet (elastic)
1	Chux	2	Saline Flush
2	Saline Lock	1	1000cc Normal Saline
1	Macro Administration Drip Set	1	100cc 5% Dextrose
1	3-Way Stopcock	2	1cc Syringe (with Needle)
2	1cc Syringe (without Needle)	2	3cc Syringe
2	5 cc Syringe	2	10 cc Syringe
Medications:			
1	Adenosine, 6mg Vial	2	Adenosine, 12mg Vial
4	Albuterol, 2.5mg Bullets	3	Amiodarone, 150mg Vial
1	Aspirin (ASA), Bottle of 81mg Tablets	1	Atropine, 1mg Preload
1	Diphenhydramine (Benadryl), 50mg Vial	1	Calcium Chloride, 1g/10ml Preload
1	Charcoal, 25g Tube/Bottle	1	50% Dextrose, 25g Preload
3	Epinephrine, 1:1000 Ampoule	3	Epinephrine, 1:10,000 Preload
1	Glucagon, 1mg Vial	1	Magnesium Sulphate, 5mg/10ml Vial
2	Naloxone (Narcan), 2mg Preload	1	Nitroglycerin (NTG), Bottle, 0.4mg Tablets Or Spray
3	Oral Glucose, 15g Tube/Bottle	2	Ondansetron (Zofran), 4mg Preload/Vial

Section 8:
Disaster

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

Policy Reference No.: 8000
Effective Date: September 2, 2014
Supersedes: January 15, 2011

MULTI-CASUALTY INCIDENT POLICY

I. PURPOSE

This policy supports the San Francisco Emergency Medical Services Multi-Incident Casualty (MCI) Plan. The MCI Plan identifies and delineates the structure and processes for the provision of emergency medical care by local EMS system participants during a MCI event of any size or magnitude.

The overall objective of the MCI Plan is to minimize the morbidity and mortality associated with large scale emergency patient care incidents occurring in San Francisco by ensuring the provision of rapid and appropriate emergency medical care to the most possible patients through a coordinated response system based on incident management principles.

II. AUTHORITY

A. Statutory authorities for the MCI plan include:
- California Health and Safety Code, Sections 1797.103; 1797.150-153; 1797.204; and 1797.220
- California Code of Regulations, Title 19, Division 2, Chapter 1
- California Code of Regulations, Title 22, Section 100167 (b) (2 - 3); 100168 (b) (4); and 100169 (a)
- California Code of Regulations, Title 22, Division 9, Section 100255
- California Government Code, Article 9, Section 8605
- California Master Mutual Aid Agreement
- California Emergency Services Act

B. The MCI Plan complies with the following standards or references the following partner plans:
- National Incident Management System (NIMS)
- City and County Emergency Response Plan, April 2008
- San Francisco Bay Area Regional Coordination Plan – Medical and Health Subsidiary Plan, March 2008
- Firescope Field Operations Guide, ICS 420-1, July 2007
- California Standardized Emergency Management System (SEMS)
- California Public Health and Medical Emergency Operations Manual, July 2011

III. POLICY

A. The San Francisco Emergency Medical Services MCI Plan is an approved policy and procedure of the Department of Emergency Management - EMS Agency. EMS provider

organizations shall comply with the operational roles and standards as defined in the MCI Plan. This includes all San Francisco ambulance providers, dispatch centers, hospitals and relevant Emergency Operations Center or departmental operations center command staff.

B. All San Francisco ambulance providers, dispatch centers, and hospitals shall develop, maintain and train staff on Emergency Response Plans for their organizations, and maintain disaster supplies and equipment that will allow for a minimum of 72-hours of self-sufficient operations.

IV. TRAINING and EXERCISES

A. All EMS provider organizations shall provide annual training and updates on the San Francisco Emergency Medical Services MCI Plan and participate in regular exercises of that plan with other EMS system participants.

B. EMS provider organizations shall provide training to relevant staff to ensure proficiency in the following:

1. First Receiver (Hospitals Only):
   a) Simple Triage and Rapid Treatment (START) and JUMPSTART
   b) Hospital Incident Command System
   c) Hospital Incident Command System Hazardous Materials Awareness
   d) Incident Command System (up to ICS 200 level)
   e) National Incident Management System (NIMS) IS-700 and IS-800
   f) Working knowledge of San Francisco EMS Agency Policies and Procedures
   g) EMS related communication tools (radios, EMSystem, etc.) as required in EMS policy.

2. All Field First Responders:
   a) Simple Triage and Rapid Treatment (START) and JUMPSTART
   b) California Standardized Emergency Management System (SEMS)
   c) Incident Command System (up to ICS 200 level)
   d) National Incident Management System (NIMS) IS-700 and IS-800
   e) Hazardous Materials First Responder Awareness
   f) Working knowledge of San Francisco EMS Agency Policies and Procedures
   g) EMS related communication tools (radios, EMSystem, etc.) as required in EMS policy.

3. Ambulance Strike Team Leader:
   a) Incident Command System (up to ICS 300 level)
   b) Ambulance Strike Team Leader Training (State EMS Authority course)
   c) Ambulance Strike Team Provider Training (State EMS Authority course)

d) EMS related communication tools (radios, EMSystem, etc.) as required in EMS policy.

4. On-Scene Command Staff:
   a) Incident Command System (up to ICS 400 level)
   b) EMS related communication tools (radios, EMSystem, etc.) as required in EMS policy.
   c) EMS related communication tools (radios, EMSystem, etc.) as required in EMS policy.

5. Assigned EOC or DOC Command Staff:
   a) City and County Emergency Response Plan
   b) City Departmental Emergency Response Plans (any city DOC staff)
   c) Provider Emergency Operations Plan (any private provider DOC staff)
   d) MGT 313 (or equivalent) – Incident Management / Unified Command
   e) EMS related communication tools (radios, EMSystem, etc.) as required in EMS policy.

V. MCI PLAN UPDATES

The EMS Agency is responsible for updates of the San Francisco Emergency Medical Services MCI Plan through its regular policy and protocol public comment process. This policy will be updated as appropriate to support the MCI Plan.

VI. QUALITY IMPROVEMENT

A. The Medical Group Supervisor for a MCI will submit the MCI Summary Report along with a written narrative to the EMS Agency within 24 hours after the incident.

B. DEC will submit a MCI Post Event Report Form to the EMS Agency within 24 hours of the incident.

C. EMS provider organizations shall submit other incident or patient-related information *as requested* by the EMS Agency. Any submitted patient information must NOT contain specific patient identifiers in compliance with all applicable federal or state patient confidentiality requirements.

D. The EMS Agency will review all MCI Post Event Report Forms and MCI Summary Reports as part of our on-going Quality Improvement process. The EMS Agency may coordinate an inter-agency debriefing for significant MCIs. A representative from each department or agency with an active role in the MCI incident will attend the debriefing. The EMS Agency will follow up all in-person inter-agency debriefings with a written After Action Report / Plan of Correction.

MCI Date / Time:
CAD Incident Number:
Report Completed By:

Fax Copy within 24 hrs after MCI
to DEM - EMS Agency at (415) 552-0194

MCI SUMMARY REPORT TO EMS AGENCY V. July 2016

SCENE INFORMATION	
Call Sign:	
Location:	
Incident Type:	
Hazards:	
Staging:	
Access:	
Egress:	

COMMAND STAFF	
IC:	
MGS:	
Triage:	
Treatment:	
Staging:	
Transport:	

ESTIMATED NUMBER OF PATIENTS			
Red	Yellow	Green	Total

UNIT STATUS					
UNIT ALS / BLS	DISPATCH TIME	STATUS HOSP / CAN	TRANSPORTED # R	TRANSPORTED # Y	TRANSPORTED # G

HOSP STATUS					
HOSP STATUS	# AVAIL BEDS	STATUS HOSP / CAN	# TYPE # R	# TYPE # Y	# TYPE # G
CalPac					
Dav					
Kais-SF					
St Fran					
St Lukes					
St Mary					
SFGH					
UCSF					
Veteran					
Chinese					
CPMC-Cal					
UC-MB					
South Kais					
Seton					

LOCATION OF	
ICP:	**Transport:**
Triage:	**Staging:**
Treatment:	**Supply:**
Green Treatment:	**Rehab:**
Morgue:	

OTHER UNITS DISPATCH		
TYPE	# PTS	TIME
Bus		
Helicop		
RedCross		

SAN FRANCISCO

MCI PLAN

June 2016

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PART 1: STANDARD OPERATING PROCEDURES

ALERT LEVELS *VERSION 2016*

Level	Definition	Purpose	Example
MCI YELLOW ALERT	Incident with a potential for multiple casualties	"Heads Up" about a situation that may become a MCI.	Large residential building is on fire, but no victims have yet been identified.
LEVEL 1 MCI (RED) ALERT	MCI with **6 - 50 victims** of any triage level.	Notifies local EMS system about a MCI with 6 – 50 victims.	Bus accident with 15 patients all triaged as YELLOW.
LEVEL 2 MCI (RED) ALERT	MCI with **51 - 100** victims of any triage level. Requires resources from or distribution of casualties to neighboring counties.	Notifies local EMS and disaster system and Regional Mutual Aid System about a MCI with 51 – 100 victims.	Mass transit accident with 95 victims. Must send trauma patients to SFGH and Trauma Centers in nearby counties.
LEVEL 3 MCI (RED) ALERT	MCI with **101 or more** victims of any triage level. Requires resources from or distribution of casualties throughout the State or federal response system.	Notifies local EMS and city disaster system, Regional Mutual Aid System, State and Federal responders about MCI with > 101 victims. Assumes infrastructure is essentially intact, but has numerous disruptions.	High magnitude earthquake with hundreds of casualties. Example: 1989 Loma Prieta Earthquake
LEVEL 4 MCI (RED) ALERT	Catastrophic disaster with significant infrastructure damage, and unknown number of injuries and deaths. Requires significant, long-term support from State and Federal government.	Notifies local EMS and city disaster system, Regional Mutual Aid System, State and Federal responders about a catastrophic disaster. Recovery outlook is long-term.	San Francisco 1906 earthquake and fire.
LEVEL ZERO MEDICAL 911 SYSTEM DISRUPTION	Disruption of normal 911 operations due to: 1) Extreme 911 call volume causing ambulance shortage, AND/ OR **2)** Hospital(s) issue closes it to 911 ambulances.	"Heads Up" about disruption to the medical 911 system. EMS and hospital providers may be requested to report about their resources (number of ambulances / hospital beds / etc.).	Extreme weather generates hundreds of medical 911 calls resulting in ambulance shortages and saturation of hospital emergency departments.

PART 1: STANDARD OPERATING PROCEDURES

911 DISPATCH (DEC) *version 2016*

Level	Actions
MCI YELLOW ALERT "Heads Up" about Incident with a potential for multiple casualties	❑ Dispatch available resources to meet the initial needs of the scene per normal procedures and as requested by Incident Commander or designee. ❑ Notify other ambulance providers and to determine available ambulances as necessary. ❑ Enter alert on the Reddinet website to poll hospital Emergency Departments for available Emergency Department beds for Red/Yellow/Green patients. ❑ Upgrade to Level 1, 2 or 3 MCI (Red) Alert as appropriate or announce Yellow Alert termination. Change alert status on Reddinet. ❑ **Alert Termination:** Field Incident Command or Medical Group Supervisor.
LEVEL 1 **MCI (RED) ALERT** **6 - 50 victims** of any triage level	❑ Dispatch available resources to meet the initial needs of the scene per normal procedures and as requested by Incident Commander or designee. Communicate to all responding ambulances designated routes for ingress / egress and staging. ❑ Notify other ambulance providers and to determine available ambulances as necessary. ❑ At the direction of the Incident Commander, designate a dedicated incident radio channels (command + tactical). Inform all responding apparatus/agencies. ❑ Enter the incident on the Reddinet website to poll hospital Emergency Departments for available Emergency Department beds for Red/Yellow/Green patients. ❑ Monitor Reddinet website and contact hospitals as necessary to determine number of Red/Yellow/Green patients they can accept. Relay information to Transportation Unit Leader. ❑ Make for hospital destinations recommendations to the Transportation Unit Leader based upon information from the "MCI Transport Form" and hospital capability reports on the Reddinet website. ❑ Notify hospitals about in-coming patients when assigned by the Transportation Unit Leader: o Name of ambulance company + unit number o Number of in-coming patients and their triage category designation (R/Y/G) o ETA ❑ Maintain "MCI Transport Form" to record number and type of patients, transport units, and hospital destinations. ❑ In-County Mutual aid ambulances from within San Francisco may be used if approved by EMS Medical Director

	(Bayshore, Pro-Transport, St Josephs). ❑ **Ambulance diversion is automatically suspended ONLY for MCI patients**. ❑ **Alert Termination:** Field Incident Command or Medical Group Supervisor.
LEVEL 2 **MCI (RED) ALERT** **51 - 100** victims of any triage level	❑ Follow same steps for Level 1 Red Alert listed above. ❑ If 911 ambulances shortage, go to "**"911 Ambulance Surge: Level Zero Actions for DEC and DEM Duty Officer."** ❑ If the Incident Commander (IC) or Medical Group Supervisor asks for an **Ambulance Strike Team**, contact the Public Safety Answering Point (PSAP) in a neighboring county to initiate an "Immediate Send" of a single Strike Team prior to contacting the DEM Duty Officer. The DEM Duty Officer will contact the SF Medical-Health Operations Coordinator for approval of additional teams. ❑ For requests of other types of **Medical Mutual Aid**, contact the DEM Duty Officer. The DEM Duty Officer will contact the SF Medical-Health Operations Coordinator for approval. ❑ Requests originating through the **Fire Mutual Aid System** for SFFD ambulances will be approved through SFFD in consultation with the MHOAC. ❑ Out-of-County Mutual aid ambulances from other counties may be used if approved by EMS Medical Director. ❑ **Diversion is automatically suspended for ALL ambulance patients during a Level 2 MCI Alert.** ❑ Requests to modify the EMS response patterns must be approved by the SF Medical-Health Operations Coordinator. ❑ Consider activating internal Emergency Response Plan for large incidents. ❑ **Alert Termination:** Incident Command
LEVEL 3 **MCI (RED) ALERT** **101 or greater** number of victims of any triage level	❑ Follow same steps for Levels 1 and 2 Red Alerts listed above. ❑ **Diversion is automatically suspended for ALL ambulance patients for the duration of the Level 3 MCI Alert.** DEM Duty Officer will determine when to reinstate. ❑ Activate internal Emergency Response Plan for large incidents. ❑ **Alert Termination:** Incident Command.
LEVEL 4 **MCI (RED) ALERT** Catastrophic disaster	❑ Ensure safety of all dispatch staff. Evacuate if building is unsafe. ❑ Activate all Emergency Response Plans. ❑ Restore communication services if disrupted. ❑ **Alert Termination**: SFFD has the authority to activate/deactivate an Emergency District Coordination Centers (EDCCs) decentralized command structure.

LEVEL ZERO MEDICAL 911 SYSTEM DISRUPTION Significant 911 ambulance shortage OR Hospital(s) issue closes it to 911 Ambulances	❑ If 911 ambulance shortage, follow actions described in **"911 Ambulance Surge: Level Zero Actions for DEC and DEM Duty Officer."** ❑ If San Francisco General Hospital cannot receive Trauma Patients: a) Notify San Mateo Public Safety Communications, and, b) Notify DEM Duty Officer. ❑ For any other hospital issue affecting their ability to receive patients, notify DEM Duty Officer. ❑ **Alert Termination:** 911 Dispatch or DEM Agency Duty Officer.

PRIVATE AMBULANCE DISPATCH *version 2016*

Level	Actions
MCI YELLOW ALERT Incident with a potential for multiple casualties	❑ Inform ambulance crews about Yellow Alert incident. Dispatch available ambulances if requested by DEC per normal procedures. ❑ Determine availability of additional ambulances as necessary. ❑ Input into Reddinet website, the number of available ALS and BLS ambulances **within 5 or less minutes.** ❑ Monitor for upgrade to Red Alert or termination of Yellow Alert.
LEVEL 1 **MCI (RED) ALERT** Has **6 - 50 victims** of any triage level	❑ Dispatch available ambulances as requested by DEC per normal procedures. ❑ Inform responding ambulance crews about: a) Designated incident radio channels (command + tactical) b) Designated routes for ingress / egress and staging. ❑ Input into Reddinet website, the number of available ALS and BLS ambulances **within 5 or less minutes.** DEC may request additional ambulance units when short 911 ambulances during a MCI response. ❑ During a MCI, all Private Ambulance Dispatch Centers are required to: o Monitor Reddinet and the incident 800 MHz radio channels for the duration of the MCI; o Update the number of available ALS and BLS ambulances as appropriate for the duration of the MCI. ❑ In-County Mutual aid ambulances from within San Francisco may be used if approved by EMS Medical Director (Bayshore, Pro-Transport, St Josephs). ❑ **Ambulance diversion is automatically suspended ONLY for MCI patients**. ❑ Inform responding ambulance crews when Red Alert is terminated.
LEVEL 2 **MCI (RED) ALERT** Has **51 - 100** victims of any triage level **AND / OR** Medical Mutual Aid from Neighboring County	❑ Follow same steps for Level 1 Red Alert listed above. ❑ **Diversion is automatically suspended for ALL ambulance patients for the duration of the Level 2 MCI Alert.** ❑ DEM Duty Officer may provide instructions about modifications to the standard medical 911Response. ❑ Consider activating internal Emergency Response Plan for large incidents.

LEVEL 3 **MCI (RED) ALERT** Has **51 - 100** victims of any triage level **AND / OR** Medical Mutual Aid from Neighboring County	❑ Follow same steps for Levels 1 and 2 Red Alerts listed above. ❑ **Diversion is automatically suspended for ALL ambulance patients for the duration of the Level 3 MCI Alert.** ❑ Activate internal Emergency Response Plan for large incidents. ❑ DEM Duty Officer may provide instructions about modifications to the standard medical 911Response ❑ Out-of-County Mutual aid ambulances from other counties may be used if approved by EMS Medical Director.
LEVEL 4 **MCI (RED) ALERT** Catastrophic disaster with significant infrastructure damage + unknown number of injuries casualties and deaths	❑ Ensure safety of all dispatch staff (evacuate if building is unsafe). ❑ Activate all Emergency Response Plans. ❑ Restore communication services if disrupted. ❑ **Alert Termination**: SFFD has the authority to activate/deactivate an Emergency District Coordination Centers (EDCCs) decentralized command structure.
LEVEL ZERO **MEDICAL 911 SYSTEM DISRUPTION** Extreme ambulances shortage. OR Issue at 1 or more hospitals preventing participation in medical 911 system	❑ Input into Reddinet the number of available ALS and BLS ambulances **within 5 or less minutes.** ❑ DEC may request additional ambulance units when short 911 ambulances during a MCI response. ❑ BLS ambulances may be requested in specific situations and when authorized by the EMS Agency Medical Director.

PART 1: STANDARD OPERATING PROCEDURES

FIELD SUPERVISORS (Medical Group) *version 2016*

Level	Actions
MCI YELLOW ALERT "Heads Up" about Incident with a <u>potential</u> for multiple casualties	❑ Call MCI Yellow Alert for if there are potential patients. ❑ Upgrade to appropriate MCI Red Alert Level if there are actual patients OR cancel alert if it is not a MCI. ❑ Follow your agency's standard response procedures.
LEVEL 1 MCI (RED) ALERT **6 - 50 victims** of any triage level	❑ (If not done by Incident Commander) - Radio a Situation Report on the initial Control Channel to DEC (911 Dispatch) within the first 15 minutes that includes: • Yellow or Red Alert • If Red Alert – the alert level, • Location of Incident and Name of Command, • Type of Incident/Nature of Incident; • Hazards (if present), • Number of victims (estimated or actual number), • Command Post and Staging Locations, • Initial route of Ingress (best route to enter) and Egress, and • Additional and / or Specialized Resources if needed. ❑ Follow your agency's standard response procedures for Medical Group activation. ❑ Radio back to the SFFD Officer located at DEC which hospitals will receive patients, how many, what type, and any special needs (pediatrics, hazmat). Update the SFFD Officer located at DEC every 30 minutes or anytime there is a significant change in the MCI incident. This action may be delegated to Patient Transport Officer. ❑ In-County Mutual aid ambulances from within San Francisco may be used if approved by EMS Medical Director

	(Bayshore, Pro-Transport, St Josephs). ❑ EMS Response Time Standards are still in effect. ❑ **Ambulance diversion is automatically suspended ONLY for MCI patients**.
LEVEL 2 **MCI (RED) ALERT** **51 - 100** victims of any triage level	❑ Follow same steps for Level 1 Red Alert listed above. ❑ **Diversion is automatically suspended for ALL ambulance patients.** ❑ Request field supplements as needed: Mobile Multi-Casualty Unit (request through SFFD) Mutual Aid Ambulance Strike Team(s) MCI Trailers (through DEM Duty Officer) Disaster Medical Supply Units Alternate transport vehicles (e.g. Muni buses, etc.) may be used to transport walking wounded (Green) patients. ❑ Out-of-County Mutual aid ambulances from other counties may be used if approved by EMS Medical Director. ❑ Consider activating internal Emergency Response Plan to surge available resources. ❑ Consider setting up Alternate Treatment Site to hold patients awaiting transport. ❑ DEC may provide instructions about modifying EMS Response patterns. EMS Response Time Standards are suspended during Modified EMS Responses.

LEVEL 3 **MCI (RED) ALERT** **101 or greater** number of victims of any triage level	❑ Follow same steps for Levels 1 and 2 Red Alert listed above. ❑ Activate Emergency Response Plan to surge available resources. ❑ Set up designated staging areas for Mutual Aid Ambulances. ❑ Set up Alternate Treatment Sites for holding patients awaiting transport. ❑ DEC may provide instructions about modifying EMS Response patterns. EMS Response Time Standards are suspended during Modified EMS Responses.
LEVEL 4 **MCI (RED) ALERT** Catastrophic disaster	The SFFD may invoke a decentralized command structure based on their division or battalion districts if central dispatch is interrupted. ❑ Each battalion station is the designated District Coordination Center (DCC) and each Battalion Chief controls all of the assets in his/her emergency district. When Fire Battalion Stations are used to house the DCC, primary coordination and communication will be with the Fire DOC utilizing all available communication systems. ❑ Ambulance response units will be organized through the District Coordination Centers until the dispatch communications infrastructure and central command are restored. This includes mutual aid ambulances. ❑ Other city department representatives at the DCC will communicate and coordinate their departmental resources with the relevant DOC when it becomes operational. Unified Command is used at the DCC when there are other city department representatives present. ❑ DCC will determine resource allocation priorities within its district. Resource requests will be communicated to the EOC through the Community Branch when it is activated.
LEVEL ZERO **MEDICAL 911 SYSTEM**	❑ If 911 ambulance shortage, DEC will receive instructions from EMS Medical Director about modifications to the EMS Response.

DISRUPTION Significant 911 ambulance shortage OR Hospital(s) issue closes it to 911 Ambulances	❑ If San Francisco General Hospital cannot receive Trauma Patients, DEC will receive instructions from EMS Medical Director about modifications to trauma destination. ❑ If other hospital is closed to ambulance, DEC will receive instructions from EMS Medical Director about modifications to hospital destination.

PART 1: STANDARD OPERATING PROCEDURES

HOSPITALS *version 2016*

Level	Actions
MCI YELLOW ALERT "Heads Up" about Incident with a <u>potential</u> for multiple casualties	❑ Be aware of a situation in progress that may result in a MCI. Be ready to receive patients from the MCI. ❑ Respond to Reddinet poll for available ED beds if initiated. **The required hospital response must be done within 15 or less minutes.**
LEVEL 1 **MCI (RED) ALERT** **6 - 50 victims** of any triage level	❑ Assess type, location and size of MCI. Notify ED staff / house supervisors and other hospital responders per normal procedures. ❑ Assess need for initiation of Internal Response Plans and Hospital Incident Command per normal procedures. ❑ ED Charge Nurse inputs into Reddinet the number of available ED beds for Immediate (Red), Delayed (Yellow) and Minor (Green) patients **within 15 or less minutes.** ❑ San Francisco hospitals are pre-assigned to receive 2 Immediate (Red) and 4 Delayed (Yellow) and 6 Minor (Green) patients OR up to 12 Minor (Green). *[SFGH will receive 1st 4 major trauma (Red) patients; Chinese, VAMC, Seton and South Kaiser will receive only Yellow + Green*]. ❑ Casualties may self-present to ED (patients not transported by EMS). ❑ **Ambulance diversion is automatically suspended ONLY for MCI patients**. ❑ During a MCI, all Emergency Department Charge Nurses are required to: • Monitor Reddinet and the 800 MHz radios for the duration of the MCI; • Input the number of available ED beds for Immediate (Red), Delayed (Yellow) and Minor (Green) patients **within the first 15 minutes or less;** and • Update the number of available ED beds as appropriate for the duration of the MCI.

LEVEL 2 **MCI (RED) ALERT** **51 - 100** victims of any triage level	❑ Follow same steps for Level 1 Red Alert listed above. ❑ **Diversion is automatically suspended for ALL ambulance patients for the duration of the MCI Alert.** ❑ Consider activating internal Emergency Response Plan for large incidents. ❑ For Reddinet HavBed Alerts, the ED Charge Nurse or House Supervisor must enter the number of **In-Patient beds available** (see last page for the list of bed categories). You must enter this information within 2 or less hours.
LEVEL 3 **MCI (RED) ALERT** **101 or greater** number of victims of any triage level	❑ Follow same steps for Levels 1 and 2 Red Alerts listed above. ❑ **Diversion is automatically suspended for ALL ambulance patients for the duration of the MCI Alert.** ❑ Activate internal Emergency Response Plan for large incidents. ❑ Prepare to receive large number of MCI patients beyond the pre-assigned numbers.
LEVEL 4 **MCI (RED) ALERT** Catastrophic disaster	❑ Ensure safety of all staff. Evacuate if building is unsafe. ❑ Activate all Emergency Response Plans. Restore services. ❑ Support to all hospitals will be organized through the Emergency District Coordination Centers until the communications infrastructure and central command are restored. ❑ Crisis standards of care MAY be invoked by your hospital.
LEVEL ZERO **MEDICAL 911 SYSTEM DISRUPTION**	❑ Notify DEC dispatch **(558-3291)** if your hospital is experiencing a disruption that prevents it from accepting 911 ambulances at the Emergency Department. ❑ Respond to requests from DEC dispatch or DEM Duty Officer about your hospital status.

Significant 911 ambulance shortage OR Hospital(s) issue closes it to 911 Ambulances	❑ Notify DEC **(558-3291)** when your hospital is open and ready to receive 911 ambulances at the Emergency Department.

MCI Yellow or MCI Red Alert vs. HavBed

- A MCI Yellow or MCI Red Alert means the ED Charge Nurse must enter the number of **Emergency Department beds available** for Immediate (Red), Delayed (Yellow) or Minor(Green) Patients. You must enter this information **within 15 or less minutes.**

- A HavBed Alert means that the ED Charge Nurse or House Supervisor must enter the number of **In-Patient beds available** for the categories listed below. You must enter this information **within 2 or less hours.**

MCI Yellow or MCI Red Alert - Number of available Emergency Department beds for MCI patients as triaged by the START Triage system:

- Immediate (Red)
- Delayed (Yellow)
- Minor(Green)

HavBed - Number of available in-patient beds for:

- Adult Medical-Surgical
- Adult ICU
- Pediatric Medical-Surgical
- Pediatric ICU
- Negative Flow Isolation
- Operating Room
- Decon
- Number of available ventilators

PART 1: STANDARD OPERATING PROCEDURES

DEM DUTY OFFICER / EOC MEDICAL-PUBLIC HEALTH GROUP *version 2016*

Level	Actions
MCI YELLOW ALERT "Heads Up" about Incident with a <u>potential</u> for multiple casualties	❑ Monitor for upgrade to Red Alert for termination of Yellow Alert.
LEVEL 1 **MCI (RED) ALERT** **6 - 50 victims** of any triage level	❑ Contact DEM Administrator on Call to determine need for additional notifications or alerts to region or state. The EMS Agency Medical Director is the San Francisco - Medical Health Operational Area Coordinator (MHOAC). Notify the MHOAC if significant MCI. ❑ Mutual aid is generally NOT activated except for unusual circumstances. ❑ **Ambulance diversion is automatically suspended ONLY for MCI patients**. ❑ Contact DPH for requests for mental health services for patients in the field. Contact American Red Cross to assist with family reunification or housing services for displaced (refer to DEM Duty Officer handbook for details). ❑ Monitor for overload of the EMS System (significant ambulance shortages and / or hospitals overloaded). • Reddinet polling of hospitals and ambulance providers. • First Watch and Computer Automated Dispatch (CAD) at 911 Dispatch - monitor call volume / type and number of standard deviations above norm. • Consultation as appropriate with: DEM AOC, DPH Communicable Disease Control or Environmental Health Duty Officer, DEM command staff, and other city, regional, state or federal agencies as warranted. (Contact information for each officer is posted on Reddinet).

LEVEL 2 **MCI (RED) ALERT** **51 - 100** victims of any triage level	❑ Follow same steps for Level 1 Red Alert listed above. ❑ **Diversion is automatically suspended for ALL ambulance patients**. ❑ Contact EMS Medical Director to determine whether modifications to the EMS response standards are necessary. Modifications of the standard responses must be authorized by the EMS Agency Medical Director. ❑ For significant MCI's, an EOC activation will support the field response in coordination with the Fire Branch EMS Group: • The EOC Operations Section - Fire Branch, EMS Group manages the immediate operations for the field response. • The EOC Operations Section – Health & Human Services Branch, Public Health & Medical Services Group assumes the both the DEM Duty Officer EMS activities and the Medical Health Operational Area Coordinator (MHOAC) function as the primary coordination body for medical-health services and resources within the Operational Area (County) for the duration of the EOC activation. • Follow actions as detailed in the EMS Agency Policy Manual #8000 Multi-Casualty Incident Plan. • Medical Mutual Aid will be invoked.
LEVEL 3 **MCI (RED) ALERT** **101 or greater** number of victims of any triage level	❑ Follow same steps for Red Alerts Levels 1 and 2 listed above. ❑ **Diversion is automatically suspended for ALL ambulance patients**. ❑ The **Department of Public Health DOC** may be activated to support the EOC's Operations Section – Health & Human Services Branch, Public Health & Medical Services Group.
LEVEL 4 **MCI (RED) ALERT** Catastrophic disaster	❑ City EOC and all departmental DOCs are activated if building sites are safe and staff available to operate. ❑ All emergency declarations are invoked. Mutual aid will be requested from the Regional Mutual Aid System, State and Federal responders about a catastrophic disaster. Recovery outlook is long-term.

LEVEL ZERO MEDICAL 911 SYSTEM DISRUPTION Significant 911 ambulance shortage OR Hospital(s) issue closes it to 911 Ambulances	❑ DEM Duty Officer will consult with DEM AOC who will determine need for additional notifications or activations. ❑ Assess cause and impact on medical 911 system capability through: • Reddinet polling • First Watch - Quantify call volume / type and number of standard deviations above norm. • CAD • Consultation with: o DEC o Ambulance company and / or hospital supervisory staff. o Consultation as appropriate with: o DEM Administrator on Call o DPH Communicable Disease Control Duty Officer or Environmental Health Duty Officer o DEM command staff o Other city, regional, state or federal agency as warranted. • MHOAC to notify RDHMC and state EMS Authority, if warranted. ❑ Develop an Action Plan in consultation with EMS Medical Director, DPH Director of Health, SFFD Chief and the leadership of affected EMS Providers that will include a determination of the need to escalate the system alert level to a same response actions used during a Level 1,2, or 3 MCI Alert.

PART 2: BACKGROUND

Section 2.1 Introduction

2.1.1 Objectives

The Department of Emergency Management - Emergency Medical Services (EMS) Agency Multi Casualty Incident (MCI) Plan (herein referred to as the "MCI Plan") identifies and delineates the structure and operations for the provision of emergency medical care during a MCI event of any size or magnitude. The intent of the MCI Plan is to ensure the provision of rapid and appropriate emergency medical care to the most possible patients through a coordinated response system based on incident management principles.

The primary objective is to minimize the morbidity and mortality associated with large scale emergency patient care incidents occurring in San Francisco. This plan is compliant with the State of California Firescope, the California Standardized Emergency Management System (SEMS), the federal National Incident Management System (NIMS), as well as local planning, policies and procedures related to MCI activities.

2.1.2 Plan Organization

The ***MCI Plan*** is subdivided into three parts:

- **Part 1 – Standard Operating Procedures** - A script for easy reference to the initial actions for responders.
- **Part 2 - Background** - Provides relevant background information about the structure and response operations. It is intended for training or for responders who are new to MCI responses.
- **Part 3 - Operations** - Describes in detail the activities that all EMS participants must follow during a general response to a MCI.

Part 3 – Operations is further subdivided into sections based on the various components and phases of a system-wide EMS MCI response. The use of discrete sections provides responders with the information they need in user-friendly format that does not require reading the entire plan. The intent of this format is to provide quick, clear information on specific response operations. It also fulfills the requirement for scalability since only portions of the plan may be required for a particular incident response operation

The **Annexes** describe special emergency medical response operations for scenario specific situations (e.g. bombings, contaminated scenes, etc.). The Annexes supplement the Core Plan and are intended to be used in tandem with the general response information in the Core Plan.

The **Appendices** provide reference information relevant to supporting a successful response operation. It includes guides to the various EMS resources, Field Incident Command System Position Descriptions, maps, glossary and etc.

2.1.3 Authorities, Standards and Guidelines

The following authorities, standards and guidelines provide compliance for the development and implementation of Plan:

Local

- The San Francisco Emergency Medical Services MCI Plan is an approved policy and procedure of the Department of Emergency Management - EMS Agency
- City and County Emergency Response Plan, April 2008

State

- Firescope Field Operations Guide, ICS 420-1, July 2007
- California Standardized Emergency Management System (SEMS)
- California Health and Safety Code, Sections 1797.103; 1797.150-153; 1797.204; and 1797.220
- California Code of Regulations, Title 19, Division 2, Chapter 1
- California Code of Regulations, Title 22, Section 100167 (b) (2 - 3); 100168 (b) (4); and 100169 (a)
- California Code of Regulations, Title 22, Division 9, Section 100255
- California Government Code, Article 9, Section 8605
- California Public Health and Medical Emergency Operations Manual, July 2011
- California Master Mutual Aid Agreement
- California Emergency Services Act

Federal

- National Incident Management System (NIMS)

2.1.4 Personnel Training and Competency Levels

All EMS providers should check with their respective training providers for the most current training requirements specific to their roles during a MCI response. At a minimum, this plan assumes that users of this plan will be familiar with and proficient in the following:

First Receiver (Hospitals Only):

- Simple Triage and Rapid Treatment (START) and JUMPSTART
- Hospital Incident Command System
- Incident Command System (up to ICS 200 level)
- National Incident Management System (NIMS) IS-700 and IS-800
- Working knowledge of relevant San Francisco EMS Agency Policies and Procedures

All Field First Responders:

- Simple Triage and Rapid Treatment (START) and JUMPSTART
- California Standardized Emergency Management System (SEMS)
- Incident Command System (up to ICS 200 level)
- National Incident Management System (NIMS) IS-700 and IS-800
- Hazardous Materials First Responder Awareness
- Working knowledge of San Francisco EMS Agency Policies and Procedures

Ambulance Strike Team Leader:

- Incident Command System (up to ICS 300 level)
- Ambulance Strike Team Leader Training (State EMS Authority course)
- Ambulance Strike Team Provider Training (State EMS Authority course)

On-Scene Command Staff:

- Incident Command System (up to ICS 400 level)

Assigned EOC or DOC Command Staff:

- City and County Emergency Response Plan
- City Departmental Emergency Operations Plans (any city DOC staff)
- Provider Emergency Operations Plan (any private provider DOC staff)
- (Recommended) MGT 313 – Incident Management / Unified Command

Section 2.2 Patients

2.2.1 Triage

Triage is a French word meaning “to sort.” It is used to identify patients that have the most immediate need for medical care vs. those that may wait. Triage is the primary tool used in determining the most appropriate allocation of available medical care resources in a large multi-casualty incident.

Field treatment and the eventual distribution of patients to receiving facilities are determined by the systematic triage of patients at the scene. The flow of the entire emergency medical

MCI response is driven by both the total number patients and their assigned triage levels. It is therefore crucial that First Responders do appropriate patient triage at the onset of every MCI – no matter how large or small the incident.

2.2.2 Required Triage Standard – START Triage and Jump START

The EMS Agency requires that field First Responders do **START Triage** during a MCI on all adult patients and **JUMP START** on all pediatric patients. Both systems are physiological assessment methods based on a simple mnemonic "**RPM" (R**espirations, **P**erfusion, **M**entation). **START** is an acronym for **S**imple **T**riage **a**nd **R**apid **T**reatment. Once the START triage evaluation is complete, the victims are labeled with one of four color-coded triage level categories:

Minor = walking wounded / can delay care for up to three hours

Delayed = serious non-life-threatening injury / can delay care for 1 hour

Immediate = life-threatening injury / requires immediate care

Deceased / Expectant = pulseless / non-breathing or imminent demise

Triage categories are an indication of the desired time to receive treatment. In a large scale incident, actual time to treatment may vary based on the availability of resources.

JumpSTART is based on the START physiologic triage system used for adults. However, JumpSTART system recognizes the key differences between adult and pediatric physiology and substitutes appropriate pediatric physiologic parameters at triage decision points. JUMP START is used for the following:

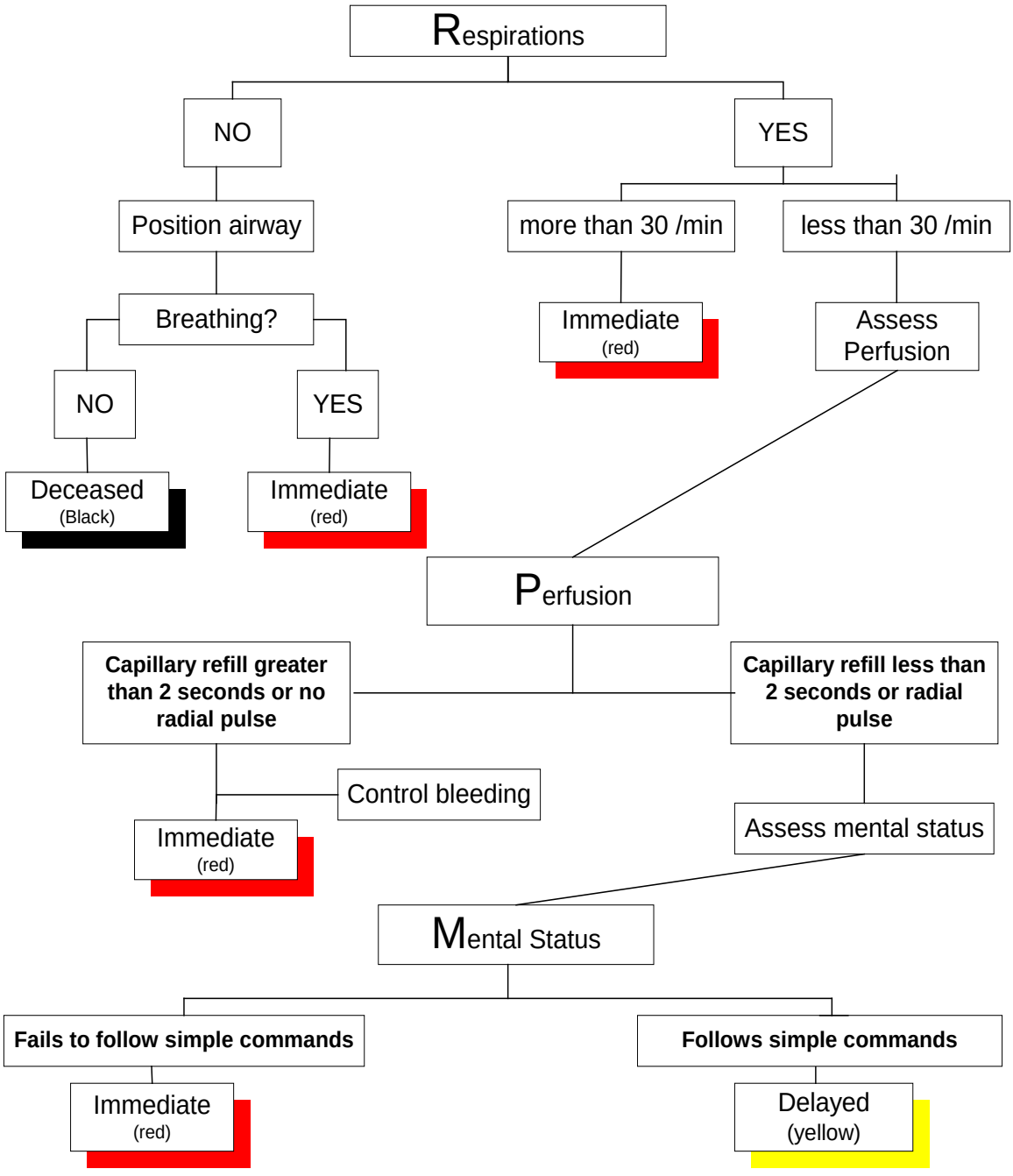
1. Children ages newborn to 8 years or,
2. When the patient appears to be a child or,
3. Whenever you can use a length-based (Broselow) resuscitation tape.

Both START Triage and JumpSTART Triage are designed for use in only disaster and multi-casualty situations, not for daily EMS or hospital triage. Refer to Figures 1 and 2 for the START and JUMP START Flow Charts.

Figure 1: START TRIAGE FLOW CHART

START: **S**imple **T**riage and **R**apid **T**reatment

1. Direct patients who are able to move to a certain area; triage as minor.
2. Begin triage: **START** with closest patient



Note: Once a patient reaches a triage level indicator in the algorithm, triage of this patient should stop and the patient tagged accordingly.

START TRIAGE STEPS

*Use the mnemonic "**RPM**"*
*(**R**espirations, **P**erfusion, **M**ental Status)*
to remember the assessment sequence.

1. MOVE WALKING WOUNDED
   - Direct patients who are able to walk to another area. Tag **GREEN.**

2. **R**ESPIRATIONS
   - If respiratory rate is 30/minute or less go to PERFUSION assessment.
   - If respiratory rate is over 30/ minute, tag **RED**.
   - If victim is not breathing, open the airway, remove any visible obstructions and re-position head to open airway. Re-assess respiratory rate.
   - If victim is still not breathing, tag **BLACK**.

3. **P**ERFUSION
   - Palpate radial pulse or assess capillary refill (CR) time.
   - If radial pulse is present or CR is 2 seconds or less, go to MENTAL STATUS assessment.
   - No radial pulse or CR is greater than 2 seconds, tag **RED**.
   - Control any major external bleeding at this point.

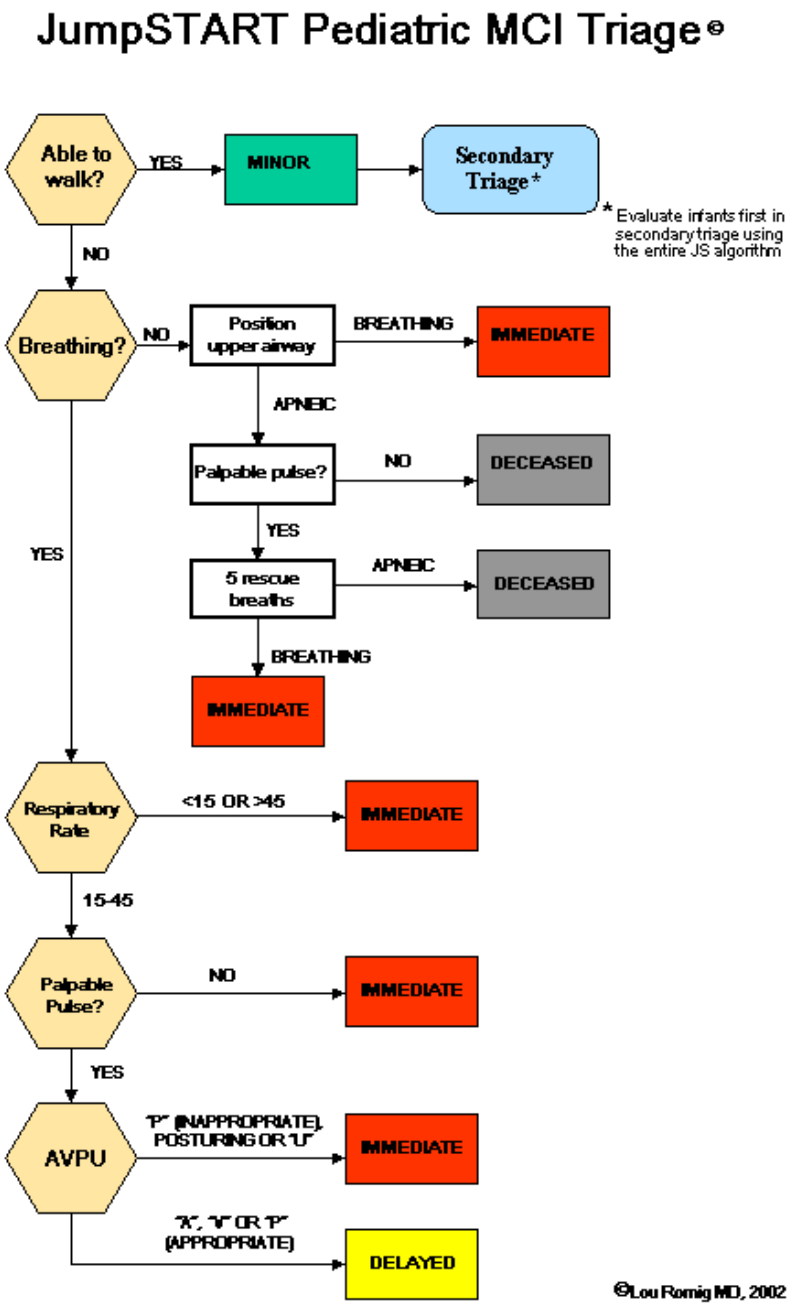
4. **M**ENTAL STATUS
   - Assess ability to follow simple commands and orientation to time, place and person.
   - If the victim does not follow commands, is unconscious, or is disoriented, tag **RED**.
   - If the victim follows simple commands tag **YELLOW.**

***SPECIAL CONSIDERATIONS**:*

- Stop at any point in the RPM assessment when a **RED** triage level is identified.
- Tag **YELLOW** obvious significant injuries (e.g. burns, fractures).
- Correct only life-threatening issues (e.g. airway obstruction, severe hemorrhage) during initial triage.

Figure 2: JUMP START TRIAGE FLOWCHART*

*See www.jumpstarttriage.com for additional information.



2.2.3 Other Considerations for Patient Triage

START Triage and JUMP START are the first triage systems used in the MCI Triage Area, followed by Trauma Triage Criteria in the designated Treatment and / or Transport Area(s). Other clinical considerations should be factored into the determination of an appropriate triage level and destination for their medical care depending on the provider training, availability of personnel, and if the situation safely allows for it. Below is a list of all triage criteria, injury scoring systems and clinical considerations that may be applicable during the MCI triage process:

- START Triage and JUMP START
- Trauma Triage Criteria
- Glasgow Coma Scale
- Burn Rule of Nines
- Significant Medical Complaints
- Special Circumstances (Hazmat exposure)
- Special Populations:
  - Age Extremes
  - Pregnant
  - Medically Fragile

2.2.4 Required Triage Tags and Patient Records

First Responders must use a triage tag to label triaged patients by the severity of their injury. Triage tape is permitted in the Triage Area, but should be replaced by a tag in the Treatment or Transport Area(s). atient identifying information, vital signs, treatment, and destination should be written on the triage tags when the time and situation permit it. EMS patient care records may be used if adequate personnel resources are available and the patient is held at the scene for an extended period of time.

2.2.5 Deceased Care

Deceased patients must be labeled as **Deceased** with the triage tag. Deceased patients require no further care and may be left in place while responders attend to other viable patients. Responders should notify the San Francisco Medical Examiner to assume responsibility for the disposition of deceased patients.

Efforts should be made to treat deceased patients with respect, and to cover or move them as resources and the situation permits. If the incident is a crime scene, the Medical Examiner or SFPD must approve moving deceased patients. When moving a body, Responders should do the following:

1. Fill out information on identifying information on the triage tag or attach a morgue tag or other label directly to the body. Include:
    - Date, time and location body found,
    - Name/address of decedent, if known,
    - If identified, how and when,
    - Name/phone of person making identity or filling out tag, and
    - Note any contamination

2. Personal effects must remain with the body at all times. If personal effects are found and thought to belong to a body, place them in a separate container and tag. Do not assume any loose effects belong to a body.

3. Place the body in a disaster body bag or in plastic sheeting and securely tie to prevent unwrapping. Attach a second exterior tag to the sheeting or pouch.

4. Move the properly tagged body with their personal effects to a separate, safeguarded location, preferably with refrigerated storage.

Section 2.3 Medical Group Organization

2.3.1 Medical Group Positions

EMS MCI field operations are the responsibility of the ICS Operations Section – Medical Group. Firescope defines the fifteen positions that comprise the Medical Group. Below briefly describes the roles and responsibilities for each Medical Group position. Detailed position descriptions for all Medical Group personnel are found in the Appendices.

1. Medical Branch Director – Has overall command of EMS field Operations in a full branch response. Responsible for the implementation of the Incident Action Plan within the Medical Branch. Reports to Operations Chief. Supervises Medical Group Supervisor(s) and Transportation function (Unit or Group). Reports out casualty information to the Operations Chief.

2. Medical Group Supervisor (MGS) - In charge of the Medical Group EMS field operations in an initial and reinforced level of response. Reports to the Medical Branch Director. Supervises Triage, Treatment and Transport Unit Leaders and Medical Supply Coordinator. Reports out casualty information to the Medical Branch Director.

3. Triage Unit Leader - Coordinates the triage of all patients. Reports to MGS. Supervises Triage Personnel / Litter Bearers and Morgue Manager.

4. Triage Personnel – Responsible for triaging patients and assigning them to appropriate Treatment Areas. Reports to Triage Unit Leader.

5. Morgue Manager - Responsible for Morgue Area functions. Reports to Triage Unit Leader.

6. Treatment Unit Leader - Coordinates on scene emergency medical treatment of all victims. Reports to MGS. Supervises Treatment Dispatch Manager, Immediate Treatment Manager, Delayed Treatment Manager and Minor Treatment Manager.

7. Immediate Treatment Area Manager – Responsible for treatment and re-triage of patients assigned to the Immediate Treatment Area.

8. Delayed Treatment Area Manager – Responsible for treatment and re-triage of patients assigned to the Delayed Treatment Area.

9. Minor Treatment Area Manager - Responsible for treatment and re-triage of patients assigned to the Minor Treatment Area.

10. Treatment Dispatch Manager – Coordinates movement of patients from Treatment Area to Transport Area. Reports to Treatment Unit Leader.

11. Patient Transportation Unit Leader (or Group Supervisor) - Oversees the coordination of patient transport vehicles and hospital destinations. Supervises Ground Ambulance Coordinator, Air Ambulance Coordinator and Medical Communications Coordinator. At his / her discretion, may add additional positions in Patient Transportation Unit to coordinate transportation to out-of-county destinations.

12. Ground Ambulance Coordinator - Coordinates ground ambulances. Reports to Transportation Unit Leader.

13. Air Ambulance Coordinator - Establishes and coordinates helispots and air medical operations with the Air Operations Group. Reports to Transportation Unit Leader.

14. Medical Communications Coordinator - Maintains medical communications with the Patient Distribution Group and selects the mode of transport and patient destination based upon patient need using patient condition information provided by the Treatment Dispatch Manager. Reports to Transportation Unit Leader.

15. Medical Supply Coordinator – Coordinates medical supply requests and maintains stock. Reports to MGS.

2.3.2 Organization of the Medical Areas

Locations of the medical areas (Triage Area, Treatment Area, etc.) shall be determined by the Medical Group Supervisor. Selection of the locations will factor in the following considerations:

- Safe distance from the scene and hazards.
- Upwind from any noxious fumes.
- Adequate space for patient care, personnel, and in-coming / out-going vehicles.
- Environmental controls, if possible (out of wind, rain or extreme heat/cold).

The Medical Group Supervisor or his/her designee will oversee the designation and set up of specific medical areas until delegated to the Unit Leaders for each area listed below:

Triage Area – Location for the triage of patients.

Treatment Area – Location for the treatment of patients. In a small incident, on Treatment Area may be set up with patients grouped together according to triage levels (Immediate, Delayed and Minor). For larger incidents, separate Immediate, Delayed and Minor Treatment Areas are established.

Patient Transport Area – Location for loading patients into transporting vehicles. Ideally, the loading area should be adjacent to the treatment area(s) and in-line with the one way traffic from the Ambulance Staging Area. When a one-way traffic pattern is not possible due the topography or building density, scene personnel should improvise (e.g. create a patient gurney shuttle using firefighters, etc.).

Ambulance Staging Area – Location for in-coming ambulances and other EMS personnel or equipment to report in and await assignment to the MCI response. In a small incident, the Ambulance Staging Area may be combined with the incident Staging Area for other response vehicles and personnel. In larger incidents, it may be a separate location.

Morgue Area – Location for holding the deceased.

Section 2.4 San Francisco Alert Levels

San Francisco uses a classification scheme for MCI Levels that is similar to the one used by the California's Disaster Medical System. The progressive MCI Levels for San Francisco are important because they determine an alert level that is communicated to all EMS participants that corresponds to a specific set of actions they should take to respond to the MCI incident**. It is important to note that the cut off points for the number of victims needed to call either a**

Level 1, 2 or 3 MCI alert is flexible. Section 3.4 of this Plan describes the operation use of the MCI alert levels. The chart on the next page describes the San Francisco alert levels followed by examples of types of incidents that would trigger those alerts.

ALERT LEVELS

Level	Definition	Purpose	Example
MCI YELLOW ALERT	Incident with a potential for multiple casualties	"Heads Up" about a situation that may become a MCI.	Large residential building is on fire, but no victims have yet been identified.
LEVEL 1 MCI (RED) ALERT	MCI with **6 - 50 victims** of any triage level.	Notifies local EMS system about a MCI with 6 – 50 victims.	Bus accident with 15 patients all triaged as YELLOW.
LEVEL 2 MCI (RED) ALERT	MCI with **51 - 100** victims of any triage level. Requires resources from or distribution of casualties to neighboring counties.	Notifies local EMS and disaster system and Regional Mutual Aid System about a MCI with 51 – 100 victims.	Mass transit accident with 95 victims. Must send trauma patients to SFGH and Trauma Centers in nearby counties.
LEVEL 3 MCI (RED) ALERT	MCI with **101 or more** victims of any triage level. Requires resources from or distribution of casualties throughout the State or federal response system.	Notifies local EMS and city disaster system, Regional Mutual Aid System, State and Federal responders about MCI with > 101 victims. Assumes infrastructure is essentially intact, but has numerous disruptions.	High magnitude earthquake with hundreds of casualties. Example: 1989 Loma Prieta Earthquake
LEVEL 4 MCI (RED) ALERT	Catastrophic disaster with significant infrastructure damage, and unknown number of injuries and deaths. Requires significant, long-term support from State and Federal governments.	Notifies local EMS and city disaster system, Regional Mutual Aid System, State and Federal responders about a catastrophic disaster. Recovery outlook is long-term.	San Francisco 1906 earthquake and fire.
LEVEL ZERO MEDICAL 911 SYSTEM DISRUPTION	Disruption of normal 911 operations due to: 1) Extreme 911 call volume causing ambulance shortage, AND/ OR 2) Hospital(s) issue closes it to 911 ambulances.	"Heads Up" about disruption to the medical 911 system. EMS and hospital providers may be requested to report about their resources (number of ambulances / hospital beds / etc.).	Extreme weather generates hundreds of medical 911 calls resulting in ambulance shortages and saturation of hospital emergency departments.

Section 2.5 Standard Operating Procedures

The classification of an incident level determines the corresponding alert and activation level that the Department of Emergency Management – Division of Emergency Communication (DEC) sends to EMS provider organizations. The alert levels correspond to **Standard Operating Procedures** which are defined as scripted participant actions in response to a MCI. Standard Operating Procedures are similar to ***Job Action Sheets (aka Job Checklists* or *Position Descriptions)*** that individual field personnel or EOC / DOC command staff follow during a disaster response. The difference though is that Standard Operating Procedures apply to the response actions of an *entire EMS provider organization* (e.g. a hospital or an ambulance provider company).

The purpose of the alert levels and corresponding Standard Operating Procedures is to improve the speed, efficiency and overall coordination of the initial operational response to a MCI. An alert initiates the start of a Standard Operating Procedures that is followed in the first hour(s) to days of a MCI response until an Incident Command is organized and able to create and distributes an Incident Action Plan with response objectives that are specific to the incident. The details for each alert level are listed in **Part 1 – Standard Operating Procedures** of this plan.

Section 2.6 EMS Provider Agency Roles and Responsibilities

2.6.1 Primary Agencies

San Francisco Fire Department: Provides fire suppression, hazmat services and ALS ambulances and BLS First Responder in the San Francisco EMS System. The SFFD field role in a MCI is to provide emergency medical care at the scene, transport victims to receiving facilities and to fill any position within the field ICS structure, especially positions within the field medical branch. SFFD operates mobile Multi-Casualty Units that can quickly bring additional emergency medical supplies to a scene.

The SFFD Departmental Operations Center provides command, coordination and support for their suppression and EMS units during a MCI.

ALS Ambulance Providers: Advanced Life Support (ALS) Ambulance Providers (American Medical Response, King American Ambulance, Bayshore Ambulance, Pro-Transport 1, and NorCal Ambulance) provide emergency ALS level ambulance services and ALS inter-facility transport services.

ALS Ambulance Providers' role in a MCI is to provide emergency medical care at the scene, transport victims to hospital or other alternate treatment sites (if in use and authorized) and to fill any position within the field ICS structure, especially positions within the medical branch.

BLS Ambulance Providers: Private Basic Life Support (BLS) Ambulance Providers (American Medical Response, King American Ambulance, Bayshore Ambulance, St. Joseph's Ambulance, ProTransport-1, NorCal Ambulance and Falck Ambulance) provide BLS inter-facility transport services in the San Francisco EMS system.

BLS Ambulances Providers' may have a direct role in a MCI field response by providing emergency medical care at the scene, transporting victims to hospital or other alternate treatment sites (if in use and authorized) and filling any position within the field ICS structure, especially positions within the medical branch. BLS may also provide back- up ambulance "surge capacity" to the day-to-day EMS System if an incident(s) requires all available ALS resources. Alternative uses of the BLS providers during a large MCI are only authorized by the EMS Medical Director in consultation with the Director of Health/Health Officer and management at each BLS provider company.

Air Medical Service Providers: Offer on scene emergency medical care and air evacuation of patients. REACH, Stanford Lifeflight and CalSTAR provide services for San Francisco EMS and throughout most of Northern California. During an MCI, air medical services are primarily used to transport the most critically injured patients to out-of-county trauma centers.

General Acute Care Hospitals: Provides emergency medical care and definitive medical treatment to patients. Their role is the same during MCI event within the limits of their capacity to "surge" their staff and internal resources. Hospitals may "stabilize and transfer" if the patient's medical needs require specialty services not available at that hospital or if they are at capacity and cannot offer an available bed or staffed treatment space.

Department of Emergency Management: Provides various emergency management functions and consists of two divisions: Division of Emergency Communications (911) and the Division of Emergency Services (DES).

- **Division of Emergency Communications (DEC):** Responsible for receiving 911 calls and dispatching police, fire, and EMS services. The primary role of DEC during a MCI is to notify and alert of key response personnel, and to dispatch and track field response resources including mutual aid resources and initially staff the Patient Distribution Group.
- **Division of Emergency Services (DES):** Responsible for developing citywide emergency plans, activating the City's Emergency Operations Center (EOC) and preparing citizens for all-hazards events (i.e. earthquakes, terrorism, and tsunamis). During an MCI, DES

may activate the City's EOC to support overall MCI operations and request emergency declarations from the Mayor.

- **EMS Agency:** The San Francisco EMS Agency is in under DES. The EMS Agency is responsible for planning, coordinating, and evaluating emergency medical services for San Francisco. During a MCI or medical disaster, the EMS Agency fulfils diverse roles, including serving as the Medical Health Operational Area Coordinator, modifying or creating EMS policy or protocols to meet changing situational needs, activating or staffing the DPH Department Operations Center, or the City Emergency Operations Center.

Department of Public Health: Provides various public health related functions and direct medical services. DPH divisions involved in emergency support include:

- **Public Health Emergency Preparedness and Response**: Responsible for planning, and coordinating the public health response and hospital disaster preparedness.
- **Communicable Disease Control and Prevention Section:** Provides community monitoring for communicable diseases, conducts epidemiological investigations, and provides communicable disease control and prevention information to medical professionals and the community that may include: infection control protective measures, prophylaxis or treatment, identification of the type and source of an outbreak, and if necessary, issue isolation or quarantine orders.
- **Environmental Health Section**: Assures the safety of the food and water supplies. They also provide technical and scientific advice to the SFFD on the detection, identification, and handling of hazardous materials and management of hazardous situation. They are also responsible for approving the health-related safety issues for the mass shelters.
- **Behavioral Health Services:** Provides mental and substance abuse services. During a large MCI, they may provide the initial crisis mental health services for victims.

2.6.2 Supporting Agencies

In addition to the primary EMS System participants, there are other organizations that may work closely with the EMS System during a MCI or Mass Casualty Event:

San Francisco Police Department: Provides law enforcement to San Francisco. They also can provide SWAT, Explosive Ordinance Disposal, and other specialized law enforcement services. During an MCI, they may provide force protection, security for critical assets, and create cordons.

San Francisco Sheriff's Department: Provides protective and security service for City and County facilities and buildings, including San Francisco General Hospital, and the Department of Public Health Department buildings. They also can provide aerial surveillance or recognizance

using their air units. During an MCI, they may provide force protection, security for critical assets, and create cordons.

California Highway Patrol: Provides law enforcement to the State and Federal highways within San Francisco and provides protection and security for state facilities and buildings. During an MCI, they may provide force protection, provide security for critical assets, and create cordons.

Auxiliary Communication Service (ACS): Coordinated by the Dept of Emergency Management's Division of Emergency Services, ACS provides amateur radio operators with equipment for disaster response and large special events. In a MCI, ACS may provide amateur radio operators to field, hospital, and emergency operations centers or be used to replace or to augment communication capabilities.

San Francisco Office of the Medical Examiner: Investigates, and determines cause and manner of death for cases under the Office's legal jurisdiction. During a large MCI, the Medical Examiner's Office is responsible for identifying and handling decedents and their personal effects.

Section 2.7 Interagency Coordination

2.7.1 Scene Organization

NIMS and SEMS are based on the Incident Command System (ICS) and are used to provide the basic organizational structure for all incident operations including MCI field operations. ICS is designed to coordinate the efforts of all involved agencies at the scene of a large, complex, emergency situation, as well as the small day-to-day situation. The organizational structure of ICS may be expanded in a modular fashion based upon the changing conditions and/or size/scope of the incident.

ICS has been summarized as a "first-on-scene" organizational structure, where the first responder to arrive on scene assumes command until the incident is resolved or there is a formal transfer of command to a more-qualified individual arriving later.

The essential elements of ICS are:

- **Command:** Overall management and setting of objectives for the response.
- **Operations:** Direct control of tactical operations and the implementation of response objectives.
- **Planning:** Development of a plan for response operations.
- **Logistics:** Coordinates acquisition and distribution of resources.
- **Finance:** Purchases resources. Records what resources were involved in the response for purposes of reimbursement.

2.7.2 Single vs. Unified Command

The Incident Commander is responsible for the overall management and setting of objectives for the incident response. Depending on the size and duration of the MCI, the Incident Commander may directly supervise operations or delegate this responsibility to an Operations Section Chief. EMS Multi-Casualty Field Operations are within the responsibility of the Operations Section.

Single Command

Most incidents involve a single Incident Commander. In these incidents, a single person commands the incident response and is the final authority for decision-making. A single incident commander is chosen when a single agency has responsibility for an incident. The Incident Commander is usually the individual first on scene representing the public safety agency having primary investigative authority. There may be exceptions to this rule, based the characteristics of the incident.

In San Francisco, the following are examples for when a single command may be implemented. Any of these scenarios may evolve from a Single Command into a Unified Command.

- *San Francisco Fire Department* – Fires, rescues and EMS incidents.
- *San Francisco Police Department* – Crime related incidents, civil disorders, and most mass gatherings and pre-planned events.
- *San Francisco Department of Public Health* – Contagious diseases and other public health emergencies.
- *California Highway Patrol* – Accidents or incidents on all freeways, including right of way.
- *US Military/Department of Defense* - National Defense Areas including a military reservation or an area with "military reservation status" that is temporarily under military control, e.g., military aircraft crash site.
- *FBI* – Terrorist incidents. However, most consequence management functions will continue to be managed by local agencies, such as police and fire.
- *US Secret Service/US Department of Homeland Security* – Events that are designated as National Special Security Events.

Unified Command

Unified Command is used for larger incidents usually when multiple agencies are involved. A Unified Command functions as a single entity. Unified Command typically includes a command representative from the involved agencies with one person from that group designated to act as the *group spokesperson,* and not as an Incident Commander. Unified Command is used anytime an incident crosses jurisdictional boundaries or exceeds the responsibility of a single agency. It allows all agencies with responsibility for an incident to establish a common set of incident objectives, strategies, plans, and priorities to jointly execute the incident operations and maximize the use of assigned resources. Most significant incidents in San Francisco will involve unified command with San Francisco Fire and Police fulfilling lead roles. However, any of the above agencies may be involved in Unified Command.

2.7.3 Field Command - Single Site Incidents and Multi-Site Incidents

In **Single Site Incidents**, all MCI field operations are at one location usually under a single ICS command structure. **Multi-Site Incidents** are two or more related or unrelated MCIs regardless of type, occurring simultaneously within a single Operational Area.

The size and configuration of the ICS structure and command for a single site or multi-site incidents depends on various factors such as jurisdictional complexity, size of involved geographic area, span of control, logistical needs and potential for growth. Incident Complexes or Area Command are ICS structures and command for major incidents. An *Incident Complex* is two or more individual incidents located in the same general proximity assigned to a single Incident Commander or Unified Command to facilitate management. These incidents are typically limited in scope and complexity and can be managed by a single entity. *Area Command* is NOT used in the San Francisco Emergency Management structure.

In the ICS structure, EMS MCI field operations are under the responsibility of the Operations Section in the Medical Group. For single-site incidents that are small, only one Operations Section - Medical Group will be established. For larger incidents or multi-site incidents with more than one Operations Section - Medical Group, a Medical Branch with several Medical Groups will be established. The Medical Branch structure maintains the appropriate span of control to manage large patient incidents.

Section 2.8 In-County Coordination

For large or multi-site incidents, higher-level support facilities above the field level may be activated. These facilities provide logistical and administrative support or in some instances, set response priorities and objectives to ensure efficient use of resources. Activated facilities may include the Emergency Operations Center and / or Departmental Operations Centers.

2.8.1 Emergency Operations Center / Departmental Operation Centers

The Emergency Operations Center (EOC) is a facility space that provides centralized, city-wide coordination of emergency responses. It is staffed with personnel trained in emergency management and is equipped with a variety of systems and tools that aid in data collection and sharing, resource allocation, and other critical functions. The EOC coordinates information with city DOCs (if activated) and other governmental and non-governmental agencies in order to maintain a comprehensive situational analysis. It also serves as San Francisco's Multi-Agency Coordination Center (MACC), as described in NIMS, thereby ensuring that all response systems are interconnected and complementary rather than duplicative.

The EOC is activated when citywide multi-agency coordination is needed for an MCI event. The EOC provides:

- A central coordination point for multi-agency emergency management of the MCI (e.g., emergency operations, communications, damage assessment, media and public information).
- A single location to collect and disseminate information to create a common operating picture of San Francisco's citywide response activities.
- Facilitate actions necessary to protect residents and property of San Francisco during a citywide event.

Like the EOC, Departmental Operations Centers (DOCs) provide facility space for the centralized coordination of usually one emergency functions (e.g. fire, police, health, etc.). In San Francisco's local government, DOCs also serve as the disaster command centers for each city department or affiliated response agencies (e.g. American Red Cross).

2.8.2 EOC and DOC Support During a MCI

The EOC would rarely be activated during a Level 1 MCI Level since those incidents are usually handled only through a field response.

The EOC will be activated for MCI's requiring multi-city agency responses or out-of-county resources that occurs in MCI Levels 2 – 4. The decision to activate the EOC is done in consultation with the DEM Deputy Director or DEM Duty Officer. The City and County of San Francisco Emergency Response Plan describes in further detail the organization and command of the citywide response to large or complex disaster incidents. The same plan is followed for citywide organization and command of large or complex multi-casualty incidents.

A DOC may be activated when single-agency coordination is needed for a large emergency response. Depending on the nature, size and scope of a MCI, a single DOC or several DOCs may

be activated to support the response. If multiple DOCs are activated, the EOC also activates to provide centralized coordination for the response. DOCs contribute to citywide response efforts through communications and coordination with the EOC. Any of the city departmental DOCs may be involved in supporting a MCI response, especially in a large-scale event that covers several operational periods.

2.8.3 Role of EOC Operations Section – Health & Human Services Branch

The EOC uses the Incident Command System (ICS) organizational structure when activated. The Emergency Medical Services and Public Health Group are located in the Operations Section – Health & Human Services Branch within the EOC ICS structure. Roles during a MCI response may include:

- Provides overall medical-health system (includes all San Francisco hospitals and medical providers) coordination and establishes medical response priorities / objectives for large MCIs or disasters with a large medical-health impact.
- Provides operational and logistical support through other City Agencies or mutual aid requests for out-of-county resources through:
    - Assists patient distribution to out-of-county hospitals.
    - Receiving, tracking and fulfilling requests for medical resources.
    - Coordinating in-coming / out-going requests for medical mutual aid with Medical-Health Operational Area Coordinator (MHOAC).
- Collates and reports situational and response information for situational assessments and reporting within the city and to other local, regional, state and federal government and non-governmental agencies.
- Approves Medical-health related public information for the EOC Joint Information Center.
- Collates incident casualty counts from the field and hospitals.

The Department of Public Health DOC may be activated to assist with any of the above functions for large, complex or multi-site MCIs when the emergency response extends over multiple operational periods.

2.8.4 Role of EOC Operations Section – Fire and Rescue Branch

SFFD EMS and / or private ambulance provider representatives may be located in the Operations Section – Fire and Rescue Branch within the EOC ICS structure (Suppression duties are not addressed in this plan.). EMS roles during a MCI response may include:

- Support for emergency medical responders at the scene.
- Establishment of field response priorities for large, complex or multi-site MCIs.

- Optimize deployment and use of SFFD resources and specialty teams and equipment including:
  - Ambulances
  - Mobile Mass Casualty Unit.
  - SFFD Hazmat Team.
  - SFFD Heavy and light rescue Teams.
- Coordination of in-coming / out-going EMS mutual aid with Medical-Health Operational Area Coordinator (MHOAC).
- Tracking and compiling field patient distribution to receiving facilities.
- Collection and reporting of EMS field situational and response information to the EOC Fire Branch.

The SFFD DOC may be activated to assist with any of the above functions for large, complex or multi-site MCIs when the emergency response extends over multiple operational periods.

Section 2.9 Out-of-County Coordination - Medical Mutual Aid

Mutual Aid is defined as the voluntary provision of services and facilities by other agencies or organizations to assist each other when existing resources are inadequate or depleted. In California, mutual aid generally refers to aid that comes from outside the Operational Area.

Medical Mutual Aid is defined as the voluntary provision of medical services/equipment and medical facilities by other agencies or organizations to assist each other when existing medical resources are inadequate or depleted. Medical Mutual Aid is specific to supplementing / augmenting medical and health resources.

All medical mutual aid requests follow the SEMS and NIMS systems. Medical mutual aid is initiated when the surging of medical resources within San Francisco has been exhausted. It also may be used in medical incidents when it is determined that it may be faster to supplement or augment San Francisco resources from assets outside of the county. For example, San Francisco has several disaster medical field care clinics that may take several hours to set up, supply and staff. Patients would get to medical treatment in less time if they are sent to out-of-county medical facilities using the Medical Mutual Aid process.

In California, counties are grouped into six Mutual Aid regions by the state California Emergency Management Agency (CalEMA). The Medical-Health Mutual Aid system uses the same county groupings for its six Mutual Aid regions. San Francisco is in Region 2. Within a region, resources are distributed from the unaffected Operational Area to the affected one. There are three personnel roles that are unique to the Medical Mutual Aid system in California:

- **Medical Health Operational Area Coordinator (MHOAC**) – An individual appointed by a county Department of Health Director / local Health Officer who is responsible for coordinating medical-health services and resources within the Operational Area (County) in the event of a disaster or major incident where medical mutual aid is required.

- **Regional Disaster Medical Health Coordinator (RDMHC)** – The RDMHC is responsible for the coordination of medical and health mutual aid among the operational areas within a California mutual aid region during a disaster or other major event**.**

- **Regional Disaster Medical Health Specialist (RDMHS)** – The RDMHS is staff to the RDMHC and provides assistance for the coordination of medical and health mutual aid among the operational areas within a California mutual aid region.

In San Francisco, the MHOAC is the DEM EMS Agency Medical Director. Several Department of Public Health's physicians are the designated back-ups. The MHOAC is in the Operations Section – Health & Human Services Branch during activation of the citywide EOC. The Regional Disaster Medical Health Coordinator (RDMHC) is based at the Alameda County EMS Agency.

During Level 2 or 3 Incidents, the Medical-Health Operational Area Coordinator (MHOAC) and his/her designees coordinate all out-of-area medical mutual aid resource requests – whether they are in-coming or out-going. The MHOAC is responsible for coordinating disaster medical resources and communicating with the Region 2 - Regional Disaster Medical Health Medical Coordinator (RDMHC) all requests for medical supplies, personnel, and equipment. All requests that have no pre-agreement go through the MHOAC to the RDMHC. The RDMHC handles requests for resources if it can be fulfilled within their assigned region. If it cannot be fulfilled with their region, the RDMHC forwards the request to the State government. State government will obtain the requested resources from either non-adjacent mutual aid regions within the state or the federal government.

State agencies handle communications with federal disaster response organizations. In some instances, State and/or Federal government response agencies may automatically begin forward deployment of resources or provide them through their own supplies channels if there is advance notice of a major event (e.g. hurricanes). Details about state and federal entities involved in a disaster response are found in the California Public Health and Medical Emergency Operations Manual (July 2011). Operational details about the Medical Mutual Aid process are further described in Sections 3.17 -19 of this Plan.

PART 3: OPERATIONS

Section3.1 Introduction

The Department of Emergency Management - Emergency Medical Services (EMS) Agency MCI Plan identifies and delineates the structure and operations for the provision of emergency medical care during a MCI event of any size or magnitude. **MCI Plan Part 3 - Operations** details the specific activities that all EMS participants must follow during a general response to a MCI.

Section 3.2 Scene Management

3.2.1 Incident Command

All MCIs / disasters are managed using SEMS and ICS. The highest-ranking official of the first on-scene agency is the Incident Commander until relieved by a higher ranking, more qualified personnel. The Incident Commander is responsible for overall management of the incident. It is his/her responsibility to prepare the response objectives. The Incident Commander also determines:

- Alert level for the incident,
- Incident name (e.g. Shotwell Street Fire; Broadway Building Collapse),
- ICS structure,
- Radio call signs for Incident Command and Medical Group Supervisor,
- Location of command post,
- Staging location(s) for incoming units,
- Whether additional response resources are needed, and
- Requests for Dept Parking Transport or SFPD (or other law enforcement) to secure scene and perimeter.

A Unified Command Post with Fire/EMS, Police, or other agency may be utilized for multi-agency responses or at jurisdictional borders. If the scene is spread out over a large area, the Incident Commander will determine whether it is more appropriately managed as two separate incidents or as a single incident and its appropriate command structure.

3.2.2 Medical Branch / Medical Group

EMS MCI field operations are the responsibility of the ICS Operations Section – Medical Group. Only one Operations Section - Medical Group is established for small, single-site incidents. A Medical Group Supervisor is in charge of the Medical Group EMS field operations.

A Medical Branch with several Medical Groups may be established for large incidents or incidents at multiple sites. Overall command of EMS field operations in a full Branch response is delegated to the Multi-Casualty Branch Director. The Medical Group Supervisor or Multi-Casualty Branch Director will report to the IC or the Operations Chief if an Operations Section is activated.

Section 3.3 Initial Set Up of the Medical Group

3.3.1 First On-Scene

The **First on-Scene EMS unit's paramedics (or EMTs)** will report to the Incident Commander or Operations Chief. The First on-Scene EMS unit paramedic #1 (or EMT #1) will function as the Medical Group Supervisor until an EMS Officer arrives to assume the Medical Group Supervisor role. Paramedic #2 (or EMT #2) will be the Triage Unit Leader until relieved.

First on-Scene EMS units will do the initial medical assessment ("windshield assessment") of the scene to establish:

- Type of incident (trauma, medical, Hazmat or combination),
- Incident location and best ingress routes for ambulances.
- Estimated number of victims, and
- If additional response EMS resources are needed.

The assessment is communicated back to DEC who relays it to all responding agencies.

The **First on-Scene EMS Field Supervisory staff** duties include:

- Report to Incident Commander. Usual work site is at the Command Post with the Incident Commander.
- Receive Situation Report (Sit Rep) from Incident Commander and interim paramedic (or EMT) Medical Group Supervisor.
- Assume the role of Medical Group Supervisor.
- Set up the Medical Group or Branch. On large incidents, designate the paramedic or EMT who served as interim Medical Group Supervisor as an "Assistant. Medical Group Supervisor" who will assist with radios and incident management.
- Repeat the medical assessment of incident and work with Incident Commander to request additional resources and personnel if needed for triage and litter teams or patient transport.
- The Medical Group Supervisor monitors/utilizes the Tactical Channel to talk to Incident Commander and Medical Group Channel to talk to Medical Officers.
- If delegated by Incident Commander, Medical Group Supervisor will assume task of giving updates and requesting additional medical resources through DEC.

3.3.2 Second, Third and Subsequent On-Scene

Second on-Scene EMS units will report to Incident Commander or Medical Group Supervisor as directed. The Second-In Unit Paramedic (or EMT) #1 will be the Treatment Unit Leader and Paramedic (or EMT) # 2 will be the Transport Unit Leader until relieved by an EMS Officer. The Second EMS Field Staff On-Scene duties include:

- Report to Medical Group Supervisor to receive a Situation Report.
- 2nd EMS Field Supervisory Staff will normally be assigned the Transport Leader role.
- Utilize secondary Medical Channel (or cell phone) to talk to DEC to distribute patients to hospitals throughout City.
- The Incident Commander and / or Medical Group Supervisor can special call additional EMS Field Supervisory Staff to the scene, if required.

The **Third EMS Field Supervisory Staff On-Scene** duties include:

- Report to Medical Group Supervisor to receive a Situation Report.
- Determine if a Medical Branch with several Medical Groups will be established. Consult with Incident Commander who will make the final determination on the organization of the field medical response.
- 3rd EMS Field Supervisory Staff may serve as Medical Branch director, if established, or as an additional Medical Group Supervisor, or support Medical Group Supervisor, or Triage, Treatment or Transport Officers as directed by the MGS. Medical Branch Director or Medical Group Supervisor should be staffed with an experienced supervisor.

Subsequent ambulances will report to the Medical Group Supervisor who will direct the crews to the Treatment Area for staffing the Immediate, Delayed and Minor Treatment Areas.

Section 3.4 Alert Level Determination

The Incident Commander determines the appropriate alert levels based on the number of victims and if outside resources are needed to manage the incident. The lowest alert level to adequately meet the situational demands should be used.

A single alert level is issued for every incident. The alert level may be upgraded or downgraded at any time during the incident based on the direction of Incident Commander. It is important to note that the cut off points for the number of victims needed to call a Level 1, 2 or 3 MCI alert are flexible. For example, 30 pediatric trauma victims may require sending some of the victims to out-of-county destinations – a Level 2 MCI alert.

In a situation with more than one incident in progress, the incident that has the higher level of need will determine the alert issued. For example, Incident #1 is a Level 1 MCI Alert and Incident #2 is a Level 2 MCI Alert. The Incident Commander will select a Level 2 MCI Alert – the higher level of the two possible alerts.

Section 3.5 EMS, 911 Dispatch and Hospitals Communications

1. The Incident Commander on scene radios a Situation Report on the initial Control Channel to DEC (911 Dispatch) within the first 15 minutes that includes:

    - Yellow or Red Alert
    - If Red Alert – the alert level,
    - Location of Incident and Name of Command,
    - Type of Incident/Nature of Incident;
    - Hazards (if present),
    - Number of victims (estimated or actual number),
    - Command Post and Staging Locations,
    - Initial route of Ingress (best route to enter) and Egress, and
    - Additional and / or Specialized Resources if needed.

2. SFFD Officers located at DEC relays the initial situation report to hospital Emergency Departments via Reddinet and an open channel on B13/ B14*. A Reddinet bed poll is also initiated. The SFFD Rescue Captain may assists in some of these functions with support from the Lieutenant, Battalion Chief, and civilian supervisors.

3. During a MCI, all Emergency Department Charge Nurses are required to:
    - Monitor Reddinet and the 800 MHz radios for the duration of the MCI;
    - Input the number of available ED beds for Immediate (Red), Delayed (Yellow) and Minor (Green) patients **within the first 15 minutes or less;** and
    - Update the number of available ED beds as appropriate for the duration of the MCI.

4. SFFD Officer located at DEC radios on B15*, the information reported on Reddinet on the number and types of MCI patients that each hospital can take to the Medical Group Supervisor or Patient Transport Officer.

5. Medical Group Supervisor or Patient Transport Officer will radio back to the SFFD Officer located at DEC which hospitals will receive patients, how many, what type, and any special needs (pediatrics, hazmat). Updates will be provided every 30 minutes or anytime there is a significant change in the MCI incident.

6. SFFD Officer located at DEC radios by an open channel on B13 / B14* hospitals will receive patients, the number, type, and any special needs.

7. Hospitals will surge their operations as necessary to prepare for the receipt of the MCI patients.

8. SFFD Officer located at DEC will announce to hospitals, ambulances and other field providers when the alert is secured and the incident is closed.

**Radio channel designations may change based on operational needs.*

Section 3.6 Medical Branch / Group Operations

3.6.1 Medical Branch Director

A Medical Branch Director has overall command of EMS field operations if a full branch response is initiated. The Medical Branch Director may supervise several Medical Group Supervisors and reports to either the Incident Commander Operations Section Chief if an Operations Section is activated.

3.6.2 Medical Group Supervisor

The Medical Group Supervisor(s) ensures command and control of all activities within the Medical Group and the integration of those activities with the overall operational response. This includes assuring that adequate personnel and resources are available to the Medical Group to accomplish its assigned objectives.

3.6.3 Ambulance Staging Area

DEC will announce to all in-coming ambulance crews the location of the Staging Area when it is established. Initial supervision of this area may be assigned to the first unit arriving in the Staging Area.

In-coming crews will park in the Ambulance Staging Area and report to the Ambulance Staging Manager who will give them their assignments. If **NO** Ambulance Staging Manager is designated, crews will report into the Transport Unit Leader (or Medical Group Supervisor, if necessary). Crews will stay with their vehicles in the Ambulance Staging Area while awaiting assignment.

Transport vehicles will be maintained in a one-way traffic pattern towards the loading area, if possible. Law enforcement assistance may be used to establish traffic patterns to optimize the flow of patients out of the incident.

3.6.4 Triage Area / Triage Team Operations

Victims are usually be triaged where they lie. A separate Triage Area may be created if there is a hazard or if the physical location is not conducive for triaging patients.

Emergency medical care during the triage process is generally limited (e.g. establishing an airway, controlling hemorrhage, etc.). The deceased are also triaged and tagged. Deceased may be are left where they lie or moved to a separate Morgue Area if adequate resources are available to set it up. If the MCI is a crime scene, decedents are not moved without prior approval of the Medical Examiner or SFPD.

All patients are triaged and tagged in the triage area. "Immediate" patients must be transported to a hospital as soon as possible. Immediate patients may be moved to the Treatment Area if there is a delay in transport due to a lack of transportation units or a high number of victims.

For large incidents, the Triage Team Leader may sets up a physical "triage funnel" with tape, sawhorses, etc. through which all patients are routed to the Treatment Area. The Triage Funnel should be in close proximity to Treatment Area.

The Triage Team Leader is responsible for tallying and reporting the total number of victims and classifying the MCI type as trauma, medical, Hazmat or combination. Results of the tally are reported as total number of patients and their triage categories (e.g. "Total of 10 trauma patients: 2 Immediate, 4 Delayed, and 4 Minors. No decontamination needed."). The Triage Team Leader reports this information to the Medical Group Supervisor.

3.6.5 Treatment Area Operations

The Treatment Areas will be set up with equipment from the initial arriving ambulances. The SFFD Multi-Casualty Unit vehicles may supplement equipment as needed. EMT and paramedic personnel must staff all Treatment Areas. Walk-up volunteer medical personnel must be cleared through the chain of command before patient contact. The Treatment Unit Leader will check through the chain of command where to send walk-up volunteer medical personnel for clearance checks.

Once a patient is in the Treatment Area, treatment will consist of:

- Re-triaging patients.
- Checking and recording vital signs and chief complaint on the triage tag.

- Establishing and maintaining an airway and controlling hemorrhage.
- First aid, BLS and ALS level care depending on provider training, availability of personnel and resources, and only if the situation safely allows for it.
- Preparing patients for transport.

Current EMS policies for evaluating and releasing patients from the scene should be followed for any MCI patients who refuse care or transport at the scene.

3.6.6 Patient Transport Area

The Patient Transport Area matches patients needing transportation with vehicles and assigned destinations. Section 3.5 describes the communications between the field, DEC and the hospitals for determining available beds and notifying hospitals about in-coming patients. Communications between the field and DEC about patient care operations is handled by the Medical Group Supervisor or Patient Transport Officer. In a full branch response, a Medical Communications Coordinator reporting to the Patient Transport Officer may be designated for communications with DEC.

The Treatment Area personnel will provide to the Patient Transport Officer which patients are prioritized for transport. The Patient Transport Officer will choose an appropriate mode of transportation for the patient. Possible patient transportation options include:

- Ground Ambulance
- Air Ambulance
- At the discretion of the Transport Unit Leader, other vehicles (e.g. buses, wheelchair vans) may be substituted for ambulances as appropriate for the patients' condition.

The Patient Transport Officer will request medical transport vehicles directly through DEC. In a large MCI response, a Ground Ambulance Coordinator or Air Medical Coordinators may be used. All requests for transportation will include specific details such as number and description of transport units, e.g., "2 ALS ground ambulances, 1 BLS ground ambulance, and 1 ALS air ambulance".

Patients will be moved from the Treatment Area to the Patient Transport Area only when:

- The patient is "packaged" and ready to go,
- A hospital bed destination is identified, and
- The transport vehicle is ready to go.

The Patient Transport Officer (or Ground Ambulance Coordinator and the Air Medical Coordinator if used) are responsible for securing requested transport vehicle(s) and for maintaining "Patient Logs" of the patients leaving the scene via ground or air that includes:

1. Triage tag number
2. Triage Level
3. Patient name and age (if known)
4. Patient gender
5. Chief complaint
6. Type of transport
7. Name of transport provider and unit number
8. Destination
9. Date and time of departure

Patient distribution to San Francisco and Bay Area county hospitals will continue until there are no patients remaining at the scene or the hospitals are at capacity.

For large incidents, Delayed (Yellow) and Minor (Green) patients may be held at the treatment area. If patients are held at the treatment site for several hours to days, it will be designated with as a formal **Field Treatment Site** and adjust its operations accordingly with additional supplies, personnel and shelter provided through field cache and alternate care supplies. <u>All decisions to hold patients at the scene or establish Field Treatment Sites will be relayed through the Medical Group Supervisor to the Incident Commander for approval.</u>

3.6.7 Morgue Area

A temporary Morgue Area may be established when adequate resources are available and / if it is necessary to remove deceased patients from the impacted site. This area should be located away from the treatment area(s) and is the responsibility of the Medical Examiner. EMS personnel assistance may be required in the establishment of the field morgue.

3.6.8 Medical Supply Operations

A Medical Supply Area may be established for large, protracted incidents. The Medical Supply Coordinator requests, receives, distributes, tracks and maintains stock for medical supplies and equipment assigned to the Medical Group. The Medical Supply Coordinator reports to the Medical Group Supervisor. If the Logistics Section is established, the Medical Supply Coordinator will coordinate request through the Logistics Section Chief or the Supply Unit Leader. Otherwise, requests are funneled through the Medical Group Supervisor to the Incident Commander.

Resource requests are done by resource type and number when possible. MCI resource requests may consist of the following:

Transportation

- Ground or Air Ambulances
- Buses
- Strike Teams or Task Forces

Supplies and Equipment

- Medical Supplies Caches and Equipment Trailers

Personnel

- ALS or BLS Personnel
- Litter Bearers
- Strike Teams or Task Forces
- Californian Medical Assistance Teams (Cal-MAT – state)
- Disaster Medical Assistance Teams (DMAT - federal)

- Rescue Equipment
- Specialized Equipment

3.6.9 Termination
The Incident Commander will make the determination when the MCI response is completed and communicate the termination notice to DEC who relays it to the relevant response participants.

Section 3.7 Modified 911 EMS Responses

Minor and / or major modifications of the standard EMS responses may be necessary to maintain the sound operations of the entire EMS system during a sizeable MCI event. An example of a *minor* modification includes suspending diversion until the incident response is closed out.

Any decision to do a major modification of the standard 911 medical responses must be authorized by the EMS Agency Medical Director in consultation with the Director of Health, the SFFD Chief and the leadership of the affected EMS providers. Part 1 Standard Operating Procedures lists the potential modifications to EMS responses. Below lists examples of possible *major* modifications to EMS response that may be invoked during a MCI.

Potential Modified Responses during a Level 2 MCI Alert
- ALS ambulances dispatched only to Code 3 (Delta and Echo) calls.
- BLS ambulances dispatched to Code 2 (Alpha, Bravo, and Charlie) calls.
- First Responder dispatched to Code 2 ((Alpha, Bravo, and Charlie) calls.

Potential Modified Responses during a Level 3 MCI Alert
- BLS Ambulance dispatched to only Code 3 (Delta and Charlie) calls.
- First Responder dispatched to only Code 2 ((Alpha, Bravo, and Charlie) calls.
- No response to Code 2 (Alpha, Bravo, and Charlie) calls.

Section 3.8 Hospital Operations

All San Francisco hospitals will surge their patient care operations through their pre-planned activities to accommodate MCI patients. Hospitals may surge their internal capacity by setting up alternate care areas through the re-purposing of current patient care sites or by setting up disaster tents on the hospital property.

At no time should more than one hospital staff person communicate with the DEC about the receipt of MCI patients. **The Emergency Department Charge Nurse is the designated Point-of-Contact for all MCI Alerts.** This designation may be transferred to Hospital Command Center staff during large, protracted incidents extending for several operational periods.

Hospitals will communicate to DEC through the 800 MHz radio and Reddinet. If Reddinet is not functioning, DEC will directly contact hospitals via the 800 MHz radio for bed availability. Landline telephones may provide backup communications in the event the 800 MHz radio is not functional. Satellite phones may also be considered for backup communications.

Section 3.9 Overview Patient Distribution

The overall goal of patient distribution is to deliver MCI patients to appropriate and available treatment beds to meet their medical needs without overwhelming any one hospital with too many patients.

Patients will be distributed to hospitals through the combined use of: **1) Assigned Distribution** and **2) Managed Distribution.** Assigned distribution automatically assigns a fixed, minimum number of patients to each hospital in the initial phase of the MCI response. San Francisco hospitals MUST accept their automatically assigned minimum number of patients. If the total number of patients from an incident **exceeds** the total number assigned slots, then Managed Distribution will determine the hospital distribution for those patients.

Section 3.10 Assigned Patient Distributions

On the following page is the initial distribution plan for MCI patients to hospital by the Patient Transport Officer.

This list does NOT imply that patients must be sent to the hospitals according to any specific sequence. DEC or the Patient Transport Officer may make adjustments based on the MCI situation or reported hospital availability.

Assigned Distribution				
Hospital	**Immediate (Red) [1]**	**Delayed (Yellow) [1]**	**Minor (Green) [1]**	**ONLY Green [2]**
ZSFG Trauma Center	1st 10 (ten) major trauma	4	6	20
UCSF Parnassus Campus *)*	2	4	6	12
CPMC Pacific Campus	2	4	6	12
Kaiser	2	4	6	12
St. Francis Memorial	2	4	6	12
CPMC St Lukes	2	4	6	12
St. Mary's Medical Center	2	4	6	12
CPMC Davies	2	4	6	12
CPMC California St Campus *(Pediatric Preferred)*	2	4	6	12
UCSF- Mission Bay *(Pediatric Preferred)*	2	4	6	12
(Only Delayed + Minor) [3]				
Chinese Hospital	0	4	6	12
VA Medical Center	0	4	6	12
Seton – Daly City	0	4	6	12
South Kaiser – So. SF *)*	0	4	6	12
SUBTOTAL:	**28**	**56**	**84**	**168**
TOTAL:	**168**			

1. Hospitals may receive either a combination of Red, Yellow, Green patients or "*Only Green*"patients.
2. **"Only Green"** refers to bulk transport of minor (green) patients via a Muni or shuttle bus. In this situation, the hospital will receive "Only Green" patients due to the large number of patients who will arrive at the Emergency Department at the same time.
3. **"Only Delayed + Minor "**refers to hospitals who will receive Yellow and Green patients or Only Green.

Critical trauma patients may be distributed to regional Trauma Centers through the mutual aid process. The Medical Health Operational Area Coordinator (MHOAC) will notify the Regional

Medical Health Operational Area Coordinator about any situation requiring out-of-county transport of critical trauma patients. Either ground or air medical transport may be used to move patients. *EMS Policy 4020 EMS Aircraft Utilization* lists regional trauma centers with helipads and describes the use of air medical resources.

Triage and Disposition of Medical and Trauma Patients

Patient Type	Triage	Disposition
Medical	Immediate (Red)	Start with hospitals with those furthest away from the incident.
	Delayed (Yellow)	Start with hospitals with those furthest away from the incident after all Red medical patients have been transported.
	Minor (Green)	Start with hospitals with those furthest away from the incident after all Yellow medical patients have been transported.
Trauma[1] Meeting Physiologic or Anatomic Criteria	Immediate (Red) or Delayed (Yellow)	• 1st Ten trauma patients to ZSFG. ZSFGH will indicate their ability to take additional patients. • When ZSFG is at capacity, remaining trauma patients may go regional trauma centers via ground or air medical services – which ever has the shortest travel time. • Trauma patients may be transported to SF community hospitals if it is determined that a patient is unlikely to survive travel time to an out-of-county trauma center.
Trauma[1] Meeting Mechanism Criteria	Minor (Green)	May be transported to community hospitals.
Deceased	Deceased (Black)	Medical Examiner

[1] Trauma patients will be re-triaged in the Treatment or Transport Area using the Trauma Triage Criteria when possible to identify critical patients requiring trauma center care.

Section 3.11 Managed Patient Distribution

A **managed distribution** process will start when the total number of patients from an incident **exceeds** the total number assigned slots. Patients will be distributed to San Francisco hospitals until they reach capacity. Managed distribution will also be used to move patients to other Bay Area hospitals or beyond through the Medical Mutual Aid process facilitated by the Medical Health Operational Area Coordinator located at the Emergency Operations Center (EOC).

Hospitals are expected to communicate with the EMS Agency / Department of Emergency Management Duty Officer the number of patients received from the MCI and the patients'

dispositions, utilizing the form found in Appendix E, Patient Tracking Form. This form should be completed within 24 hours of the conclusion of the Red Alert/notification of ending of the MCI level 0 through 4.

3.11.1 Role of EOC Operations Section – Health & Human Services Branch, Public Health & Medical Services Group

In San Francisco, the Medical Health Operational Area Coordinator (MHOAC) is the DEM - EMS Agency Medical Director. The MHOAC (or designated backup) reports to the Emergency Operations Center (EOC) when it is activated. In the ICS structure, the MHOAC is in the EOC's Operations Section – Health & Human Services Branch, **Public Health & Medical Services Group**. The EOC's - Public Health & Medical Services Group assumes the MHOAC function as the primary coordination body for medical-health services and resources within the Operational Area (County) when the EOC is activated.

During a MCI, the EOC's - Public Health & Medical Services Group will notify the Region 2 Regional Disaster Medical Health Coordinator (RDMHC) through the Mutual Aid process as described in Section 3.17. The RDMHC will identify available hospital beds in the Bay Area and other sites within Region 2.

1. The RDMHC will provide direction on patient distributions to hospitals within the Bay Area.

2. The RDMHC will provide direction on patient distributions to hospitals beyond the Bay Area if the incident is large or there are incidents simultaneously occurring in other counties that require sending patients to more distant areas within Region 2.

3. The EOC's - Public Health & Medical Services Group will work with the other ICS sections or branches within the city EOC to support patient operations in the field such as facilitating ambulance strike teams requests to either do the patient transports to Bay Area hospitals or backfill San Francisco 911 ambulances.

The Department of Public Health – Departmental Operations Center (DPH DOC) may be activated to assist with or assume any of the above functions for large, complex or multi-site MCIs when the emergency response extends over multiple operational periods.

3.11.2 Role of the State and Federal Governments

The Region 2 RDMHC identifies out-of-county hospital beds. If there are no available beds within our region, the RDMHC will work with the California Dept of Public Health/State EMS Authority Medical-Health Coordination Center (MHCC) to identify the next appropriate

region(s) within California to identify available beds. If there are no beds within California, the California Dept of Public Health/State EMS Authority at the State Operations Center will contact the federal National Disaster Medical System to identify beds in other states.

The MHOAC, RDMHC, and California Dept of Public Health/State EMS Authority MHCC do all initial contacts, briefings and coordination between the local, region, state and federal levels of government responsible for the movement of patients in a disaster. The MHOAC, San Francisco EOC, RDMHC, and State EMS Authority will jointly work together to secure and coordinate as needed medical transportation arrangements and / or other logistical needs for moving patients to out-of-county hospitals.

Section 3.12 Patient Distributions in a Level 4 MCI (Red) Alert

A Level 4 MCI is a citywide catastrophic event. For planning purposes, it is assumed that there is a complete disruption of the City response and communications infrastructure. The ability for a formal emergency response and patient distribution system to be organized will be determined at the time of the incident based upon the presenting circumstances. A decentralized command structure using Emergency District Coordination Centers may be invoked by SFFD when central dispatch is interrupted. Ambulance response units may be organized through the Emergency District Coordination Centers until the dispatch communications infrastructure and central command are restored. Patient distributions may be directed through the Emergency District Coordination Center with the overall goal of executing mass medical evacuations.

Section 3.13 Alternate Care Sites

The Department of Public Health may set up free-standing alternative care sites with their disaster tents. The MHOAC and Department of Public Health - Health Officer will determine the role of free-standing alternative care sites in supporting the medical system and / or field operations and what outside support is needed (e.g. state or federal Disaster Medical Assistance Teams).

Section 3.14 Mass Medical Evacuations

3.14.1 Procedures

Mass medical evacuations may be undertaken when all in-county medical and health facilities are at capacity, or compromised due to damage to their infrastructure. Due to the resource intensive nature of medical care, mass medical evacuations may also be done when there is

significant damage to non-medical infrastructures or utilities (e.g. water, etc.) that interferes with the ability to provide critical support services to medical facilities to keep them open.

The MHOAC, in consultation with the Health Officer, city leadership, and the medical facilities will determine whether to undertake mass medical evacuations after weighing its benefits versus risks. The MHOAC with support from the EOC's Public Health & Medical Services Group will work through the RDMHC and California Dept of Public Health/State EMS Authority JEOC to secure transportation and out-of-county destinations. Possible transportation options include:

Mobile Ground Vehicles
- Private vehicles
- Buses
- Wheel Chair Vans / Gurney Vans
- Ambulances - BLS, ALS, Critical Care Transport Units, Specialty Units (Neonatal transports, Bariatric Ambulances)

Air Medical Services
- Rotary
- Fixed Wing

Large Military Transport or Federalized Medical Aircraft

For mobile ground medical vehicles, field operations will follow the same mutual aid procedures used for the Ambulance Strike Teams. EMS Policy #4020 EMS Aircraft Utilization will be followed for air medical transport categorized as:
- Air Ambulance
- ALS or BLS Rescue Aircraft
- Auxiliary Rescue Aircraft

San Francisco International Airport (SFO) will be used as a landing and coordinating facility if large numbers of air ambulances are used to move patients. The San Francisco EOC's Public Health & Medical Services Group will coordinate patient evacuation operations with SFO.

3.14.2 Mass Medical Evacuations Requiring Large Military Transport or Federalized Aircraft

The EOC's - Public Health & Medical Services Group will work through the Region 2 RDMHC to contact state or federal agencies to secure large capacity military transport or federalized aircraft if thousands of patients must be moved. Federal transportation resources will likely be coordinated through the U.S. Dept of Defense Aero-Medical Evacuation System.

Potential landing sites for large medical aircraft are SFO, Moffett Airfield or Travis Air Force Base. The 129th Rescue Wing of the Air National Guard, based at Moffett Airfield, has large transport helicopters that may land in San Francisco. The EOC's EMS and Public Health Group

will work through the other EOC Sections to coordinate with SFO, Moffett Airfield or Travis Air Force Base to secure landing sites and patient transport areas.

The Department of Public Health (DPH) DOC (if activated) may assist with or assume any of the above functions for large, complex or multi-site MCIs when the emergency response extends over multiple operational periods.

3.14.3 Patient Destination and Distribution When Large Military Transport or Federalized Aircraft Are Used

The National Disaster Medical System (NDMS) will identify and distribute patients to out-of-state destinations through the Federal Coordination Centers if they are not done through the CalEMA Region 2 RDMHC to in-state locations. The RDMHC contacts NDMS through the State Operations Centers.

All large military transport or federalized aircraft landing sites must have an established an on-site temporary medical facility that includes a sheltering structure, medical personnel and supplies. These temporary facilities are used to stage and provide care to patients while they await long-range evacuation by air. These temporary sites are called **Casualty Distribution Points.** The EOC's Public Health & Medical Services Group will determine whether San Francisco can assemble the resources or whether it will be staffed by California Medical Assistance Teams (CAL-MATs) or federal Disaster Medical Assistance Teams (DMATs).

The EOC's Public Health & Medical Services Group will confer with the ICS Operations Chief and Incident Commander to determine if a separate Air Operations Branch will be established in the ICS structure to manage and support the Casualty Distribution Point at the landing site for the aircraft. The Firescope ICS 420-1 Manual Air Operations Branch organizational chart and position descriptions may be adapted for organizing air medical evacuations.

Section 3.15 Mass Medical Evacuation Patient Tracking

Patient information will be tracked on both the sending and receiving side of MCI operations. The Patient Transportation Coordinator in the field Transport Area and the Patient Unit Leader in the Patient Distribution Group both maintain Patient Logs that include:

- Incident Name / Incident Type
- Patient name (if known)
- Patient Age and Gender
- Triage tag number
- Triage Level
- Chief complaint
- Name of transport provider with unit number
- Destination
- Date/Time of departure
- City/State of Origin (for out-of-county destinations)

Section 3.16 Receipt of Out-of-County Patients

3.16.1 Procedures for Accepting Out-of-County Patients

The Medical-Health Operations Coordinator (MHOAC) and the San Francisco Health Officer are the only authorized individuals to make the final determination of whether or not to accept patients that are evacuated through the California Medical Mutual Aid System. Staff in other City departments must refer to the MHOAC any requests from another California county or the State involving receiving evacuated patients.

The Region 2 RDMHC will first contact the San Francisco MHOAC to brief him/her on the number and types of out-of-county patients needing care. The MHOAC will work with the DEC or, if activated, EOC's Public Health & Medical Services Group, to determine the number of available medical facility beds. Every effort will be made to accommodate the request. However, the MHOAC and Health Officer will weigh the supply of available beds against the current local demands for those resources and only accept out-of-county patients if San Francisco medical facilities can reasonably accommodate additional patients while continuing to meet local demands for medical resources.

3.16.2 Organization for Receipt of Out-of-County Patients

The number and types of incoming patients will determine the local organizational structure for accepting and managing their distribution:

1. For a small number of patients, the MHOAC may request that the sending facility directly contact the local receiving facility to initiate a transfer process.
2. For larger numbers of patients, the MHOAC may request a limited activation of the EOC's Public Health & Medical Services Group to serve as the single-point-of-contact for the RDMHC. The MHOAC may also request a limited citywide EOC activation of other sections or branches to support the receipt of out-of-county patients.
3. For significant events in other counties that necessitate sending large numbers of patients to San Francisco, the MHOAC in consultation with the Dept of Emergency Management will fully activate:
    - Emergency Operations Center
    - DPH DOC and other relevant departmental DOCs
    - Hospital Command centers

If large numbers of patients are being airlifted into San Francisco, the MHOAC will follow the same procedures for mass medical evacuations to out-of-county destinations identified in Section 3.13 to receive the patients. When *receiving* patients evacuated by air, the medical

facility at the landing site is called the **Casualty Receiving Point**. The MHOAC will also work with local ambulance providers to secure transportation to in-county hospital destinations from the landing site.

Section 3.17 Medical Mutual Aid Resources

Many medical assets are available within San Francisco and should be accessed first before activating California's Medical Mutual Aid System, unless it has been determine by direct patient care providers (field or hospital) that an out-of-county asset may provide a better patient outcome or if it is determined that local resources are exhausted/overwhelmed. Options for medical mutual aid resources or responses within include:

Patient Transportation
- Ground – Ambulances; alternative transport (Muni buses for green patients able to tolerate sitting upright)
- Air Ambulances
- Strike Teams or Task Forces

Supplies and Equipment
- Medical Supplies Caches and Equipment Trailers
- Specialized Equipment

Treatment Areas
- Portable or Mobile Facilities
- Medical Equipment and Supplies
- Pharmaceuticals

Personnel
- ALS or BLS Personnel
- Californian Medical Assistance Teams (Cal-MAT – state)
- Disaster Medical Assistance Teams (DMAT - federal)
- Medical and Nursing Personnel affiliated with Medical Volunteer Registries
- Mission Support Teams provide administrative, logistical, and liaison support.

Non-medical supplies lists maybe found through the citywide EOC's Logistics Section.

The MHOAC maintains a Medical & Health Special Resources guide. The San Francisco Department of Public Health Emergency Operations Manual also contains a list of other available medical and health resources. The DPH list does not include equipment and supplies that may be available from individual medical providers within San Francisco such as private hospitals.

Other available options for in-county resources include the caches that each medical-health provider maintains. This may be the best available option if your resource need is very limited or if there are medical specialty items that may only be immediately available through another medical provider (e.g. special surgical instruments, etc.). Requests to access provider caches must go through an individual provider's leadership or, if activated, their disaster command center.

Section 3.18 Initiating Medical Mutual Aid

3.18.1 The Use of Medical Mutual Aid

Medical mutual aid is driven by patient medical needs. Therefore, medical mutual aid may be used in more situations that non-medical mutual aid. These situations may include:

- When the surging of medical resources within San Francisco has been exhausted due to overwhelming patient demand.
- For medical resources that have a limited supply in San Francisco. For example, limited supplies of trauma center beds for critical trauma patients or burn care beds for severely burned patients may necessitate sending patients to out of county facilities even though the total number of patients resulting from a particular incident is low.
- When it is determined that patients may receive treatment faster if they are sent to out-of-county facilities using the Mutual Aid process rather than "surging" in-county assets. For example, San Francisco has disaster medical field care clinics that may take several hours to set up, supply and staff whereas sending patients to out-of-county facilities may take less than one hour.

Many medical assets are available within San Francisco and should be accessed first before requesting Mutual Aid, unless it has been determine by direct patient care providers (field or hospital) that out-of-county assets may provide a better patient outcome.

3.18.2 Initiating a Medical Mutual Aid Request for Resources into San Francisco

The Incident Commander (IC), the DEC, any hospital or medical facility, DPH or other city agency may initiate a medical mutual aid resource request by notifying the following:

- DEM Duty Officer if the EOC is not activated. The DEM Duty Officer may be contacted 24/7 through the DEC. The DEM Duty Officer will contact the MHOAC.
- EOC's Public Health & Medical Services Group, if activated, will contact the MHOAC.

All requests for Health and Medical mutual aid resources into the San Francisco Operational Area shall be authorized and coordinated through the MHOAC or his/her designee. The MHOAC or EOC's Public Health & Medical Services Group (if activated) shall complete the mutual aid resource request using the California Disaster Health Operations Manual process and templates. The California Emergency Management Agency (CalEMA) will assign a Mission Number once the request is entered into the Regional Information Management System (RIMS).

The MHOAC or designee may also request EOC or DOC activations to assist in supporting the receipt of out-of-county mutual aid assets. The MHOAC and / or EOC's Public Health & Medical Services Group will advise city leadership about any medical mutual requests.

3.18.3 Providing Medical Mutual Aid Resource to Other Counties

1. Requests originating through the **Fire Mutual Aid System** for SFFD ambulances will be approved through SFFD in consultation with the MHOAC.
2. Requests originating through the **Medical Mutual Aid System** are authorized and coordinated through the MHOAC or his/her designee. The Region 2 RDMHC will contact the MHOAC to make a request. The MHOAC or designee will take the mutual aid request information and contact the appropriate city agency or medical-health facility to fulfill the request. The MHOAC may elect to coordinate the sending of mutual aid assets to the out-of-county destinations, or delegate that task to the agency fulfilling the request or request EOC and/or DOC activations to supporting the sending of San Francisco mutual aid assets to out-of-county destinations.

3.18.4 Resource Request Tracking and Fulfillment

The RDMHC and the MHOAC will advise each other when a resource request(s) has been fulfilled, whether any changes in quantity or substitutions were necessary, its projected delivery time, or if the request was cancelled. The MHOAC may task the EOC Logistic Section with tracking the status of the resource request.

Section 3.19 Ambulance Strike Teams

Ambulance Strike Teams from other counties may be requested through mutual aid. In California, the standard Ambulance Strike Team consist of five ambulances (ambulance with two personnel) with common communications and a leader and are typed according to FEMA typing for medical and health resources. Each may include a Disaster Medical Support Unit or comparable local support unit to serve as an operational command, control, and communications center.

3.19.1 Ambulance Strike Teams Standard Configurations

1. ***ALS Ambulance Strike Team**:* 5 ambulances with 2 ALS personnel, or 1 ALS and 1 BLS personnel, both trained in ICS 100 plus 1 Strike Team Leader trained in ICS 100, 200 & 300, and Strike Team Leader Training. (**NOTE:** The Strike Team Leader may be omitted if for short deployments lasting only several hours).

2. ***BLS Ambulance Strike Team**:* 5 ambulances with BLS personnel trained in ICS 100 plus 1 Strike Team Leader trained in ICS 100, 200 & 300, and Strike Team Leader Training. (**NOTE:** The Strike Team Leader may be omitted if for short deployments lasting only several hours).

3.19.2 Sending San Francisco Ambulance Strike Teams to Other Counties

Requests originating through the **Fire Mutual Aid System** for SFFD ambulances will be approved through SFFD in consultation with the MHOAC. Requests originating through the **Medical Mutual Aid System** are authorized and coordinated through the MHOAC or his/her designee.

The MHOAC (or EOC's Public Health & Medical Services Group if activated) will contact local ambulance providers, including SFFD, to ascertain their availability of ambulances and staff for a Strike Team. The RDMHC and the MHOAC will advise each other of the following when an ambulance Strike Team request(s) has been fulfilled:

- Provider company or agency name, unit number, unit type (ALS or BLS), and estimated time of arrival (ETA) for each ambulance dispatched.
- Contact number in the event of for cancellation while the Strike Team is en route.
- Location of ambulance staging area(s).

3.19.3 Receiving Ambulance Strike Teams from Other Counties

1. **MCI Alert (actual incident in progress):** The Incident Commander (IC) or Medical Group Supervisor may initiate an Ambulance Strike Team request by contacting DEC who may contact the Public Safety Answering Point (PSAP) in a neighboring county to initiate an "Immediate Send" of a single Strike Team prior to contacting the MHOAC.
   - The San Francisco MHOAC is responsible for the approval of the request(s) for Ambulance Strike Teams into San Francisco.
   - The MHOAC or EOC's Public Health & Medical Services Group (if activated) shall complete the mutual aid resource request using the California Disaster Health

Operations Manual process and templates. The California Emergency Management Agency (CalEMA) will assign a Mission Number once the request is entered into the Regional Information Management System (RIMS).

- The San Francisco MHOAC is also responsible for coordinating the receipt of out-of-county ambulance strike teams with the OES Region 2 RDMHC, but may delegate that responsibility to the field Incident Commander.

2. **Level Zero Alert (with a shortage of ambulances):** DEC will contact the DEM Duty Officer who will contact the MHOAC. DEC will also follow the Level Zero procedures to initiate "in-county mutual aid" from the non-911 ambulance providers before initiating a request for out-of-county Ambulance Strike Teams.

3.19.4 Patient Treatment Protocols during a Mutual Aid Response

EMS Personnel operating in another county during a mutual aid response will follow all applicable San Francisco EMS Agency Policies and Medical Protocols with the exception of EMS Agency #5000 Destination Policy. The Incident Commander, Medical Group Supervisor or Transport Unit Leader for the incident will assign local receiving facility destinations for the mutual aid response.

Section 3.20 Emergency Declarations – Invoking Austere Medical Care Standards

3.20.1 Definition and Intent

Austere Medical Care is a modified standard of care provided during disaster situations when medical resources, supplies and / or medical personnel are extremely limited or unavailable.

The goal of a modified standard of care is to provide a basic (austere) level of medical care that is less time and resource intensive. By modifying the standard of care to a more basic (austere) level, fewer medical resources are provided to an individual person, but, instead are distributed to a greater number of individuals in a given population. The intent of austere medical care standards is to attempt to do the most good for the greatest number of people during a disaster situation.

3.20.2 Authorization and Limitations

In San Francisco, austere care only applies to EMS field care. It does not affect in-patient hospital services. Austere medical care is only used in situations of extreme resource shortage resulting from a catastrophic event. Field personnel should consider requests for authorization

of Austere Medical Care Standards when the situation is completely overwhelming local resources and the possibility of receiving mutual aid resources are remote.

Requests for authorization of Austere Medical Care Standards must be routed through the chain of command. Austere medical care in the pre-hospital environment is authorized only by the **County Health Officer or, in his/her absence, the Deputy Health Officer.** Authorization of the use of austere medical care will be communicated through the Incident Command System.

3.20.3 How to Perform Austere Care

The San Francisco EMS Agency P-100 Austere Care Protocol is the approved guideline for austere care in the pre-hospital environment. Refer to that protocol for further details. EMS Agency P-100 Austere Care Protocol does NOT apply to in-hospital care.

Section 3.21 Demobilization

Demobilization will not be covered in this MCI Plan. For incidents in San Francisco, demobilization plans will be developed and disseminated through the EOC or delegated to the relevant DOC when an incident response winds down. San Francisco EMS responders deployed in mutual aid response will be released from their assignment according to the incident demobilization plan developed by the original responder agency that requested mutual aid.

Annexes

(TO BE DEVELOPED)

Appendices

APPENDIX A: MEDICAL & HEALTH CONTACTS

The contact list is provided directly to local EMS providers and is **not** posted on-line.

APPENDIX B: MEDICAL BRANCH / GROUP POSITIONS

1. Common Tasks: All Field Personnel

2. Medical Branch Director

3. Medical Group Supervisor (MGS)

4. Triage Area:
    a. Triage Area Unit Leader
    b. Triage Personnel
    c. Morgue Manager

5. Treatment Area:
    a. Treatment Area Unit Leader
    b. Immediate Treatment Area Manager
    c. Delayed Treatment Area Manager
    d. Minor Treatment Area Manager
    e. Treatment Dispatch Manager

6. Patient Transportation Area:
    a. Patient Transport Area Unit Leader
    b. Medical Communications Coordinator
    c. Air Ambulance Coordinator
    d. Ground Ambulance Coordinator

7. Medical Supply Coordinator

First On-Scene Tasks

Field Personnel – Immediate Actions

- Report for duty and receive assignment position from Incident Commander (IC), Medical Branch Director or Medical Group Supervisor if used.
- Don color-coded MCI Position Vests. Use flashcards, command boards and triage tags to manage incident work and treat patients.
- Acquire any necessary work materials.
- Know your assigned radio frequency and ensure that radios are available and functioning.
- Use clear text and ICS terminology in all communications.
- Maintain activity log (ICS form 214).
- Respond to orders to escalate response and response actions.
- Response to order to demobilize or scale back efforts.

Field Supervisory Personnel – Immediate Actions

- Complete all immediate actions listed for field personnel above.
- Assign, organize and brief subordinates.
- Maintain accountability of assigned personnel as to Assignment Location, personal safety and welfare.
- Assure rotation of personnel from high stress or high risk areas.
- Monitor personnel for signs of stress or fatigue.
- Request additional resources as needed.

Medical Branch Director

Reports to: Operations Section Chief or Incident Commander

Supervises: Medical Group Supervisor(s) and Transportation function (Unit or Group).

Assignment Location: Command Post

Talk Group: _____ **Radio call sign:** Medical Branch Director

Skills needed: ALS level EMS professional with management and command experience and knowledge of SEMS, ICS and MCI management policies.

Mission: To implement the Incident Action Plan within the Medical Branch, including the direction and execution of branch planning for the assignment of resources.

Immediate Actions:

- Assist the IC in setting strategic goals, establish objectives, setting priorities and assigning specific objective to units or groups.
- Act as liaison between the Medical Groups and the Operations Chief and/or Incident Commander
- Supervise personnel in the Medical Groups
- Coordinate activities and response efforts between Medical Groups
- Reports out casualty information to the Operations Chief.

Ongoing Actions:

- Maintain a written record of activities using the Standardized MCI Forms.
- Monitor conditions within the medical incident for safe practices
- Coordinate re-supply efforts with Logistics
- Coordinate special staffing procedures including call backs and hold over of employees
- Updates casualty information for the Operations Chief.

Medical Group Supervisor

Reports to: Incident Commander or Operations Section Chief (may report to Medical Branch Director in larger events)

Supervises: Triage, Treatment and Transport Unit Leaders and Medical Supply Coordinator

Assignment Location: Command Post

Talk Group: _____ **Radio call sign:** MGS

Skills needed: ALS level EMS professional with management and command experience and knowledge of SEMS, ICS and MCI management policies.

Mission: To supervise the Unit Leaders and establish command and control of the activities within the Medical Group for effective delivery of emergency medical care during the MCI.

Immediate Actions:

- Designate areas for triage, treatment areas, transport, and ambulance staging.
- Designate temporary morgue, helicopter landing zones and medical equipment resources staging area if appropriate.
- Medical Group Supervisor communicates with SFFD Officer located at DEC which hospitals will receive patients, how many, what type, and any special needs (peds, hazmat). Provides updates every 30 minutes or if a significant change in the MCI (this action may be delegated to the Patient Transport Officer).
- Maintain an ICS 214 record for the incident. Assist the IC with preparation of IC 201.
- Oversees Medical Group personnel and operations. Monitors conditions for hazards. Notifies Safety Officer of unsafe or hazardous conditions.
- Requests additional resources through the Incident Commander
- Acts as the liaison between MCI Branch and the Operations Section Chief or IC and gives updates as needed.
- Reports out casualty information to the Medical Branch Director.

Ongoing Actions:

- Maintain a written record of activities using the Standardized MCI Forms.
- Monitor conditions within the medical incident for safe practices
- Coordinate re-supply efforts with Logistics
- Coordinate special staffing procedures including call backs and hold over of employees
- Updates casualty information to the Medical Branch Director.
- Ensures that there are enough personnel to assist in Medical Group / Branch activities.

Triage Area Unit Leader

Reports to: Medical Group Supervisor

Supervises: Triage Personnel, Litter Bearers and Morgue Manager

Assignment Location: Triage Area or base of Triage route

Talk Group: _____ **Radio call sign:** Triage Area Leader

Skills needed: EMS professional with experience and training in principles of *START* and *JUMP START* triage.

Mission: Supervise and coordinate triage personnel to rapidly identify and triage all MCI patients and assign them to appropriate Treatment Areas.

Immediate Actions:

- Designate triage teams. Complete sweep through scene to locate and triage casualties.
  Organize Litter Teams – Comprised or four persons on flat terrain and 6 persons on broken terrain or uneven terrain. Used to evacuate patient or move them between the Medical Group Areas.
- Establish route with barrier tape through which casualties are moved.
- Coordinate patient triage using the *START* (adults) and *JUMP START (*pediatric) triage systems.
- Maintain written records for patients using triage tags. In a Level 1 MCI, PCRs will be completed on all patients.
- Ensure safe practices within the Triage Area including monitoring of adequate decontamination in the event a hazardous materials incident.
- Periodically scan the scene for new or overlooked patients.
- Reassign triage teams to treatment Areas after al victims have been evaluated.
- Notify Medical Group Supervisor, Treatment Unit Leader when all patients have received initial and secondary triage.

Ongoing Actions:

- Monitor patient flow.
- Provide medical Supply Manger with list of supplies to be replenished
- Participate in incident planning meetings as directed.

Triage Personnel

Reports to: Triage Unit Leader

Assignment Location: Triage Area

Talk Group: _____ **Radio call sign:** Triage

Skills needed: First responders, EMT-1s, and paramedics with experience in *START* triage, *JUMP START* triage and trauma triage criteria.

Mission: Triage patients and assign them to appropriate Treatment Areas.

Immediate Actions:

- Report to designated on scene triage assignment location(s).
- Using the principles of START and JUMP START, triage and tag injured patients with triage tags affixed to upper extremities.
- Classify patients while noting injuries and vital signs taken.
- Direct movement of patients to appropriate Treatment Areas.
- Carry non-ambulatory patients to Treatment Areas.
- Assist with secondary triage of patients in treatment Areas using Trauma Center triage criteria.
- Provide appropriate medical treatment to patients prior to movement as incident conditions allow.

Morgue Manager

Reports to: Triage Unit Leader

Assignment Location: Morgue Area

Talk Group: _____ **Radio call sign**: Morgue Manager

Skills needed: First responders or Medical Examiner's Office Staff.

Mission: Responsible for all Morgue Area operations.

Immediate and On-Going Actions:

- Tracks, records and reports out the number of deceased and their names (if known) to Triage Unit Leader.
- Assess resource/supply needs and order as needed.
- Keep area off limits to all but authorized personnel.
- Coordinate with law enforcement and assist the Coroner or Medical Examiner representative.
- Evidence preservation for crime scenes.

Treatment Area Unit Leader

Reports to: Medical Group Supervisor

Supervises: Immediate Treatment Manager, Delayed Treatment Manager, Minor Treatment Manager and Treatment Dispatch Manager

Assignment Location: Treatment Area or between Red and Yellow Treatment Areas

Talk Group: _____ **Radio call sign:** Treatment Area Leader

Skills needed: EMTs and paramedics with experience in BLS and ALS as appropriate.

Mission: Supervise and coordinate Treatment Area Managers to rapidly perform on-scene medical treatment of victims and preparation / coordination for their transport.

Immediate Actions:

- Supervise personnel in the Treatment Area
- Coordinate all patient care in the Treatment Area
- Oversee preparations for patient transport
- Provides supplies for Red, Yellow and Green Treatment Areas.
- Coordinate the rapid movement of patients from Triage Areas to Treatment Areas.
- Ensures ongoing triage and reclassification of all patients in Treatment Areas.
- Redirects Treatment Area Managers to perform secondary triage of patients using the Trauma Triage categories.
- Ensures patients are "packaged" for transport.
- Coordinates the movement of patients to Transportation Area.
- Maintain written records of patients using triage tags and Treatment Areas Status Boards.

Ongoing Actions:

- Requests additional staffing and resources through the Medical Group Supervisor.

Immediate Treatment Manager

Reports to: Treatment Unit Leader

Assignment Location: Immediate Treatment Area

Talk Group: _____ **Radio call sign:** as assigned

Skills needed: EMTs and paramedics with experience in BLS and ALS as appropriate.

Mission: Supervises treatment and re-triage of patients assigned to Immediate Treatment Area.

Immediate Actions:

- Establish medical teams as necessary; request personnel from Treatment Unit Leader
- Assign treatment personnel to patients received in the Immediate Treatment Area
- Perform secondary triage of patients.
- Ensure that patients are prioritized for transportation.
- Ensures patients are "packaged" for transport.
- Coordinate transportation of patients with the Transport Unit Leader
- Notify Treatment Unit Leader of patient readiness and priority for transport.
- Assure that treatment is documented and patient information is recorded on triage tags and patient status boards.

Ongoing Actions:

- Request additional resources and personnel as needed.

Delayed Treatment Manager

Reports to: Treatment Unit Leader

Assignment Location: Delayed Treatment Area

Talk Group: _____ **Radio call sign:** as assigned

Skills needed: EMTs and paramedics with experience in BLS and ALS as appropriate.

Mission: Supervises treatment and re-triage of patients assigned to Delayed Treatment Area.

Immediate Actions:

- Establish medical teams as necessary; request personnel from Treatment Unit Leader.
- Assign treatment personnel to patients received in the Delayed Treatment Area
- Perform secondary triage of patients.
- Ensure that patients are prioritized for transportation.
- Ensures patients are "packaged" for transport.
- Coordinate transportation of patients with the Transport Unit Leader.
- Notify Treatment Unit Leader of patient readiness and priority for transport.
- Assure that treatment is documented and patient information is recorded on triage tags and patient status boards.

Ongoing Actions:

- Request additional resources and personnel as needed.

Minor Treatment Manager

Reports to: Treatment Unit Leader

Assignment Location: Treatment Area

Talk Group: _____ **Radio call sign:** as assigned

Skills needed: EMTs and paramedics with experience in BLS and ALS as appropriate.

Mission: Supervises treatment and re-triage of patients assigned to Minor Treatment Area.

Immediate Actions:

- Establish medical teams as necessary; request personnel from Treatment Unit Leader
- Assign treatment personnel to patients received in the Minor Treatment Area
- Perform secondary triage of patients.
- Ensure that patients are prioritized for transportation
- Coordinate transportation of patients with the Transport Unit Leader
- Ensures patients are "packaged" for transport.
- Notify Treatment Unit Leader of patient readiness and priority for transport.
- Assure that treatment is documented and patient information is recorded on triage tags and patient status boards.

Ongoing Actions:

- Request additional resources and personnel as needed

Treatment Dispatch Manager

Reports to: Treatment Unit Leader

Assignment Location: Treatment Area or between Immediate, Delayed and Minor Treatment Areas

Talk Group: _____ **Radio call sign:** Treatment Dispatch Manger

Skills needed: EMTs and paramedics with experience in BLS and ALS as appropriate.

Mission: Coordinates movement of patients between Treatment Area to Transport Area with Patient Transportation Unit Leader (or Group Supervisor if established).

Immediate Actions:

- ❑ Establish communications with the Immediate, Delayed, and Minor Treatment Managers.
- ❑ Establish communications with the Patient Transportation Unit Leader.
- ❑ Verify that patients are prioritized for transportation.
- ❑ Verify that patients are "packaged" and ready for transport.
- ❑ Advise Medical Communications Coordinator of patient readiness and priority for transport.
- ❑ Coordinate transportation of patients with Medical Communications Coordinator.
- ❑ Assure that appropriate patient tracking information is recorded.
- ❑ Coordinate ambulance loading with the Treatment Managers and ambulance personnel.
- ❑ Maintain Unit/Activity Log (ICS Form 214).

Patient Transportation Area Unit Leader

Reports to: Medical Group Supervisor

Supervises: Ground Ambulance Coordinator, Air Ambulance Coordinator and Medical Communications Coordinator

Assignment Location: Transport Corridor

Talk Group: _____ **Radio call sign:** Patient Transport Area Leader

Skills needed: EMTs and paramedics with experience in BLS and ALS as appropriate. Knowledge of hospital destination criteria.

Mission: Responsible for communications with Patient Distribution Group and coordinating patient loading into ambulances or other patient transport vehicles. Maintains patient records.

Immediate Actions:

- Determine and maintain access and egress routes for patients and transporting units
- Coordinate movement of patients to transportation Area with Treatment Unit Leader
- Coordinate ambulance flow through Transport Area.
- Oversee assignment of sufficient personnel to bear litters.
- Utilize destination schematics for patient movement.
- Review available trauma center and hospital resources. Determine need for transport to regional trauma centers; notify MGS if indicated.
- Ensure that trauma triage criteria are utilized in determining patient movement to trauma center(s).
- *If delegated by* Medical Group Supervisor*,* will radio back to the SFFD Officer located at DEC which hospitals will receive patients, how many, what type, and any special needs (pediatrics, hazmat). Updates will be provided every 30 minutes or anytime there is a significant change in the MCI incident*.*
- *Ensure that patients in different triage categories are not mixed together in transport vehicles (ex: do not mix red and green patients in same ambulance).*

On-Going Actions:

- Maintain Unit/Activity Log (ICS Form 214)
- Request additional resources through Patient Transport Area Unit Leader or Medical Supply Coordinator if used.

Medical Communications Coordinator

Reports to: Patient Transportation Unit Leader

Assignment Location: Transport Corridor

Talk Group: _____ **Radio call sign:** Medical Communications Coordinator

Skills needed: EMTs and paramedics with experience in BLS and ALS as appropriate. Knowledge of hospital destination criteria.

Mission: Maintains medical communications with the Patient Distribution Group for assignment of hospital facilities for MCI patients. Selects the mode of medical transport based upon patient need using patient condition information provided by the Treatment Dispatch Manager.

Immediate Actions:

- Receives basic patient information and condition from Treatment Dispatch Manager.
- Contacts the Patient Distribution Group to obtain the name and contact information for the Patient Distribution Unit Leader.
- Reports to the Patient Distribution Unit Leader, the number of MCI patients, their triage levels and triage tag numbers.
- Obtains from the Patient Distribution Unit Leader, the assigned receiving facility for each patient.
- Confirms assigned facilities, ("This is Medical Comms at Transport Area – I copy to take 2 Green patients with Triage Tag numbers 6293 and 6456 to St Lukes Hospital. Is the correct?").
- Advises the Patient Distribution Unit Leader of any remaining field MCI patients awaiting disposition.
- Communicates ground transportation requests to Ground Ambulance Coordinators.
- Communicates air ambulance requests to the Air Operations Branch Director or Air Ambulance Coordinator.

Ground Ambulance Coordinator

Reports to: Patient Transportation Unit Leader

Assignment Location: Transport Corridor

Talk Group: _____ **Radio call sign:** Ground Ambulance Coordinator

Skills needed: Knowledge of hospital Assignment Locations and destination criteria.

Mission: Coordinates ground ambulances or other ground-based patient transportation vehicles. Manages the Ambulance Staging Area(s). Dispatches ambulances as requested.

Immediate Actions:

- Establishes access and egress routes for ground ambulances.
- Establish appropriate staging area(s) for ambulances.
- Establish and maintain communications with the Medical Communications Coordinator and Treatment Dispatch Manager.
- Establish and maintain check-in procedures for new arrivals.
- Provide ambulances upon request from the Medical Communications Coordinator.
- Request additional transportation resources as appropriate.

On-Going Actions:

- Maintain Transport Worksheet of patient transports that includes:
  1. Triage tag number
  2. Triage Level
  3. Patient name (if known)
  4. Patient Age and Gender
  5. Type of transport unit
  6. Name of transport unit provider
  7. Transport unit provider unit number
  8. Destination
  9. Time of departure
  10. ETA
- Assure that necessary equipment is available for patient needs during transportation.
- Request additional resources through Patient Transport Area Unit Leader or Medical Supply Coordinator if used.

Air Ambulance Coordinator

Reports to: Patient Transportation Unit Leader

Assignment Location: Transport Corridor

Talk Group: _____ **Radio call sign:** Ambulance Coordinator

Skills needed: Knowledge of hospital Assignment Locations and destination criteria.

Mission: Establishes and coordinates helispots and air medical operations with the Air Operations Group.

Immediate Actions:

- Establish appropriate helispots for air ambulances.
- Establish routes of travel for air ambulances for incident operations.
- Establish and maintain communications with the Air Operations Branch Director regarding Air Ambulance Transportation Assignments.
- Establish and maintain communications with the Medical Communications Coordinator and Treatment Dispatch Manager.
- Establish and maintain check-in procedures for new arrivals.
- Provide air ambulances upon request from the Medical Communications Coordinator.
- Coordinate ground ambulance transport of patients to helispots.

On-Going Actions:

- Maintain Transport Worksheet of patient transports that includes:
  1. Triage tag number
  2. Triage Level
  3. Patient name (if known)
  4. Patient Age and Gender
  5. Type of transport unit
  6. Name of transport unit provider
  7. Transport unit provider unit number
  8. Destination
  9. Time of departure
  10. ETA
- Assure that necessary equipment is available for patient needs during transportation.
- Request additional resources through Patient Transport Area Unit Leader or Medical Supply Coordinator if used.

Medical Supply Coordinator

Reports to: Medical Group Supervisor

Assignment Location: Supply cache on scene, Treatment area or Bureau of Equipment

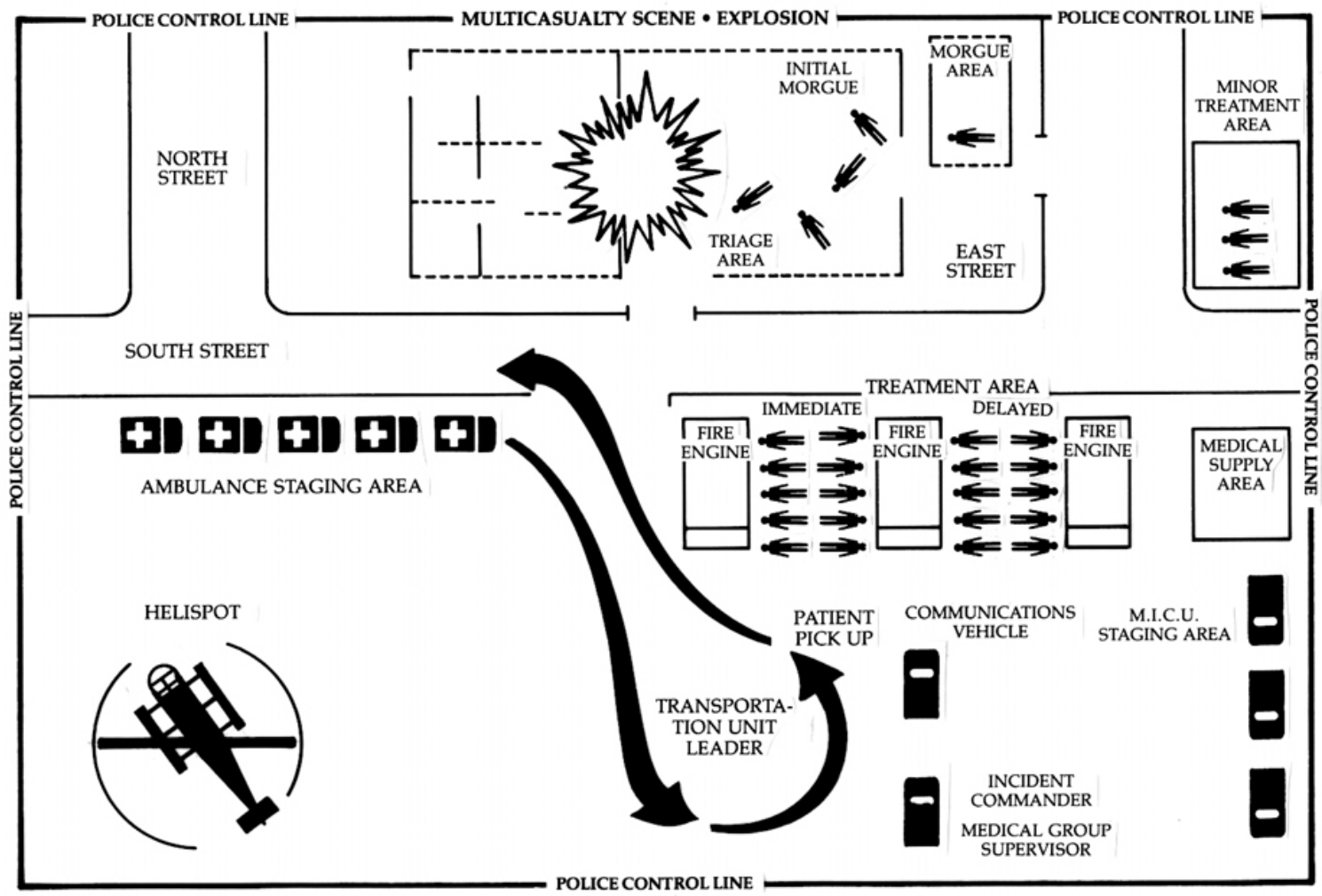
Talk Group: _____ **Radio call sign:** Medical Supply Coordinator

Skills needed: Knowledge of medical supplies and equipment, but may be a non-medical person. Knowledgeable about managing and maintaining inventory.

Mission: Coordinates requests, receives, distributes, tracks and maintains stock for medical supplies and equipment assigned to the Medical Group.

Immediate Actions:

- If the Logistics Section is established, the Medical Supply Coordinator will coordinate requests through the Logistics Section Chief or Supply Unit Leader. Otherwise, requests are funneled through the Medical Group Supervisor to the Incident Commander.
- Maintain and distribute inventory
- Coordinate personnel performing medical re-supply
- Establish secure medical supply cache near incident
- Oversee retrieval and management of cached supplies


POLICE CONTROL LINE
MULTICASUALTY SCENE • EXPLOSION
POLICE CONTROL LINE
INITIAL MORGUE
MORGUE AREA
MINOR TREATMENT AREA
NORTH STREET
TRIAGE AREA
EAST STREET
POLICE CONTROL LINE
SOUTH STREET
TREATMENT AREA
IMMEDIATE
DELAYED
FIRE ENGINE
FIRE ENGINE
FIRE ENGINE
MEDICAL SUPPLY AREA
AMBULANCE STAGING AREA
HELISPOT
PATIENT PICK UP
COMMUNICATIONS VEHICLE
M.I.C.U. STAGING AREA
TRANSPORTA-TION UNIT LEADER
INCIDENT COMMANDER
MEDICAL GROUP SUPERVISOR
POLICE CONTROL LINE

APPENDIX C: MCI FIELD BOARDS

Distributed separately due the large file size.

APPENDIX D: ABBREVIATIONS, ACRONYMS & GLOSSARY

Abbreviations and Acronyms

ALS	Advanced Life Support
BLS	Basic Life Support
CAL-MAT	California Medical Assistance Team
CDMN	California Disaster Medical Network
CDPH	California Department of Public Health
DEM	Department of Emergency Management
DMAT	Disaster Medical Assistance Team
DMORT	Disaster Mortuary Team
DOC	Department Operations Center
EMS	Emergency Medical Services
EOC	Emergency Operations Center
EOP	Emergency Operations Plan
ESF	Emergency Support Function
FEMA	Federal Emergency Management Agency
DMAT	Disaster Medical Assistance Team
DPH	Department of Public Health
ICS	Incident Command System
JEOC	Joint Emergency Operations Center
MCI	Multi-Casualty Incident
MGS	Medical Group Supervisor
MHOAC	Medical/Health Operational Area Coordinator
NDMS	National Disaster Medical System
NIMS	National Incident Management System
OA	Operational Area
OES	Office of Emergency Services
PDC	Patient Distribution Center
RDMHC	Regional Disaster Medical/Health Coordinator
RDMHS	Regional Disaster Medical/Health Specialist
SEMS	Standardized Emergency Management System
SFFD	San Francisco Fire Department
SFPD	San Francisco Police Department

Glossary

Ambulance Strike Team	A team of five staffed and equipped medical transport vehicles of the same capabilities with like communications equipment and one team leader with vehicle and like communications equipment. In California's, Ambulance Strike Teams consist of five ambulances with two personnel) and a Strike Team leader.
Alternate Care Sites	Used by public health departments or hospitals for as a temporary patient overflow area when healthcare facilities are overwhelmed. ACS are appropriate only for low acuity or end-of-life patients. May be used to cohort infectious disease patients.
Area Command (Unified Area Command)	An ICS organization established (1) to oversee the management of multiple incidents that are each being handled by an ICS command or (2) to oversee the management of large or multiple incidents to which several Incident Management Teams have been assigned.
Austere Medical Care	A modified standard of care provided during disaster situations when medical resources, supplies and / or medical personnel are extremely limited or unavailable.
Casualty Distribution Points	Sites established at airports near impacted Operational Areas to gather and stage victims for long-range evacuation by air to unaffected areas. These sites may be staffed by CAL-MATs or DMATs.
Casualty Receiving Points	Sites established at airports in unaffected areas to receive victims evacuated by air and distribute them to local hospitals.
Delayed Treatment	Patients with injuries are not immediately life threatening who can wait up to several hours for definitive medical care or surgical intervention.
Emergency Operations Center (EOC)	The physical location at which civil jurisdictions coordinate information and resources to support incident management (on-scene operations). An EOC may be a temporary facility or permanently established in a fixed facility.
Field Treatment Site	Used by EMS for the congregation, triage temporary care, holding and evacuation of injured patients in a multiple or mass casualty situation. A Field Treatment site operates for brief periods of time (e.g. 48 hours) or until new patients no longer arrives at the site.
Immediate Treatment	Patients with life threatening injuries that require immediate definitive medical or surgical intervention.
Incident Command System (ICS)	Standardized, on-scene, all-hazard incident management concept designed to allow diverse emergency management agencies to work together by providing a flexible and scalable response organization framework.

Medical Health Operational Area Coordinator (MHOAC)	An individual appointed by a county Department of Health Director / local Health Officer who is responsible for coordinating medical-health services and resources within the Operational Area (County) in the event of a disaster or major incident where medical mutual aid is required.
Minor Treatment	Ambulatory patients with injuries that only require first-aid treatment.
Mutual Aid Region	One of the six geographical areas defined by the California Governor's Office of Emergency Services for the coordination of resources in the event of a disaster or major incident where mutual aid is requested.
National Disaster Medical System (NDMS)	A section of the United States Department of Health and Human Services (HHS) responsible for managing Federal government's medical response to major emergencies and disasters. It is under the Emergency Support Function #8 – Public Health and Medical Services.
National Incident Management System (NIMS)	A system mandated by Homeland Security Presidential Directory 5 (HSPD-5) that provides a consistent nationwide approach for Federal, State, local, and tribal governments; the private-sector; and nongovernmental organizations to work effectively and efficiently together to prepare for, respond to, and recover from domestic incidents, regardless of cause, size, or complexity. California has incorporated NIMS into the State's SEMS process.
Operational Area (OA)	An intermediate level of the State emergency medical services organization, consisting of a county and all political subdivisions within the county.
Regional Disaster Medical and Health Coordinator (RDMHC)	At the regional level, EMS Authority and CDPH jointly appoint the Regional Disaster Medical Health Coordinator (RDMHC) whose responsibilities include supporting the mutual aid requests of MHOACs for disaster response within the region and providing mutual aid support to other areas of the state in support of the state medical response system.
Regional Disaster Medical Health Specialist (RDMHS)	The RDMHS provides the day-to-day planning and coordination of medical and health disaster response in the six mutual aid regions. During disaster response, the RDMHS may be designated by the RDMHC as the key contact for OAs to request and/or to provide medical and health resources.
Regional Emergency Operations Center (REOC)	The first level facility of the Governor's Office of Emergency Services to manage a disaster. The REOC provides an emergency support staff operating from a fixed facility, which are responsive to the needs of the Operational Areas and coordinates with the State Operational Center.
Simple Triage And Rapid Treatment	Usually called START. Initial triage system that has been adopted for use by the California Fire Chiefs' Association.

Standardized Emergency Management System (SEMS) The emergency management system identified in the California Government Code 8607, for managing emergency response to multi-agency or multi-jurisdictional operations. SEMS is based on the ICS and is intended to standardize response to emergencies in the State.

Triage The screening and classification of sick, wounded, or injured persons to determine priority needs in order to ensure the efficient use of medical manpower, equipment, and facilities.

Policy 8000 Appendix E: Report of Hospital Patients Received from Incident

INCIDENT NAME:

INCIDENT DATE:

PERSON COMPLETING FORM:

YOUR CONTACT PHONE:

HOSPITAL NAME:

Arrival Date	Time Of Arrival	Hosp MR #	Patient Name	Age	Gender	Nationality	Mode Of Arrival	Current Status / Disposition (CHOOSE ONE)	Receiving Transfer Facility	Comments
MM/DD/YY	24-Hour		Last, First	# / units	Male, Female, Other, Unknown	USA or List Country Name	Ambulance Self-Transport, Transfer, Other	1) Still in ED; 2)Discharged from ED; 3) Expired in ED; 4) Left ED without Being Seen; 5) Admitted and still in-patient; 6) Admitted and discharged home; 7) Expired during in-patient stay; 8) Transferred to another facility.	List name and address of tranfer facility that received patient.	List any comments

SAN FRANCISCO EMERGENCY MEDICAL SERVICES AGENCY

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Review Date: January 1, 2011
Supersedes: February 1, 2004

HAZARDOUS MATERIALS INCIDENT FIELD POLICY

I. PURPOSE

A. This policy establishes guidelines for the response of ambulance providers to incidents involving hazardous materials or weapons of mass destruction.

II. AUTHORITY

A. California Health and Safety Code, Division 2.5, Sections 1797.150, 1797.151, 1797.204, 1797.214, 1798.6
B. California Code of Regulations, Title 22, Sections 100172 and 100175
C. 29 Code of Federal Regulations 1910.120

III. POLICY

A. All EMS personnel, public and private, responding to the scene will follow current San Francisco Fire Department (SFFD) Hazardous Materials (HAZMAT) Standard Operating Procedures (SOP) dated January 2008 once the presence of known or potential hazardous materials have been identified.

IV. PROCEDURE

A. Initial Ambulance Response

1. If upon arrival of the first ambulance to the scene, the incident is determined to be or is suspicious of a hazardous material, ambulance providers will
    a. First provide for their own safety.
    b. Ensure notification of the SFFD HAZMAT team.
    c. Follow the HAZMAT team leader's direction for scene tasking, such as isolating the scene if this has not been done prior to arrival.
    d. Coordinate with other public safety personnel at the scene to establish the Incident Command System (ICS) per the *Multi-Casualty Incident (MCI) Plan*. If the ICS has been established, report to the Medical Group Supervisor on site.
2. Ambulance providers will park uphill and upwind from the site (see attached diagram entitled "Hazardous Materials Incident Control Zones" from the SFFD Manual.

3. Ambulance providers will isolate and deny entry to the site, and confirm that fire and police have been notified to respond through the SFFD Communications Center.
4. The highest-ranking officer from the SFFD will assume the role of Incident Commander. The paramedic or the Communications Officer (if the MCI Plan is activated) will notify the Base Hospital Physician of all pertinent information via standard Base Physician Consultation mechanism.

B. Approach and Treatment of the Victims

1. If the event is thought to be a chemical, nuclear, or biological (Weapons of Mass Destruction) event, the ambulance crew must first protect themselves, then deny entry to the area and activate the MMTF. Paramedics are not to physically examine or treat patients who are contaminated and are a potential threat until the arrival of HAZMAT personnel.

2. Follow the Incident Commander's instructions regarding:
    a. Approaching the victims and/or contact with anyone coming from within the Hot Zone.
    b. Victim decontamination.
    c. Use of Personal Protective Equipment.
    d. Minimal medical treatment of victims is to be rendered in the "Cold Zone" area of the incident site per SFFD HAZMAT Standard Operating Procedures. Examples of appropriate medical treatment may include airway control, positive pressure ventilation, and administration of certain antidotes, such as atropine. Standard prehospital medical care will be rendered once decontamination has occurred as directed by the Incident Commander. For examples of these levels of care, consult current San Francisco MMTF treatment protocols.
    e. Follow current EMS Agency and MMTF treatment protocols.

Under no circumstance, should ambulance personnel use Personal Protective equipment or assist in patient decontamination without completing the required training.

TRAINING STANDARDS MATRIX FOR EMS PERSONNEL

FUNCTION /CORE COMPETENCY:	**AWARENESS** Ability to recognize a potential WMD incident	**PATIENT DECONTAMI-NATION** Ability to decontaminate a patient	**TRANSPORT OF DECON PATIENTS** Ability to identify a contaminated patient	**TREATMENT OF DECON PATIENTS** Ability to treat patients for exposure to WMD agents
Personnel: Dispatchers	Awareness training (EMSS curriculum)	N/A	N/A	N/A
1st Responders and BLS	8 hour state course (HM awareness)	48 hour state course (First Responder Operations-Decon)	Awareness training	N/A
ALS	8 hour state course	48 hour state course (FRO-D)	Awareness training	40 hour state course

3. If the MCI Plan is not activated, contact the Base Hospital Physician Consultant (BHPC) who will give medical direction regarding patient treatment. For BHPC, you must be prepared to give the following information:

    -Identification of the Hazardous Materials Incident
    -Name of the agent, route, and length of exposure
    -Number of victims involved
    -Medical assessment of the victims
    -Degree of decontamination in progress or completed

If the MCI Plan is activated, proceed according to MCI plan for patient assessment, treatment and transport. If the hazardous material incident is part of a Weapons of Mass Destruction release and the Metropolitan Medical Response System is activated, be aware that hospital destination may be altered. Follow appropriate direction according to the Incident Command System chain of command.

4. Patients must be decontaminated prior to transport. Per Section 5 of the "Hazardous Material Operating Guide of January 2008, published by the San Francisco Fire Department. The guidelines for removal of decontamination include washing with large quantities of water, removal of contaminated clothing and jewelry, and continued washing until clothes are removed. This procedure

includes petrochemical decontamination. All clothing and jewelry must be bagged.

5. Enroute to the receiving hospital, the ambulance provider shall notify the facility with the information as noted in II.B.3. as well as all medical intervention, BHPC recommendations, and changes in the patient's status.

C. Arrival at the Hospital

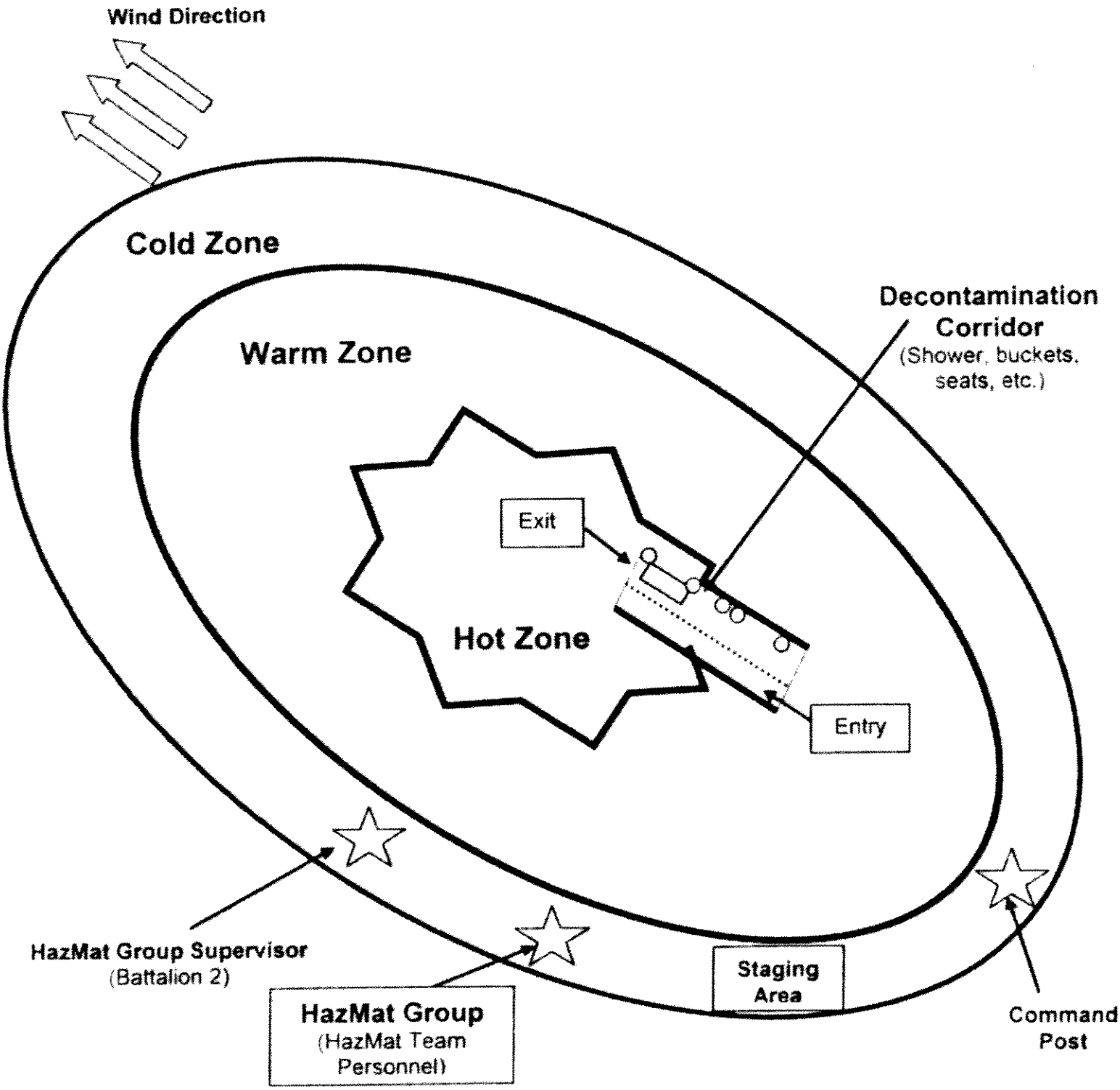
1. In virtually all cases, performing on-scene decontamination is preferable to transporting contaminated patients. Under no circumstances will ambulances transport contaminated patients.

2. After transfer of patient care, the paramedics will follow current SFFD HAZMAT policy for decontamination of themselves and their equipment.

3. If contaminated patients are transported to the hospital, ensure Receiving Hospital notification and follow individual hospital's decontamination procedures.

4. Clearing Contaminated Ambulances for Return to the Field: A contaminated ambulance must be properly decontaminated before returning to service. This can be conducted by designated members of the SFFD HazMat team or any Environmental Health Emergency Responder in the Environmental Health Section of DPH. The final decision on returning an ambulance to service lies with the ambulance provider.

ATTACHED DIAGRAM: From Hazardous Materials Operating Guide, SFFD, Jan/08.



Hazardous Materials Incident Control Zones