# County of San Diego

HEALTH AND HUMAN SERVICES AGENCY

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## EMERGENCY MEDICAL CARE COMMITTEE
## PREHOSPITAL/HOSPITAL SUBCOMMITTEE MEETING

Linda Broyles R.N., Chair/Jim Marugg, Vice-Chair

**Minutes**
**Thursday, July 11, 2013**

**Members Present**

Carlson, R.N., Sharon – Hospital Association of S.D. & Imperial Counties
Meadows-Pitt, R.N., Mary – District 2
Rice, Mike – San Diego County Ambulance Association
Rosenberg, R.N., Linda – Emergency Nurses Association
Wells, R.N., Christine – Base Hospital Nurse Coordinators

**Attendees**

Forman R.N., Kelly – Mercy Air
Pierce, Jodie – San Diego Fire
Rod, Rick – San Diego City EMS
Russo, Joe – Rural Metro/CSA-17

**County Staff**

Conte, R.N., Meredith
Haynes, M.D., Bruce
Smith, R.N., Susan

**Recorder**

Wolchko, Janet

## I. CALL TO ORDER/INTRODUCTIONS/ANNOUNCEMENTS

Mike Rice, Chair of the EMCC full committee, called the meeting to order at 9:02 am in the absence of the EMCC Prehospital/Hospital Subcommittee Chair and Vice-Chair. Attendees introduced themselves.

## II. APPROVAL OF MINUTES

**A motion was made by Christine Wells, seconded by Mary Meadows-Pitt to approve the minutes of April 11, 2013. Motion carried.**

## III. PUBLIC COMMENTS/PETITIONS

There were no public comments or petitions.

## IV. OFF-LOAD ISSUES

Seven (7) months of data from San Diego Fire and medical records on reported patient offloads shows there are offload delays. Discussion included reporting accuracy with time on scene to back in service, reevaluating the time stamp turnover of care, arrival on scene to departure from hospital including help for transfer, verbal and signature turn over, and gurney transfer.

## V. POLICIES FOR REVIEW

### A. S-010, Guidelines for Hospitals Requesting Ambulance Diversion

Source of input regarding diversion and recording offloads is from the Emergency Medine Oversight Committee (EMOC) and the current way of practice. Policy updates include:

1. Authority – California Health and Safety Code description was removed as it is in the California Highway Patrol (CHP) regulations.
2. Purpose - Ensuring that prehospital provider units are not unreasonably removed from their area of primary response when transporting patients to a hospital during delays in unloading and transferring care of patients.
3. Emergency Department (ED) Saturation – Add a caveat regarding ED resource commitment and availability for additional incoming ambulance patients before going on diversion. Discussion ensued on the notation regarding nurse to patient staffing ratios, number of patients in the ED waiting room, and lack of available Intensive Care Unit (ICU) beds in the hospital.
4. CT Scan Unavailability – Focus on CT scan ability, remove condition regarding availability of a neurosurgeon.
5. Internal Disaster – Hospitals notify the EMS Duty Officer if they cannot receive additional patients because of a physical plant breakdown (e.g. fire or power outage, etc.). There was continued discussion on notifying the duty officer of noncompliance off-load issues in a timely manner and providing a contact number.
6. Statement of patient request during ED saturation to take patients who usually receive their care or physician practices at that facility.
7. Hospital assessment regarding the appropriateness of continued ED saturation diversion by someone who is authorized by hospital administration.

8. After one hour of saturation, the hospital will come off of saturation and take at least one ALS ambulance patient prior to going back on. Reassess appropriateness of continued ED saturation hourly.
9. Turnover guidelines: Acute patient offload will occur upon arrival. Off-load delays greater that 30 minutes are considered delays.

Review of Policy S-010 draft and discussion will continue at the September meeting.

**B. <u>P-806, Advanced Life Support (ALS) First Responder Inventory</u>**

Changes were made to match S-103, BLS/ALS Ambulance Inventory.

1. Airway Adjuncts (A):
   - Aspiration based endotracheal tube placement verification devices moved to *Optional Equipment*.
   - Bag valve mask device - add description.
   - Intubation tubes - delete sizes 8.5 and 9.
   - $O_2$ masks and suction catheters sizes and description to match S-103.
   - End Tidal $CO_2$ detector moved to *Optional Equipment*.
2. Vascular Access/Monitoring Equipment (B):
   - IV administrations sets - add multi-drip.
   - Syringe size 5ml removed as in S-103.
   - Needles, IO – remove Jamshidi brand name.
3. Packs (D): Omit Drug Box and Trauma Box/Pack.
4. Other (E): Remove description/type of thermometer.
5. Communication items (F): Delete Communication Failure Protocol (laminated). Pediatric Drug Chart (laminated) and Standing Orders (laminated) are listed under *Other Equipment*.
6. Replaceable Medications (G):
   - Change minimum amounts of Albuterol and Atropine sulfate. Discussion on minimum dose of ASA.
   - Change Muti Dose Atropine and Dopamine to match S-103.
7. Optional Equipment (I):
   - Move Tourniquets to *Other Equipment*. No longer optional.
   - Remove Tympanic description/type of thermometer as it is listed under *Other*.
   - Add hemostatic gauze (optional) to match S-103.

**A motion was made by Christine Wells, to forward the edits to the full EMCC committee, seconded by Mary Meadows-Pitt. Motion carried.**

**C. <u>S-836, Critical Care Transport Unit Inventory</u>**

1. BLS requirements updated to match S-103:
   - Oropharyngeal airways - changed newborn to neonate.
   - Bag-valve-mask – added neonate mask.
   - Added Glucose Paste/Tablets, one 15g tube or 3 tabs.
   - Suction catheter - remove sizes 6, 10, 14.
   - Obstetrical Supplies – sterile added to gloves description.

2. Critical Care Transport requirements:
   - Move Aspiration based endotracheal tube placement verification devices to *Optional*.
   - Correct End Tidal $CO_2$ and add Detector Device and Capnography.
   - Add King Airway sizes to laryngeal/tracheal airway.
   - Ventilator (optional) available according to CCT permit requirement.
3. Vascular Access/Monitoring Equipment (B):
   - Remove arm board
   - IV administration sets - add or multi drip, change minimum to 1 each.
   - Needles: IV Cannula - change minimum to 1 each.
   - Syringes: change minimum to 2 each.
4. Monitoring (C): Change to match list in S-103.
5. Other Equipment (E):
   - Remove description/type of thermometer.
   - Optional items: Endotracheal tube sizes – delete 8.5 and 9.
6. Replaceable Medications (F):
   - Delete amiodarone, atropine sulfate multidose vials, bacteriostatic water, furosemide, glucagon, procainamide, sodium bicarbonate and normal saline 100 ml bag
   - Minimum dose changes: Dextrose, 50% to minimum of 1; Epinephrine 1:1,000 to minimum of 2; Naloxone HCL minimum 1 each and Verapamil HCL to minimum of 1.
   - Normal saline 1000 ml bag add or equivalent of 2-500 ml bags.
   - Change D5W to 100 ml bag, minimum of 1.
   - Add Nitro drip, 50 mg categorized as optional item.

**A motion was made by Christine Wells to forward S-836 to the full EMCC committee, seconded by Mary Meadows-Pitt. Motion carried.**

**D. <u>P-303, Mobile Intensive Care Nurse (MICN) – Authorization/Reauthorization</u>**

1. Reauthorization Process:
   Discussion ensued regarding Continuing Education (CE) courses and online classes. It was decided that online CE courses <u>are not</u> eligible and <u>do not</u> qualify for MICN reauthorization credit.

**A motion was made by Christine Wells to forward P-303 to the full EMCC committee, seconded by Sharon Carlson. Motion carried.**

## VI. STAFF REPORT

**A.** Chula Vista Fire inspection was completed and the anticipated start date for their ALS First Responder is July 19, 2013.

**B.** Temecula Valley Hospital will be opening in September.

1. Location is off of the I-15 just across the County line.
2. Radio communication capabilities are being worked out.

3. They will have a helicopter pad in March.
4. Riverside County requires six months data before they are approved as a STEMI center.

**C.** Flu season has started. Facilities should be ordering vaccines.

**D.** Protocol sepsis standing orders are currently being reviewed.

**E.** Some hospital bases are overloaded with volume and overtime. Units are asked to call their assigned base. The volume should be evenly distributed between the bases.

**F.** The State has two subcommittees reviewing Community Paramedics and Off-load Solutions.

**G.** In response to the San Francisco air crash on July 13, 2013, the County EMS burn surge plan and capability was reviewed. The most critical will go to the burn centers, Children's Hospital will accept the pediatric burn patients, trauma centers will take the less critical burns, satellites and non trauma facilities will take patients with less than 30% body surface burns.

**H.** Back orders are coming in on previous drug shortages.

**I.** Base Station Physicians Committee (BSPC) recommended that if you have an acute status patient, call the receiving base as you would call a trauma facility receiving base.

**Additional information:**
Sharon Carlson is leading a workgroup that is writing a Neonatal Intensive Care Unit (NICU) evacuation plan for San Diego County. The plan will include provisions for hospital staff such as a bedside NICU nurse, pulmonary technician and/or an intensivist to attend the infant and continue care when transporting during a disaster. The subcommittee discussed what the legal guidelines would be for transporting units with hospital based personnel accompanying the NICU patient.

## VII. SET NEXT MEETING /ADJOURNMENT

EMCC Prehospital/Hospital Subcommittee does not meet in August. The next meeting is scheduled for September 12, 2013 at Emergency Medical Services, 6255 Mission Gorge Road, San Diego, CA 92120.

The meeting was adjourned at 11:07 am.

Submitted by

Janet I. Wolchko, Administrative Secretary III
County of San Diego, Emergency Medical Services