Central California Emergency Medical Services Agency

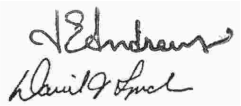
A Division of Fresno County
Department of Public Health

SPECIAL MEMORANDUM

FILE #: F/K/M/T #05-2016

TO: All Fresno/Kings/Madera/Tulare EMS Providers, Hospitals, First Responder Agencies, and Interested Parties

FROM: Jim Andrews, M.D., EMS Medical Director
Daniel J. Lynch, Director



DATE: August 26, 2016

SUBJECT: EMS System Changes and Reinforcement of EMS Policy

The EMS Agency is working towards the implementation of innovative and substantial changes in the EMS System. These changes are designed to provide a more effective response system and increase or protect the availability of paramedic ambulances throughout the four-county EMS Region.

It is clear that healthcare has changed and continues to change. More people are accessing the EMS System and hospital emergency departments for primary care services. The result of these healthcare changes causes local issues to arise. Patients with potential life threatening emergencies throughout our region are left with delayed EMS ambulance responses because paramedic ambulances are responding to low acuity patients and are facing extended ambulance patient off-load delays (APOD) at hospitals. While we have included some alternative destinations to assist in the protection of emergency departments, we continue to work extensively with hospitals to resolve the extended patient turn over issues. The EMS Agency is implementing the following changes to further protect the response system.

Reinforcement of policies should be occurring already. Effective September 1, 2016, the EMS Agency will be implementing additional procedures included below. EMS providers need to update personnel on the following:

1. Reinforce Delivering Patients to Waiting Rooms – Ambulance providers need to reinforce Policy #547 regarding the delivery of ambulance patients meeting waiting room criteria to be taken directly to emergency department waiting rooms. No ETA Call-in is required when transporting directly to the waiting room regardless of the receiving facility.

NEW – September 1, 2016: If the ambulance crew takes the patient through hospital triage and are advised that no bed is available, the patient can walk or sit unassisted, and is not receiving ALS treatment, the patient shall be taken to the waiting room. If patient has an IV or saline lock, the triage nurse shall be notified prior to sending the patient to the waiting room.

2. **NEW – September 1, 2016 -** Discontinue and remove the cardiac monitor prior to entering the hospital: If the patient is not being treated under an ACLS protocol and the monitor has shown a sinus rhythm or stable pre-existing rhythm (atrial fibrillation, bigeminy, asymptomatic bradycardia), the monitor should be removed from the patient when arriving at hospital. No ETA Call-in is required if the cardiac monitor is discontinued.

3. Reinforce the policy on Oxygen Administration – Oxygen administration should only be considered in a patient when the treatment protocol requires oxygen.

   Oxygen should be discontinued on patients when it is not indicated according to protocol. For example, if an ambulance crew arrives on scene where oxygen is initiated by the first responder agency, they should discontinue the oxygen if not indicated. Oxygen is overused and should only be used on patients as noted in the patient treatment protocols. Frequently, the use of oxygen (when not needed) prevents the patient from being delivered to the waiting room. No ETA Call-in is required if oxygen is discontinued.

   NEW – September 1, 2016 – Oxygen given for patients with Pulse Oximetry reading 93 or less: This will be effective on September 1, 2016 and updated in EMS policy at a later date. Paramedics and EMTs should only administer oxygen when the treatment protocol requires oxygen, or when a patient's pulse oximetry reading is 93 or less.

4. Reinforce the policy on IVs and Saline Locks – IV access should only be considered in a patient when the treatment protocol requires an IV or there is a reasonable and imminent chance that the patient's condition may deteriorate enroute to the hospital. Similarly, a saline lock should only be initiated in patients who require vascular access based upon the specific treatment protocol. IV access should not be obtained solely for the administration of non-emergent medications. Frequently, the IV or saline lock prevents the patient from being delivered to the waiting room.

In addition to the above items, the EMS Agency is also reviewing changes in the prehospital response system that includes the use of BLS ambulances as the primary responder to specific priority 3 prehospital ambulance requests. This is a work-in-progress, and we will update the system participants as we proceed with this project.

As the healthcare system changes, the EMS System needs to change and allow the ambulance providers to operate more efficiently in order to protect the paramedic ambulance response and the delivery of emergency care and transportation to patients who need it. If you have any questions or additional ideas, please contact the EMS Agency at (559) 600-3387.

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