ADULT CARDIAC ARREST GUIDELINE

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- To provide effective, quality cardiopulmonary resuscitation in a sequential and organized manner

CRITICAL INFORMATION

- Witnessed vs. unwitnessed
- Bystander CPR vs. No Bystander CPR
    - For documentation purposes, inappropriately given CPR = NO CPR

TREATMENT

- If unwitnessed arrest, complete 5 cycles (2 minutes) of CPR before rhythm analysis. If witnessed arrest with effective bystander CPR, immediately attach monitor/defibrillator.
- Compressions
    - Begin compressions at a rate of at least 100 per minute or apply mechanical CPR device
    - Compress the chest at least 2 inches and allow for full recoil of chest
    - Change compressors every 2 minutes
    - Minimize interruptions in compressions. If necessary to interrupt, limit to 10 seconds or less
    - Do not stop compressions while defibrillator is charging
    - Resume compressions immediately after any shock
- Monitor/Defibrillator
    - Priority of second rescuer is to apply pads while compressions are in progress
    - Determine rhythm and shock if indicated
    - Follow specific treatment guideline based on rhythm
- Basic Airway Management
    - During the first 5 minutes of resuscitation BLS airway management is preferred
    - Open airway and provide 2 ventilations after every 30 compressions
    - Ventilation should be about one second each- enough to cause visible chest rise. Avoid excessive ventilation.
    - Use two-person BLS Airway management (one holding mask and one squeezing bag) whenever possible
- Establish IV/IO Access
- Advanced Airway Management
    - **Placement of advanced airway is not a priority during the first 5 minutes of resuscitation unless no ventilation is occurring with basic maneuvers**
    - King Airway is the preferred device if an advanced airway is required.
    - Laryngoscopy for endotrachael tube placement must occur with CPR in progress. Compressions should not be interrupted for more than 10 seconds for advancement of tube through the cords
    - AVOID EXCESSIVE VENTILATION – provide no more than 8-10 ventilations per minute
    - Maintain O2 saturation level of >94% and <100%.
    - Continuous monitoring of End-Tidal CO2 to monitor effectiveness of CPR and advanced airway placement.
- Treatment on Scene
    - Movement of patient during CPR may be detrimental to patient outcome

- Provide resuscitation on scene until ROSC, patient meets Determination of Death criteria, or transport is indicated. Paramedic discretion to transport patients receiving CPR may be warranted in certain situations (refractory VF, unsafe scene conditions, hypothermic, etc.).
- If ROSC, transport to a STEMI Receiving Center.

RELATED POLICIES/ PROCEDURES

- Determination of Death ATG6
- Determination of Death BLS5
- King Airway Procedure ALS14
- Ventricular Fibrillation / Pulseless Ventricular Tachycardia C1
- PEA C2
- Asystole C3
- Return of Spontaneous Circulation C10

CANCELLATION OF ALS UNIT

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- First Responders request to cancel an ALS unit

TREATMENT /PROCEDURE

- First Responder personnel may cancel the response of ALS personnel under the following conditions:
  - Patient does not have a priority complaint or symptoms warranting a Level D response as outlined in Emergency Medical Dispatch Policy 4200
  - Patient meets criteria for BLS Declaration of Death in the pre-hospital setting

RELATED POLICIES/ PROCEDURES

- Emergency Medical Dispatch Policy 4200
- Determination of Death in the Pre-hospital Setting First Responder/BLS Personnel BLS 5

AGAINST MEDICAL ADVICE (AMA)

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- For patients or Designated Decision Maker (DDM) refusing medical care against the advice of the medical personnel on scene or of the receiving hospital

☎ PHYSICIAN CONSULT - required

- Patient requests transport to a facility that is not the recommended destination, and that decision would create a life-threatening or high-risk situation
- Patient requests an out of county transport when informed of the recommended destination within Marin County
- Pediatric Apparent Life-Threatening Event (ALTE)

☎ PHYSICIAN CONSULT – strongly recommended, but not required

- Patients ≥ 65 years requesting AMA with the following complaints:
  - Chest pain
  - SOB/ Dyspnea
  - Syncope
- New onset of headache
- New onset of seizure
- TIA/ resolving stroke symptoms
- Traumatic injuries
- Pediatric complaints
- Pregnancy related issues

CRITICAL INFORMATION

- Patients who may legally give consent or refuse medical treatment are as follows:
  - At least 18 years of age
  - A minor (<18 years) who is lawfully married/ divorced, or on active duty with the armed forces
  - A minor who seeks prevention or treatment of pregnancy or sexual assault
  - A minor ≥12 years of age seeking treatment of rape, contagious diseases, alcohol or drug abuse
  - A self sufficient minor, ≥ 15 years of age, caring for themselves
  - A legally emancipated minor
- DDM is an individual to whom the patient or a court has given legal authority to make medical decisions concerning the patient's healthcare (a parent or Durable Power of Attorney)
- An AMA may be obtained by telephone consent from patients who do not have a DDM physically present

TREATMENT/ PROCEDURE

- All patients requesting medical attention will be offered treatment and/ or transportation after a complete assessment.
- Mentally competent patients/ DDMs have the right to accept or refuse any or all pre-hospital care and transportation as long as medical personnel have explained the care and the patient /DDM understands by restating the nature and implications of such decisions.
- The following information must be provided to the patient or DDM by the EMS personnel:
  - The recommended treatment and benefits for receiving care

  - The risks and possible complications involved
  - Reasonable consequences for not seeking care and treatment for the condition
- EMS personnel should advise the patient of alternative care and transport options which may include:
  - Private transport to a clinic, a physician's office or an Emergency Department
  - Telephone consultation with a physician
- Have patient/ DDM sign the AMA form

SPECIAL CONSIDERATION

- Consider early involvement of law enforcement if there is any threat to self, others or grave disability
- Treat as necessary to prevent death or serious disability
- If the patient cannot legally refuse care or is mentally incapable of refusing care, document on the PCR that the patient required immediate treatment and /or transport, and lacked the mental capacity to understand the risks / consequences of the refusal (implied consent)
- Do not request a 5150 hold unless the patient presents a danger to self or others as an apparent result of a psychiatric problem.
- At no time are field personnel to put themselves in danger by attempting to transport or treat a patient who refuses. At all times, good judgment should be used, appropriate assistance obtained, and supporting documentations completed.

DOCUMENTATION- ESSENTIAL ELEMENTS

- Who activated 911 and the reason for the call
- Any medical care provided
- The apparent competency of the patient/ DDM to sign out AMA
- The ability of the patient/ DDM to verbalize understanding of his/her illness or injury, as well as any risks involved and potential outcomes for not receiving treatment or transport
- Reasons given by the patient/DDM for refusing care/ transport and alternate plan for patient follow up if one has been stated
- The presence or absence of any impairment such as drugs or alcohol
- The patient/ DDM understanding that they may re-access 911 if needed
- Signature of the patient/ DDM on the AMA form, or reason why signature was not obtained

RELATED POLICIES/ PROCEDURES

- Pediatric Apparent Life-Threatening Event (ALTE) P14

RELEASE AT SCENE (RAS)

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- EMS personnel and the patient or Designated Decision Maker (DDM) concur that the illness/injury does not require immediate treatment/transport via emergency / 911 services

☎ PHYSICIAN CONSULT

- If there are any questions or concerns regarding the patient's disposition

CRITICAL INFORMATION

- Patients who may legally request RAS are as follows:
  - At least 18 years of age
  - A minor <18 years who is lawfully married/divorced, or on active duty with the armed forces
  - A minor ≥12 years of age seeking treatment of rape, contagious diseases, alcohol or drug abuse
  - A self sufficient minor, ≥ 15 years of age, caring for themselves
  - A legally emancipated minor
- DDM is an individual that the patient or a court has legally given authority to make medical decisions on behalf of the patient.
- Patients who do not have a DDM physically present may be released at the scene after telephone consent is obtained (this would most often occur with a minor when the parent is not at the scene).

TREATMENT/ PROCEDURE

- All patients requesting medical attention will be offered treatment and/ or transportation after a complete assessment.
- Mentally competent patients/ DDM have the right to accept or refuse any or all pre-hospital care & transportation as long as medical personnel have explained the care & the patient /DDM understands by restating the nature and consequences of such decisions.
- EMS personnel should advice the patient of alternative care & transport options which may include:
  - Private transport to a clinic, a physician office or an Emergency Department
  - Telephone consultation with a physician
- Have patient/ DDM sign the RAS form

SPECIAL CONSIDERATION

- Consider involvement of law enforcement early if there is any threat to self or others.

DOCUMENTATION- ESSENTIAL ELEMENTS

- Who activated 911 and the reason for the call
- The apparent competency of the patient/ DDM to sign the RAS form
- The ability of the patient/ DDM to verbalize the understanding of his/her illness or injury, risks and the outcome for not treating/ transporting
- Alternate plan for patient follow up
- The presence or absence of impairment due to drugs/ alcohol
- The patient/ DDM understanding that they may re-access 911 if needed
- Signature or reason stated why it was not obtained on the RAS form

RELATED POLICIES/ PROCEDURES

- Against Medical Advice GPC 2

MARIN COUNTY EMS
AGAINST MEDICAL ADVICE (AMA)–RELEASE AT SCENE (RAS) FORM

CRITERIA FOR REFUSING CARE

The patient meets all of the following:
1. Is an adult (18 or over), or if < 18 meets the criteria stated in the AMA/RAS policy
2. Exhibits no evidence of:
   - Altered level of consciousness
   - Alcohol or drug ingestion that impairs judgment
3. Understands the nature of the medical condition, as well as the risks and consequences refusing care

1. ACKNOWLEDGMENT OF INFORMATION:

A. ☐ AMA: I have been advised that medical assistance on my behalf is necessary, and that refusal of said assistance could be hazardous to my health, and under certain circumstances, including disability and/or death. I have been advised to discuss my medical complaints with my regular health care provider as soon as possible. Nevertheless, I refuse to accept treatment or transport to a medical facility and assume all risks and consequences of any decision.

or

B. ☐ RAS: I acknowledge that I may have a medical problem, which may require 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.

2. RELEASE OF LIABILITY: By signing this form, I am releasing the County of Marin, the responding Provider Agency(ies), and the Receiving Hospital (if contacted) of any liability or medical claims resulting from my decision to refuse the medical care/transport offered.

I have read and understand the "Acknowledgment of Information" and "Release of Liability". I also acknowledge that I have received a Notice of Privacy Practices.

Signature: _____☐ Refused to sign, Reason: _____
Relationship (if not the patient): Lawful: ❒parent ❒guardian ❒conservator (pertains to a child/dependent only)
❒ Physician Consulted: _____
❒Telephone consent/refusal obtained. Witnessed by: _____
❒ Interpreter used: _____

DISPOSITION:

❒ Released in care or custody of self.

❒Released in custody of law enforcement
Agency: _____
Badge #: _____
Released in care or custody of:
❒Parent ❒ Guardian
❒Other: _____

Instructions

1. If you change your mind or your condition changes, call 9-1-1 (in an emergency), go to an emergency department in your area, or call your private doctor (if appropriate).
2. _____
   _____
3. _____
   _____

Completed by (Print)_____Signature_____ Unit #/Agency #_____

Witness Information
Signature: _____ Name Printed: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: ( ) _____ Driver's License #: _____

Patient Name: _____ AO#: _____

DDM: _____ Date: _____

DESTINATION GUIDELINES

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- To identify destination choices and appropriate facilities for patients in Marin County

☎ PHYSICIAN CONSULT

- Patient requests transport to a facility not capable of providing specific care for their needs

CRITICAL INFORMATION

- Destination choices:
  - The destination for patients shall be based upon several factors including, but not limited to the clinical capabilities of the receiving hospital, the patient's condition, and paramedic discretion.
  - When the patient's condition is unstable or life threatening, the patient should be transported to the time closest receiving facility:
    - Patients with unmanageable airway
    - Uncontrolled external hemorrhage
    - CPR in progress
    - Patients requiring ALS but having no paramedic in attendance
  - The following factors will be considered in determining patient destination:
    - Patient condition
    - Clinical capabilities of the receiving hospital
    - Paramedic discretion
    - Patient/family request
    - Patient's physician request or preference
  - Patients with return of spontaneous circulation post cardiac arrest will be transported to the nearest STEMI Receiving Center.
  - Burn patients, without other trauma mechanism, shall be transported by ground ambulance to the time closest emergency department.
  - Marin County receiving facilities:
    - **Marin General Hospital**- Level III Trauma Center- Greenbrae
      - Neurological Emergencies- sudden, witnessed onset of coma or rapidly deteriorating GCS with high likelihood of intracranial bleed
      - Pregnant patients - 20 weeks or > with a complaint related to pregnancy
      - STEMI Receiving Center (SRC)
      - Primary Stroke Center
    - **Kaiser Permanente San Rafael** – Emergency Department Approved for Trauma (EDAT) – Terra Linda
      - STEMI Receiving Center (SRC)
      - Primary Stroke Center
    - **Novato Community Hospital-** Basic level receiving facility – Novato
      - Primary Stroke Center

RELATED POLICIES/ PROCEDURES

- Trauma Triage & Destination Guidelines Policy 4613
- STEMI Policy C 9
- Ambulance Diversion Policy 5400
- Pediatric Sexual Assault P16
- Sexual Assault GPC 10
- Cerebrovascular Accident (Stroke) N 4
- Burns E4 and P12

INTER-FACILITY TRANSFER

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- Inter-facility transfer of patients from a Marin County Facility (includes physician's office with physician in attendance) for destinations within or outside Marin County

CRITICAL INFORMATION

- Transporting personnel will operate under the medical direction of the transferring physician in compliance with the County of Marin, State and Federal laws, through direct contact or standing orders, in a safe and timely manner.
- **Level I- BLS unit** (EMT- I, EMT-I staffing):
  - Patient is non-critical & deemed stable
  - EMT-I Scope of Practice
- **Level II- ALS unit** (EMT-I, EMT-P staffing; Respiratory Therapist if continuous respiratory assistance required):
  - EMT-P Scope of Practice
  - Any situation where by continuous respiratory assistance is needed
- **Level III- ALS or critical care unit** (EMT-I, EMT-P, RN):
  - IV containing medication is not on the "Paramedic Drug list" or their use is anticipated.
  - PA, arterial or ICP lines present. IABP in place.
  - Patient is not considered stable and/ or physician requests Level III transport.
- **Level IV- ALS or critical care unit** (EMT-I, EMT-P, R.N., physician and other staff as needed):
  - Patient is unstable and level of care is medically indicated.

TREATMENT

- The transferring physician will provide the following information:
  - Patients name
  - Diagnosis/ level of acuity
  - Destination
  - Transfer date and time
  - Accepting unit
  - Accepting physician
  - Special equipment with patient
  - Additional personnel attending patient or required for transport
  - Insurance information, if available
- The transporting unit agrees to accept transfer based on reported information and advises ETA of transfer unit.
- The transferring unit must receive an appropriate patient status report from the transferring physician and/ or RN.
- Transfer personnel receive patient report and confirm appropriate level of care for transfer (see critical information for Level's of care).
- If transferring personnel do not agree with or are unable to provide the level of care requested, they will confer with the transferring physician to assure appropriate level of care during transfer.
- Copies of all pertinent medical records, lab reports, x-rays and transfer forms accompany patent to receiving hospital.

- The following communication is required by each transporting unit:
  - **Level I**
    - Between transporting unit and receiving hospital
  - **Level II, III, IV**
    - Patient remains stable enroute - no communication is necessary
    - Patient unstable enroute - contact transferring physician; if unavailable, request another physician in that facility or contact any other available Marin County hospital physician

DOCUMENTATION- ESSENTIAL ELEMENTS

- Inter-facility transfer calls with hospital contact will be reviewed by hospitals directing the calls.
- Statistics on total numbers of ALS level transfer calls per month will be maintained by each provider and submitted to the EMS Office on request (transfers with EMT-P, RN and MD).

RELATED POLICIES/ PROCEDURES

- Consolidated Omnibus Budget Reconciliation Act (COBRA) 1985
- Emergency Medical Treatment & Labor Act (EMTLA) 1986
- Authorized Procedures for EMT-1 Personnel BLS PR 1
- Extended Scope of Practice Procedures for EMT-P ALS PR 1

MEDICAL PERSONNEL ON SCENE

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- Determination of patient care responsibilities at the scene of an emergency when someone present identifies themselves as medically trained

☎ PHYSICIAN CONSULT

- On-scene physician has chosen option #2 or #3 on the "Note to Physicians on Involvement with EMT-I and EMT-Ps" card and should speak directly with the receiving hospital physician.

TREATMENT

- Person is not a physician:
  - First Responder/ EMT-I or EMT-P should inform the non-physician individual that they may assist and/ or offer suggestions within the scope of their licensure but may not assume medical management for the patient.
  - Continue with care in usual manner
  - Ask to see proof of licensure/ certification/ accreditation
- Person is a physician:
  - Unless physician is known to the pre-hospital personnel, ask to see proof of licensure.
  - First Responder/ EMT yield medical management to the physician until the arrival of ALS personnel.
  - Upon arrival of ALS personnel, the EMT-P will provide the physician with "Note to Physicians on Involvement with EMT-Is and Paramedics" card (Appendix A) to determine option #1, #2, or #3, he/ she has chosen to follow.
  - Option #1:
    - The physician assists the ALS treatment team and/ or offers suggestions, but allows the EMS personnel to provide medical treatment according to policy.
  - Option #2 :
    - The physician requests to provide on-scene medical advice and/ or assistance after speaking with the intended receiving hospital physician.
  - Option #3 :
    - The physician is willing to take total responsibility for care, and will physically accompany the patient to the hospital.
      - Make all ALS equipment and supplies available to the physician and offer assistance as needed.
- Complete a "System Notification Form" (available on web site) for review of the call

DOCUMENTATION- ESSENTIAL ELEMENTS

- Document all care rendered to the patient on the PCR and ensure that the physician signs for all instructions and medical care given; include physician's phone number.

RELATED POLICIES/PROCEDURES

- Note to Physicians on Involvement with EMT-1s and Paramedics GPC 6A

STATE OF CALIFORNIA

cma CALIFORNIA MEDICAL ASSOCIATION

NOTE TO PHYSICIANS ON INVOLVEMENT WITH EMT-Is AND PARAMEDICS

A life support team (EMT-II or Paramedic) operates under standard policies and procedures developed by the local EMS agency and approved by their Medical Director under Authority of Division 2.5 of the California Health and Safety Code. The drugs they carry and procedures they can do are restricted by law and local policy.

If you want to assist, this can only be done through one of the alternatives listed on the back of this card. These alternatives have been endorsed by CMA, State EMS Authority, CCLHO and BMQA.

Assistance rendered in the endorsed fashion, without compensation, is covered by the protection of the A Good Samaritan Code@ (see Business and Professional Code, Sections 2144, 2395-2298 and Health and Safety Code, Section 1799.104). (over)

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ENDORSED ALTERNATIVES FOR PHYSICIAN INVOLVEMENT

After identifying yourself by name as a physician licensed in the Sate of California, and, if requested, showing proof of identity, you may choose one of the following:

1. Offer your assistance with another pair of eyes, hands or suggestions, but let the life support team remain under base hospital control; or,

2. Request to talk to the base station physician and directly offer your medical advice and assistance; or,

3. Take total responsibility for the care given by the life support team and physically accompany the patient until the patient arrives at a hospital and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedures. (Whenever possible, remain in contact with the base station physician)

(REV. 7/88) 88 49638 Provided by the EMS Authority

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3. Take total responsibility for the care given by the life support team and physically accompany the patient until the patient arrives at a hospital and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedures. (Whenever possible, remain in contact with the base station physician)

(REV. 7/88) 88 49638 Provided by the EMS Authority

ENDORSED ALTERNATIVES FOR PHYSICIAN INVOLVEMENT

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DO NOT RESUSCITATE (DNR) PHYSICIANS ORDER FOR LIFE-SUSTAINING TREATMENT (POLST)

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- Patients in respiratory or cardiopulmonary arrest with valid DNR documentation at scene

☎ PHYSICIAN CONSULT

- If there is any problem of any sort at the scene or if any therapy was instituted and the therapy is now in question

CONTRAINDICATION

- DNR order is not valid in suspected homicide or suicide situations

CRITICAL INFORMATION

- If the patient or Designated Decision Maker (DDM) requests treatment, including resuscitation, the request should be honored.
- The patient should receive treatment for pain, dyspnea, major hemorrhage, relief of choking or other medical conditions.
- Do Not resuscitate (DNR) means **NO:**
  - Assisted ventilation
  - Chest compressions
  - Defibrillation
  - Intubation
  - Cardiotonic drugs
- Approved pre-hospital DNR directives include:
  - A DNR directive signed by both the patient and physician; a copy or original is valid
  - A DNR order signed by a physician in the patient's chart at a licensed health facility
  - A Physician's Order for Life-Sustaining Treatment (POLST) form indicating DNR
  - An Emergency Medical Services Authority/ California Medical Association (EMSA/CMA) "Pre-hospital Do Not Resuscitate" form
  - An approved medallion (e.g. Medic-Alert) inscribed with the words: "Do Not Resuscitate-EMS"
  - A DNR order issued by the patient's physician who is on scene, or who issues a DNR order verbally over the phone to field personnel
- If any doubt exists begin CPR immediately. Once initiated, CPR should be continued unless it is determined the patient meets determination of death criteria or a valid DNR order / form is presented. If conflicting documents exist, follow the most recently dated document.

TREATMENT

- Follow standard procedures on arrival and assess the patient
- If information of a DNR exists, responders must see the signed order, form or medallion and should not accept a verbal order unless from the intended receiving ED physician or from the patient's own physician, who is in attendance or is available by phone.
- If a patient with a DNR order collapses in public, responders will notify the appropriate public safety agency and remain on the scene until their arrival.

DOCUMENTATION- ESSENTIAL ELEMENTS

- Bring the DNR form or order to the hospital if patient is transported.
- Attach a copy of the DNR to the PCR. If a copy is unavailable document the following:
  - Type of DNR
  - Date order was issued
  - Name of physician
- If the physician issued the DNR order verbally, document the physician's name and phone number.

ANATOMICAL GIFT/ DONOR CARD SEARCH

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- Conducting a “reasonable search” on an unconscious adult patient for whom it appears death is imminent for the purpose of locating documents to identify organ donation requests.

CRITICAL INFORMATION

- This procedure shall be secondary to the requirement that ambulance or emergency personnel provide emergency services to the patient.

TREATMENT/PROCEDURE

- Conduct the search in the presence of a witness not involved in the search, preferably a law enforcement officer.
- If the individual is declared or pronounced dead in the field the coroner or law enforcement officer should perform the search instead of pre-hospital personnel.
- If pre-hospital personnel searched the patient before arrival of the law enforcement/ coroner, notification of such search must be disclosed when law enforcement and/or coroner arrive at the scene.
- Documentation of donor status must remain with the patient.
- Notify the receiving hospital if documentation of donor status is located.

DOCUMENTATION- ESSENTIAL ELEMENTS

- Identification of witness involved in search

RELATED POLICIES/ PROCEDURES

- Title 22 Health & Safety Code 7150.55 (a,b,c)

SUSPECTED CHILD/ DEPENDENT ADULT/ ELDER ABUSE

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- Identification and guidelines for reporting and treating suspected child abuse (persons < 18 years of age), dependent adults between the ages of 18 and 64 years (those with physical or mental limitations restricting their ability to carry out normal activities) and elder adults (> 65 years)
- Abuse is defined as harmful, wrongful, neglectful or improper treatment which may result in physical or mental injury.

TREATMENT

- BLS/ ALS RMC
- Treat and transport the patient according to Destination Guidelines Policy GPC 4
- If patient or patient's DDM (Designated Decision Maker) refuses transportation to the hospital and patient's life is not in imminent danger:
  - Leave the scene, contact law enforcement, establish radio contact with the intended receiving hospital, describe situation including reasons for suspecting abuse.
- If patient or patient's DDM refuses transportation to the hospital and patient's life is in imminent danger:
  - Stay on the scene, request local law enforcement agency to respond and place patient in protective custody.
- If abuse is suspected in individuals other than the patient:
  - Follow the procedures stated above for imminent and/ or non-imminent danger.
- Contact one of the following protective service agencies by phone within 24 hours and submit completed report within 36 hours of incidence:
  - Marin Child Protective Services, 415-499-7418. State of California Report of Suspected Child Abuse Report SS 8583 (see GPC 9A)
  - Marin County Adult protective Services, 415-507-2774. State of California Report of Suspected Dependent Adult/ Elder Abuse Form SOC 341 (see GPC 9B)

CRITICAL INFORMATION

- Common findings in victims of child abuse are as follows:
  - Suspicious fractures in children < 3 years
  - Multiple fractures
  - Unexplained bruising
  - Starvation/ dehydration
- Common findings in parents/ guardian of abused child/ elder/ dependent adult are as follows:
  - Contradictory stories regarding patient's injury
  - Evasive answers in questions
  - Anger directed towards or little concern for the patient
  - Drug use
  - Inability to locate guardian

RELATED POLICIES/ PROCEDURES

- California Department of Social Services, Welfare & Institution Code (SS 15630, 15658 (a) (1), 8583
- Destination Guidelines Policy GPC 4

Print

SUSPECTED CHILD ABUSE REPORT

Reset Form

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ❒ YES ❒ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

❒ LAW ENFORCEMENT ❒ COUNTY PROBATION ❒ COUNTY WELFARE / CPS (Child Protective Services)	AGENCY	
ADDRESS Street City Zip		DATE/TIME OF PHONE CALL
OFFICIAL CONTACTED - TITLE		TELEPHONE ( )

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip		TELEPHONE ( )	
PRESENT LOCATION OF VICTIM	SCHOOL	CLASS	GRADE

PHYSICALLY DISABLED? ❒ YES ❒ NO	DEVELOPMENTALLY DISABLED? ❒ YES ❒ NO	OTHER DISABILITY (SPECIFY)	PRIMARY LANGUAGE SPOKEN IN HOME
IN FOSTER CARE? ❒ YES ❒ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ❒ DAY CARE ❒ CHILD CARE CENTER ❒ FOSTER FAMILY HOME ❒ FAMILY FRIEND ❒ GROUP HOME OR INSTITUTION ❒ RELATIVE'S HOME		TYPE OF ABUSE *(CHECK ONE OR MORE)* ❒ PHYSICAL ❒ MENTAL ❒ SEXUAL ❒ NEGLECT ❒ OTHER (SPECIFY)
RELATIONSHIP TO SUSPECT	PHOTOS TAKEN? ❒ YES ❒ NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ❒ YES ❒ NO ❒ UNK

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )	BUSINESS PHONE ( )	
NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE ( )	BUSINESS PHONE ( )	

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	TELEPHONE ( )		
OTHER RELEVANT INFORMATION			

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ❒ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT	PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

SEXUAL ASSAULT

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- Patients with complaints consistent with sexual assault

CRITICAL INFORMATION

- Preserve possible evidence and advise patient not to clean, bathe or change clothes until after examination by hospital personnel
- Notify police and dispatch of nature of call

TREATMENT

- BLS / ALS RMC
- Calm/ reassure patient
- Assign responder of same gender as patient if possible
- Treat medical conditions, traumatic injuries per protocol
- Transport per Destination Guidelines Policy
- If patient/ Designated Decision Maker (DDM) refuses transport, instruct patient not to bathe, shower, or change clothes until after contact with and advice by law enforcement. Advise patient of alternative care/ transport options per AMA and RAS Policy.

SPECIAL CONSIDERATION

- If patient's clothing is removed and law enforcement is not at scene, place clothing in a paper bag and bring to the hospital. Do not use a plastic bag.

DOCUMENTATION- ESSENTIAL ELEMENTS

- Date and time of alleged assault
- Details of injuries noted
- Patient description of mechanism of injury

RELATED POLICIES/ PROCEDURES

- AMA Policy GPC 2
- RAS Policy GPC 3
- Destination Guidelines Policy GPC 4
- ALS to BLS Transfer of Care ATG 4
- Trauma Triage and Destination Guidelines Policy 4613

PATIENT RESTRAINT

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- Violent or potentially violent patient capable of harming themselves or others

CONTRAINDICATIONS

- The following devices and restraint techniques should NOT be applied by EMS personnel:
  - Hard plastic ties or any restraint device requiring a key to remove
  - Backboard, scoop-stretcher or flat as a “sandwich” restraint
  - Restraint of a patient’s hands and feet behind the patient
  - Methods or materials that could cause vascular or neurological compromise

EQUIPMENT

- Quick release synthetic, soft, or padded leather restraints

PROCEDURE

- BLS/ ALS RMC
- Apply the minimum restraint necessary to accomplish patient care and safe transportation.
- Restraints must not compromise airway, breathing or circulation
- Restraint equipment applied by law enforcement (i.e. handcuffs, plastic ties, hobble restraints, or WRAP) must not compromise airway, breathing or circulation
- Evaluate restrained extremities for CSM every 15 minutes

SPECIAL CONSIDERATIONS

- Aggressive or violent behavior may be indications of: head trauma, alcohol or drug ingestion, metabolic disorders, stress and psychiatric disorders which require ALS intervention.
- Restraints applied by law enforcement require the officer’s continued presence

DOCUMENTATION- ESSENTIAL ELEMENTS

- Reason for application of restraints
- Which agency applied restraints
- CSM every 15 minutes

RELATED POLICIES/ PROCEDURES

- Adult Sedation ATG 3

MULTI-CASUALTY INCIDENT (M.C.I.)

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- Any incident with multiple patients may indicate the use of the County Multiple Patient Management Plan (MPMP).

PROCEDURE

- Initiate the MPMP for scene management.
- Request additional resources as needed.
- Evaluate each patient using S.T.A.R.T. (Simple Triage and Rapid Treatment)
- Triage and tag patients into the appropriate category (Dead, Immediate, Delayed, Minor).

RELATED POLICIES/ PROCEDURES

- Marin County Multiple Patient Management Plan

SPINAL IMMOBILIZATION

ALWAYS USE BODY SUBSTANCE ISOLATION PRECAUTIONS

INDICATION

- Patient with actual or potential axial spine trauma as determined during assessment using State of Maine guidelines. Any patient with a mechanism of injury, excluding isolated extremity injuries, should be evaluated for application of spinal immobilization.

EQUIPMENT

- Rigid back board or other rigid immobilization device
- Cervical collar
- Lateral cervical immobilization devices
- Back board straps
- Tape

PROCEDURE

- Maintain spinal axial alignment throughout application
- Evaluate sensation and motor function of all extremities before and after application
- Apply appropriate size of rigid cervical collar (see Special Considerations)
- Place patient on spinal immobilization device with as little movement as possible
- Apply head immobilization (towel rolls, foam head blocks, or equipment) to prevent movement of head
- Immobilize chest, hips and knees in a manner to prevent movement
- Secure head to board at the forehead and chin
- Pregnant patients should be positioned on the left side, supporting fetus
- Recheck sensory and motor function of all extremities
- **In order to omit the application of spinal immobilization the following must apply:**
  - Significant mechanism of injury does not exist
  - Normal neurological examination:
    - Alert and cooperative patient
    - Fully oriented to person, place, time and situation
    - Demonstrating normal sensory and motor function in extremities; without complaints or history of tingling, numbness or paresthesias
  - No mid-line vertebral pain by patient report
  - No evidence of intoxication or impairment from medication, alcohol or other drugs
  - No distracting injuries or emotional conditions
  - No spinal tenderness elicited on palpation (see Special Consideration)
  - No cervical spine pain with *active* movement (i.e., patient should be instructed to gently. move head and neck and should have no complaint of pain. Neck should not be moved by provider).

DOCUMENTATION- ESSENTIAL ELEMENTS

- Sensation and motor function of all extremities prior and subsequent to application of immobilization
- Neurological, motor, sensory, other examination findings & situational circumstances which qualifies patient for omission of spinal immobilization

SPECIAL CONSIDERATION

- Spinal tenderness is determined by a stairstep manual exam over the spinous processes from top to bottom of the spine
- Motor exam
  - Upper extremities
  - Test abduction/adduction of the 4^{th} and 2^{nd} fingers together
  - Test finger/hand extension by pushing down on the extended wrist
- Lower extremities
  - Test plantar flexion by pressing against the soles of the feet (with patient resistance)
  - Test dorsiflexion by pressing against the top of the feet (with patient resistance)
- Sensory exam – upper and lower extremities
  - Assess patient's ability to distinguish sharp and dull sensation in several locations.
- Cervical collar may be omitted for patients with isolated lumbar and/or lower thoracic spine tenderness.
- Modified immobilization techniques should be considered for safer transportation of uncooperative or combative patients
- In the absence of a focal neurologic deficit, routine spinal immobilization is not indicated for patients presenting with:
  - Penetrating trauma to the neck or torso
  - Isolated penetrating trauma to the cranium