I. PURPOSE

To establish a policy for identification and reporting of incidents of suspected child, dependent adult, or elder abuse/neglect.

II. AUTHORITY:

Health and Safety Code, Division 2.5, Section 1798; California Child Abuse and Neglect Reporting Act, Penal Code Sections 11166 and 11168; and Elder Abuse and Dependent Adult Civil Protection Act, Penal Code Sections 15630-15632.

III. DEFINITION(S)

Abuse: Any action with resulting physical harm, pain, or mental suffering, or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

Mandated Reporters: To include, but are not limited to health care practitioners, medical personnel, care providers, social workers, law enforcement officers, senior center staff, and staff of government-funded programs that provide services for children, dependent adults, or elders. This includes physicians, nurses, paramedics, and Emergency Medical Technicians (EMTs).

Serious Bodily Injury: An injury involving physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention including, but not limited to, hospitalization, surgery, or physical rehabilitation. Physical abuse that does not meet this definition is considered to be abuse with “no serious bodily injury.”

IV. POLICY

All prehospital care personnel are required to report incidents of suspected neglect of, or abusive behavior toward, children, dependent adults, or elders.

DRAFT

V. PROCEDURES

A. Child Abuse/Neglect

1. Suspicion of Child Abuse/Neglect is to be reported by prehospital personnel by telephone to the Child Abuse Hotline at (858) 560-2191 or (800) 344-6000 immediately, or as soon as possible. Be prepared to give the following information[1]:
   a. Name, agency, and phone number of person making report
   b. Name, address, and age of the child
   c. Present location of the child
   d. Nature and extent of the abuse/neglect
   e. Information that led reporting person to suspect child abuse/neglect
   f. Location where incident occurred, if known
   g. Presence of siblings or other children in the home
   h. Names of parents or caregivers
   i. Names and contact information of other relatives
   j. Name of school child attends
   k. If the child receives services through an Individualized Education Program (IEP) or has a current diagnosis
   l. If the child has developmental delays or medical concerns
   m. Description of injury, behavior, or concerns
   n. Other information as requested
2. Telephone report must be followed by a written report within 36 hours using "Suspected Child Abuse Report" Form SS8572. Form SS8572 can be accessed on the CoSD EMS website at www.sandiegocountyems.com~~.~~ on the Mandatory Reporting page. The mailing address for this report is:

   CWS Hotline
   8911 Balboa Avenue
   San Diego, CA 92123

   The report may be faxed to (858) 467-0412 or submitted online at cwsmra.sandiegocounty.gov.
3. The identity of all persons who report under this article shall be confidential and disclosed only between child protective agencies, agencies receiving or investigating the report, or to counsel representing a child protective agency, or to the District Attorney in a criminal prosecution or by court order.

[1] Prehospital personnel are only expected to provide the information they have knowledge of.

B. Dependent Adult and Elder Abuse/Neglect

1. Suspicion of Dependent Adult and Elder Abuse/Neglect should be reported as soon as possible by:
   a. Online: Mandated reporters Agencies that have registered can use an online system to make a referral at www.aiswebreferral.org https://sandiego.leapsportal.net/LEAPSIntake/NewPublicIntakeReport.aspx. Use of the online portal satisfies the requirement to submit a written report.
      Urgent or immediate response referrals are not accepted via the WebReferral process. A phone call must be made to the HHSA Aging and Independence Services (AIS) Call Center at (800) 339-4661, which is available 24 hours a day, 7 days a week. The WebReferral can be used as the written report following a phone referral for an immediate need situation.
   b. Telephone: Telephone report to the Adult Protective Services at AIS at (800) 339-4661. For the Long-Term Care (LTC) Ombudsman (for Skilled Nursing Facility or licensed long-term care facilities), call (800) 640-4661. Be prepared to give the following information[2]:
      1) Name of person making report
      2) Name, address, and age of the dependent adult or elder
      3) Nature and extent of person's condition
      4) Other information, including information that led the person to suspect abuse/neglect.

   Telephone report must be followed by a written report within two working days (48 hours) using "Report of Suspected Dependent Adult/Elder Abuse" Form SOC 341. Form SOC 341 can be accessed on the CoSD EMS website at www.sandiegocountyems.com. on the Mandatory Reporting page. The mailing address for this report is:

   Adult Protective Services
   P.O. Box 23217
   San Diego, CA 92193-3217

   The report may be faxed to (619) 344-8077 or emailed to adrc.hhsa@sdcounty.ca.gov.

   OR

   Adult Protective Services
   Attn: Ombudsman
   P.O. Box 23217
   San Diego, CA 92193-3217

[2] Prehospital personnel are only expected to provide the information they have knowledge of.

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

The report may be faxed to (858) ~~694-2568~~250-2407 or emailed to ais_ltcop@sdcounty.ca.gov.

2. Physical Abuse in a LTC Facility (includes skilled nursing facilities, residential care facilities for the elderly, assisted living facilities, board and care facilities, adult care facilities, and group homes) after observing, obtaining knowledge of, or suspecting physical abuse that results in:
   a. Serious Bodily Injury:
      1) Immediately:
         i. Telephone report to Law Enforcement
         AND
      2) Within two hours:
         i. Written report SOC 341 to LTC Ombudsman
   b. No Serious Bodily Injury:
      1) Within 24 hours:
         i. Telephone report to Law Enforcement
         AND
         ii. Written Report SOC 341 to LTC Ombudsman
   c. Cause by Resident Diagnosed with Dementia by Physician. No serious bodily injury:
      1) Immediately, or as soon as possible:
         i. Telephone LTC Ombudsman
         AND
      2) Within 24 hours:
         i. Written report SOC 341 to LTC Ombudsman
3. Please see S-411 Attachment A for Mandated Reporter Flowchart.
4. Copies of Form SOC 341 can be accessed on the CoSD EMS website at www.sandiegocountyems.com~~.~~ on the Mandatory Reporting page.
5. The identity of all persons who report shall be confidential and disclosed only by court order, or between elder protective agencies.

C. When two or more persons who are required to report are present at the scene and jointly have knowledge of a suspected instance of child, dependent adult, or elder abuse/neglect, and when there is an agreement among them, the online or telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by such selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make such report. As mandated reporters, it is each agency's responsibility to ensure a report has been filed.

D. The reporting duties are individual and no supervisor or administrator may impede or inhibit such reporting duties, and no person making such report shall be subject to any sanction for making such report. However, internal procedures to facilitate reporting and apprise supervisors

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

and administrators of reports may be established provided they are consistent with the provisions in this document.

VI. ATTACHMENTS

A. **S-411 Attachment A:** Mandated Reporter Flowchart

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

DRAFT

I. PURPOSE

To establish a policy for identification and reporting of incidents of suspected child, dependent adult, or elder abuse/neglect.

II. AUTHORITY:

Health and Safety Code, Division 2.5, Section 1798; California Child Abuse and Neglect Reporting Act, Penal Code Sections 11166 and 11168; and Elder Abuse and Dependent Adult Civil Protection Act, Penal Code Sections 15630-15632.

III. DEFINITION(S)

Abuse: Any action with resulting physical harm, pain, or mental suffering, or the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering.

Mandated Reporters: To include, but are not limited to health care practitioners, medical personnel, care providers, social workers, law enforcement officers, senior center staff, and staff of government-funded programs that provide services for children, dependent adults, or elders. This includes physicians, nurses, paramedics, and Emergency Medical Technicians (EMTs).

Serious Bodily Injury: An injury involving physical pain, substantial risk of death, or protracted loss or impairment of function of a bodily member, organ, or of mental faculty, or requiring medical intervention including, but not limited to, hospitalization, surgery, or physical rehabilitation. Physical abuse that does not meet this definition is considered to be abuse with “no serious bodily injury.”

IV. POLICY

All prehospital care personnel are required to report incidents of suspected neglect of, or abusive behavior toward, children, dependent adults, or elders.

V. PROCEDURES

A. Child Abuse/Neglect

1. Suspicion of Child Abuse/Neglect is to be reported by prehospital personnel by telephone to the Child Abuse Hotline at (858) 560-2191 or (800) 344-6000 immediately, or as soon as possible. Be prepared to give the following information[1]:
   a. Name, agency, and phone number of person making report
   b. Name, address, and age of the child
   c. Present location of the child
   d. Nature and extent of the abuse/neglect
   e. Information that led reporting person to suspect child abuse/neglect
   f. Location where incident occurred, if known
   g. Presence of siblings or other children in the home
   h. Names of parents or caregivers
   i. Names and contact information of other relatives
   j. Name of school child attends
   k. If the child receives services through an Individualized Education Program (IEP) or has a current diagnosis
   l. If the child has developmental delays or medical concerns
   m. Description of injury, behavior, or concerns
   n. Other information as requested
2. Telephone report must be followed by a written report within 36 hours using "Suspected Child Abuse Report" Form SS8572. Form SS8572 can be accessed on the CoSD EMS website at www.sandiegocountyems.com on the Mandatory Reporting page. The mailing address for this report is:

   CWS Hotline
   8911 Balboa Avenue
   San Diego, CA 92123

   The report may be faxed to (858) 467-0412 or submitted online at cwsmra.sandiegocounty.gov.
3. The identity of all persons who report under this article shall be confidential and disclosed only between child protective agencies, agencies receiving or investigating the report, or to counsel representing a child protective agency, or to the District Attorney in a criminal prosecution or by court order.

[1] Prehospital personnel are only expected to provide the information they have knowledge of.

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

B. Dependent Adult and Elder Abuse/Neglect

1. Suspicion of Dependent Adult and Elder Abuse/Neglect should be reported as soon as possible by:
   a. Online: Mandated reporters can use an online system to make a referral at https://sandiego.leapsportal.net/LEAPSIntake/NewPublicIntakeReport.aspx. Use of the online portal satisfies the requirement to submit a written report.
      Urgent or immediate response referrals are not accepted via the WebReferral process. A phone call must be made to the HHSA Aging and Independence Services (AIS) Call Center at (800) 339-4661, which is available 24 hours a day, 7 days a week. The WebReferral can be used as the written report following a phone referral for an immediate need situation.
   b. Telephone: Telephone report to the Adult Protective Services at AIS at (800) 339-4661. For the Long-Term Care (LTC) Ombudsman (for Skilled Nursing Facility or licensed long-term care facilities), call (800) 640-4661. Be prepared to give the following information[2]:
      1) Name of person making report
      2) Name, address, and age of the dependent adult or elder
      3) Nature and extent of person's condition
      4) Other information, including information that led the person to suspect abuse/neglect.

   Telephone report must be followed by a written report within two working days (48 hours) using "Report of Suspected Dependent Adult/Elder Abuse" Form SOC 341. Form SOC 341 can be accessed on the CoSD EMS website at www.sandiegocountyems.com on the Mandatory Reporting page. The mailing address for this report is:

   Adult Protective Services
   P.O. Box 23217
   San Diego, CA 92193-3217

   The report may be faxed to (619) 344-8077 or emailed to adrc.hhsa@sdcounty.ca.gov.

   OR

   Adult Protective Services
   Attn: Ombudsman
   P.O. Box 23217
   San Diego, CA 92193-3217

   The report may be faxed to (858) 250-2407 or emailed to ais_ltcop@sdcounty.ca.gov.

---

[2] Prehospital personnel are only expected to provide the information they have knowledge of.

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

2. Physical Abuse in a LTC Facility (includes skilled nursing facilities, residential care facilities for the elderly, assisted living facilities, board and care facilities, adult care facilities, and group homes) after observing, obtaining knowledge of, or suspecting physical abuse that results in:
   a. Serious Bodily Injury:
      1) Immediately:
         i. Telephone report to Law Enforcement
         AND
      2) Within two hours:
         i. Written report SOC 341 to LTC Ombudsman
   b. No Serious Bodily Injury:
      1) Within 24 hours:
         i. Telephone report to Law Enforcement
         AND
         ii. Written Report SOC 341 to LTC Ombudsman
   c. Cause by Resident Diagnosed with Dementia by Physician. No serious bodily injury:
      1) Immediately, or as soon as possible:
         i. Telephone LTC Ombudsman
         AND
      2) Within 24 hours:
         i. Written report SOC 341 to LTC Ombudsman
3. Please see S-411 Attachment A for Mandated Reporter Flowchart.
4. Copies of Form SOC 341 can be accessed on the CoSD EMS website at www.sandiegocountyems.com on the Mandatory Reporting page.
5. The identity of all persons who report shall be confidential and disclosed only by court order, or between elder protective agencies.

C. When two or more persons who are required to report are present at the scene and jointly have knowledge of a suspected instance of child, dependent adult, or elder abuse/neglect, and when there is an agreement among them, the online or telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by such selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so shall thereafter make such report. As mandated reporters, it is each agency's responsibility to ensure a report has been filed.

D. The reporting duties are individual and no supervisor or administrator may impede or inhibit such reporting duties, and no person making such report shall be subject to any sanction for making such report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established provided they are consistent with the provisions in this document.

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

VI. ATTACHMENTS

A. S-411 Attachment A: Mandated Reporter Flowchart

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

I. PURPOSE

To identify the basic scope of practice of an Emergency Medical Technician (EMT) in San Diego County

---

II. **AUTHORITY:** Health and Safety Code, Division 2.5, Sections 1797.170, 1797.202, 1797.214, and 1798.

III. POLICY

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

1. Evaluate the ill and injured.
2. Render Basic Life Support (BLS), rescue, and first aid to patients.
3. Obtain diagnostic signs, including, but not limited to:
   a. Temperature
   b. Blood pressure
   c. Pulse
   d. Respiratory rate
   e. Level of consciousness
   f. Pupil status
4. Perform cardiopulmonary resuscitation (CPR); including the use of mechanical adjuncts to basic CPR (e.g., use of chest compression devices).
5. Administer oxygen.
6. Use the following adjunctive airway breathing aids:
   a. Oropharyngeal airway
   b. Nasopharyngeal airway
   c. Suction devices
   d. Basic oxygen delivery devices, manual and mechanical ventilating devices designed for prehospital use
   ~~e. Perilaryngeal Airway Adjuncts, if authorized by the local EMS agency~~
7. Use various types of stretchers and body motion restriction or immobilization devices.

DRAFT

8. Provide initial prehospital emergency care to patients, including, but not limited to:
   a. Bleeding control through the application of tourniquets
   b. Use of hemostatic dressings from a list approved by California EMS agency (EMSA)
   c. Spinal motion restriction or immobilization
   d. Seated spinal motion restriction or immobilization
   e. Extremity splinting
   f. Traction splinting
9. Administer or assist patient to administer oral glucose or sugar solutions.
10. Assist patient to take his/her own prescribed Nitroglycerin.
11. Extricate entrapped person(s).
12. Perform basic field triage.
13. Transport patients.
14. Apply mechanical patient restraint.
15. Set up for Advanced Life Support (ALS) procedures under the direction of an Advanced EMT (AEMT) or paramedic.
16. Perform automated external defibrillation.
17. Assist patients with the administration of physician prescribed devices, including, but not limited to:
    a. Patient operated medication pumps
    b. Self-administered emergency medications (including epinephrine devices)
18. Manage patients within their scope of practice.

B. A supervised EMT student or certified EMT may monitor and transport patients with peripheral lines delivering Intravenous (IV) fluids under the following circumstances:
1. The patient's condition is not critical and is deemed stable by the transferring physician or base hospital physician.
2. The fluid infusing is a glucose solution or isotonic balanced salt solution, including Ringer's Lactate.
3. The IV is infusing at a pre-set rate of flow. Turn off device only with base hospital direction.
4. No other ALS equipment is attached to the patient that will require monitoring that is outside the scope of practice of the EMT.
5. The patient has not received additional treatment by paramedics that are outside the scope of practice of the EMT, if in the prehospital setting.

C. A supervised EMT student or certified EMT may monitor and transport patients, as described in B.1. above, with nasogastric (N.G.) tubes, gastrostomy tubes, heparin locks, Foley catheters, tracheostomy tubes, and/or indwelling vascular access lines, excluding arterial lines and uncapped central lines or other items approved by local EMS Agency.

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

D. Administer Naloxone or other opioid antagonist by intranasal route for suspected narcotic overdose.

E. Administer Epinephrine by autoinjector for suspected anaphylaxis and/or severe asthma.

F. Perform finger stick blood glucose testing.

G. An EMT student or certified EMT may utilize additional skills and/or medications included as part of pilot study as determined by the County of San Diego, Emergency Medical Services (CoSD EMS) Medical Director in accordance with Health and Safety Code, Division 2.5, Section 1797.214.

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

DRAFT

I. PURPOSE

To identify the basic scope of practice of an Emergency Medical Technician (EMT) in San Diego County

---

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.170, 1797.202, 1797.214, and 1798.

III. POLICY

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

1. Evaluate the ill and injured.
2. Render Basic Life Support (BLS), rescue, and first aid to patients.
3. Obtain diagnostic signs, including, but not limited to:
   a. Temperature
   b. Blood pressure
   c. Pulse
   d. Respiratory rate
   e. Level of consciousness
   f. Pupil status
4. Perform cardiopulmonary resuscitation (CPR); including the use of mechanical adjuncts to basic CPR (e.g., use of chest compression devices).
5. Administer oxygen.
6. Use the following adjunctive airway breathing aids:
   a. Oropharyngeal airway
   b. Nasopharyngeal airway
   c. Suction devices
   d. Basic oxygen delivery devices, manual and mechanical ventilating devices designed for prehospital use
7. Use various types of stretchers and body motion restriction or immobilization devices.
8. Provide initial prehospital emergency care to patients, including, but not limited to:

   a. Bleeding control through the application of tourniquets
   b. Use of hemostatic dressings from a list approved by California EMS agency (EMSA)
   c. Spinal motion restriction or immobilization
   d. Seated spinal motion restriction or immobilization
   e. Extremity splinting
   f. Traction splinting
9. Administer or assist patient to administer oral glucose or sugar solutions.
10. Assist patient to take his/her own prescribed Nitroglycerin.
11. Extricate entrapped person(s).
12. Perform basic field triage.
13. Transport patients.
14. Apply mechanical patient restraint.
15. Set up for Advanced Life Support (ALS) procedures under the direction of an Advanced EMT (AEMT) or paramedic.
16. Perform automated external defibrillation.
17. Assist patients with the administration of physician prescribed devices, including, but not limited to:
    a. Patient operated medication pumps
    b. Self-administered emergency medications (including epinephrine devices)
18. Manage patients within their scope of practice.

B. A supervised EMT student or certified EMT may monitor and transport patients with peripheral lines delivering Intravenous (IV) fluids under the following circumstances:
1. The patient's condition is not critical and is deemed stable by the transferring physician or base hospital physician.
2. The fluid infusing is a glucose solution or isotonic balanced salt solution, including Ringer's Lactate.
3. The IV is infusing at a pre-set rate of flow. Turn off device only with base hospital direction.
4. No other ALS equipment is attached to the patient that will require monitoring that is outside the scope of practice of the EMT.
5. The patient has not received additional treatment by paramedics that are outside the scope of practice of the EMT, if in the prehospital setting.

C. A supervised EMT student or certified EMT may monitor and transport patients, as described in B.1. above, with nasogastric (N.G.) tubes, gastrostomy tubes, heparin locks, Foley catheters, tracheostomy tubes, and/or indwelling vascular access lines, excluding arterial lines and uncapped central lines or other items approved by local EMS Agency.

D. Administer Naloxone or other opioid antagonist by intranasal route for suspected narcotic overdose.

E. Administer Epinephrine by autoinjector for suspected anaphylaxis and/or severe asthma.

F. Perform finger stick blood glucose testing.

G. An EMT student or certified EMT may utilize additional skills and/or medications included as part of pilot study as determined by the County of San Diego, Emergency Medical Services (CoSD EMS) Medical Director in accordance with Health and Safety Code, Division 2.5, Section 1797.214.

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

COUNTY OF SAN DIEGO EMERGENCY MEDICAL SERVICES	DATA COLLECTION	S-610
	TRANSFER OF CARE GUIDELINESAMBULANCE PATIENT OFFLOAD TIME STANDARD	
	Date: 1/1/20177/1/2024	Page 1 of 7

I. PURPOSE

A. To ensure appropriate, timely, and patient-centered care transition from EMS personnel to receiving facility medical personnel.

B. To establish standards for the transfer of patient care from 9-1-1 ambulances to Emergency emergency Department department (ED) providers in San Diego County. These standard ambulance patient offload time standards, as these ares are essential to public safety.

A.C. To declare that timely ambulance patient offloads are in the best interests of the patient, the EMS delivery system, and the public's health and safety.

D. To alignsupport the with a statewide standard methodology for calculating, verifying, and reporting ambulance patient offload time as defined in Health and Safety Code 1797.120.5 and developed by the California EMS Authority.

B.

c. To establish standards for ambulance patient offload time data collection, reporting, and quality assurance follow-up.

II. AUTHORITY:

Health and Safety Code, Division 2.5, Sections 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.123.

III. DEFINITION(S)

Ambulance Arrival at the Emergency Department (ED): The time ambulance stops at the location outside the hospital ED where the patient will be unloaded from the ambulance.

Ambulance Patient Offload Delay (APOD): The occurrence of a patient remaining on the ambulance gurney and/or the emergency departmentreceiving facility staff has not assumed

DRAFT

patient care responsibility for patient care beyond the Local EMS Agency-approved APOT standard of 30 minutes. (synonymous with *non-standard patient offload time*).

Ambulance Patient Offload Time (APOT): The time interval between the arrival of an ambulance patient at an EDreceiving facility and the time the patient is transferred to the EDreceiving facility gurney, bed, chair or other acceptable location and the receiving facility emergency department staff assumes the responsibility for patient careof the patient.

Ambulance Patient Offload Time (APOT) Standard: The time interval standard established by the LEMSA within which an ambulance patient that has arrived in an ED should be transferred to an ED gurney, bed, chair or other acceptable location and the ED assumes the responsibility for care of the patient.**Ambulance Transport:** The transport of a patient from the prehospital EMS system by ambulance to an ED or authorized alternate destination. This includes inter-facility transports, 7-digit responses, and other patient transports to the ED.

APOT 1: An ambulance patient offload time interval measure. This metric is a continuous variable measured in minutes and seconds then aggregated and reported at the 90th percentile.

APOT 2: An ambulance patient offload time interval process measure. This metric demonstrates the incidence of ambulance patient offload times expressed as a percentage of total EMS patient transports within a twenty (20) minute target and exceeding that time in reference to 60-, 120- and 180-minute time intervals.

Clock Start: The timestamp that captures when APOT begins. This is captured in the current NEMSIS data set as the time the patient/ambulance arrives at destination/receiving hospital at the location outside the hospital ED where the patient will be unloaded from the ambulance.[1]

Clock Stop: The timestamp that captures when APOT ends. This is captured in the current NEMSIS data set as destination patient transfer of care date/time.[2]

Emergency Department Medical Personnel: An ED physician, mid-level practitioner (e.g., Physician Assistant, Nurse Practitioner) or Registered Nurse (RN).

EMS Personnel: EMTs, AEMTs, EMT-II and/or paramedics responsible for out of hospital patient care and transport consistent with the scope of practice as authorized by their level of credentialing.

Non-Standard Patient Offload Time: The ambulance patient offload time for a patient exceeds the standard period of time designated by the LEMSA.

---

[1] NEMSIS data element "Patient Arrived at Destination Date/Time" (eTimes.11). Transport units shall enter their status at the receiving facility upon arrival to the Emergency Department (ED) via MDT or radio if the MDT is out of service or unavailable.
[2] NEMSIS data element "Destination Patient Transfer of Care Date/Time" (eTimes.12)

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

~~**Transfer of Care:** The transition of patient care responsibility from EMS personnel to receiving hospital ED medical personnel.~~
~~**Offload Delay:** The interval of wall time greater than 30 minutes until EMS personnel and ED personnel transfer the patient to the ED gurney, bed, chair, or other acceptable location and the ED Nurse or Physician assumes responsibility for care of the patient.~~
~~**Verbal Patient Report:** The face-to-face verbal exchange of key patient information between EMS personnel and ED medical personnel provided that is presumed to indicate transfer of patient care.~~

~~**Written EMS Report:** The written report supplied to ED medical personnel that details patient assessment and care that was provided by EMS personnel.~~
~~**Ambulance Stacking:** Three or more ambulances with wall times greater than 30 minutes at a single facility.~~

~~**County of San Diego, Emergency Medical Services (CoSD EMS) Duty Officer:** Paramedic or Registered Nurse (RN) employed with CoSD EMS who provides 24/7 point of contact and support for prehospital, hospital, and disaster related activities. CoSD EMS Duty Officers respond to events and situations having potential or actual impact on the ability to provide medical response in the County of San Diego.~~

~~**ED Bypass:** Diversion of non-emergency ambulance transports to the next closest facility with the exception of medical home transports.~~

~~**Extended Offload Delay:** One or more ambulance(s) with wall times greater than 60 minutes at a single facility.~~

~~**Medical Home Transport:** Base Hospital Mobile Intensive Care Nurse (MICN) and CoSD EMS prehospital personnel ensure that the ambulance patient will be transported to their requested facility and/or to the hospital where the patient normally receives medical care.~~

~~**Optimal Transfer of Care:** TOC between 9-1-1 ambulance providers and ED personnel in 30 minutes or less.~~

~~**Wall Time:** The time interval between ambulance arrival on hospital grounds and TOC. It is also known as Offload Time.~~

IV. POLICY

A. All ambulance patient care transfers to receiving facility staff shall maintain a patient-centered focus.

B. EMS personnel are required to complete formal transfer of care.

C. Receiving facility personnel are required to document via the ePCR receiving facility signature when transfer of care is executed.

D. EMS personnel and EDreceiving facility medical personnel shall ensure there is no interruption or delay in patient care while waiting for a formal transfer of care. All patient care by EMS personnel shall be documented according to CoSD EMS policies.

A. **APOT Standard**

Receiving hospitals have a responsibility to ensure policies and processes are in place that facilitates the rapid and appropriate transfer of patient care from EMS personnel to the ED medical personnel within 30 minutes of arrival at the ED. This standard will be measured and reported at the 90th percentile (see APOT Calculations and Reporting).

Acute care hospital EDs receiving 9-1-1 transported patients shall be prepared to receive patients from ambulance providers and accept care of patients up arrival.

The patient transfer of care performance expectation for CoSD EMS is 30 minutes or less.

A. EMS personnel and ED medical personnel shall ensure there is no interruption or delay in patient care while waiting for a formal transfer of care. All patient care by EMS personnel shall be documented according to CoSD EMS policies.

B. **Transfer of Care**

TOC EMS personnel are required to complete a formal transfer of care. Receiving hospital ED medical personnel should make every attempt to accept a verbal patient report and offload the patient at the earliest possible time, not to exceed the APOT standard. Transfer of care will be noted whenis completed once:

1. The patient is removed from the ambulance gurney and transferred to an emergency department gurney, bed, chair, or other acceptable location.transferred to the ED gurney, bed, chair, or other acceptable location.
2. EMS personnel provide a face-to-face verbal patient report[3] (refer to CoSD EMS Policy S-601 "Documentation Standards and Transferral of Prehospital Care Record (PCR) Information") to the accepting ED Nurse or PhysicianED medical personnel.

[3] Refer to CoSD EMS Policy S-601 "Documentation Standards and Transferral of Prehospital Care Record (PCR) Information"

Accepting ED Nurse or PhysicianED medical personnel signs the electronic PCR.

The signature shall be collected when physical transfer of the patient occurs and the verbal patient report is given.

a. The signature timestamp shall indicate Clock Stop.

3. Accepting ED Nurse or Physician pushes the TOC button within the FirstWatch® TOC application which resides on the Advanced Life Support (ALS) Transporting Unit's mobile device (refer to CoSD EMS Policy S-610A "Transfer of Care Procedure").

TOC is not considered complete until all four steps are completed.

This period includes EMS personnel patient care face-to-face verbal report to the accepting ED Nurse or Physician but does not include PCR completion or ambulance turnaround time by EMS personnel.

APOT Data Collection

EMS personnel shall accurately record clock stop on the ambulance service provider's electronic PCR.

E. APOT Calculations and Reporting

1. Transfer of care standard is within 30 minutes of arrival at the receiving facility.
2. This standard will be measured and reported at the 90th percentile.
3. The California EMS Authority will calculate, validate, and report APOT data using information provided by the LEMSA to CEMSIS.

The California EMS Authority, using an audit tool(s) to improve the data accuracy of transfer of care, will calculate APOT with validation from hospitals and CoSD EMS.

The California EMS Authority shall monitor monthly APOT data for each hospital required to report under Health and Safety Code Section 1797.120.5.

The California EMS Authority will report APOT time exceedance to CoSD EMS.

CoSD EMS may measure additional time intervals. These metrics will be publicly available through an online dashboard on the CoSD EMS webpage.

Criteria for Quality Assurance Follow-up

APOD concerns will be evaluated by the existing EMS quality assurance/quality improvement process. Triggers for specific quality assurance or quality improvement actions include, but are not limited to:

Occurrence of extended APOD, for example, more than one hour (APOT 2)

Occurrence of APOD with the patient decompensating or worsening in condition

Occurrence of APOD with an associated patient complaint

Facility or system performance below established fractile for compliance with the APOT standard

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

V. PROCEDURES

EMS Provider Personnel Responsibilities

EMS provider will notify the MICN of their estimated time of arrival once patient destination has been established via radio.

EMS personnel shall provide continuity of treatments upon arrival at the ED which typically may involve oxygen, intravenous fluids, cardiac monitoring, and nebulizer treatments which have been started prior to the patient arrival in the ED.

If a change in patient condition or other situation arises in which EMS personnel believes additional care is required, EMS personnel shall immediately notify appropriate ED medical personnel.

EMS personnel will make face-to-face contact with the ED supervisory staff regarding ED bed availability timing and to inquire for potential offload delayAPOD reason to input into FirstWatch® when wall times reach 20 minutes..

EMS personnel will notify their EMS supervisor when wall offload times exceed the APOT standard are greater than 30 minutes and they have not received satisfactory resolution from ED supervisory staff.

EMS supervisor, once notified by EMS personnel, will make contact withcontact the ED supervisory staff to communicate urgent need to release ambulance resources.

The CoSD EMS Duty Officer will be notified for an APOD exceeding 120 minutes that cannot be resolved at the EMS/ED medical personnel supervisory level. The CoSD EMS Duty Officer will intervene where possible. Additional issues related to transfer of care can be reported through an online form on the CoSD EMS webpage. CoSD EMS will review all reports and follow-up accordinglywill be notified if offload delays cannot be resolved at the EMS personnel and ED supervisory level and will intervene if and where possible.

Receiving ED Hospital Responsibilities

The hospital's responsibility for the care of the patient begins when the ambulance arrives on the hospital grounds and requires an initial assessment of the patient without delayReceiving hospitals should implement processes for ED medical personnel to promptly triage and provide the appropriate emergency medical care for patients upon arrival to the ED by ambulance.

ED personnel shall provide ongoing care beyond oxygen and intravenous fluids once the patient has arrived in the ED.

ED supervisory staff will ensure Hospitalhospital/ED administration is notified of periods of high ED demand associated with offload delayAPOD situations.

ED medical personnel will work with EMS personnel and/or EMS supervisor to assure optimal TOCtransfer of care and, resolve instances of offload delays and/or extended offload delays and assist with providing offload delay reason for input into FirstWatch®APOD.

During periods of high ED demand associated with offload delay APOD situations, the hospital shall activate internal protocols and procedures for ED and hospital capacity.

~~Internal hospital communication with situational awareness must include the on-call hospital Administrator~~administrator~~.~~

~~**CoSD EMS Responsibilities**~~

~~CoSD EMS Duty Officer will receive automatic alerts via FirstWatch® when offload delay triggers are met and will respond per offload delay algorithm direction.~~

~~Provide hospital administration, prehospital agencies, and ED leadership with TOC reports.~~

~~Monitor offload delay occurrences and percentages to collaboratively assist hospitals in improving EMS TOC delays and issues.~~

~~Provide hospital TOC reports to EMS Authority for required EMS data performance measures.~~

~~**ATTACHMENTS**~~

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

I. PURPOSE

A. To ensure appropriate, timely, and patient-centered care transition from EMS personnel to receiving facility medical personnel.

B. To establish standard ambulance patient offload time standards, as these are essential to public safety.

C. To declare that timely ambulance patient offloads are in the best interests of the patient, the EMS delivery system, and the public's health and safety.

D. To support the statewide standard methodology for calculating, verifying, and reporting ambulance patient offload time as defined in Health and Safety Code 1797.120.5 and developed by the California EMS Authority.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.120, 1797.120.5, 1797.120.6, 1797.120.7, and 1797.123.

III. DEFINITION(S)

Ambulance Patient Offload Delay (APOD): The occurrence of a patient remaining on the ambulance gurney and/or the receiving facility staff has not assumed patient care beyond the Local EMS Agency-approved APOT standard of 30 minutes.

Ambulance Patient Offload Time (APOT): The time interval between the arrival of an ambulance patient at an receiving facility and the time the patient is transferred to the receiving facility gurney, bed, chair or other acceptable location and the receiving facility staff assumes patient care.

IV. POLICY

A. All ambulance patient care transfers to receiving facility staff shall maintain a patient-centered focus.

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION

DRAFT

B. EMS personnel are required to complete formal transfer of care.

C. Receiving facility personnel are required to document via the ePCR receiving facility signature when transfer of care is executed.

D. EMS personnel and receiving facility medical personnel shall ensure there is no interruption or delay in patient care while waiting for a formal transfer of care. All patient care by EMS personnel shall be documented according to CoSD EMS policies.

E. APOT Calculations and Reporting

1. Transfer of care standard is within 30 minutes of arrival at the receiving facility.
2. This standard will be measured and reported at the 90th percentile.
3. The California EMS Authority will calculate, validate, and report APOT data using information provided by the LEMSA to CEMSIS.

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

I. PURPOSE

To define the process and procedure for designating a Trauma Center.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798.164 and 1798.165.

III. POLICY

A. The need for additional designated Trauma Centers shall be assessed by the County of San Diego (CoSD), Emergency Medical Services (EMS). This assessment will include but not be limited to:

1. Geographic locations
2. Prehospital transport times
3. Projected trauma patient volume
4. Projected population growth for trauma catchment
5. Current system impact
6. Hospital services available for trauma care
7. Pre-Hospital hospital out of service/out of district times

B. CoSD Board of Supervisors designates all trauma centers, including their designated levels. A new trauma center may receive a temporary designation from the CoSD BOS, for a specified period of time, until a verification survey by the American College of Surgeons (ACS), Committee on Trauma can be obtained. **A temporary designation will not exceed a two yeartwo-year period.**

C. Each Trauma Center shall pay the designation fee annually as described in County Administrative Code Section 254 370 and approved by the Board of Supervisors.

D. Each Trauma Center shall meet the criteria set forth in the Trauma Center Statement of Work and demonstrate a continuous ability and commitment to comply with policies, procedures, and protocols developed by CoSD EMS.

DRAFT

E. Each Trauma Center shall undergo ongoing performance evaluations based upon the Trauma Center Statement of Work. A full verification review will be done every ~~3~~ three years. Results of the evaluation shall be made available to the trauma center.

F. All designated Trauma Centers shall participate in a performance improvement process per the CoSD Quality Assurance Plan.

IV. PROCEDURE

Management of County identified need for additional trauma centers

A. If the CoSD EMS determines there is a need for an additional trauma center, EMS will develop and distribute a Request for Proposal (RFP) for Trauma Center Designation.

B. The RFP process will follow established county guidelines.
1. Trauma Center level designation will not exceed the verified level awarded by the American College of Surgeons

C. CoSD trauma centers will not advertise their level to be anything different than the County designated level.

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.

I. PURPOSE

To define the process and procedure for designating a Trauma Center.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798.164 and 1798.165.

III. POLICY

A. The need for additional designated Trauma Centers shall be assessed by the County of San Diego (CoSD), Emergency Medical Services (EMS). This assessment will include but not be limited to:

1. Geographic locations
2. Prehospital transport times
3. Projected trauma patient volume
4. Projected population growth for trauma catchment
5. Current system impact
6. Hospital services available for trauma care
7. Pre-hospital out of service/out of district times

B. CoSD Board of Supervisors designates all trauma centers, including their designated levels. A new trauma center may receive a temporary designation from the CoSD BOS, for a specified period of time, until a verification survey by the American College of Surgeons (ACS), Committee on Trauma can be obtained. **A temporary designation will not exceed a two-year period.**

C. Each Trauma Center shall pay the designation fee annually as described in County Administrative Code Section 370 and approved by the Board of Supervisors.

D. Each Trauma Center shall meet the criteria set forth in the Trauma Center Statement of Work and demonstrate a continuous ability and commitment to comply with policies, procedures, and protocols developed by CoSD EMS.

DRAFT

E. Each Trauma Center shall undergo ongoing performance evaluations based upon the Trauma Center Statement of Work. A full verification review will be done every three years. Results of the evaluation shall be made available to the trauma center.

F. All designated Trauma Centers shall participate in a performance improvement process per the CoSD Quality Assurance Plan.

IV. PROCEDURE

Management of County identified need for additional trauma centers

A. If the CoSD EMS determines there is a need for an additional trauma center, EMS will develop and distribute a Request for Proposal (RFP) for Trauma Center Designation.

B. The RFP process will follow established county guidelines.

1. Trauma Center level designation will not exceed the verified level awarded by the American College of Surgeons

C. CoSD trauma centers will not advertise their level to be anything different than the County designated level.

DISCLAIMER: PRINTED COPIES ARE FOR REFERENCE ONLY. PLEASE REFER TO THE ELECTRONIC COPY FOR THE LATEST VERSION.