VERONICA KELLEY, DSW, LCSW
AGENCY DIRECTOR

LORRAINE DANIEL, MPA
ASSISTANT AGENCY DIRECTOR

MINDY WINTERSWYK, DPT, PCS
DIRECTOR OF SPECIALIZED MEDICAL SERVICES

MIKE NOONE, NRP
EMERGENCY MEDICAL SERVICES
ASSISTANT DIRECTOR

405 W. 5th STREET, SUITE 301-A
SANTA ANA, CA 92701
PHONE: 714-834-5032
FAX: 714-834-3125
Email: mnoone@ochca.com

# SPECIALIZED MEDICAL SERVICES
# EMERGENCY MEDICAL SERVICES

**DATE:** October 20, 2025

**TO:** Base Hospital Coordinators
ERC Medical Directors
911 Provider EMS Coordinators/Managers
IFT-ALS Nurse Coordinators
Paramedic Training Centers
BLS Ambulance Providers

**FROM:** Carl H. Schultz, MD
EMS Medical Director
Orange County Health Care Agency

CHS.

**SUBJECT:** **NEW AND UPDATED EMS POLICIES, PROCEDURES, AND STANDING ORDERS**

Typically, the Orange County EMS Agency reviews, updates, and edits its policies, procedures, and standing orders on a biannual basis. New policies may also be added. It is now time to publish our next scheduled update. I am listing, immediately below, the documents that will be added to the Upcoming section of our website (https://www.ochealthinfo.com/ems). Usually, these are optional for 6 months to permit training. This time, there are two policies that will take effect immediately due to data reporting requirements and regulatory impact. These are policies #100.10 and #300.50.

## OCTOBER 1, 2025 EMS UPDATES TO EXISTING DOCUMENTS FOR IMMEDIATE IMPLEMENTATION

POLICIES

100.30 Emergency Medical Care Committee Bylaws: Outdated information was removed from the policy and corrected language was added. These referred to the address of the committee (405 W. 5th Street to 8300 Marine Way) and updating the names for all the subcommittees.

300.50 Emergency Receiving/Specialty Center Data Reporting Criteria: Language changes were made to update the policy as new requirements around data reporting now exist. The following statements represent these changes:

- Added language related to management and maintenance of recently implemented Bi-Directional Data Exchange.
- Added clarification regarding submission of Hospital Discharge Data Summaries (HDDS) by ERCs.
- Added clarification of training requirements for Trauma Registrars.
- Edited language related to stroke data submissions to be consistent with California regulations and newly implemented OC Stroke Registry.
- Edited language related to cardiovascular and Comprehensive Children's Emergency Receiving Center (CCERC) data submissions to be consistent with California regulations.

For the remaining documents, implementation will be optional until April 1, 20256 when they become mandatory.

**OCTOBER 1, 2025 EMS UPDATES TO EXISTING DOCUMENTS, EFFECTIVE APRIL 1, 2026**

POLICIES

325.00 Advanced Life Support (ALS) Provider Unit Minimum Inventory: Under Section V, required equipment, OCEMS has added Continuous Positive Airway Pressure device (CPAP) for pediatric and adult patients. In addition, ketamine has been added to Section VII Pharmaceutical Inventory.

900.00 Multi-Casualty Incident Response Plan: Language has been changed to Sections IV.E.4. thru 6. and F.to more accurately reflect how patients are managed and how/what information is collected. For Section IV.F under ALS Providers:, numbers 2-5 have been modified or added. For BLS Providers: in this same section, numbers 1-3 have been modified or added.

STANDING ORDERS:

SO-C-40 Wide QRS complex Tachycardia with a Pulse – Adult/Adolescent: Additional language has been added to clarify the need to use synchronized cardioversion when administering electric shocks. Also, the time required to allow drug therapy to have an effect before initiating cardioversion was modified so no more than 2-3 minutes should expire before moving on to cardioversion.

SO-M-30 Psychiatric/Behavioral Emergencies-Adult/Adolescent: Under Item 7., the dose for IM/IN midazolam for those under age 65 is increased to 10 mg as a one-time administration. In addition, an IV dose is added in the unlikely event that an IV can be established. Also, a reduced initial dose of IM/IN midazolam has been added for those patients 65 and older, as they are more sensitive to the respiratory depressant effects of midazolam.

SO-M-35 Respiratory Distress – Adult/Adolescent: The option of making BH contact is added for authorization to give IM epinephrine to patients with an acute exacerbation of asthma or COPD that are not responding to continuous nebulized albuterol.

SO-P-35 Acute Respiratory Distress – Pediatric: The option of making BH contact is added for authorization to give IM epinephrine to patients with an acute exacerbation of asthma that are not responding to continuous nebulized albuterol.

SO-P-70 Psychiatric/Behavioral Emergencies – Pediatric: Under Item 7., the dose for IM/IN midazolam is increased to 0.2 mg/kg IM/IN with a maximum dose of 10 mg as a one-time administration.

SO-P-120 Pre-existing Endotracheal Intubation Requiring Sedation – Pediatric: This is a new standing order. It addresses the situation when an IFT is in progress with an intubated pediatric patient who becomes agitated and starts struggling. This risks loss of the ET tube and ability to control the airway. The standing order authorizes the transporting paramedics to administer midazolam 0.1 mg/kg IV/IO/IM one time with a maximum dose of 5 mg if the blood pressure is above 80 mmHg. If the blood pressure drops after administering midazolam, a 20 mL/kg bolus is authorized. After administering the midazolam, paramedics need to notify the base hospital (CCERC preferred) that sedation was required.

PROCEDURES:

PR-70 Ketamine Analgesia: This is a new procedure that authorizes the use of ketamine as an option for pain management. It can be administered IV, IM,or IN. Doses vary by the route of administration. It is indicated when fentanyl is refused or contraindicated. It is not as effective as fentanyl for pain relief so should be considered a second-choice option unless fentanyl can't be given.

PR-110 Transcutaneous Pacing (TCP): This procedure has been modified to designate an initial dose of atropine IV as a first priority before moving on to TCP. If the first dose of atropine is ineffective, treating paramedics should implement TCP while continuing to administer atropine. In addition, if paramedics encounter difficulty with establishing an IV, further delay should be avoided, and TCP should be initiated before further attempts at IV placement.

CS:em#5624