Public Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Agenda	June 12, 2012 9:30 a.m.

I.	**Introductions**		
II.	**Approve Agenda**		
III.	**Minutes**		
IV.	**Medical Issues**		
	A.	Stroke System	
	B.	CPR Audit	
	C.	Policy 705.07:	Cardiac Arrest Asystole & PEA
	D.	Other	
V.	**New Business**		
	A.	Policy 1135:	Paramedic Program Approval Process – C. Rosa
	B.	Policy 717:	Intraosseous Infusion – C. Rosa
	C.	Policy 606:	Withholding or Termination of Resuscitation and DOD – C. Rosa
	D.	Policy 1000:	Documentation
	E.	Other	
VI	**Old Business**		
	A.	Sidewalk CPR Report – S. Carroll	
	B,	PSC Chairperson Election	
	C.	Policy 410:	ALS Base Hospital Approval Process
	D.	Policy 420:	Receiving Hospital Standards
	E.	Policy 732:	Restraints – C. Rosa
	F.	Other	
VII.	**Informational/Discussion Topics**		
	A.	Continuing Education Certificates	
	B.	Policy 112:	Ambulance Rates
	C.	Cardiac Arrest Management (ART/BART)	
	D.	Other	
VIII.	**Policies for Review**		
	A.	Policy 705.21:	Shortness of Breath – Pulmonary Edema
	B.	Policy 705.23:	Supraventricular Tachycardia
	C.	Policy 705.24:	Symptomatic Bradycardia
	D.	Policy 705.01:	Trauma Treatment Guidelines
	E.	Policy 705.06:	Burns
	F.	Policy 731:	Tourniquet Use
	G.	Policy 705.11:	Crush Injury/Syndrome
	H.	Policy 1001:	Paramedic/BH Communication Record
	I.	Policy 105:	PSC Operating Guidelines
	J.	Policy 106:	Development of Proposed Policies/Procedures
	K	Policy 440:	Code STEMI Interfacility Transfer
	L.	Other	
IX.	**Reports**		
	TAG Report		
X.	**Agency Reports**		
	A.	ALS Providers	
	B.	BLS Providers	
	C.	Base Hospitals	
	D.	Receiving Hospitals	
	E.	ALS Education Programs	
	F.	EMS Agency	
	G.	Other	
XI.	**Closing**		

TEMPORARY
PARKING PASS
Expires July 12, 2012

Health Care Services
2240 E. Gonzales Rd
Oxnard, CA 93036

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2240 Gonzales Rd. location
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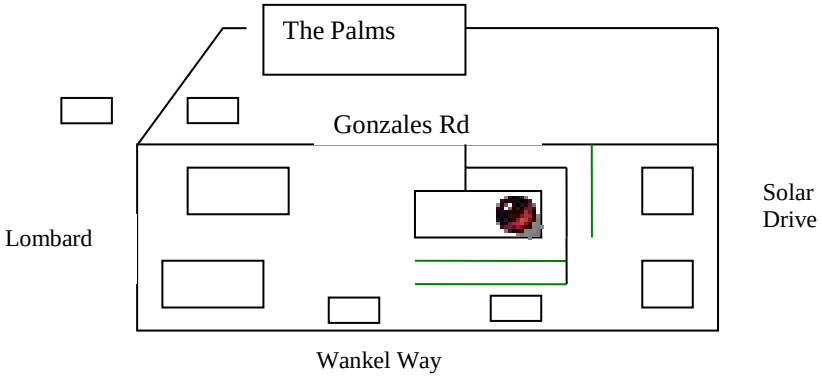
2100 Solar Drive
An additional amount of "Green Permit Parking" spaces (only 30) are available in adjacent parking lot, those that back-up against venue parking area, (Enter this parking lot off of Gonzales[3rd driveway] or Solar Drive). **Place this flyer on your dash.** If all of those stalls are occupied, overflow parking is available at The Palms shopping area or side streets.

The Palms - shopping mall
Enter The Palms at Lombard and Gonzales. Allow for a ten minute walk to venue location.

Additional parking is available on side streets, Lombard, Solar and Wankel Way.



Public Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Minutes	April 12, 2012 9:30 a.m.

Topic	Discussion	Action	Assigned
I. Introductions	Meeting was called to order at 9:35 a.m. AMR introduced Mike Taigman who is taking Gil Glass position with the company. Gil is moving to Seattle where family is located. LRHMC - Matt Beatty was introduced as the new PLP and PSC representative. The committee introduced themselves.		
II. Approve Agenda	It was M/S/C (M. Mundell/J. Winter) to approve the Agenda as submitted.		
III. Minutes	D. Chase – Correction to minutes • Under study 1, 5th bullet change to "but possibly at the cost of decreased cerebral perfusion." • Study 2 - 3rd bullet change epiglottic to supraglottic. • 7th bullet change to the higher the cuff pressure the worse the effect.	It was M/S/C (R. Shedlosky/M. Merman) to approve the minutes with corrections	
IV. Medical Issues			
A. Stroke Discussion	• August introduced launch of countywide stroke program with a start date of Dec 1. EMS met with all of the hospital administrators in the hope that they will all proceed with designation. • 705 protocols will be developed. • There has been some forward motion with the designations: o LR is a stoke center already o CMH and SJRMC have a survey arranged, o SVH is in committee at this point. • Happy to have hospitals on board and education will be forthcoming. • Probably follow model of STEMI and Trauma. • Primary and comprehensive are the designations and we are asking our hospitals to become a primary stroke center. • If a hospital is not a designated stroke center, EMS will be developing diversion criteria for stroke patients		
B. 705.09: Chest Pain – Acute Coronary Syndrome		The policy was approved as submitted.	Approved
C. CPR Audit	It has been 6 months since Sterling Johnson performed the random audit.		

Topic	Discussion	Action	Assigned
	The audit did not test to American Heart Association guidelines. Next month we will sample 10% of EMT and paramedics to perform to the 2010 guidelines. This will be the third audit done in the county. Need to be at least 100 compressions per minute. The providers asked to please call before coming to the stations. This will ensure a crew is available. A call will be made the morning of the audit. Would like to present the data at the ECC in Orlando in June.		
D. Other			
V. New Business			
A. Policy 504: BLS And ALS Unit Equipment And Supplies	• Per a discussion that started at the TAC committee, blood tubing will be removed from all rigs. The tubing is not compatible with hospital tubing • Amp vs vial changed. • 3 of 5 typo tongue depressor • Life vest – remove • Ondansetron – don't blow tablet remove • Lasix changed to Furosemide will be considered for removal as protocols will have to be adjusted. Deletion discussion will occur before deletion • Page 5 of 5 air ambulance items removed. • Benadryl change to generic. 705 policies will have to be changed. Eventually change to generic as they come up for review • Normal saline change to 10 ml remove multi dose vial	Change all the brand name to generic. Put brand name in () for a time.	Approved with changes
B. Policy 705.14: Hypovolemic Shock	Remove first line evaluation… Add place patient supine Normal saline strike consider in both sections	Training bulletin will be completed. It was M/S/C (C. Panke/J. Winter) to approve the policy	Approved

Topic		Discussion	Action	Assigned
C.	Policy 1404: Emergent/Urgent Transfer.	Code Trauma cause confusion. 1407 has been moved into 1404 and 1407 will be deleted. Level of transfer will be emergent or urgent. VCMC has a hotline number for trauma. IN a few weeks Katy will be contact all ER to explain the process with staff Emergent and Urgent page will both be bold. This may not be appropriate for the non transport providers.	Flow sheet will go into effect on May 1, 2012. This will be part of EMS Update. Hospitals responsible to training their staff. It was MSC (T. Larson/K. McShea) to approve the policy as submitted.	Approved for May 1, 2012 implementation.
D.	Policy 1407:Emergency Trauma Transfer – for deletion	Information moved to 1404	It was MSC (T. Larson/K. McShea) to approve the policy as submitted.	Approved for deletion
E.	PSC Chairperson Election	Just a reminder, please forward nomination to Dede Utley, N. Merman, Steve frank. Elections will be next month		
F.	Other	Tourniquet – how many uses and what was satisfaction. VNC – few uses, Using Matt. Good input, no complications LMT used one time. Easy to use and train. Use Matt OFD – two uses, works well. No issues in follow up. Good so far. Tourniquet policy, no requirements regarding width, etc. Up to provider to decide on brand etc.		
VI	**Old Business**			
A.	Sidewalk CPR	AHA sponsoring statewide community outreach event. VC joining other Counties in this event. 5-6 minute instruction per person. Education in compressions only SB and San Mateo have done this and challenged other counties to exceed their numbers. EMS is looking at high traffic areas to hold the event. In the near future will be contacting providers to man booths. June 7 is the event date. Bundles of information will be distributed to those who participate. Looking for all hospitals and providers to participate in this event and sponsor sites in their city. We would like to proceed with this on a quarterly basis and can make a difference in our outcomes.		Please forward Stephanie your contact person for each provider.

Topic	Discussion	Action	Assigned
	Weekdays allows providers more staffing. Down the road may look at a weekend. Need a contact person from each provider, meeting later in the month. Looking for firm commitment from providers and hospitals to staff the booths. Need commitment from all providers. SB had 3-10 mannequins at each site and instructors were 2-3 instructors per site.. Everyone seems to be on board at the locations, some technical bugs to work out. Possibly look at the school districts Need Spanish speaking instructors		
B. Other			
VII. Informational Topics			
A. Other			
VIII. Policies for Review			
A. Policy 410: ALS Base Hospital Approval Process	Page 4 of 5 of minutes. Language with BH MD being PLP. No comments were sent to Stephanie for update 6H possible removal.		Tabled for next meeting
B. Other			
IX. Reports			
TAG Report	Cardiac management pit crew will be looked at. 3 groups formed. Trauma report was given by Katy Spinal immobilization is being reviewed New chair for committee this is Robin Shedlosky		
X. Agency Reports			
A. ALS Providers	• VNC – o The new fire chief is Mark Lorenzen. There will be a new deputy in the future. o Hospital assistance for ePCR offered for assistance with staff training by service administrators at VNC. Contact Norm or Robin if you would like to arrange training. o VNC is still some connection issues with PCR. • VCFD – o Chief Rennie has announced his retirement for June 15. o Have four new firefighters in the field who recently completed the		

Topic	Discussion	Action	Assigned
	academy. • SAR. Carl Patterson has returned to the Air Unit. Hungry Valley, Oct 26 2010 auto to delay, auto 68 dispatches, only 16 flights now. Majority were requested for medivac. Specific incidences requested to EMS. Concern if there is a delay of 20-30 minutes. Incident # to EMS for analysis • LMT – April 1, CCT became fully functional with 24 hour coverage. Contact Jeff Winter for additional information.		
B. BLS Providers			
C. Base Hospitals	• LRHMC - Still working on e-PCR implementation. Next week offering a two day pediatric course • SVH Still working on ePCR implementation. May 4 offering a lecture from Grossman Burn Center • SJ – epcr still working on. Hosp dashboard is up withing the ER. Actively training doctors. 50-80% of staff trained. VCMC dr being trained. MD are logging at system in to review patient chart. Some lag in posting information from the field. Dashboard has HIPAA information and may not be posted on a wall because of violations. Dr are logging into the system for review of charts. VNC service administrationr are reviewing to ensure transfer of the call KM ty for MICN course		
D. Receiving Hospitals	CMH still in middle of construction. Borchard is now open but no ER interest. If issue getting into the department, please let Cheryl know. Sandy – turn around will be closed. Roof repair will be done		
E. ALS Education Programs	Student isn field. Great experience. A lot of intubation. NR scheduled to May 1 and graduation May 18.		
F. EMS Agency	11:10		
G. Other			
XI. Closing			

Prehospital Services Committee 2012

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/12/2012	2/9/2012	03/08\12	4/12/2012	5/10/2012	6/14/2012	7/12/2012	8/9/2012	9/13/2012	10/11/2012	11/8/2012	12/13/2012	%
AMR															
AMR	Panke	Chad		CP		CP									
CMH - ER	Canby	Neil		NC											
CMH - ER	Cobb	Cheryl		CC		CC									
FFD	Herrera	Bill		BH											
FFD	Scott	Bob		BS											
GCA	Norton	Tony		TN		TN									
GCA	Stillwagon	Mike		MS		MS									
Lifeline	Kuroda	Brian		BK		BK									
Lifeline	Winter	Jeff		JW		JW									
LRRMC - ER	Beatty	Matt				MB									
LRRMC - ER	Licht	Debbie		DL		DL									
OFD	Carroll	Scott		SC											
OFD	Huhn	Stephanie		SPH		SPH									
OVCH	Boynton	Stephanie		SB		SB									
OVCH	Patterson	Betsy		BP		BP									
SJPVH	Hernandez	Sandi		SH		SH									
SJPVH	Davies	Jeff													
SJRMC	McShea	Kathy		KM		KM									
SJRMC - SJPVH	Larsen	Todd		TL		TL									
SPFD	Dowd	Andrew				AD									
SVH - ER	Tilles	Ira		IT		IT									
SVH - ER	Hoffman	Jennie		JH		JH									
V/College	Mundell	Meredith		MM		MM									
VCFD	Merman	Nancy		NM		NM									
VCFD	Tapking	Aaron		AT		AT									
VNC	Plott	Norm		NP		NP									
VNC	Black	Shannon		SB											
VNC	Shedlosky	Robin		RS		RS									
VCMC - ER	Chase	David		DC		DC									
VCMC - ER	Utley	Dede		DU		DU									
VCMC-SPH	Daucett	Michelle				MD									
VCMC-SPH	Beatty	Karen		KB		KB									
VCSO SAR	Hadland	Don		DH		DH									

Agency	LastName	FirstName	1/12/2012	2/9/2012	03/08\12	4/12/2012	5/10/2012	6/14/2012	7/12/2012	8/9/2012	9/13/2012	10/11/2012	11/8/2012	12/13/2012	%
VCSO SAR	White	Don		DW		DW									
VFF	Rhoden	Crystal		CR											
VFF	Jones	Brad													
Eligible to Vote	**Date Change/cancelled - not counted against member for attendance**														
Non Voting Members															
EMS	Carroll	Steve		SC		SC									
AMR	Drehsen	Charles		CD		CD									
VCMC	Duncan	Thomas		TD											
EMS	Fisher	Barry													
LMT	Frank	Steve		SF		SF									
EMS	Hadduck	Katy		KH		KH									
EMS	Haney	Debora				DH									
EMS	Lara-Jenkins	Stephanie		SLJ		SLJ									
EMS	Rosa	Chris		CR		CR									
EMS	Salvucci	Angelo				AS									
SAR	Askew	Chris													
CSUDA	Parker	Pilar													
OFD	Donabedian	Chris													
VNC	Komins	Mark		MK		MK									
AMR	Glass	Gil		GG											
VNC	Gregson	Erica		EG		KD									
AMR	Taigman	Mike				MT									

Cardiac Arrest – Asystole/Pulseless Electrical Activity (PEA)

ADULT	PEDIATRIC
BLS Procedures	
If collapse before dispatch, complete 5 cycles (2 minutes) of CPR, then attach AED If witnessed, immediately attach AED Airway management per VCEMS policy	If collapse before dispatch, complete 5 cycles (2 minutes) of CPR, then attach AED If witnessed, immediately attach AED Airway management per VCEMS policy
ALS Prior to Base Hospital Contact	
Assess/treat causes IV/IO access **Epinephrine** • IV/IO – **1:10,000**: 1 mg (10 mL) q 3-5 min If suspected hypovolemia: • **Normal Saline** o IV/IO bolus – 1 Liter ALS Airway Management • If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures	Assess/treat causes IV/IO access **Epinephrine 1:10,000** • IV/IO – 0.01mg/kg (0.1 mL/kg) q 3-5 min If suspected hypovolemia: • **Normal Saline** o IV/IO bolus – 20 mL/kg • Repeat x 2 ALS Airway Management • If unable to ventilate by BLS measures, initiate appropriate advanced airway procedures Make early Base Hospital contact for all pediatric cardiac arrests
Base Hospital Orders only	
Tricyclic Antidepressant Overdose • **Sodium Bicarbonate** o IV/IO – 1 mEq/kg • Repeat 0.5 mEq/kg q 5 min Beta Blocker Overdose • **Glucagon** o IV/IO – 2 mg • May give up to 10mg if available Calcium Channel Blocker Overdose • **Calcium Chloride** o IV/IO – 1 gm • Repeat x 1 in 10 min • **Glucagon** o IV/IO – 2 mg • May give up to 10mg if available History of Renal Failure/Dialysis • **Sodium Bicarbonate** o IV/IO – 1 mEq/kg • Repeat 0.5 mEq/kg q 5 min • **Calcium Chloride** o IV/IO – 1 gm • Repeat x 1 in 10 min	Tricyclic Antidepressant Overdose • **Sodium Bicarbonate** o IV/IO – 1 mEq/kg • Repeat 0.5 mEq/kg q 5 min Beta Blocker Overdose • **Glucagon** o IV/IO – 0.1 mg/kg • May give up to 10mg if available Calcium Channel Blocker Overdose • **Calcium Chloride** o IV/IO – 20 mg/kg • Repeat x 1 in 10 min • **Glucagon** o IV/IO – 0.1 mg/kg • May give up to 10mg if available History of Renal Failure/Dialysis • **Sodium Bicarbonate** o IV/IO – 1 mEq/kg • Repeat 0.5 mEq/kg q 5 min • **Calcium Chloride** o IV/IO – 20 mg/kg • Repeat x 1 in 10 min
Consult with ED Physician for further treatment measures	**Consult with ED Physician for further treatment measures**

Additional Information :

- If sustained ROSC (> 30 seconds), perform 12-lead EKG. ~~Consult base hospital for destination determination~~Transport to SRC.
- If suspected hypovolemia, initiate immediate transport
- In cases of normothermic cardiac arrest patients 18 years and older with unwitnessed cardiac arrest, adequate ventilations, vascular access, and persistent asystole or PEA despite 20 minutes of standard advanced cardiac life support, the base hospital should consider termination of resuscitation in the field. If transported, the patient may be transported Code II. If unable to contact the base hospital, resuscitative efforts may be discontinued and patient determined to be dead.
- If patient is **hypothermic** – only ONE round of medication administration prior to Base Hospital contact. Field determination of death is discouraged in these patients and they should be transported to the most accessible receiving facility.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Paramedic Training Program Approval	Policy Number 1135
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: June 9, 2011
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: June 9, 2011
Origination Date: October 20, 1993 Date Revised: June 9, 2011 Date Last Reviewed: June 9, 2011 Next Review Date: June, 2014	Effective Date: June 9, 2011

I. PURPOSE: To define the procedure to be followed when applying for approval for a paramedic training program in Ventura County.

II AUTHORITY: Health and Safety Code Sections 1797.172, 1797.178, 1797.200, 1797,202, 1797.204, 1797.208, 1797.220, 1798 and 1798.100. California Code of Regulations, Title 22 Division 9, Sections 100147, and 100153.

III. POLICY: The purpose of a paramedic training program shall be to prepare individuals to render prehospital advanced life support within an organized EMS system. The following procedure shall be followed when applying for approval for a paramedic training program approval.

IV. DEFINITION(S): Paramedic Approving Authority means the local EMS agency. Title 22, California Code of Regulations (CCR), Section 100137.

V. PROCEDURE:

A. Paramedic training shall be offered only by approved training programs. Eligibility for program approval shall be limited to the following institutions:

1. Accredited universities and colleges, including junior and community colleges and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private Postsecondary and Vocational Education.
2. Medical training units of a branch of the Armed Forces or Coast Guard of the United States.
3. Licensed general acute care hospitals which meet the following criteria:
   a. Hold a special permit to operate a basic or comprehensive emergency service pursuant to the provisions of Division 5,
   b. Provide continuing education to other health care professionals, and care accredited by the Joint Commission on the Accreditation of

Healthcare Organizations or the Healthcare Facilities Accreditation Program of the American Osteopathic Association.

4. Agencies of government.

B. Application for Paramedic Training Program Approval

1. Eligible training institutions shall submit a written request for paramedic training program approval to the EMS agency. A paramedic training program approving authority may deem a paramedic training program approved that has been accredited by the CAAHEP upon submission of proof of such accreditation.

2. The following materials must be submitted to the EMS agency unless CAAHEP ~~accreditation~~ accredited and approved by the EMS Agency.

a. A statement verifying that the course content is equivalent to the U.S. Department of Transportation (DOT) Emergency Medical Technician-Paramedic National Standard Curriculum HS 808 862 March 1999..

b. An outline of course objectives

c. A detailed course outline. This outline must include all curricula outlined in 22 CCR 100159 as well as all mandatory training programs specified by the local EMS agency.

d. Performance objectives for each skill.

e. The name and qualifications and duty statement of the training program course director, program medical director, and principal instructor.

f. Provisions for supervised hospital clinical training.

1) Training programs in non-hospital institutions shall enter into a written agreement with one or more licensed general acute care hospital(s), approved by the local EMS agency, which hold a permit to operate a Basic or Comprehensive Emergency Medical Service for the purpose of providing supervised clinical experience as well as clinical preceptors to instruct and evaluate the trainee. Final program approval will be withheld until such agreements are in place.

2) The training program must not enroll any more students than the program can commit to providing a clinical internship to begin no later than thirty days after a student's completion of

the didactic and skills instruction portion of the training program. The course director and a student may mutually agree to a later date for the clinical internship to begin in the event of special circumstances (e.g. student or preceptor illness or injury, student's military duty, etc).

3) The training program shall submit a sample of the clinical evaluation to be used by clinical preceptors to evaluate trainees.

4) The clinical preceptor may assign the student to another health professional for selected clinical experience. No more than two students shall be assigned to one preceptor or health professional during the supervised clinical experience at any one time. Clinical experience shall be monitored by the training program staff and shall include direct patient care responsibilities, which may include the administration of any additional medications, approved by the VCEMS medical director and the director and the director of the EMS Authority to result in competency. Clinical assignments shall include, but are not to be limited to, emergency, cardiac, surgical, obstetric and pediatric patients.

g. Provisions for supervised field internship

1) The training program shall enter into a written agreement with one or more Advanced Life Support providers, approved by the local EMS agency, for the purpose of providing supervised field internship experience as well as preceptors to instruct and evaluate the trainee. Preceptors shall meet criteria developed by the local EMS agency. Final program approval will be withheld until such agreements are in place.

2) The training program shall not enroll any more students than the training program can commit to providing a field internship to begin no later than ninety days after a student's completion of the hospital clinical education and training portion

3) The training program shall utilize the performance standards and internship evaluations developed and approved by the local EMS agency.

h. The location at which the training program is to be offered and the proposed dates as well as the number of trainees to be accepted per class.

i. A time analysis and sample schedule of each training phase (didactic, clinical, and internship).

j. Student eligibility requirements and screening process for entrance into the program.

k. Samples of instructor schedule for skills practices/laboratories.

3. Following submission and approval of the above materials, the EMS agency will review the following:

a. Samples of written and skills examinations used for periodic testing.

b. Final skills competency examination.

c. Final written examination.

d. Facilities, equipment, examination security, and student recordkeeping.

4. Training Program Staff Requirements

a. Medical Director: Each program shall have an approved program medical director who shall be a physician currently licensed in the State of California, who has two years experience in prehospital care in the last five years, and who is qualified by education or experience in methods of instruction. Duties of the program medical director shall include, but not be limited to:

1) Review and approve educational content of the program curriculum, including training objectives for the clinical and field instruction, to certify its ongoing appropriateness and medical accuracy.

2) Review and approve the quality of medical instruction, supervision, and evaluation of the students in all areas of the program.

3) Approval of provision for hospital clinical and field internship experiences.

4) Approval of principal instructors.

b. Course Director: Each program course director shall be licensed in California as a physician, a registered nurse who has a baccalaureate degree or a paramedic who has a baccalaureate degree, or shall be an individual who holds a baccalaureate degree in a related health field or in education. The course director shall be qualified by education and experience in methods, materials, and evaluation of instruction, and shall have a minimum of one year experience in an administrative or management level position and have a minimum of three years academic or clinical experience in prehospital care education within the last five years. Duties of the course director shall include, but not be limited to:

1) Administration, organization and supervision of the educational program.
2) In coordination with the program medical director, approve the principal instructor, teaching assistants, field and hospital clinical preceptors, clinical and internship assignments, and coordinate the development of curriculum including instructional objectives, and approve all methods of evaluation
3) Ensure training program compliance with this chapter and other related laws.
4) Ensure that the preceptor(s) are trained according to the curriculum in VCEMS Policy 319.

c. Principal Instructor: Each program shall have a principal instructor(s) who may also be the program medical director or course director if the qualifications in VB.2.d.1)-2) have been met who shall:

1) Be a physician, registered nurse, physician assistant, or paramedic, currently certified or licensed in the State of California
2) Have two years experience in advanced life support prehospital care and be knowledgeable in the course content of the U.S. Department of Transportation Paramedic National Standard Curriculum HS 808 862 March 1999
and

3) Have six years experience in an allied health field or related technology and an associate degree or two years experience in an allied health field or related technology and a baccalaureate degree.
4) Be responsible for areas including but not limited to curriculum development, course coordination and instruction.
5) Be qualified by education and experience in methods, materials and evaluation of instruction, which shall be documented by at least forty hours of instruction in teaching methodology. Following, but not limited to, are examples of courses that meet the required instruction in teaching methodology:
   a) California State Fire Marshall (CSFM) "Fire Instructor 1A and 1B"
   b) National Fire Academy (NFA) "Fire Service Instructional Methodology" course, and
   c) A course that meets the U.S. DOT/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors, such as the National Association of EMS Educators' EMS Education Course.

d. Teaching Assistants: Each training program may have a teaching assistant(s) who shall be an individual(s) qualified by training and experience to assist with teaching of the course. A teaching assistant shall be supervised by a principal instructor, the course director and/or the program medical director.

e. Field Preceptors: Each program shall have preceptor(s) who shall:
   1) Be a licensed paramedic and
   2) Be working in the field as a licensed paramedic for the last two years and
   3) Be under the supervision of a principal instructor, the course director and/or the program medical director.
   4) Have completed the field preceptor training approved by VCEMS (VCEMS Policy 319).

f. Hospital Clinical Preceptor(s): Each program shall have preceptor(s) who shall:

1) Be a physician, registered nurse or physician assistant currently licensed in the State of California.

2) Have worked in emergency medical care for the last two years.

3) Be under the supervision of a principal instructor, the course director, and/or the program medical director.

4) Receive instruction in evaluating paramedic students in the clinical setting and shall include how to do the following in cooperation with the paramedic training program.

(a) Evaluate a student's ability to safely administer medications and perform assessment.

(b) Document a student's performance.

(c) Assess student behaviors using cognitive, psychomotor, and affective domains.

(d) Create a positive and supportive learning environment.

(e) Identify appropriate student progress.

(f) Counsel the student who is not progressing

(g) Provide guidance and applicable procedures for dealing with an injured student or student who has had an exposure to illness, communicable disease or hazardous material

C. Program Approval/Disapproval

1. The materials submitted for program approval will be reviewed and evaluated by EMS agency staff, an educator with a medical/nursing background and who is not associated with the submitting agency, an RN who is not associated with the submitting agency, and an MD who is not associated with the submitting agency.

2. Program approval or disapproval shall be made in writing by the EMS agency to the requesting training program within a reasonable period of time after receipt of all required documentation. This time period shall not exceed three (3) months.

3. The EMS agency shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all program requirements.
4. Program approval shall be for four years following the effective date of approval and may be renewed every four years subject to the procedure for program approval specified in 22 CCR.
5. All approved programs shall be subject to periodic on-site evaluation by the EMS agency.
6. Paramedic training programs approved after January 1, 2000 shall submit their application, fee and self study to the Commission of Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP) for accreditation within 12 months of the start up of classes and receive and maintain Commission of Accreditation of Allied Health (CAAHEP) accreditation no later than two years from the date of application to CoAEMSP for accreditation in order to continue to operate as an approved paramedic training program.
   a. Paramedic training programs approved according to the provisions of this Chapter shall provide the following information to all their paramedic training program applicants prior to the applicant's enrollment in the paramedic training program:
      1) Date by which the program must submit their application and self study for initial accreditation or their application for accreditation renewal to CoAEMSP.
      2) Date by which the program must be initially accredited or have their accreditation renewal by CAAHEP.
      3) Failure of the paramedic training program to submit their application and self study or their accreditation renewal to CoAEMSP by the date specified will result in closure of the paramedic training program by the approving authority unless an approved plan for meeting compliance is provided.
      4) Failure of the program to obtain or maintain CAAHEP accreditation by the required date will result in closure of the program by the approving authority unless an approved plan for meeting compliance is provided.

5) Students graduating from a paramedic training program that fails to apply for accreditation with, receive accreditation from, or maintain accreditation with, CAAHEP by the dates required will not be eligible for state licensure as a paramedic.

b. Paramedic training programs shall submit to their respective paramedic training program approving authority all documents submitted to, and received from CoAEMSP and CAAHEP for accreditation, including but not limited to, the initial application and self study for accreditation and the documents required for maintaining accreditation.

c. Paramedic training programs shall submit to the approving authority ~~EMS A~~uthority the date their initial application was submitted to CoAEMSP and copies of documentation from CoAEMSP and/or CAAHEP verifying accreditation.

d. Approved programs shall participate in the emergency medical services system QIP.

D. Denial or Withdrawal of Program Approval

1. Noncompliance with any criteria required for program approval, use of any unqualified teaching personnel or non compliance with any other applicable provision may result in denial, probation, suspension or revocation of program approval by the approving authority.

a. A training program approving authority shall notify the approved paramedic training program course director in writing, by certified mail, of the provisions with which the training program is not in compliance.

b. Within fifteen days of receipt of the notification of noncompliance, the approved training program shall submit in writing, by certified mail to the approving authority the following:

1) Evidence of compliance or

2) A plan for meeting compliance with the provision within sixty days from the day of receipt of the notification of noncompliance

3) Within fifteen days of receipt of the response from the training program or within thirty days from the mailing date of

the non compliance notification if no response is received from the program, the approving authority shall notify the EMS Authority and the training program in writing, by certified mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend or revoke the paramedic training program approval.

4) If the approving authority decides to suspend or revoke the training program approval, the notification shall include the beginning and ending dates of the probation or suspension and the terms and conditions for lifting the probation or suspension or the effective date of the revocation, which may not be less than sixty days from the date of the paramedic training program approving authority's letter of decision to the EMS Authority and the training program.

E. Program Expansion

Approved paramedic training programs must request approval to add additional training classes or to enlarge class size. The training program must provide written confirmation guaranteeing clinical and internship placement as outlined in sections IV.B.2.e-f of this policy.

Paramedic Training Program
Application Checklist

	Check One		For County Use Only
Materials to be Submitted (in the order listed)	**Enclosed**	**To Follow**	
1. Checklist for Paramedic Training Program Approval			
2. Written request to Paramedic Approving Authority requesting approval (100153			
3. CoAEMSP/CAAHEP Accreditation (100148)			
4. Documentation of Eligibility for Program Approval (100148)			
5. Completed Application form for Program Approval (attached)			
6. Program Medical Director qualification form, and job description (10014 9(a))			
7. Program Course Director qualification form, and job description (10014 9(b))			
8. Program Principal Instructor(s) qualification form, and job description (10014 9(c))			
9. Teaching Assistant(s) (10014 9(d)) Submit Names and subjects assigned to each Teaching Assistant, qualifications, and job description. There shall be at least one teaching assistant for each six students in skills practice/laboratory settings.			
10. Field Preceptor(s) (10014 9(e)) Submit Name(s) of each field Preceptor, qualifications, and job description.			
11. Hospital Clinical Preceptor(s) (100151) Submit Name(s) of each Hospital Clinical Preceptor(s), qualifications, and job description.			
12. Copy of written agreements with (one or more) Base Hospital(s) to provide Clinical Experience (100151)			
13. Provisions for supervised hospital clinical training including student evaluation criteria, and copy of standardized forms for evaluating paramedic students			

Materials to be Submitted (in the order listed)	Check One: Enclosed	Check One: To Follow	For County Use Only
and monitoring of preceptors by the training program. (100151)			
14. Copy of written agreement with (one or more) paramedic service provider(s) to provide field experience. 100152			
15. Provisions for supervised field internship including student evaluation criteria, and copy of standardized forms for evaluating paramedic students and monitoring of preceptors by the training program.			
16. Course Curriculum, including:			
a. Course Outline			
b. Statement of Course Objectives			
c. At least 6 sample lesson plans			
d. Performance objectives for each skill			
e. 3 samples of written and skills exams used in periodic testing			
f. Final Skills Exam			
g. Final Written Exam			
17. Copy of Course Outline, if different than course content outlined in 100159			
18. Class Schedules, places and dates. Estimate if necessary (100153)			
19. Copy of Course Completion Record (100161)			
20. Copy of Liability Insurance on students.			
21. Copy of Fee Schedule.			
22. Description of how program provides adequate facilities, equipment, examination security, and student recordkeeping. (100153)			
23. If the course curriculum is not developed by the agency applying for program approval, submit written permission from the developer of the curriculum.			

	Check One		For County Use Only
Materials to be Submitted (in the order listed)	**Enclosed**	**To Follow**	
24. Copy of Student Eligibility Document (100157)			
24. Statement verifying use of curriculum equivalent to US DOT Paramedic (HS808 862 March 1999) National Standard curriculum (100153).			

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES
PARAMEDIC TRAINING PROGRAM APPROVAL APPLICATION FORM

Training Institution/Agency	
Name	
Address	
City/ZIP	
Contact Person	
Telephone Number	
Course Hours	
Total	
Didactic and Skills Lab	
Hospital Clinical Training	
Field Internship	
Personnel: Submit form for each person named.	
Course Director	
Program Medical Director	
Principal Clinical Preceptor	
Principal Field Evaluator	
Principal Instructors	
Teaching Assistants	

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES
PARAMEDIC TEACHING STAFF

Check one

____ Program Medical Director
____ Course Director
____ Principal Instructor
____ Teaching Assistant
____ Principal Clinical Preceptor
____ Principal Field Evaluator

Name: _____

Occupation: _____

Professional/Academic Degrees Held:	**Professional License/Certification Number(s):**

Expiration Date of Certificate/License: _____

California Teaching Credentials Held:

Type:		Expiration Date:	
Type:		Expiration Date:	

Emergency Care Related Education within the last 5 years:			
Course Title	**School**	**Course Length**	**Date Completed**

Approvals:			
Program Medical Director	Date	**Course Director**	Date

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: INTRAOSSEOUS INFUSION	Policy Number: 717
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2011
APPROVED: Medical Director: Angelo Salvucci, MD	Date: June 1, 2011
Origination Date: September 10, 1992 Date Revised: April 14, 2011 Date Last Reviewed: April 14, 2011 Review Date: June 2013	Effective Date: June 30, 2011

I. PURPOSE: To define the indications, procedure, and documentation for intraosseous insertion (IO) and infusion by paramedics.

II. AUTHORITY: Health and Safety Code, Sections 1797.178, 1797.214, 1797.220, 1798 and California Code of Regulations, Title 22, Sections 100145 and 100169.

III. POLICY: IO may be performed by paramedics who have successfully completed a training program approved by the EMS Medical Director.

A. Training

The EMS service provider will ensure their paramedics successfully complete an approved training program and will notify EMS when that is completed.

B. Indications

Patient with an altered level of consciousness (ALOC) or in extremis AND there is an urgent need to administer intravenous fluids or medications AND venous access is not readily available.

1. Manual IO: For patients less than 8 years of age.
2. EZ-IO device: For patients of all ages.

C. Contraindications

1. Recent fracture (within 6 weeks) of selected bone.
2. Congenital deformities of selected bone.
3. Grossly contaminated skin, skin injury, burn, or infection at the insertion site.
4. Excessive adipose tissue at the insertion site with the absence of anatomical landmarks.
5. IO in same bone within previous 48 hours.

IV. PROCEDURE:

~~A. Manual IO insertion~~

~~1. Assemble the needed equipment~~

~~a. 16-18 gauge IO needle (1.5 inches long)~~

~~b. Alcohol wipes~~

~~c. Sterile gauze pads~~

~~d. Two (2) 5 mL syringes and a primed IV line (with or without stopcock)~~

~~e. IV fluids: 500 mL NS only~~

~~f. Tape~~

~~g. Splinting device~~

~~2. Choose the appropriate insertion site. Locate the landmarks approximately 2 cm below the patella and 1 cm medial, on the anteromedial flat bony surface of the proximal tibia.~~

~~3. Prepare the site utilizing aseptic technique with alcohol wipe.~~

~~4. Fill one syringe with NS~~

~~5. To insert the IO needle:~~

~~a. Stabilize the site.~~

~~b. Grasp the needle with obturator and insert through skin over the selected site at a 90° angle to the skin surface.~~

~~c. Once the bone has been reached, continue to apply pressure rotating and gently pushing the needle forward.~~

~~d. When the needle is felt to 'pop' into the bone marrow space,remove the obturator, attach the empty 5 mL syringe and attempt to aspirate bone marrow.~~

~~e. For responsive patient infuse 2% cardiac lidocaine prior to fluid/medication administration for pain management:~~
~~1 mg/kg (max 40 mg) slow IVP over 60 seconds.~~

~~f. Attach the 5 mL syringe containing NS and attempt to flush the IO needle. If successful, remove the syringe, connect the IV tubing and secure the needle.~~

~~g. Infuse NS and/or medications.~~

~~h. Splint and secure the IO needle.~~

~~i. Document distal pulses and skin color to extremity utilized for IO insertion before and after procedure. Monitor for complications.~~

~~B.~~A. ~~EZ-IO insertion~~Insertion

1. Assemble the needed equipment
   a. Choose appropriate size IO needle

1) 15 mm needle sets (pink): 3-39 kg
2) 25 mm needle sets (blue): ≥ 40 kg
3) 45 mm needle sets (yellow): For patients with excessive adipose tissue at insertion site

b. Alcohol wipes
c. Sterile gauze pads
d. 10 mL syringe
e. EZ Connect tubing
f. IV fluids
1) 3-39 kg: 500 mL NS
2) ≥40 kg: 1 L NS
g. Tape or approved manufacturer securing device

2. Prime EZ Connect tubing with 1 mL fluid
a. If less than 2 years old, prime with NS
b. If ≥ 2 years old, and conscious, prime with 2% cardiac lidocaine (20 mg)
3. Locate the appropriate insertion site on the anteromedial flat surface of the proximal tibia.
a. Pediatric: 2 cm below the patella, 1 cm medial
b. Adult: 2 cm medial to the mid tibial tuberosity
4. Prepare the site utilizing aseptic technique with alcohol wipes.
5. To insert the EZ-IO needle:
a. Connect appropriate size needle set to the EZ-IO driver.
b. Stabilize the site. .
c. Position the EZ-IO needle at 90° to the underlying bone and insert it into the skin. Continue to insert the needle until contacting the bone. Ensure at least one black band is visible above the skin.
d. Once contact with the bone is made, activate the driver and advance the needle without pressure until the bone has been penetrated.
e. Once properly placed, attach primed EZ Connect tubing and attempt to aspirate bone marrow.
f. For responsive patients, slow infusion of 2% cardiac lidocaine over 60 seconds prior to fluid/medication administration for pain management.

1) 3-39 kg: 1 mg/kg
2) ≥40 kg: 40 mg

g. Flush with 10 mL NS to assess patency. If successful, begin to infuse fluid.

h. Splint the IO needle with tape or an approved manufacturer stabilization device.

i. Document time of insertion on included purple arm band and place on patient's wrist.

j. Document distal pulses and skin color before and after procedure and monitor for complications.

~~C.~~B. IO Fluid Administration

1. Active pushing of fluids may be more successful than gravity infusion. Use of a pressure to assist with fluid administration is recommended, and usually needed, but not required.
2. Fluid administration on smaller patients should be given via syringe boluses to control/monitor amount infused. Close observation of the flow rate and total amount of fluid infused is required.
3. If infiltration occurs or the IO needle is accidentally removed, stop the infusion, leave the connector tubing attached.

D. Documentation

1. Document any attempt(s) at establishing a peripheral IV prior to attempting/placing an IO infusion on the approved Ventura County documentation system (AVCDS) and Intraosseous Infusion Data Form (Appendix A).
2. The site(s) and number of attempts to establish an IO infusion shall be documented on the AVCDS, as well as the medications and amount of fluids administered during patient care.

E. Quality Assurance

Each use of an IO infusion will be reviewed by the Base Hospital, EMS service provider and EMS. The Intraosseous Infusion Data Form (Appendix A) will be completed for all IO insertion attempt.

Appendix A

VENTURA COUNTY EMS AGENCY
INTRAOSSEOUS INFUSION CQI FORM*

DEMOGRAPHICS	
DATE:	INCIDENT NUMBER:
INSERTING PARAMEDIC:	AGENCY:
PATIENT AGE:	PATIENT WEIGHT: ▢ lbs ▢ kgs
INDICATIONS: ▢ Cardiac Arrest ▢ Shock ▢ Other:	
Describe conditions:	
ALOC? : ▢ Yes ▢ No Extremis? ▢ Yes ▢ No	IV access unavailable? ▢ Yes ▢ No Explain:
IO INFUSION ATTEMPT	
Needle size: ▢15mm ▢ 25mm ▢45mm	Number of IO attempts:
Insertion site:	Distal Pulses Documented: ▢ Yes ▢ No
EZ Connect Primed: ▢ Lidocaine ▢ NS	Infiltration: ▢ Yes ▢ No
Saline infused ▢ 500mL ▢ 1000mL	IO Secured:
Lidocaine 2% ▢ Yes ▢ No	Pressure infusion? ▢ Yes ▢ No
COMMENTS:	

**This form is to be completed on all cases where IO infusion is attempted*
Please submit this form to your agency, the base hosptial and to VC EMSA

Appendix B

VENTURA COUNTY
EMERGENCY MEDICAL SERVICES AGENCY

Skills Assessment

Name_____Agency_____Date_____

- ☐ Demonstrates, proper body substance isolation
- ☐ States indication for EZ-IO use
- ☐ States contraindication for EZ-IO use
- ☐ Correctly locates target site
- ☐ Cleans site according to protocol
- ☐ Considers 2% cardiac lidocaine for patients responsive to pain
- ☐ Correctly assembles EZ-IO Driver and Needle Set
- ☐ Stabilizes the insertion site, inserts EZ-IO Needle Set, removes stylet and confirms placement
- ☐ Demonstrates safe stylet disposal
- ☐ Connects primed extension set and flushes the catheter
- ☐ Connects appropriate fluid with pressure infuser and adjusts flow as instructed
- ☐ Demonstrates appropriate securing of the EZ-IO
- ☐ States requirements for VC EMS documentation

Instructor Signature: _____**Date**_____

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Withholding or Termination of Resuscitation and Determination of Death	Policy Number: 606
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2012
APPROVED: Medical Director Angelo Salvucci, MD	Date: June 1, 2012
Origination Date: June 1984 Date Revised: October 13.2011 Date Last Reviewed: October 13, 2011 Next Review Date: October, 2014	Effective Date: June 1, 2012

I. PURPOSE: To establish criteria for withholding or termination of resuscitation and determination of death by prehospital EMS personnel.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.220,1798 and 7180. Government Code 27491 and 27491.2. California Code of Regulations, Title 22, Division 9, Section 100175.

III. POLICY: Prehospital EMS personnel may withhold or terminate resuscitation and determine that a patient is dead, and leave the body in custody of medical or law enforcement personnel, according to the procedures outlined in this policy.

IV. DEFINITION:

1. Prehospital EMS personnel: Prehospital EMS personnel mean all responding EMT-Is and Paramedics, and flight nurses.
2. Further Assessment: “Further assessment” refers to a methodical evaluation for signs/symptoms of life in the apparently deceased person. This evaluation includes examination of the respiratory, cardiac and neurological systems, and a determination of the presence or absence of rigor mortis and dependent lividity. The patient who displays any signs of life during the course of this assessment may NOT be determined to be dead,
3. Hospital: A licensed health care institution that provides acute medical care.
4. Skilled Nursing Facility: A licensed health care institution that provides non-acute care for elderly or chronically ill patients, and has licensed medical personnel on scene (RN or LVN).
5. Hospice: A care program into which terminally ill patients may be enrolled, to assist with the management of palliative care during the terminal stages of illness.

V. PROCEDURE:

A. General Guidelines:

1. The highest medical authority on scene shall determine death in the field.
   a. If BLS responders have any questions or uncertainty regarding determination of death, BLS measures shall be instituted until arrival of ALS personnel.
   b. If ALS responders have questions or uncertainty regarding determination of death, ALS measures shall be instituted until base hospital contact is made and orders received.
2. Prehospital EMS personnel who have determined death in the field in accordance with the parameters of this policy are not required to make base hospital contact.
3. Prehospital EMS personnel who arrive on scene after the patient is determined to be dead shall not re-evaluate the patient.

PATIENTS WHO ARE OBVIOUSLY DEAD

Upon arrival, prehospital EMS personnel shall rapidly assess the patient. For patients suffering any of the following conditions, no further assessment is required. No treatment shall be started and the patient shall be determined to be dead.

- Decapitation,
- Incineration,
- Hemicorporectomy, or
- Decomposition.

PATIENTS WHO APPEAR TO BE DEAD
(WITH Rigor Mortis and/or Dependent Lividity)

B. Patients who are apneic and pulseless require further assessment as described in table 1.

1. If rigor mortis and/or dependent lividity are present, and if no response for all the assessment procedures indicates signs of life, the patient shall be determined to be dead.
2. Rigor mortis is determined by checking the jaw and other joints for rigidity.

3. Dependent lividity is determined by checking dependent areas of the body for purplish-red discoloration.

Table 1.

CATEGORY	ASSESSMENT PROCEDURES	FINDINGS FOR DETERMINATION OF DEATH
Respiratory	Open the patient's airway. Auscultate lungs or feel for breaths while observing the chest for movement for a minimum of 30 seconds	No spontaneous breathir No breath sounds on auscultation.
Cardiac	Palpate the carotid artery (brachial for infant) for a minimum of 1 minute. Auscultate for heart sounds for minimum 1 minute. OR **ALS ONLY-** Monitor the patient's cardiac rhythm for minimum of 1 minute. Check asystole in 2 leads. Obtain a 6-second strip to be retained with the EMS provider documentation.	No pulse. No heart sounds.
Neurological	Check for pupil response to light. Check for response to painful stimuli.	No pupillary response. No response to painful Stimuli.

1. While in the process of the assessment procedures, if any response indicates signs of life, resuscitation measures shall take place immediately.
2. **If rigor mortis and/or dependent lividity are present**, and if no response for all the assessment procedures indicates signs of life, the patient shall be determined to be dead.

PATIENTS WHO APPEAR TO BE DEAD:
(WITHOUT Rigor Mortis and/or DEPENDENT LIVIDITY)

C. Patients who appear to be dead but display no signs of rigor mortis and/or dependent lividity shall have the cause of apparent death determined to be **MEDICAL** (including drowning, ingestion, asphyxiation, hanging, poisoning, lightning strikes, and electrocution), or **TRAUMATIC** (and injuries are sufficient to cause death).

1. **MEDICAL ETIOLOGY**: Resuscitation measures shall take place.
2. **TRAUMATIC ETIOLOGY**: Further assessment as defined in Table 1 shall be performed. If no response for all the assessment procedures, the

patient's age should be determined. (reasonable estimation appropriate if positive determination of age is not possible)

a. For patients younger than 18 years of age, resuscitation measures, including transport to the closest trauma center, shall take place.

b. For patients 18 years or older:

1) BLS RESPONDERS:

a) If the time from **initial determination** of pulselessness and apnea until trauma center arrival is estimated to be less than 20 minutes, resuscitation measures, including transport to the closest trauma center, shall take place.

b) If the time from **initial determination** of pulselessness and apnea until trauma center arrival is estimated to be 20 minutes or more, the patient may be determined to be dead.

2) **ALS RESPONDERS:**

a) If the time from **initial determination** of pulselessness and apnea until trauma center arrival is estimated to be less than twenty minutes, using a cardiac monitor, the patient's rhythm should be assessed.

(1) If the rhythm is narrow complex PEA, wide complex PEA greater than 30 beats per minute, ventricular tachycardia or ventricular fibrillation, resuscitation measures, including transport to the closest trauma center, shall take place.

(2) If the rhythm is asystole or wide complex PEA at a rate of 30 beats per minute or slower, the patient shall be determined to be dead.

b) If the time from **initial determination** of pulselessness and apnea until trauma center arrival is estimated to be twenty minutes or more, the patient may be determined to be dead, regardless of cardiac rhythm..

D. Termination of Resuscitation

1. Base hospitals and EMS personnel should consider terminating resuscitation measures on adult patients (age 18 and older) who are in cardiopulmonary

arrest and fail to respond to treatment under VC EMS Policy 705: Cardiac Arrest, Adult.

2. If resuscitation measures have been initiated, base hospital contact should be attempted before resuscitation is terminated and the patient determined to be dead.
3. If unable to make base hospital contact, resuscitation efforts may be terminated and the patient determined to be dead using the following criteria:
   a. Patients without evidence of trauma who meet termination of resuscitation criteria in VC EMS Policy 705: Cardiac Arrest, Adult.
   b. Patients with blunt or penetrating trauma if the cardiac rhythm is or becomes asystole or wide complex PEA at a rate less than 30 beats per minute.
4. In cases of cardiopulmonary arrest as a result of a lightning strike, electrocution or suspected hypothermia, CPR shall be performed for a minimum of one hour. **BLS responders in these circumstances shall make all reasonable attempts to access ALS care.**

E. Documentation

1. EMS personnel will document determination of death in the approved Ventura County Documentation System (AVCDS).

F. Disposition of Decedent's Body

1. Deaths that occur in hospitals or skilled nursing facilities, or to patients enrolled in hospice programs, do not require law enforcement response. Under these circumstances the body may be left at the scene.
2. Deaths that occur anyplace other than a hospital or skilled nursing facility **except to patients enrolled in hospice programs**, must be reported to law enforcement personnel and the body must be left in their custody.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Documentation of Prehospital Care	Policy Number 1000
APPROVED: Administration: Steven Carroll, Paramedic	Date: June 1, 2012
APPROVED: Medical Director Angelo Salvucci, M.D.	Date: June 1, 2012
Origination Date: June 15, 1998 Date Revised: November 10, 2011 Date Last Reviewed: November 10, 2011 Review Date: November 30, 2014	Effective Date: June 1, 2012

I. PURPOSE: To define the use of standardized records to be used by Ventura County Emergency Medical Service (VCEMS) providers for documentation of pre-hospital care.

II. AUTHORITY: Title 22 Section 100147.

III. POLICY: Patient care provided by first responders and ambulance personnel will be documented using the appropriate method.

IV. PROCEDURE:

A. Provision of Access

VCEMS will provide access to the approved Ventura County Electronic Patient Care Report (VCePCR) system and software to EMS system stakeholders required to enter, edit, or analyze data.

B. Documentation

1. The VCEMS VCePCR will be used to document the care provided by pre-hospital personnel for every patient contact and/or incident to which a particular unit or provider is attached. An incident will be defined as any response involving Ventura County pre-hospital personnel to any event in which there is an actual victim, or the potential for a victim, regardless of whether the responding unit was cancelled enroute or not. A patient contact is defined as any encounter involving Ventura County pre-hospital personnel with any person consenting, either implied or informed, to assessment and/or treatment. Documentation shall be completed on any

person with obvious injury or significant mechanism regardless of consent. The following are exceptions:

a. If a First Responder Advanced Life Support (FR ALS) Paramedic initiates care of the patient, the FR ALS Paramedic shall document all care provided to the patient on VCePCR.

b. If care is turned over to another ALS agency, a VCePCR shall be completed by all pre-hospital provider agencies who delivered patient care and/or transport.

c. The appropriate level VCePCR shall be completed to correspond to the level of care provided to the patient. If an ALS provider determines a patient to only require basic level care, a VCePCR-BLS report can be utilized. If a unit or provider is attached to an incident, but cancelled enroute, a VCePCR-Cancelled Call form shall be completed and posted.

d. A minimum validation score of 95 shall be required for all VCePCRs prior to completion and locking of the document.

e. Patient side documentation is encouraged and should be practiced whenever patient care would not be negatively affected.

f. In the event of multiple patients, documentation will be accomplished as follows:

    1) Level 1 MCI: The care of each patient shall be documented using an VCePCR.

    2) Level 2 and 3 MCI: Each patient transported to a hospital shall have their care documented on a Ventura County Multi-Casualty Patient Record.

        a) The transporting agency is responsible for completion of the multi-casualty patient record. The record is designed to be

completed by the transporting crew enroute to the receiving hospital.

b) The transporting agency retains the original of the multi-casualty patient record. A copy shall be left with the patient at the receiving hospital. The triage tag shall be attached to this copy and is included as official documentation in the patient's medical record.

c) The transporting agency shall distribute copies of the multi-casualty patient record to the base hospital and EMS Agency within twenty-four hours of demobilization of the incident.

2. Transfer of Care
Transfer of care between two field provider teams and between field provider and hospital shall be documented on appropriate VCePCR. The first arriving agency will post to the server and perform a coordinated electronic transfer of care whenever possible within the VCePCR system to the next incoming unit. This includes intra-agency units and inter-agency units.

3. A VCePCR shall be completed in accordance with training administered by VCEMS, or designee.

C. In the event the cardiac monitor is attached as required by any of the VCEMS 705 policies, a complete ECG data transfer shall be recorded and attached to the corresponding VCePCR. ECG data shall be downloaded by each provider agency involved in that incident and attached to the corresponding VCePCR. An original 12 lead ECG shall be printed and submitted upon transfer of care to hospital staff for any patient where a 12 lead ECG was performed.

D. Submission to VCEMS

1. In the following circumstances, a complete VCePCR shall be completed and posted by any transporting unit, and by FR ALS

personnel retaining care, prior to leaving the hospital and returning to service:

a. Any patient that falls into Step 1 or Step 2 (1.1 – 2.8) of the Ventura County Field Triage Decision Scheme

b. Any patient that is in cardiac arrest, or had a cardiac arrest with ROSC.

c. Any patient with a STEMI positive 12 lead ECG.

d. Any patient with a positive Cincinatti Stroke Screening (CSS +).

e. Any patient that is unconscious, or has a significantly altered level of consciousness (ALOC), to the point he is unable to effectively communicate information regarding present or past medical history.

f. An exception to this circumstance would be during times of EMS system overload where a delay in a unit returning to service could pose significant delays in response times.

2. For circumstances not listed above, in which the patient was transported to a hospital, the approved minimum data set shall be electronically posted to the server by transporting agencies, and by FR ALS personnel retaining care, prior to that unit leaving the hospital and returning to service.

a. An exception to this circumstance would be during times of EMS system overload where a delay in a unit returning to service could pose significant delays in response times.

3. All other reports not falling into the above criteria shall be completed and posted to the server as soon as possible and no later than the end of shift.

F. Dry Run/Against Medical Advice

Every patient contact resulting in refusal of medical attention/transport must be documented with the following information, the reason dispatched and/or chief complaint, assessment and vital signs, base hospital contact (when appropriate), patient advised to seek medical attention and completion of AMA. The AMA checklist as well as patient

signatures shall be captured whenever possible by each applicable agency at the time of patient contact/refusal. If, at any point, a signature is not obtained for any reason, explanation shall be documented in the narrative section of the VCePCR.

G. ALS Inter-facility Transfers (Acute Care Facility to Acute Care Facility)
Documentation shall be completed on all ALS Interfacility transfers only. Documentation will include, but not be limited to, baseline assessment, medications administered, reason for transfer, procedures done to the patient, vital signs and any changes from baseline assessment.
If the transferring facility sends staff to accompany the patient, the staff member(s) name(s) shall be documented on the VCePCR.

H. The completion of any VCePCR should not delay patient transport to the hospital.

I. Patient Medical Record
The VCePCR and Ventura County Multi-Casualty Patient Record shall be considered a legal document and part of the patient's medical record. The first responder agency, transport agency, and hospital are custodians of record. Printing should only be performed as needed, and an electronic copy of the VCePCR should be utilized and referred to whenever feasible. A print log and reason for printing shall be monitored regularly to help ensure security of protected health information within the system.

Attachment A

These abbreviations have been accumulated from the California approved EMT Curriculum and various other resource material. The abbreviations were collected by the Ventura County ALS CQI Team to assist EMS field, hospital and dispatch personnel in providing consistent medical documentation.

Term	Abbreviation
5% Dextrose in Water	D5W
Abdomen	Abd
Above knee amputation	AKA
Acquired Immunodeficiency Syndrome	AIDS
Ad Libitum (as desired)	Ad lib
Advanced Life Support	ALS
Against medical advise	AMA
Alcohol	ETOH
Alert and oriented	A & O
Also known as	AKA
Altered Level Of Consciousness	ALOC
Amount	Amt
Ampule	Amp
Antecubital	AC
Anterior	Ant
Anterior/Posterior	AP
Appointment	Appt
Arterial Blood Gas	ABG
Arteriosclerotic Heart Disease	ASHD
As necessary	prn
As soon as possible	ASAP
Aspirin	ASA
At	@
Atrial Fibrillation	A fib, AF
Attention Deficit Hyperactivity Disorder	ADHD
Automated external Defibrillator	AED
Automatic Implantable Cardiac Defibrillator	AICD
Bag Valve Mask	BVM
Basic Life Support	BLS
Birth Control Pill	bcp
Bowel Movement	BM
Bundle Branch Block	BBB
By Mouth	p.o.
By Order Of	per
Cancer	CA
Carbon Dioxide	CO_2
Carbon Monoxide	CO

Term	Abbreviation
Cardio Pulmonary Resuscitation	CPR
Central Nervous System	CNS
Cerebrospinal Fluid	CSF
Cerebrovascular Accident	CVA
Cervical Spine	C-Spine
Chief Complaint	CC
Chronic Obstructive Pulmonary Disease	COPD
Circulation, Sensation, Motor	CSM
Clear	Cl
Continuous Positive Airway Pressure	CPAP
Coronary Artery Bypass Graft	CABG
Coronary Artery Disease	CAD
Date of Birth	DOB
Dead on Arrival	DOA
Defibrillated	Defib
Delirium Tremens	DTs
Diabetes Mellitus	DM
Dilation and curettage	D & C
Discontinue*	D/C*
Deformity, Contusion, Abrasion, Penetration, Burn, Tenderness, Laceration, Swelling	DCAPBTLS
Do Not Resuscitate	DNR
Doctor of Osteopathy	DO
Drops	gtts
Dyspnea On Exertion	DOE
Electrocardiogram	ECG
Electroencephalogram	EEG
Emergency Department	ED
Emergency Medical Services	EMS
Emergency Medical Technician	EMT
Endotracheal	ET
Equal	=
Estimated	Est
Estimated Time of Arrival	ETA
Etiology	Etiol.

Term	Abbreviation
Every	q
Every day*	qd*
Evening	pm
Extended Care Facility	ECF
Eye, ear, nose, throat	EENT
Fahrenheit	F
Female	F
Fetal Heart Rate	FHR
Fluid	Fl
Foot	Ft
Foreign body	FB
Four times a day	QID
Fracture	Fx
Gallbladder	GB
Gastrointestinal	GI
Genitourinary	GU
Glasgow Coma Score	GCS
Grain	Gr
Gram	gm
Gravida 1,2,3, etc	G1, G2, G3
Gun Shot Wound	GSW
Gynecological	Gyn
Heart Rate	HR
Hematocrit	Hct
Hemoglobin	Hgb
Hepatitis A Virus	HAV
Hepatitis B Virus	HBV
Hepatitis C Virus	HCV
History	Hx
History and Physical	H & P
Hour of Sleep (bedtime)*	hs*
Human Immunodeficiency Virus	HIV
Hydrochlorothiazide	HCTZ
Hypertension	HTN
Immediately	STAT
Insulin Dependent Diabetes Mellitus	IDDM
Intake and Output	I & O
Intensive Care Unit	ICU
Intercostal Space	ICS
Intracranial Pressure	ICP
Intralingual	IL
Intramuscular	IM
Intraosseous	IO
Intrauterine Device	IUD
Intravenous	IV
Intravenous Push	IVP
Irregular	Irreg
Jugular venous distention	JVD
Kilogram	kg
Kilometer	Km
Labor and Delivery	L & D
Laceration	Lac
Last Menstrual Period	LMP
Lateral	Lat
Left	L
Left Eye*	OD*

Term	Abbreviation
Left Lower Extremity	LLE
Left Lower Lobe	LLL
Left Lower Quadrant	LLQ
Left Upper Extremity	LUE
Left Upper Lobe	LUL
Left Upper Quadrant	LUQ
Less Than	<
Lower Extremity	LE
Lumbar Puncture	LP
Male	M
Medical Doctor	MD
Metered Dose Inhaler	MDI
Microgram	mcg
Milliequivalent	mEq
Milligram	mg
Milliliter	ml
Millimeter	mm
Minute	Min
Morning	am
Morphine Sulphate*	MS*
Motor Vehicle Collision	MVC
Mouth	MO
Moves all Extremities	MAE
Multiple Casualty Incident	MCI
Multiple sclerosis	MS
Myocardial Infarction	MI
Nasal cannula	NC
Nausea/Vomiting	NV
Negative	neg
Night	Noc
Nitroglycerine	NTG
No Acute Distress	NAD
No Known Allergies	NKA
No Known Drug Allergies	NKDA
Non Insulin Dependent Diabetes Mellitus	NIDDM
Non Rebreather Mask	NRBM
Non Steroidal Anti-inflammatory Drugs	NSAID
Normal Saline	NS
Normal Sinus Rhythm	NSR
Not applicable	NA
Nothing by Mouth	NPO
Obstetrics	OB
Occupational Therapy	OT
Oral Dissolving Tablet	ODT
Operating Room	OR
Organic Brain Syndrome	OBS
Ounce	oz
Over the Counter	OTC
Overdose	OD
Oxygen	O2
Palpable	Palp
Para, number of pregnancies	Para 1,2,3, etc
Paramedic	PM

Term	Abbreviation
Paroxysmal Supraventricular Tachycardia	PSVT
Paroxysmal Nocturnal Dyspnea	PND
Past Medical History	PMH
Pediatric Advanced Life Support	PALS
Pelvic Inflammatory Disease	PID
Per Rectum	pr
Percutaneously Inserted Central Catheter	PICC
Phencyclidine	PCP
Physical Exam	PE
Positive	+, pos
Pound	lb
Pregnant	Preg
Premature Ventricular Contraction	PVC
Primary Care Physician	PCP
Private/Primary Medical Doctor	PMD
Privately Owned Vehicle	POV
Pro Re Nata – As Needed	PRN
Pulmonary Embolism	PE
Pulse, Motor, Sensation	PMS
Pulseless Electrical Activity	PEA
Pupils Equal Round and Reactive to Light	PERRL
Range of Motion	ROM
Registered Nurse	RN
Respiration	R
Respiratory Rate	RR
Respiratory Therapist	RT
Right	Rt
Right Eye*	OD*
Right Lower Extremity	RLE
Right Lower Lobe	RLL
Right Lower Quadrant	RLQ
Right Middle Lobe	RML
Ringer's Lactate	RL
Rule Out	R/O
Sexually Transmitted Disease	STD

Term	Abbreviation
Shortness of Breath	SOB
Sinus Bradycardia	SB
Sinus Tachycardia	ST
Sodium Bicarbonate	NaHCO3
Sodium Chloride	NaCl
Streptococcus	Strep
Subcutaneous*	SQ*
Sublingual	SL
Sudden Acute Respiratory Syndrome	SARS
Sudden Infant Death Syndrome	SIDS
Supraventricular Tachycardia	SVT
Temperature	T
Temperature, Pulse, Respiration	TPR
Three Times a Day	TID
Times	X
To Keep Open	TKO
Tracheostomy	Trach
Traffic Collision	TC
Transient Ischemic Attack	TIA
Transcutaneous Pacing	TCP
Treatment	Tx
Tuberculosis	TB
Twice a day	BID
Upper Respiratory Infection	URI
Urinary Tract Infection	UTI
Ventricular Fibrillation	VF
Ventricular Tachycardia	VT
Vital Signs	VS
Volume	Vol
Water	H20
Weight	Wt
With	w/
Within Normal Limits	WNL
Without	w/o
Wolf-Parkinson-White	WPW
Year	Yr
Years Old	y/o

*JOINT COMMISSION and ISMP have indicated these abbreviations have a high likelihood of misinterpretation; thereby leading to medical errors, therefore, they are ***not*** to be used in ***handwritten*** documentation.

Date: July 4, 2012

To: Steve Carroll, EMT-P
Ventura County EMS Administrator

From: Dede Utley, BSN, RN, CEN
PSC Chair Nominations Committee

Re: Prehospital Services Committee Chair Nomination

Dear Steve,

This is to inform you that the nominations committee has received one nomination for Chairperson of the Ventura County Prehospital Services Committee. The nomination period has been open for several weeks with notice given to committee members through the monthly meetings and email.

The committee supports nominee, Jeff Winter, EMT-P, for this position. The committee thanks you for allowing us to participate in this opportunity. Please let me know if you have any questions.

Cc: Prehospital Services Committee, July agenda
Steve Frank, EMT-P
Nancy Merman, RN

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title ALS Base Hospital Standards	Policy Number: 410
APPROVED Administration: Steven L. Carroll, Paramedic	Date: June 1, 2009
APPROVED Medical Director: Angelo Salvucci, M.D.	Date: June 1, 2009
Origination Date: August 22, 1986 Date Revised: February 12, 2009 Date Last Reviewed: February 12, 2009 Review Date: February 28, 2012	Effective Date: June 1, 2009

I. PURPOSE: To define the criteria, which shall be met by an acute care hospital in Ventura County for Base Hospital (BH) designation.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798, 1798.101, 1798.105, 1798.2 and California Code of Regulations, Title 22, Section 100175.

III. POLICY:

A. An Advanced Life Support (ALS) ~~Base Hospital (~~BH~~)~~, approved and designated by the Ventura County Emergency Medical Services (VCEMS), shall:

~~1.~~ 1. ~~Meet all requirements of an ALS Receiving Hospital (RH) per VCEMS Ventura County Emergency Medical Services~~ Policy 420.

2. ~~2.~~ Have an average emergency room census of 1200 or more visits per month.

3. ~~3.~~ Have the capability to provide, at all times, operational phone with the capability to record the communications, between the BH and paramedics.

a. If the communications capability of the BH is interrupted, the ALS provider and the nearest BH shall be notified immediately by telephone.

b. ALS calls shall be routed to the nearest BH until communication capability is restored and telephone notification of the ALS provider and nearest BH is made.

c. All equipment used for ALS communications shall operate within the frequency requirements of the Ventura County Communications Department. At the time that a countywide communication system is implemented, all ALS providers shall comply with the Ventura County Communications Department ALS communications plan.

4. ~~4.~~ Assure that communication between the BH and ALS Unit for each ALS call shall be provided only by the BH Emergency Department (ED) physician or Ventura County authorized Mobile Intensive Care Nurse (MICN) by radio or telephone.

5. ~~6.~~ Designate a Prehospital Liaison Physician (PLP) ~~BH Medical Director~~ who shall be a physician on the hospital staff, licensed in the State of California and have experience in emergency medical care. The PLP ~~Medical Director~~ shall:
   a. Be regularly assigned to the ED~~Emergency Department~~.
   b. Have experience in and knowledge of BH operations.
   c. Be responsible for overall medical control and supervision of the ALS program within the BH's area of responsibility including review of patient care records and critique of personnel involved.
   d. Be responsible for reporting deficiencies in patient care to VC-EMS.
   e. Coordinate BH activities with ~~-~~ RH~~Receiving Hospital~~, Prehospital Services Committee (PSC) and VCEMS policies and procedures.
   f. Attend PSC meetings.
   g. Provide ED~~Emergency Department~~ staff education.
   h. ~~Schedule medical staffing for the Emergency Department on a 24-hour basis.~~
   i. Evaluate paramedics for clinical performance and makes recommendation to VCEMS.
   j. Evaluate MICN's for authorization/reauthorization and makes recommendation to VCEMS.
6. ~~7.~~ Have on duty, on a 24-hour basis, one (1) MICN who meets who meets the criteria in VCEMS Policy 321.
7. ~~8.~~ Identify an MICN with experience in, and knowledge of, BH ~~radio~~ communications operations and VCEMS policies and procedures as a Prehospital Care Coordinator (PCC) to assist the ~~BH Medical Director~~ PLP in the medical control, supervision, and continuing education (CE) of prehospital care personnel.
8. ~~9.~~ Provide for the CE ~~continuing education~~ of prehospital care personnel, ~~'~~paramedics MICNs, EMTs ~~I's~~, and first responders, in accordance with VCEMS:
9. ~~10.~~ Cooperate with and assist the PSC and the VCEMS ~~Medical Director~~MD in the collection of statistics and review of necessary records for program evaluation and compliance.
10. ~~11.~~ Assure that paramedics perform medical procedures only under medical direction of a physician or Ventura County authorized MICN except for approved standing orders.
11. ~~12.~~ Agree to maintain all recorded communications and prehospital data in a manner consistent with hospital data requirements. Prehospital data includes, but is not limited to, the recording of the prehospital communication, prehospital care

record, paramedic BH communications form and documentation of telephone communication with the RH (if utilized). All prehospital data except the recording will be integrated with the patient chart.

12.~~3.~~ Resident physicians shall attend BH ~~Base Hospital~~ Physician course.

B. There shall be a written agreement between the BH and VCEMS indicating the commitment of hospital administration medical staff, and emergency department staff to meet requirements for ALS program participation as specified by State regulations and VCEMS policies and procedures.

C. The VCEMS shall review its agreement with each BH at least every two years.

D. The VCEMS may deny, suspend, or revoke the approval, of a BH for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the PSC and Board of Supervisors for appropriate action.

E. A hospital wishing to become an ALS BH~~Base Hospital~~ in Ventura County must meet Ventura County BH~~Base Hospital~~ Criteria and agree to comply with Ventura County regulations.

1. Application:

   Eligible hospitals shall submit a written request for BH~~Base Hospital~~ approval to VCEMS documenting the compliance of the hospital with the Ventura County ~~Base Hospital~~ BH Criteria.

2. Approval:

   a. Program approval or disapproval shall be made in writing by the VCEMS to the requesting BH ~~Base Hospital~~ within a reasonable period of time after receipt of the request for approval and all required documentation. This time period shall not exceed three (3) months.

   b. The VCEMS shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all the program requirements.

3. Withdrawal of Program Approval:

   Non-compliance of any criterion associated with program approval, use of non-certified personnel, or non-compliance with any other Ventura County regulation applicable to a ~~BH Base Hospital~~, may result in withdrawal, suspension or revocation of program approval by the VCEMS.

F. Advanced Life Support BH ~~Base Hospital~~s shall be reviewed on an annual basis.

1. All ~~Base Hospital~~BH's shall receive notification of evaluation from the VCEMS.

2. All BH's~~Base Hospitals~~ shall respond in writing regarding program compliance.

3. On-site visits for evaluative purposes may occur.
4. Any BH ~~Base Hospital~~ shall notify the VCEMS by telephone, followed by a letter within 48 hours of changes in program compliance or performance.

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

BASE HOSPITAL
CRITERIA COMPLIANCE CHECK LIST

Base Hospital: _____ Date: _____

	YES	NO
An Advanced Life Support (ALS) Base Hospital (BH), approved and designated by the Ventura County Emergency Medical Services (VCEMS), shall:		
1. Meet all requirements of an ALS Receiving Hospital (RH) per ~~Ventura County Emergency Medical Services~~ (VCEMS) Policy 420.		
2. Have the capability to provide, at all times, operational phone with the capability to record the communications, between the BH and paramedics. If the communications capability of the BH is interrupted, the ALS provider and the nearest BH shall be notified immediately by telephone.~~Have the capability to provide, at all times, operational biomedical and radio communications with the capability to tape record the communications, between the BH and paramedics~~. All equipment used for ALS communications shall operate within the frequency requirements of the Ventura County Communications Department. At the time that a countywide communication system is implemented, all ALS providers shall comply with the Ventura County Communications Department ALS communications plan.		
3. Have the capability to provide, at all times, operational phone with the capability to record the communications, between the BH and paramedics.		
4. ~~Designate a BH Prehospital Care Coordinator (PCC), a paramedic representing each ALS service provider affiliated with the BH, and an ED physician and/or ED Registered Nurse from each Receiving Hospital affiliated with the BH, to function as the BH Paramedic Committee. Additional committee members may be designated according to BH committee policies.~~		
5. Designate a ~~BH Medical Director~~Prehospital Liaison Physician (PLP) who shall be a physician on the hospital staff, licensed in the State of California, and have experience in emergency medical care. The ~~Medical Director~~PLP shall:		
• Be regularly assigned to the Emergency Department (ED).		
• Have experience in and knowledge of BH operations.		
• Be responsible for overall medical control and supervision of the ALS program within the BH's area of responsibility including review of patient care records and critique of personnel involved.		
• Be responsible for reporting deficiencies in patient care to VC EMS.		
• Coordinate BH activities with ~~RH Receiving Hospital~~, Prehospital Services Committee (PSC) and VCEMS policies and procedures.		
• Attend ~~BH Paramedic Committee and~~ PSC meetings.		

		YES	NO
	• Provide ED ~~Emergency Department~~ staff education.		
	• ~~Schedule medical staffing for the Emergency Department on a 24-hour basis.~~		
	• Evaluate MICNs for authorization/reauthorization and make recommendation to VCEMS.		
6.	All ~~Base Hospital~~BH MICN's shall:		
	• Be authorized in Ventura County by the VCEMS ~~Medical Director.~~MD		
	• Be assigned only to the ~~Emergency Department~~ED while functioning as an MICN.		
	• Maintain current ACLS certification.		
	• Be a BH ~~Base Hospital~~ employee.		
7.	Identify an MICN with experience in and knowledge of BH ~~radio~~ communication operations and VCEMS policies and procedures as a Prehospital Care Coordinator (PCC) to assist the PLP ~~BH medical director~~ in the medical control, supervision, and continuing education (CE) of prehospital care personnel.		
8.	Provide for the ~~continuing education~~CE of prehospital care personnel (~~'~~paramedics MICN's, EMTs~~-I's~~, and first responders), in accordance with VC-EMS Policy 1131:		
9.	Cooperate with and assist the ~~Paramedic~~ Prehospital Services Subcommittee (PSC), ~~the,~~ and the VCEMS ~~Medical Director~~MD in the collection of statistics and review of necessary records for program evaluation and compliance.		
10.	Assure that paramedics perform medical procedures only under medical direction of a physician or Ventura County authorized MICN except for approved standing orders and medical procedures.		
11.	Agree to maintain all tape communications and prehospital data in a manner consistent with hospital data requirements. Prehospital data includes, but is not limited to the tape of the prehospital communication, prehospital care record paramedic BH communications form, documentation of telephone communication with the RH (if utilized). All prehospital data except the tape recording will be integrated with the patient chart.		
12.	Submit a letter to VC-EMS indicating the commitment of hospital administration medical staff, and emergency department staff to meet requirements for program participation as specified by State regulations and VC-EMS policies and procedures.		
13.	Resident physicians shall attend BH ~~Base Hospital~~ Physician course.		

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES		HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title: Receiving Hospital Standards		Policy Number 420
APPROVED Administration:	Steven L. Carroll, Paramedic	Date: February 10, 2011
APPROVED Medical Director:	Angelo Salvucci, M.D.	Date: February 10, 2011
Origination Date: Date Revised: Date Last Reviewed: Review Date:	April 1, 1984 February 10, 2011 February 10, 2011 February, 2014	Effective Date: February 10, 2011

I. PURPOSE: To define the criteria, which shall be met by an acute care hospital in Ventura County for Receiving Hospital (RH) designation.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798, 1798.101, 1798.105, 1798.2 and California Code of Regulations, Title 22, Section 100175.

III. POLICY:

A. A RH ~~Receiving Hospital~~, approved and designated by the Ventura County, shall:

1. Be licensed by the State California as an acute care hospital.
2. Meet the requirements of the Health and Safety Code Sections 1250-1262 and Title 22, Sections 70411, 70413, 70415, 70417, 70419, 70649, 70651, 70653, 70655 and 70657 as applicable.
3. Be accredited by a CMS accrediting agency.
4. Operate an Intensive Care Unit.
5. Have the following specialty services available at the hospital or appropriate referral hospital (at the discretion of the Emergency Department Physician. and consultant Physician.) within 30 minutes:

Cardiology	Anesthesiology	Neurosurgery
Orthopedic Surgery	General Surgery	General Medicine
Thoracic Surgery	Pediatrics	Obstetrics

6. Have operating room services available within 30 minutes.
7. Have the following services available within 15 minutes.

X-ray	Laboratory	Respiratory Therapy

8. Evaluate all ambulance transported patients promptly, either by RH Physician, Private Physician or other qualified medical personnel designated by hospital policy.

9. Have the capability at all times to communicate with the ambulances and the Base Hospital (BH).

10. Designate a ~~Receiving Hospital Emergency Department~~ ED Medical Director who shall be a physician on the hospital staff, licensed in the State of California and have experience in emergency medical care. The Medical Director shall:

    a. Be regularly assigned to the ED~~Emergency Department~~.

    b. Have knowledge of VC-EMS policies and procedures.

    c. Coordinate ~~Receiving Hospital~~ RH activities with ~~Base Hospital~~BH, Prehospital Services Committee (PSC), and VC-EMS policies and procedures.

    d. Attend, or have designee attend, ~~Base Hospital Paramedic Committee and Prehospital Services Subcommittee~~ PSC meetings.

    e. Provide ED ~~Emergency Department~~ staff education.

    f. Schedule medical staffing for the ~~Emergency Department~~ED on a 24-hour basis.

11. Agree to provide, at a minimum, on a 24-hour basis, a physician ~~specializing in Emergency Medicine~~ Dr. Chase had concern with the smaller ER, suggest possible removal??;sand a ~~Registered Nurse~~ RN that meets the following criteria:

    a. All Emergency Department physicians shall:

        1) Be immediately available to the Emergency Department at all times.

        2) Be certified by the American Board of Emergency Medicine or be board eligible or have all of the following:

            a) Have and maintain current Advanced Cardiac Life Support (ACLS) certification.

            b. Have and maintain current Advanced Trauma Life Support certification.

            c) Complete at least 25 Category I CME hours per year with content applicable to Emergency Medicine.

        3) Full-time resident physicians working in their own institution's Emergency Departments whose function as backup to Advanced Life Support (ALS) personnel shall fulfill Section 11.a and shall be senior (second and third year) residents.

    b. ~~Receiving Hospital~~RH ED's ~~Emergency Departments~~ shall be staffed by:

1) Full-time staff: those physicians who practice emergency medicine 120 hours per month or more, and/or

2) Regular part-time staff: those physicians who see 90 patients or more per month in the practice of emergency medicine.

a) Formula: Average monthly census of acute patients divided by 720 hours equals average number of patients per hour. This figure multiplied by average hours worked by physician in emergency medicine equals patients per physician per month.

b) Physicians working in more than one hospital may total their hours.

c) Acute patients exclude scheduled and return visits, physicals, and patients not seen by the ED Physician.

d) During period of double coverage, the whole shall be met if one of the physician's meets the above standards.

c. All ~~Receiving Hospitals Registered Nurses~~ RH RNs shall:

1) Be regular hospital staff assigned solely to the ~~Emergency Department~~ ED for that shift.

2) Maintain current ACLS ~~Advanced Cardiac Life Support~~ certification.

d. All other nursing and clerical personnel for the Emergency Department shall maintain current Basic Cardiac Life Support certification.

e. Sufficient licensed personnel shall be utilized to support the services offered.

12. Cooperate with and assist the PSC and EMS Medical Director in the collection of statistics for program evaluation.

13. Agree to maintain all prehospital data in a manner consistent with hospital data requirements and provide that the data be integrated with the patient's chart. Prehospital data shall include the Prehospital Care Record, Paramedic Base Hospital communication form (from the ~~Base Hospital~~BH), and documentation of a ~~Base Hospital~~ BH telephone communication with the ~~Receiving Hospital~~RH.

14. Participate with the BH ~~Base Hospital~~ in evaluation of paramedics for reaccreditation.

15. Permit the use of the hospital helipad as an emergency rendezvous point if a State-approved helipad is maintained on hospital premises.

B. There shall be a written agreement between the ~~Receiving Hospital~~RH and EMS indicating the commitment of hospital administration, medical staff, and emergency department staff to meet requirements for ~~Advanced Life Support~~ALS program participation as specified by EMS policies and procedures.

C. EMS shall review its agreement with each ~~Receiving Hospital~~RH at least every two years.

D. EMS may deny, suspend, or revoke the approval of a ~~Receiving Hospital~~RH for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Board of Supervisors for appropriate action.

E. The EMS Medical Director may grant an exception to a portion of this policy upon substantiation of need by the PSC that, as defined in the regulations, compliance with the regulation would not be in the best interests of the persons served within the affected local area.

F. A hospital that applies to become a ~~Receiving Hospital~~RH in Ventura County must meet Ventura County ~~Receiving Hospital~~RH Criteria and agree to comply with Ventura County regulation.

1. Application:
   Eligible hospital shall submit a written request for ~~Receiving Hospital~~RH approval to the VC-EMS, documenting the compliance of the hospital with the Ventura County ~~Receiving Hospital~~RH.
2. Approval:
   Program approval or denial shall be made in writing by EMS to the requesting ~~Receiving Hospital~~RH within a reasonable period of time after receipt of the request for approval and all required documentation. This period shall not exceed three (3) months.

G. ~~Advanced Life Support~~ALS ~~Receiving Hospitals~~RHs shall be reviewed on an annual basis.

1. All ~~Receiving Hospitals~~RH shall receive notification of evaluation from the EMS.
2. All ~~Receiving Hospitals~~RH shall respond in writing regarding program compliance.
3. On-site visits for evaluative purposes may occur.
4. Any ~~Receiving Hospital~~RH shall notify the EMS by telephone, followed by a letter within 48 hours, of changes in program compliance or performance.

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

RECEIVING HOSPITAL
CRITERIA COMPLIANCE CHECKLIST

Receiving Hospital: _____ Date: _____

	YES	NO
A. Receiving Hospital (RH), approved and designated by the Ventura County , shall:		
1. Be licensed by the State of California as an acute care hospital.		
2. Meet the requirements of the Health and Safety Code Section 1250-1262 and Title 22, Sections 70411, 70413, 70415, 70417, 70419, 70649, 70651, 70653, 70655 and 70657 as applicable.		
3. Be accredited by a CMS accrediting agency		
4. Operate an Intensive Care Unit.		
5. Have the following specialty services available at the hospital or appropriate referral hospital (at the discretion of the Emergency Department (ED) Physician. and consultant Physician.) within 30 minutes:		
• Cardiology		
• Anesthesiology		
• Neurosurgery		
• Orthopedic Surgery		
• General Surgery		
• General Medicine		
• Thoracic Surgery		
• Pediatrics		
• Obstetrics		
6. Have operating room services available within 30 minutes.		
7. Have the following services available within 15 minutes.		
• X-Ray		
• Laboratory		
• Respiratory Therapy		
8. Evaluate all ambulance transported patients promptly, either by RH Physician, Private Physician or other qualified medical personnel designated by hospital policy.		
9. Have the capability at all times to communicate with the ambulances and the ~~-~~BH~~Base Hospital~~.		
10. Designate an ~~Receiving Hospital~~ Emergency Department Medical Director who shall be a physician on the hospital staff, licensed in the State of California and have experience in emergency medical care. The Medical Director shall:		
a. Be regularly assigned to the Emergency Department.		
b. Have knowledge of VC EMS policies and procedures.		

				YES	NO
	c.		Coordinate ~~Receiving Hospital~~RH activities with Base Hospital, Prehospital Services Committee (PSC), and VC ~~-~~EMS policies and procedures.		
	d.		Attend or have designee attend ~~Base Hospital Paramedic Committee and~~ PSC meetings.		
	e.		Provide Emergency Department staff education.		
	f.		Schedule medical staffing for the ~~Emergency Department~~ED on a 24-hour basis.		
11.			Agree to provide, at a minimum, on a 24-hour basis, a physician ~~specializing in Emergency Medicine~~ and a Registered Nurse that meets the following criteria:		
	a.		All Emergency Department physicians shall:		
		1).	Be immediately available to ~~Emergency Department~~ED at all times.		
		2)	Be certified by the American Board of Emergency Medicine or be board eligible or have all of the following:		
			a). Have and maintain current Advanced Cardiac Life Support (ACLS) certification.		
			b) Have and maintain current Advanced Trauma Life Support (ATLS)certification.		
			c) Complete at least 25 Category I CME hours per year with content applicable to Emergency Medicine.		
		3)	Full-time resident physician working in their own Institution's ~~Emergency Departments~~ED. Resident physicians who function, as backup to ALS ~~Advanced Life Support~~ personnel shall fulfill Section 11.a and shall be senior (second and third year) residents.		
	b.		~~Receiving Hospital Emergency Departments~~RH EDs shall be staffed by:		
		1).	Full-time staff: those physicians who practice emergency medicine 120 hours per month or more, and/or		
		2)	Regular part-time staff: those physicians who see 90 patients or more per month in the practice of emergency medicine.		
			a) Formula: Average monthly census of acute patients divided by 720 hours equals average number of patients per hour. This figure multiplied by average hours worked by physician in emergency medicine equals patients per physician per month		

	YES	NO
b) Physicians working in more than one hospital may total their hours		
c) Acute patients exclude scheduled and return visits, physicals, and patients not seen by the ED Physician		
d) During period of double coverage, the whole shall be met if one of the physicians meets the above standards.)		
c. All ~~Receiving Hospitals~~RH ~~Registered Nurses~~RNs shall:		
1) Be regular hospital staff assigned solely to the ~~Emergency Department~~ED for that shift.		
2) Maintain current ACLS ~~Advanced Cardiac Life Support~~ certification.		
d. All other nursing and clerical personnel for the ~~Emergency Department~~ED shall maintain current Basic Cardiac Life Support certification.		
e. Sufficient licensed personnel shall be utilized to support the services offered.		
12. Cooperate with and assist the PSC and EMS Medical Director in the collection of statistics for program evaluation.		
13. Agree to maintain all prehospital data in a manner consistent with hospital data requirements and provide that the data be integrated with the patient's chart. Prehospital data shall include the Prehospital Care Record paramedic Base Hospital communication form (from the ~~Base Hospital~~BH), and documentation of a BH ~~Base Hospital~~ telephone communication with the ~~Receiving Hospital~~RH.		
14. Participate with the ~~Base Hospital~~BH in evaluation of paramedics for reaccreditation.		
15. Permit the use of the hospital helipad as an emergency rendezvous point if a State-approved helipad is maintained on hospital premises.		
B. There shall be a written agreement between the ~~Receiving Hospital~~ RHand EMS indicating the commitment of hospital administration, medical staff, and emergency department staff to meet requirements for employment as specified by EMS policies and procedures.		

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

RECEIVING HOSPITAL PHYSICIAN
CRITERIA COMPLIANCE CHECKLIST

Physician Name: _____ Date: _____

All Emergency Department physicians shall:		YES	NO
1.	Be immediately available to the RH ~~Receiving Hospital~~ ED ~~Emergency Department~~ at all times.		
2.	Be certified by the American Board of Emergency Medicine or have the following:		
a.	Have and maintain current ~~Advanced Cardiac Life Support~~ ACLS certification.		
b.	Complete at least 25 Category I CME hours per year with content applicable to Emergency Medicine.		
c.	It is recommended that ~~Receiving Hospital~~RH physicians be ATLS certified.		
3.	Full-time resident physician working in their own Institution's ~~Emergency Departments~~EDs. Resident physicians who function, as backup to ALS ~~Advanced Life Support~~ personnel shall fulfill Section 14.a and shall be senior (second and third year) residents.		

The above named physician is:

1)	Full-time staff: A physician who practices emergency medicine 120 hours per month or more, and/or		
2)	Regular part-time staff: A physician who see 90 patients or more per month in the practice of emergency medicine (Average monthly census of acute patients divided by 720 hours equals average number of patients per hour. This figure multiplied by average hours worked by physician in emergency medicine equals patients per physician per month, Physicians working in more than one hospital may total their hours, Acute patients exclude scheduled and return visits, physicals, and patients not seen by the ED Physician)		

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Use of Restraints		Policy Number 732
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: December 1, 2011
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: December 1, 2011
Origination Date: Date Revised: Date Last Reviewed: Review Date:	April 1, 2011 June 9, 2011 June 9, 2011 June 30, 2014	Effective Date: December 1, 2011

I. PURPOSE: To provide guidelines for the use of physical and chemical restraints during the course of emergency medical treatment or during an inter-facility transport (IFT) for patients who are violent or potentially violent to themselves or others.

II. AUTHORITY: California Health and Safety Code, Sections: 1797.2, 1798; California Code of Regulations, Title 22, Sections: 100075, 100147, 100160; California Administrative Code, Title 13, Section 1103.2.

III. DEFINITIONS:

A. Verbal Restraint: Any verbal communication from a pre-hospital provider to a patient utilized for the sole purpose of limiting or inhibiting the patient's behavior.

B. Physical Restraint: Any method in which a technique or piece of equipment is applied to the patient's body in a manner that reduces the subject's ability to move his arms, legs, head, or body.

C. Chemical Restraint: Any pharmaceutical administered by healthcare providers that is used specifically for the purpose of limiting or controlling a person's behavior or movement.

IV. POLICY:

A. Physical Restraint

1. Prior to use of physical or chemical restraints, every attempt to calm patient should be made using verbal, non physical means.
2. Perform a physical assessment and obtain a medical history as soon as safe and appropriate. Treat any underlying conditions per VCEMS 705 Treatment guidelines.
3. If necessary, apply soft physical restraints while performing assessment and obtaining history.

4. Padded soft restraints shall be the only form of restraints utilized by EMS providers.
5. Restraints shall be applied in a manner that does not compromise vascular, neurological, or respiratory status.
6. Extremities in which restraints are applied shall be continuously monitored for signs of decreased neurologic and vascular function
7. Patients shall not be transported in a prone position. The patient's position shall be in a manner that does not compromise vascular or respiratory status at any point. Additionally, the patient position shall not prohibit the provider from performing any and all assessment and treatment tasks.
8. Restraints shall be attached to the frame of the gurney.
9. Handcuffs applied by law enforcement require that an officer accompany the patient to ensure provider and patient safety and to facilitate removal of the restraint device if a change in the patient's condition requires it.
    a. If the patient is restrained with handcuffs and placed on a gurney, both arms shall be restrained to the frame of the gurney in a manner that in no way limits the ability to care for the patient. The patient should not be placed on gurney with hands or arms restrained behind patient's back.
    b. In the event that the law enforcement agency is not able to accompany the patient in the ambulance, a law enforcement unit must follow the ambulance in tandem along a predetermined route to the receiving facility.

B. Chemical Restraint

1. If while in restraints, the patient demonstrates behavior that may result in harm to the patient or providers, chemical restraint should be considered.
    a. Refer to VCEMS Policy 705: Behavioral Emergencies for guidance and administration of appropriate chemical restraint.
    b. It is important again to investigate and treat possible underlying causes of erratic behavior (e.g. hypoglycemia, trauma, meningitis).

C. Required Documentation

1. Instances in which physical or chemical restraints are applied shall be documented according to VCEMS Policy 1000. Required documentation shall include:
   a. Type of restraint applied (e.g. soft padded restraint, midazolam, handcuffs by law enforcement)
   b. Reason restraints were utilized.
   c. Location on patient restraints were utilized
   d. Personnel and agency applying restraints.
   e. Time restraints were applied
   f. Every 10 minute neurologic and vascular checks

~~2. Base Hospital shall be notified in all circumstances in which physical and chemical restraints are utilized.~~

.COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Ambulance Rates		Policy Number 112
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: July 1, 2012
Origination Date: Date Revised: Last Review: Review Date:	1984 July 1, 2012 July 1, 2012 July 1, 2013	Effective Date: July 1, 2012

I. PURPOSE: To define the allowable ambulance rates for the County of Ventura.

II. AUTHORITY: Ventura County Ambulance Ordinance.

III. POLICY: The rates described in this policy shall be the maximum charged by the ambulance companies in Ventura County.

IV. PROCEDURE: Ambulance rates are approved by the Board of Supervisors and are established based upon the cost to the ambulance operators to provide emergency ambulance service to the citizens of Ventura County. The rates listed are revised annually as needed, and are the maximum to be charged by all licensed ambulance companies to all users of the service. No rates shall be set, established, changed, modified or amended, unless according to the Ventura County Ambulance Ordinance.

COUNTY OF VENTURA

2012/13 Maximum Allowable Ambulance Rates

Pursuant to Ventura County Ordinance Code Section 2423-3, the following constitutes the schedule of maximum rates that may be charged, effective July 1, 2012

NON-EMERGENCY & ADVANCED LIFE SUPPORT RATES

Charge	2012-13	Definition
Non-Emergency Base Rate	$829.25	Transport from site of illness or injury to hospital or from hospital to home or other facility resulting from a non-emergency request.
Advanced Life Support Base Rate	$1,588.00	Transport from site of illness or injury to hospital as the result of an emergency request or for provision of ALS level services during any request for service.
Mileage	$33.00	Rate per mile from point of pickup to hospital. This charge is pro rated among the patients if more than one (1) patient is transported.
Oxygen Administration	$103.75	Charge made to patient for administration of oxygen and related adjuncts.

No charge is made for dispatch that is cancelled or that results in no provision of prehospital care.

Shortness of Breath – Pulmonary Edema

BLS Procedures

Administer oxygen as indicated

ALS Prior to Base Hospital Contact

Nitroglycerin

- SL or lingual spray – 0.4 mg q 1 min x 3
  - Repeat 0.4 mg q 2 min
  - No max dosage
  - Hold for SBP < 100 mmHg

Initiate CPAP for moderate to severe distress

Perform 12-lead ECG

IV access

If wheezes are present and suspect COPD/Asthma, consider:

- **Albuterol**
  - Nebulizer – 5mg/6mL

Communication Failure Protocol

Lasix

- IV – 40 mg
  - Only if patient prescribed Lasix or Bumex

If patient becomes or presents with hypotension

- **Dopamine**
  - IVPB – 10 mcg/kg/min

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Supraventricular Tachycardia

BLS Procedures

Administer oxygen as indicated

ALS Prior to Base Hospital Contact

Valsalva maneuver

IV Access

Stable – Mild to moderate chest pain/SOB

Unstable – ALOC, signs of shock or CHF

- Place on backboard and prepare for synchronized cardioversion

Communication Failure Protocol

Stable

- **Adenosine**
  - IV – 6 mg rapid push immediately followed by 10-20 mL NS flush

No conversion or rate control

- **Adenosine**
  - IV – 12 mg rapid push immediately followed by 10-20 mL NS flush
    - May repeat x 1 if no conversion or rate control

Unstable

- **Midazolam**
  - IV – 2 mg
    - Should only be given if it does not result in delay of synchronized cardioversion
    - For IV use – Dilute 5 mg (1 mL) Midazolam with 4 mL NS for a final volume of 5 mL concentration of 1 mg/mL
- **Synchronized Cardioversion**
  - Use the biphasic energy settings that have been approved by service provider medical director

Base Hospital Orders only

Consult with ED Physician for further treatment measure

Additional Information:

- Adenosine is contraindicated in pt with 2° or 3rd° AV Block, Sick Sinus Syndrome (except in pt with functioning pacemaker), or known hypersensitivity to adenosine
- Unless the patient is in moderate or severe distress, consider IV access and transport only. Consider withholding adenosine administration if patient is stable until ED Physician evaluation
- Document all ECG strips during adenosine administration and/or synchronized cardioversion

Symptomatic Bradycardia

ADULT (HR < 45 bpm)	PEDIATRIC (HR < 60 bpm)
BLS Procedures	
Administer oxygen as indicated Shock position as tolerated	Administer oxygen as indicated Assist ventilations if needed If significant ALOC, initiate CPR
ALS Prior to Base Hospital Contact	
IV access **Atropine** • IV – 0.5 mg (1 mg/10 mL) **Transcutaneous Pacing (TCP)** • Should be initiated only if patient has signs of hypoperfusion • Should be started immediately for 3º heart blocks and 2º Type 2 (Mobitz II) heart blocks • If pain is present during TCP o **Morphine** – per policy 705 - Pain Control	IV access • IO access only if pt in extremis **Epinephrine 1:10,000** • IV/IO – 0.01 mg/kg (0.1 mL/kg) q 3-5 min
Communication Failure Protocol	
If symptoms persist for 3 minutes after first atropine dose and if no capture with TCP • **Atropine** o IV – 0.5 mg q 3-5 min • Max 0.04 mg/kg • **Dopamine** o IVPB – 10 mcg/kg/min • Use if patient continues to be unresponsive to atropine and TCP	
Base Hospital Orders only	
For suspected hyperkalemia • **Calcium Chloride** o IV – 1 gm over 1 min • Withhold if suspected digitalis toxicity • **Sodium Bicarbonate** o IV – 1 mEq/kg	**Atropine** • IV/IO – 0.02 mg/kg o Minimum dose – 0.1 mg
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures
Additional Information • Bradycardia does not require treatment unless signs and symptoms are present (chest pain, altered level of consciousness, abnormal skin signs, profound weakness, or low BP)	

Trauma Assessment/Treatment Guidelines

I. Purpose: To establish a consistent approach to the care of the trauma patient

A. Rapid trauma survey

1. Airway

a. Maintain inline cervical stabilization

1) Follow spinal precautions per VCEMS Policy 614

b. Open airway as needed

2) Utilize a trauma jaw thrust to maintain inline cervical stabilization if indicated

c. Suction airway if indicated

2. Breathing

a. Assess rate, depth and quality of respirations

b. If respiratory effort inadequate, assist ventilations with BVM

c. Insert appropriate airway adjunct if indicated

d. Assess lung sounds

e. Initiate airway management and oxygen therapy as indicated

1) Maintain SpO2 ≥ 95%

3. Circulation

a. Assess skin color, temperature, and condition

b. Check distal/central pulses and capillary refill time

c. Control major bleeding

d. Initiate shock management as indicated

4. Disability

a. Determine level of consciousness (Glasgow Coma Scale)

b. Assess pupils

5. Exposure

a. If indicated, remove clothing for proper assessment/treatment of injury location. Maintain patient dignity

b. Maintain patient body temperature

B. Detailed physical examination

1. Head

a. Inspect/palpate skull

b. Inspect eyes, ears, nose and throat

2. Neck

a. Palpate cervical spine

b. Check position of trachea

c. Assess for jugular vein distention (JVD)

3. Chest

a. Visualize, palpate, and auscultate chest wall

4. Abdomen/Pelvis
    a. Inspect/palpate abdomen
    b. Assess pelvis, including genitalia/perineum if pertinent
5. Extremities
    a. Visualize, inspect, and palpate
    b. Assess Circulation, Sensory, Motor (CSM)
6. Back
    a. Visualize, inspect, and palpate thoracic and lumbar spines

C. Trauma care guidelines
1. Head injuries
    a. General treatments
        1) Evaluate head and face – maintain high index of suspicion for injury if significant mechanism of injury is present or physical examination is remarkable for findings
        2) If in spinal precautions, elevate head of backboard 30° unless contraindicated
        3) Do not attempt to intubate head injured patients unless unable to manage with BLS airway measures
        4) Do not delay transport if significant airway compromise
    b. Penetrating injuries
        1) DO NOT REMOVE IMPALED OBJECT (unless airway obstruction is present)
        2) Stabilize object manually or with bulky dressings
    c. Facial injuries
        1) Assess airway and suction as needed
        2) Remove loose teeth or dentures if present
    d. Eye injuries
        1) Remove contact lenses
        2) Irrigate eye thoroughly with suspected acid/alkali burns
        3) Avoid direct pressure
        4) Cover both eyes
        5) Stabilize any impaled object manually or with bulky dressings
2. Spinal cord injuries
    a. General treatments
        1) Evaluate spinal column – maintain high index of suspicion for injury if significant mechanism of injury is present or physical examination is remarkable for findings
        2) Place patient in shock position if hypotension is present
    b. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT

1) Stabilize object manually or with bulky dressings
2) Control bleeding if present
3) Even in the presence of penetrating injuries, if no neurologic deficit is present upon physical examination, consider withholding spinal immobilization

c. Neck injuries
1) Monitor airway
2) Control bleeding if present

3. Thoracic Trauma
a. General treatments
1) Evaluate chest – maintain high index of suspicion for internal injury if significant mechanism of injury is present or physical examination is remarkable for findings
2) Keep patients sitting high-fowlers
a) If in spinal precautions, elevate head of backboard 30° unless contraindicated
b) Even in the presence of penetrating injuries, if no neurologic deficit is present upon physical examination, consider withholding spinal immobilization

b. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
a) Remove object if CPR is interfered
b) Stabilize object manually or with bulky dressings
c) Control bleeding if present

c. Flail Chest/Rib injuries
a) Immobilize with padding and bulky dressings to affected area
b) Assist ventilations if respiratory status deteriorates

d. Pneumothorax/Hemothorax
a) Keep patient sitting high-fowlers
b) Assist ventilations if respiratory status deteriorates
1) Suspected tension pneumothorax should be managed per VCEMS Policy 715

e. Open (Sucking) Chest Wound
a) Place an occlusive dressing to wound site. Secure on 3 sides only
b) Assist ventilations if respiratory status deteriorates

f. Cardiac Tamponade – If suspected, expedite transport
a) Beck's Triad
1) Muffled heart tones
2) JVD

3) Hypotension

g. Traumatic Aortic Disruption

a) Assess for quality of radial and femoral pulses

b) If suspected, expedite transport

4. Abdominal/Pelvic Trauma

a. General Treatments

1) Evaluate abdomen and pelvis – maintain high index of suspicion for internal injury if significant mechanism of injury is present or physical examination is remarkable for findings

2) Goal of fluid resuscitation is to maintain SBP of > 80 mmHg. If SBP > 80 mmHg, then maintain IV at TKO rate

b. Blunt injuries

1) Place patient in shock position if hypotension is present

c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT

1) Stabilize object manually or with bulky dressings

2) Control bleeding if present

d. Eviscerations

1) DO NOT REPLACE ABDOMINAL CONTENTS

a) Cover wound with saline-soaked dressings

2) Control bleeding if present

e. Pregnancy

1) Place patient in left-lateral position

2) If in spinal immobilization, place padding under backboard to tilt to the left

f. Pelvic injuries

1) DO NOT LOG ROLL PATIENT

a) Assessment of pelvis should be only performed once to limit additional injury

2) Control bleeding if present

3) Consider wrapping a bed sheet tightly around the pelvis and tying it together for use as a sling

4. Extremity Trauma

a. General Treatments

1) Evaluate CSM distal to injury

a) If decrease or absence in CSM is present:

(1) Manually reposition extremity into anatomical position

(2) Re-evaluate CSM

b) If no change in CSM after repositioning, splint in anatomical position and expedite transport
c) Cover open wounds with sterile dressings
d) Place ice pack on injury area (if closed wound)
e) Splint/elevate extremity with appropriate equipment

b. Dislocations
1) Splint in position found with appropriate equipment

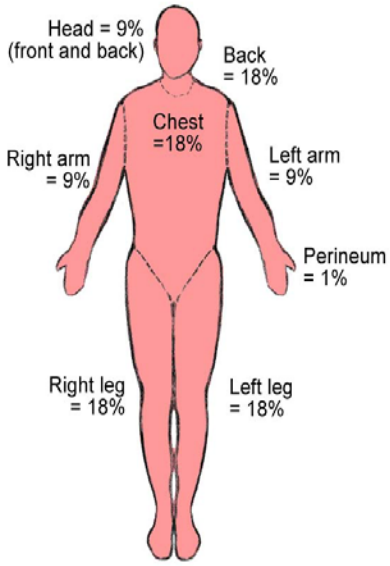
c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECTS
1) Stabilize object manually or with bulky dressings
2) Control bleeding if present

d. Femur fractures
1) Utilize traction splint only if isolated mid-shaft femur fracture is suspected
2) Assess CSM before and after traction splint application

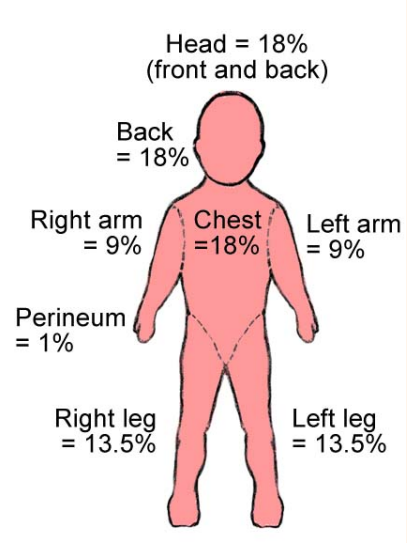
e. Amputations
1) Clean the amputated extremity with NS
2) Wrap in moist sterile gauze
3) Place in plastic bag
4) Place bag with amputated extremity into a separate bag containing ice packs
5) Prevent direct tissue contact with the ice packs

Burns

ADULT



PEDIATRIC



BLS Procedures

- Remove rings, constrictive clothing and garments made of synthetic material
- Assess for chemical, thermal, electrical, or radiation burns and treat accordingly
- If < 10% Total Body Surface Area (TBSA) is burned, cool with saline dressings and elevate burned extremities if possible
- Once area is cooled, remove saline dressings and cover with dry, sterile burn sheets
- Maintain body heat at all times
- Administer oxygen as indicated

ALS Prior to Base Hospital Contact

IV access
Morphine – per Policy 705 - Pain Control

If TBSA > 10% or hypotension is present:
- **Normal Saline**
  - IV bolus – 1 Liter

IV/IO access
Morphine – per Policy 705 - Pain Control

If TBSA > 10% or hypotension is present:
- **Normal Saline**
  - IV/IO bolus – 20 mL/kg

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Consult with ED Physician for further treatment measures

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES		HEALTH CARE AGENCY POLICIES AND PROCEDURES
Policy Title: Tourniquet Use		Policy Number: 731
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: December 1, 2010
APPROVED: Medical Director	Angelo Salvucci, M.D.	Date: December 1, 2010
Origination Date: Date Revised: Date Last Reviewed: Review Date:	July 2010 August, 2010 August, 2010 August 31, 2012	Effective Date: December 1, 2010

I. Purpose: To define the indications, procedure and documentation for tourniquet use by EMTs and paramedics.

II. Authority: Health and Safety Code, Sections 1797.220 and 1798.

III. Policy: EMTs and Paramedics may utilize tourniquets on patients in accordance with this policy.

IV. Procedure:

A. Indications

1. Life threatening extremity hemorrhage that can not be controlled by other means.

B. Contraindications

1. Non-extremity hemorrhage.
2. Proximal extremity location where tourniquet application is not practical.

C. Tourniquet Placement:

1. Visually inspect injured extremity and avoid placement of tourniquet over joint, angulated or open fracture, stab or gun shot wound sites.
2. Assess and document circulation, motor and sensation distal to injury site.
3. Apply tourniquet proximal to wound (usually 2-4 inches).
4. Tighten tourniquet rapidly to least amount of pressure required to stop bleeding.
5. Cover wound with appropriate sterile dressing and/or bandage.
6. Do not cover tourniquet- the device must be visible.
7. Re-assess and document absence of bleeding distal to tourniquet.
8. Remove any improvised tourniquet that may have been previously applied.
9. Tourniquet placement time must be documented on the tourniquet device.
10. Ensure receiving facility staff is aware of tourniquet placement and time tourniquet was placed.

D. Tourniquet Removal (Paramedic only)

1. Indications
    a. Releasing the tourniquet should only be considered if applied for 60 minutes or longer.
    b. Absence of bleeding distal to the tourniquet should be confirmed.
2. Procedure
    a. Obtain IV/ IO access.
    b. Maintain continuous ECG monitoring.
    c. Hold firm direct pressure over wound for at least 5 minutes before releasing tourniquet.
    c. Gently release the tourniquet and monitor for reoccurrence of bleeding
    d. Document time tourniquet was released.
    e. Bandage wound and re-assess and document circulation, motor and sensation distal to the wound site regularly.

E. Documentation

1. All tourniquet uses must be documented in the Ventura County Approved Documentation System.
2. Documentation will include location of tourniquet, time of application, and person at the receiving hospital to whom the tourniquet is reported.

Crush Injury/Syndrome

ADULT	PEDIATRIC
BLS Procedures	
Perform spinal precautions as indicated Determine Potential vs. Actual Crush Syndrome Administer oxygen as indicated	Perform spinal precautions as indicated Determine Potential vs. Actual Crush Syndrome Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
Potential crush injury • IV access • Maintain body heat • Release compression • Monitor for cardiac dysrhythmias	Potential crush injury • IV access • Maintain body heat • Release compression • Monitor for cardiac dysrhythmias
Communication Failure Protocol	
Actual crush syndrome • Initiate 2nd IV access • **Normal Saline** o IV bolus – 1 Liter • Caution with cardiac and/or renal history • **Sodium Bicarbonate** o IV mix – 1 mEq/kg • Added to 1st Liter of Normal Saline • **Albuterol** o Nebulizer – 5 mg/6 mL • Repeat x 2 • **Morphine** – Per Policy 705 - Pain Control • Maintain body heat • Release compression • Monitor for cardiac dysrhythmias • For cardiac dysrhythmias: o **Calcium Chloride** • IV – 1 gm over 1 min For continued shock • *Repeat* **Normal Saline** o IV bolus – 1 Liter	Actual crush syndrome • Initiate 2nd IV access if possible or establish IO • **Normal Saline** o IV/IO bolus – 20 mL/kg • Caution with cardiac and/or renal history • **Sodium Bicarbonate** o IV mix– 1 mEq/kg • Added to 1st Liter of Normal Saline • **Albuterol** o Less than 2 years old • Nebulizer – 2.5 mg/3 mL o Repeat x 2 o 2 years old and greater • Nebulizer – 5 mg/6 mL o Repeat x 2 • Maintain body heat • Release compression • Monitor for cardiac dysrhythmias • For cardiac dysrhythmias: o **Calcium Chloride** • IV/IO – 20 mg/kg over 1 min For continued shock • *Repeat* **Normal Saline** o IV/IO bolus – 20 mL/kg
Base Hospital Orders only	
For ongoing extended entrapment and no response to fluid therapy: • **Dopamine** o IVPB – 10 mcg/kg/min Consult with ED Physician for further treatment measures	For ongoing extended entrapment and no response to fluid therapy: • **Dopamine** o IVPB – 10 mcg/kg/min Consult with ED Physician for further treatment measures

Additional Information:
- If elderly or cardiac history is present, use caution with fluid administration. Reassess and treat accordingly.
- Dysrhythmias are usually secondary to Hyperkalemia. ECG monitor may show: Peaked T-waves, Absent P-waves, widened QRS complexes, bradycardia
- Calcium Chloride and Sodium Bicarbonate precipitate when mixed. Strongly consider starting a second IV (if feasible) for administration of Calcium Chloride

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Paramedic/MICN BH Communication Record		Policy Number 1001
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: 12/01/07
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: 12/01/07
Origination Date: Date Revised: Last Reviewed: Review Date:	July 6, 2007 July 9, 2007 June 11, 2009 July 31, 2011	Effective Date: December 1, 2007

I. PURPOSE: To define the use of the "EMT-P/MICN BH Communication Record" by approved Ventura County the Base Hospitals.

II. PROCEDURE:

A. This form should be used to document communication between the paramedic and mobile intensive care nurse (MICN). All pertinent areas of the form are to be completed by the MICN to document each patient contact between the paramedic and the MICN.

B. Base Hospital is responsible for providing the forms and ensuring documentation compliance.

C. Base Hospital is responsible for maintenance of records according to hospital data requirements.

D. Attachment A is provided as a sample only.

Policy 1001

HCA Ventura County Health Care Agency

EMT-P/BH COMMUNICATION RECORD

Patient's Name _____ Date _____ BH _____
Unit No. _____ Log No. _____ ☐ PM Radio ☐ Telephone ☐ County Radio Time _____ a.m./p.m.
PFR No. _____ Location _____ Age _____ ☐ M ☐ F Weight _____ Category _____

Complaint and Findings: _____

History: _____

Allergies: _____

Medications: _____

PMD _____

MENTAL STATUS
☐ Conscious
☐ Responds to Verbal
☐ Responds to Pain
☐ Purposefully
☐ Non Purposefully
☐ Posturing
☐ Non-Responsive
☐ Unconscious _____ min.

SPEECH
☐ Oriented X _____
☐ Confused
☐ Incomprehensable
☐ Silent

CHEST
☐ Symmetrical
☐ Asymetrical

PUPILS
☐ PERL
☐ Unequal
☐ R. Larger
☐ L. Larger
☐ Fixed
☐ Dilated
☐ Midpoint
☐ Pinpoint

SKIN

COLOR
☐ Pale
☐ Ashen
☐ Cyanotic
☐ Flushed

MOISTURE
☐ Normal
☐ Dry
☐ Diaphoretic

TEMP
☐ Normal
☐ Hot
☐ Cool
☐ Cold

CARDIAC ARREST
☐ Unwitnessed
☐ Witnessed _____ min.
☐ Bystander CPR

LUNG SOUNDS
☐ Clear R L
☐ Tidal Volume _____
☐ Wheezes R L
☐ Rales R L
☐ Other _____

ASSOC. SIGNS
☐ JVD
☐ Dep. Edema
☐ Tracheal Shift
☐ Tripoding
☐ Accessory Muscle Use

ABDOMINAL
☐ Distention
☐ Tenderness
☐ Mass

TREATMENT PRIOR TO BASE HOSPITAL CONTACT

BP _____
PULSE _____
RESP. _____
EKG _____

☐ IV Fluids _____
Route:
☐ Peripheral
☐ IO
☐ Fluid Challenge
_____ cc's
☐ Saline Lock

☐ Chemstick _____
☐ SAED _____
☐ DEFIB. _____
☐ Cardiovert _____
☐ Spinal Immobilization
☐ O, at _____ liters
☐ NRB
☐ NC

Airway Management
☐ Oral Airway
☐ Assisted
☐ ET
☐ Alt. Airway
☐ Lung Sounds Verified
☐ Tube Sounds Verified

Medication	Time	Dose/Route	Results
Albuterol			
Dextrose			
Narcan			
NTG			
Epi			
Atropine			
Lidocaine			
Valium			

TIME	BP	PULSE	RHYTHM	RESP	COMMENTS/ORDERS	RESULTS

ETA _____ min. Transported to _____ Hospital Notified (time) _____

Signature _____ MICN _____ M.D.

Diagnosis at Emergency Room _____

Patient Disposition:
☐ AMA on scene
☐ Treated and released
☐ Transferred to _____ Hospital
☐ Admitted to Hospital, Unit _____
☐ Died in ER

HCA 255 (rev. 8/95)

DISTRIBUTION: White - Chart Canary - HCA Pink - Hospital

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Prehospital Services Committee Operating Guidelines	Policy Number 105
APPROVED: Administration: Steve L. Carroll, EMT-P	Date: June 1, 2009
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: June 1, 2009
Origination Date: March, 1999 Date Revised: April 9, 2009 Date Last Reviewed: April 9, 2009 Review Date: April 30, 2012	Effective Date: June 1, 2009

I. Committee Name

The name of this committee shall be the Ventura County (VC) Prehospital Services Committee (PSC).

II. Committee Purpose

The purpose of this committee shall be to provide input to the VC Emergency Medical Services (EMS) Medical Director and VC EMS administration on matters pertaining to emergency medical services, including, but not limited to, dispatch, first responders, ambulance services, communications, medical equipment, training, personnel, facilities, and disaster medical response.

III. Membership

A. Voting Membership

Voting membership in the committee shall be composed of 2 representatives, as appointed by the organization administrator, from each of the following organizations:

Type of Organization	Member	Member
Base Hospitals	PCC	PLP
Receiving Hospitals	ED Manager	ED Physician
First Responders	Administrative	Field (provider of "hands-on" care)
Ambulance Companies	Administrative	Field (provider of "hands-on" care)
Emergency Medical Dispatch Agency	Emergency Medical Dispatch Coordinator (1 representative selected by EMD Agency coordinators)	
Air Units	Administrative	Field (provider of "hands-on" care)
Paramedic Training Programs	Director (1 representative from each program.)	

B. Membership Responsibilities

C. Non-voting Membership

Non-voting members of the committee shall be composed of the following

1. VC EMS Medical Director
2. VC EMS Administrator
3. VC EMS Administrative Support
4. VC County Counsel, as appropriate
5. VC EMS CQI Coordinator
6. VC EMS Emergency Medical Services Specialist

D. Membership Responsibilities

Representatives to PSC represent the views of their agency. Representative should ensure that agenda items have been discussed/reviewed by their agency prior to the meeting.

E. Voting Rights

Designated voting members shall have equal voting rights.

F. Attendance

1. Members shall remain as active voting members by attending 75% of the meetings in a (calendar) year. If attendance falls below 75%, the organization administrator will be notified and the member will lose the right to vote.
   (a) Physician members may have a single designated alternate attend in their place, no more than two times per calendar year.
   (b) Agencies may designate one representative to be able to vote for both representatives, no more than two times per calendar year.
2. The member whose attendance falls below 75% may regain voting status by attending two consecutive meetings.
3. If meeting dates are changed or cancelled, members will not be penalized for not attending.

IV. Officers

A. The chairperson of PSC is the only elected member. The chairperson shall perform the duties prescribed by these guidelines and by the parliamentary authority adopted by the PSC.

B. A nominating committee, composed of 3 members, will be appointed at the regularly scheduled March meeting to nominate candidates for PSC Chair. The election will take place in May, with duties to begin at the July meeting.

C. The term of office is one (1) year. A member may serve as Chair for up to three (3) consecutive terms.

V. Meetings

A. Regular Meetings

The PSC will meet on the second Thursday of each month, unless otherwise determined by the PSC membership. VCEMS will prepare and distribute electronic PSC Packet no later that one week prior to a scheduled meeting.

B. Special Meetings

Special meetings may be called by the chairman, VC EMS Medical Director, VC EMS Administrator or Public Health Director. Except in cases of emergency, seven (7) days notice shall be given.

C. Quorum

The presence a simple majority (1/2 of committee membership plus 1) of voting members shall constitute a quorum. The presence of a quorum at the beginning of the meeting shall allow the committee to continue to do business until adjournment, regardless of the number of members who leave during the meeting.

VI. Task Forces and Ad-hoc Committees

The PSC Chair, VC EMS Administrator, VC EMS Medical Director or Public Health Director may appoint task forces or ad-hoc committees to make recommendations to the PSC on particular issues. The person appointing the task force or ad-hoc committee will name the chair. A task force or ad-hoc committee shall be composed of at least three (3) members and no more than seven (7) individuals. Persons other than voting members may be appointed to task forces or ad-hoc committees.

VII. Calendar Year

The Prehospital Services Committee will operate on a calendar year

VIII. Parliamentary Authority

The rules contained in the current edition of Robert's Rules of Order, newly revised, shall govern the organization in all cases to which they are applicable and in which they are not inconsistent with these guidelines, and any special rules of order the PSC may adopt.

IX. Submission of Agenda Items

Agenda items shall be received by the Ventura County EMS Office 14 days before the meeting it is to be presented. Items may be submitted by US mail, fax or e-mail and must include the following information:

A. Subject

B. Reason for request

C. Description/Justification

D. Supporting medical information/other research as applicable

E. List of affected VC EMS policies, if a requested policy change

F. Agenda Category:

1. Operational
2. Medical

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Development Of Proposed Policies/Procedures; Amendments To Existing Policies		Policy Number 106
APPROVED: Administration	Steven L Carroll, EMT-P	Date: 12/01/09
APPROVED: Medical Director	Angelo Salvucci, M.D.	Date: 12/01/09
Origination Date: Date Revised: Last Reviewed: Review Date:	March 7, 1990 June 11, 2009 June 11, 2009 June 30, 2012	Effective Date: December 1, 2009

I. PURPOSE: To establish procedures to be followed when proposing new policies or amendments to existing policies

II. AUTHORITY: Health and Safety Code Section 1797.220

III. POLICY: Development/revision of policies and proposals for projects will follow the sequence outlined below

IV. PROCEDURE:

A. New Policies and/or Procedures

1. Proposals for new or revised policies and/or procedures will be considered from any interested agency or individual and will be submitted to Ventura County EMS using the attached form. Proposals shall include a complete description of the request and a system analysis including: advantages, disadvantages and any potential fiscal impact.
2. The proposal or amendment will be placed on the Prehospital Services Committee (PSC) agenda as an information item. The time interval between date of submission and the date of the next meeting will be considered when determining agenda placement. The PSC will review, amend, and make recommendations to the EMS Agency regarding adoption.
3. A first draft will be developed from the proposal by VC EMS staff for presentation at the PSC meeting.
4. The proposal and draft policy will be evaluated for need, impact on other policies, training needs, impact on Base Hospitals and Providers, etc. If necessary, special committees will be assigned for further evaluation. Composition of special committees will be determined by the type of policy/ procedure to be assessed.
5. If special committees are assigned:

a. The evaluation will take place as quickly as possible. Representatives of the special committees will confer as needed.

b. The consensus evaluation and consensus recommendations will be presented to the PSC for further action.

6. The EMS Medical Director and EMS Administrator will receive copies of all comments to proposals and draft policies for review and comment.

7. Proposals and policies may be distributed to potentially affected provider agencies and/or organizations, as appropriate for review and comment.

C. Amendments/Revisions to Existing Policies

1. Suggestions for amendment/revision to an existing policy will be submitted to VC EMS for review by the EMS Medical Director and EMS Administrator using the attached form.

2. The item will be placed on the agenda of the next meeting of the PSC.

3. Information regarding discussion and recommendations will be submitted to the EMS Medical Director for appropriate action.

Prehospital Services Committee
Agenda Item Request

Upon completion of this form, submit to the EMS Agency for review.

Submitted by:_____ Date:_____

Representing:_____

A. Description

Title of Agenda Item:_____

Description of Item

_____
_____
_____
_____
_____
_____

B. Analysis

How will this enhance the Ventura County EMS System?

_____
_____
_____

Advantages

_____
_____
_____

Disadvantages

_____
_____
_____

Financial Impact

Who has this item been presented to or reviewed by?

Attach any proposals or supportive documentation to this form.

C. EMS Agency Review

Received by VC EMS Agency: _____

Reviewed by EMS Administrator: _____

Assigned to:

_____ Purpose: _____
_____ Purpose: _____
_____ Purpose: _____
_____ Purpose: _____

EMS Staff Review Summary

D. Disposition

- ☐ Add as PSC Agenda item on: _____
- ☐ Inadequate or incomplete information - return submission
- ☐ Not to be addressed at this time, resubmit in _____.
- ☐ Adopt item
- ☐ Refer to: (for review and comment)
  - ☐ CQI Subcommittee
  - ☐ EMD Subcommittee
  - ☐ Prehospital Educators
  - ☐ MCI Subcommittee
  - ☐ Other: _____

EMS Administrator Signature:_____ Date:_____

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: "Code STEMI": Transfer of Patients with STEMI for PCI		Policy Number 440
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: 12/01/09
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: 12/01/09
Origination Date: Date Revised: Last Reviewed: Review Date:	July 1, 2007 June 11, 2009 June 11, 2009 September 30, 2012	Effective Date: December 1, 2009

I. PURPOSE: To define the "Code STEMI" process by which patients with a STEMI are transferred to a STEMI Receiving Center (SRC) for emergency percutaneous coronary intervention (PCI).

II. AUTHORITY: Health and Safety Code, Sections 1797.220 and 1798. California Code of Regulations, Title 22, Sections 100147 and 100169.

III. DEFINITIONS:

A. STEMI: ST Segment Elevation Myocardial Infarction.

B. STEMI Receiving Center (SRC): an acute care hospital with percutaneous coronary intervention (PCI) services that has been designated according to VC EMS Policy 430.

C. STEMI Referral Hospital (SRH): an acute care hospital in Ventura County that meets the requirements for a receiving hospital in VC EMS Policy 420 and is not designated as a STEMI Receiving Center according to VC EMS Policy 430.

D. PCI: Percutaneous Coronary Intervention.

IV. POLICY:

A. STEMI Referral Hospitals will:

1. Assemble and maintain a "STEMI Pack" in the emergency department to contain all of the following:
    a. Checklist with phone numbers of Ventura County SRCs.
    b. Preprinted template order sheet with recommended prior-to-transfer treatments. Treatment guidelines will be developed with input from the SRH and SRC cardiologists.
    c. Patient Consent/Transfer Forms.
    d. Treatment summary sheet.
    e. Ventura County EMS Code STEMI data entry form.
2. Have policies, procedures, and a quality improvement system in place to minimize door-to-ECG and STEMI-Dx-to-transfer times.

3. Establish policies and procedures to make personnel available to accompany the patient during the transfer to the SRC. These policies will include patient criteria for requiring an RN to accompany patient.

B. Ambulance Dispatch Center will:

1. Respond to a “Code STEMI” transfer request by immediately dispatching the closest available ALS ambulance to the requesting SRH.

C. Ambulance Companies

1. Ambulance Companies will:
   a. Respond immediately upon request for “Code STEMI” transfer.
   b. Staff all ambulances with a minimum of one paramedic who has been trained in the use of intravenous heparin and nitroglycerine drips, and the pump being used, according to VC EMS Policy 722.
2. Transports performed according to this policy are not to be considered an interfacility transport as it pertains to ambulance contract compliance.

D. STEMI Receiving Centers will:

1. Maintain accurate status information on ReddiNet regarding the availability of a cardiac catheterization lab.
2. Publish a single phone number, that is answered 24/7, to receive notification of a STEMI transfer.
3. Immediately upon initial notification by a transferring physician at an SRH, accept in transfer all patients who have been diagnosed with a STEMI and who, in the judgment of the transferring physician, require urgent PCI.
4. Authorize the emergency physician on duty to confirm the acceptance in transfer of any patient with a STEMI.
5. Establish an internal communications plan that assures the immediate notification of all necessary individuals, including the cardiac catheterization services staff and on-call interventional cardiologist, of the transfer.
6. Adopt procedures to make an ICU/CCU bed available or to make alternate arrangements for post-PCI care.

V. PROCEDURE:

A. Upon diagnosis of STEMI, and after discussion with the patient, the SRH will:

1. Determine availability of the SRC by checking ReddiNet.
2. Immediately call the Ventura County Fire Communication Center at 805-384-1500 for an ambulance.

3. Identify their facility to the dispatcher and advise they have a Code STEMI transfer to [SRC].
4. After calling for ambulance, the SRH transferring physician will notify the SRC emergency physician of the transfer.
5. Perform all indicated diagnostic tests and treatments.
6. Complete transfer consent, treatment summary, and Code STEMI data forms.
7. Include copies of the ED face sheet and demographic information.
8. Arrange for one or more healthcare staff, as determined by the clinical status of the patient, to accompany the patient to the SRC.
    a. If, because of unusual and unanticipated circumstances, no healthcare staff is available for transfer, the SRH may contact the responding ambulance company to make a paramedic or EMT available.
    b. If neither the SRH or ambulance company has available personnel, a CCT transfer may be requested.
9. Contact SRC for nurse report at the time of, or immediately after, the ambulance departs.

B. Upon request for "Code STEMI" transfer, the dispatch center will dispatch the closest ALS ambulance and verbalize "MEDxxx Code STEMI from [SRH]". The SRC will be denoted in the Incident Comments, which will display on the Mobile Data Computer (MDC). If a unit does not have an operational MDC, the SRH will advise the responding ambulance personnel of the SRC.

C. Upon notification, the ambulance will respond Code (lights and siren) and the ambulance personnel will notify their ambulance company supervisor of the "Code STEMI" transfer.

D. Ambulance units will remain attached to the incident and FCC will track their dispatch, en-route, on scene, en-route hospital, at hospital, and available times.

E. The patient shall be urgently transferred without delay. Every effort will be made to minimize on-scene time.
1. All forms should be completed prior to ambulance arrival.
2. Any diagnostic test results may be relayed to the SRC at a later time.
3. Intravenous drips may be discontinued or remain on the ED pump.
4. Ambulance personnel will place defibrillation pads on the patient.

F. Upon notification, the SRC will notify the interventional cardiologist and cardiac catheterization staff, who will respond immediately and prepare for the PCI procedure.

G. The SRH and SRC shall review all STEMI transfers within 24 hours for appropriate and timely care and to identify opportunities for improvement. Results will be reviewed and discussed at the Countywide EMS STEMI CQI Committee.