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

I.	**Introductions**		
II.	**Approve Agenda**		
III.	**Minutes**		
IV.	**Medical Issues**		
	A.	Other	
V.	**New Business**		
	A.	Policy 905:	Required Frequencies – S. Carroll
	B.	Sepsis Alert – C. Panke	
	C.	Policy 705.19:	Pain control - C. Panke
	D.	Other	
VI	**Old Business**		
	A.	Policy 1000:	Documentation – C. Rosa
	B.	Other	
VII.	**Informational/Discussion Topics**		
	A.	Other	
VIII.	**Policies for Review**		
	A.	Policy 1204:	EMS Aircraft Classification
	B.	Policy 620:	Oral Glucose
	C.	Policy 705.00:	General Patient Guidelines
	D.	Policy 705.02:	Allergic/Adverse Reaction and Anaphylaxis
	D.	Policy 705.03:	Altered Neurologic Function
	E.	Policy 705.04:	Behavioral Emergencies
	F.	Policy 705.05:	Bites and Stings
	G	Policy 705.12:	Heat Emergencies
	H.	Policy 705.13:	Hypothermia
	I.	Policy 705.16:	Neonatal Resuscitation
	J.	Policy 705.18:	Overdose/Poisoning
	L.	Policy 705.20:	Seizures
	L.	Policy 705.22:	Shortness of Breath - Wheezes/Other
	M.	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 August 9, 2012

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

For use in "Green Permit Parking" Areas only, EXCLUDES Patient parking areas

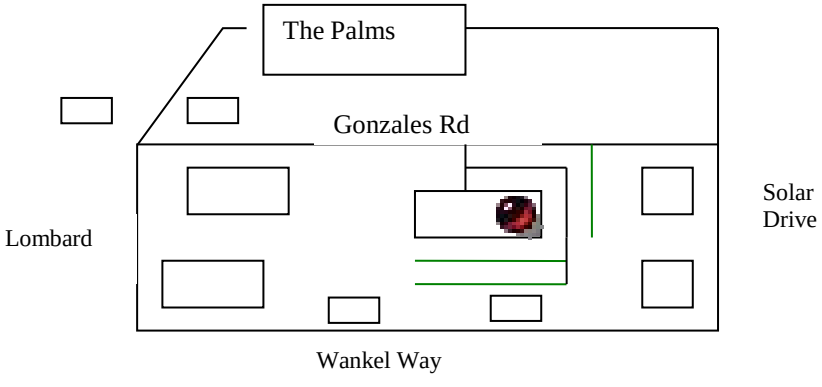
Parking Instructions: Parking at workshop venue is limited. Arrive early to allow for offsite parking if venue parking lot is full.

2240 Gonzales Rd. location
If you park in a designated "green permit parking" slot, fold this flyer in half and place pass face-up on the dash of your car, to avoid receiving a ticket.

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	July 12, 2012 9:30 a.m.

Topic	Discussion	Action	Assigned
I. Introductions	• Meeting was called to order at 937 AM • Susan Scott introduced Veronica Berardi who is the Stroke Coordinator for VCMC & SPH. • Jeff Winter introduced Kelly Kam, CCT Coordinator for LMT. • Dr. Larsen introduced Susan Martin • Rod Thorpe from OFD is standing in for Stephanie Huhn		
II. Approve Agenda		It was MS/C (J. Winter/M. Mundell) to approve the agenda as submitted.	
III. Minutes		Correction: Correct spelling of Dr. Larsen's name on page 3.	
IV. Medical Issues			
A. Stroke System	Stroke System in Ventura County will go live December 1. Most hospitals will be primary stroke centers by December 1.		
B. CPR Audit	Dr. Salvucci would like it to continue. Someone will be going around the county to audit CPR compliance.		
C. Policy 705.07: Cardiac Arrest Asystole & PEA			Approved as submitted.
D. Other			
V. New Business			
A. Policy 1135: Paramedic Program Approval Process – C. Rosa		• Change: • Page 9, duplicate word "authority" deleted.	Approved with change.
B. Policy 717: Intraosseous Infusion – C. Rosa	• How many agencies still carry them? • Have there been many failures? • Review date: June 2013 to revisit this issue.	• Change to page 3.a. approved. • All other changes not accepted.	Approved with change
C. Policy 606: Withholding or Termination of Resuscitation and DOD – C. Rosa		It was M/S/C (M. Stillwagon/ Larsen) to approve the policy as submitted.	Approved as submitted
D. Policy 1000: Documentation		The numbering beginning on page 4 is incorrect. Correct numbering.	• Tabled for next month. • Pending a report from Chris Rosa regarding the arrival at destination, post incident and clearing the call.
E. Other			
VI Old Business			

	A. Sidewalk CPR Report – S. Carroll	Sidewalk CPR was a huge success. Ventura County will be doing more events on a smaller scale with less sites June 2013 will be CPR week; and will conduct another Sidewalk CPR event.		
	B, PSC Chairperson Election		Jeff Winter was elected as the new PSC chair.	
	C. Policy 410: ALS Base Hospital Approval Process		Correction to page 6, 11. Change tape communication to recorded communication It was M/S/C (K. McShea/D. Licht) to approve the policy with a.	Approved with change.
	D. Policy 420: Receiving Hospital Standards		Change: Removed "specializing in Emergency…on page 2 along with comment. It was M/S/C (D. Chase/T. Norton) to approve the policy with above change.	Approved with change.
	E. Policy 732: Restraints – C. Rosa		Change: Page 3.C.2, remove the last line. It was M/S/C (N. Plott/K. McShea) to approve the policy with above change.	Approved with change.
	F. Other			
VII.	**Informational/Discussion Topics**			
	A. Continuing Education Certificates	Steve Carroll reported that: • EMSA is returning continuing education for Field Care Audit, EMS Update, and Airway Lab certificates as they look like duplicate course completions. • Paramedics need to clarify the date, time and name of the class that they received the CE certificate for (ex: EMS Update, Spring 2012) • VCEMS is working with EMSA to get Airway lab approved by the state EMSA as this is a CQI required course.		
	B. Policy 112: Ambulance Rates		Policy is on agenda for review only.	Information only
	C. Cardiac Arrest Management (ART/BART)	• CQI committees were combined into one group • Broken down into 3 subcommittees: • Cardiac Arrest subcommittee, Training Committee, and Logistics committee • OFD and GCA will be doing the trainings		
	D. Other			
VIII.	**Policies for Review**			
	A. Policy 705.21: Shortness of Breath – Pulmonary Edema		Approved as submitted	Approved

B. Policy 705.23: Supraventricular Tachycardia		Approved as submitted	Approved
C. Policy 705.24: Symptomatic Bradycardia		Change: Remove shock position and replace with supine if tolerated	Approved with change
D. Policy 705.01: Trauma Treatment Guidelines		Change: • Page 2.C.2: General Treatment, number 2, replace shock position with supine if tolerated. • Page 3.C.2C.3: Remove the word "even" and replace with "isolated". • Remove the word "consider" and change withholding to withhold. • Page 4.B.1, remove "shock" and replace with the "supine".	Approved with changes
E. Policy 705.06: Burns			Approved as submitted
F. Policy 731: Tourniquet Use			Approved as submitted
G. Policy 705.11: Crush Injury/Syndrome			Approved as submitted
H. Policy 1001: Paramedic/BH Communication Record		Mike Stillwagon will submit the communication log that field personnel use for BH Communication record	
I. Policy 105: PSC Operating Guidelines			Approved as submitted
J. Policy 106: Development of Proposed Policies/Procedures			Approved as submitted
K Policy 440: Code STEMI Interfacility Transfer			Approved as submitted
L. Other	C-Spine policy will need to be reviewed at next PSC in conjunction with the changes to Policy 705.01 Trauma Treatment Guidelines		C-Spine policy for agenda next month along with 705.01.
IX. Reports			
TAG Report	Meredith Mundell is standing in for Robin Shedlosky • STEMI: 15 of 16 STEMI patients were treated in 90 minutes or less. • ALS/BLS: CAM will be starting October 1, 2012. • Base Hospital: Fall Skills will be September 7, 10, 24, and 28th at SJRMC, Classrooms 1 -4, from 930 to 1230. • Stroke: now have a Stroke Committee; Stroke Programs go live December 1, 2012.		

X.	**Agency Reports**			
	A. ALS Providers	VNC • 4 CPR saves, one of them was a 5 year old child and a 31 year old female. . • New academy will start next week with 15 firefighters GCA: Reorganization; • Chad Panke will be taking over CE for GCA and AMR and Mike Stillwagon will be Chad's back-up. • Mike Stillwagon will be doing community outreach education for both companies. Good response from community requesting CPR education/information • Promoted 9 to field assistant supervisors VEN: Conducting sidewalk CPR at Street Fair, over 110 people. A few more are scheduled 3-4 people will be starting in the academy		
	B. BLS Providers	SPA: Received a state grant and are in the process of hiring 5 full time firefighters and will be staffed full time OFD: July 23 had 5 new firefighters hired. Received a grant and will be hiring 12 additional firefighters		
	C. Base Hospitals	SJRMC: Skills lab is coming up in September LRHMC: ART/BART in hospital		
	D. Receiving Hospitals	No report		
	E. ALS Education Programs	Program graduated all students. 100% on practical and written exam. Thanks to all those who have assisted with the program. 19 so far enrolled for August.		
	F. EMS Agency	Magnolia clinic will be moving into the EMS building. We may likely run out of the ability to hold PSC at this location and parking will be an issue. EMS Newsletter will be discontinued as it is too time consuming.		
	G. Other	None		
XI.	**Closing**	**Meeting adjourned at 11:10 AM**		

Respectfully submitted,
Debora Haney

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			CP						
CMH - ER	Canby	Neil		NC					NC						
CMH - ER	Cobb	Cheryl		CC		CC									
FFD	Herrera	Bill		BH											
FFD	Scott	Bob		BS											
GCA	Norton	Tony		TN		TN			TN						
GCA	Stillwagon	Mike		MS		MS			MS						
Lifeline	Kuroda	Brian		BK		BK			BK						
Lifeline	Winter	Jeff		JW		JW			JW						
LRRMC - ER	Beatty	Matt				MB			MB						
LRRMC - ER	Licht	Debbie		DL		DL			DL						
OFD	Carroll	Scott		SC											
OFD	Huhn	Stephanie		SPH		SPH			RT						
OVCH	Boynton	Stephanie		SB		SB									
OVCH	Patterson	Betsy		BP		BP									
SJPVH	Hernandez	Sandi		SH		SH			SH						
SJPVH	Davies	Jeff													
SJRMC	McShea	Kathy		KM		KM			KM						
SJRMC - SJPVH	Larsen	Todd		TL		TL			TL						
SPFD	Dowd	Andrew				AD			AD						
SVH - ER	Tilles	Ira		IT		IT			IT						
SVH - ER	Hoffman	Jennie		JH		JH									
V/College	Mundell	Meredith		MM		MM			MN						
VCFD	Merman	Nancy		NM		NM			NM						
VCFD	Tapking	Aaron		AT		AT			AT						
VNC	Plott	Norm		NP		NP			NP						
VNC	Black	Shannon		SB					SB						
VNC	Shedlosky	Robin		RS		RS									
VCMC - ER	Chase	David		DC		DC			DC						
VCMC - ER	Utley	Dede		DU		DU									
VCMC-SPH	Daucett	Michelle				MD			KB						

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	%
VCMC-SPH	Beatty	Karen		KB		KB			DH						
VCSO SAR	Hadland	Don		DH		DH									
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			SC						
AMR	Drehsen	Charles		CD		CD			CD						
VCMC	Duncan	Thomas		TD					TD						
EMS	Fisher	Barry													
LMT	Frank	Steve		SF		SF									
EMS	Hadduck	Katy		KH		KH			KH						
EMS	Haney	Debora				DH									
EMS	Lara-Jenkins	Stephanie		SLJ		SLJ			SLJ						
EMS	Rosa	Chris		CR		CR			CR						
EMS	Salvucci	Angelo				AS			AS						
SAR	Askew	Chris													
CSUDA	Parker	Pilar													
OFD	Donabedian	Chris													
VNC	Komins	Mark		MK		MK									
AMR	Glass	Gil		GG											
VNC	Gregson	Erica		EG		KD			EG						
AMR	Taigman	Mike				MT			MT						
VCMC-ED	Scott	Susan							SS						
VCMC	Berardi	Veronica							VB						
EMS	Grimes	Nikki							NG						

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Ambulance Provider Response Units: Required Frequencies	Policy Number 905
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: December 1, 2012
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: December 1, 2012
Origination Date: July 1, 1999 Date Revised: Date Last Reviewed: Next Review Date:	Effective Date: December 1, 2012

I. PURPOSE: To ~~list~~ define the communications frequencies required on ambulance provider response units.

II. AUTHORITY: Health and Safety Code, Division 2.5, Section 1797.204

III. POLICY: Ambulance provider response units shall be equipped ~~to use the frequencies~~as listed in this policy.

IV. PROCEDURE:

A. Ambulance provider response unit mobile radios shall be programmed ~~with the following frequencies~~with the first 64 channels of the current Ventura County Fire Protection District radio plan. To reduce confusion, assignments for channels 1-~~16~~ 64 will be programmed exactly as ~~follows~~ listed in the radio plan on all vehicle mounted mobile radios. It is recommended that all portable radios also utilize the same program list; however, providers may adjust the portable lists to accommodate agency specific issues.

~~CH.~~	~~GRP CH~~		~~DISPLAY~~	~~ASSIGNMENT~~	~~RX~~	~~CTCSS~~	~~TX~~	~~CTCSS~~
~~1~~	~~1/A~~	~~1~~	~~DISPATCH~~	~~Dispatch~~	~~154.0100~~	~~100.0~~	~~154.0100~~	~~100.0~~
~~2~~	~~1/A~~	~~2~~	~~CMND 2~~	~~East Command~~	~~154.3250~~	~~100.0~~	~~154.3250~~	~~100.0~~
~~3~~	~~1/A~~	~~3~~	~~TAC 3~~	~~East Tactical~~	~~153.9500~~	~~127.3~~	~~153.9500~~	~~127.3~~
~~4~~	~~1/A~~	~~4~~	~~CMND 4~~	~~North Command~~	~~154.1000~~	~~100.0~~	~~155.1000~~	~~123.0~~
~~5~~	~~1/A~~	~~5~~	~~TAC 5~~	~~North Tactical~~	~~154.0250~~	~~100.0~~	~~154.0250~~	~~100.0~~
~~6~~	~~1/A~~	~~6~~	~~CMND 6~~	~~West Command~~	~~155.8350~~	~~100.0~~	~~155.8350~~	~~100.0~~
~~7~~	~~1/A~~	~~7~~	~~TAC 7~~	~~West Tactical~~	~~153.8300~~	~~100.0~~	~~153.8300~~	~~100.0~~
~~8~~	~~1/A~~	~~8~~	~~WHITE 1~~	~~OES White 1~~	~~154.2800~~	~~CSQ~~	~~154.2800~~	~~100.0~~
~~9~~	~~1/A~~	~~9~~	~~WHITE 2~~	~~OES White 2~~	~~154.2650~~	~~CSQ~~	~~154.2650~~	~~100.0~~
~~10~~	~~1/A~~	~~10~~	~~WHITE 3~~	~~OES White 3~~	~~154.2950~~	~~CSQ~~	~~154.2950~~	~~100.0~~
~~11~~	~~1/A~~	~~11~~	~~LAC T-17~~	~~LAC Tac 17~~	~~154.4300~~	~~CSQ~~	~~154.4300~~	~~151.4~~
~~12~~	~~1/A~~	~~12~~	~~LAC T-18~~	~~LAC Tac 18~~	~~154.3400~~	~~CSQ~~	~~154.3400~~	~~151.4~~
~~13~~	~~1/A~~	~~13~~	~~OXD Ch.1~~	~~OXD Ch. 1~~	~~154.1450~~	~~141.3~~	~~156.2100~~	~~141.3~~
~~14~~	~~1/A~~	~~14~~	~~OXD Ch.3~~	~~OXD Ch. 3~~	~~154.0700~~	~~123.0~~	~~156.0300~~	~~123.0~~
~~15~~	~~1/A~~	~~15~~	~~TAC 15~~	~~Ventura City Tactical~~	~~155.8650~~	~~100.0~~	~~155.8650~~	~~100.0~~
~~16~~	~~1/A~~	~~16~~	~~CMND 16~~	~~Ventura City Command~~	~~155.0400~~	~~100.0~~	~~154.3700~~	~~100.0~~

B. ~~Ambulance provider response unit radios shall be programmed with the following frequencies; however, the specific channel order may be adjusted to accommodate agency specific issues.~~ Channels 30, 31 and 32, in the Ventura County Fire Protection District radio plan, are available

for the ambulance provider to program agency specific frequencies, if desired. Frequencies on channels 65 and above may be programmed at provider's discretion.

17	2/B	1	MOB RPT	Mobile Repeater	159.1800	CSQ	159.1800	67.0
18	2/B	2	VCSD 1	V.C.S.D. West County [SEMS 1]	159.2100	110.9	159.2100	110.9
19	2/B	3	VCSD 3	V.C.S.D. East County [SEMS 2]	156.1500	123.0	156.1500	123.0
20	2/B	4	VCSD 4	V.C.S.D. North County	151.1300	151.4	151.1300	151.4
21	2/B	5	VPD	Ventura PD	155.3100	100.0	156.1200	100.0
22	2/B	6	OXPD	Oxnard PD	155.7450	100.0	159.1200	100.0
23	2/B	7	PHPD	Port Hueneme PD	158.8800	100.0	158.8800	100.0
24	2/B	8	SVPD	Simi Valley PD	160.7850	100.0	154.8900	100.0
25	2/B	9	SPPD	Santa Paula PD	158.8350	100.0	158.8350	100.0
26	2/B	10	FILLMORE	Fillmore City Tactical	154.2050	100.0	154.2050	100.0
27	2/B	11	LARTCS 5	LARTCS 5V	159.0300	100.0	155.5800	100.0
28	2/B	12	MED 2	MedNet 2	155.3550	103.5	155.3550	103.5
29	2/B	13	MED 3	MedNet 3	155.3850	103.5	155.3850	103.5
30*	2/B	14	-	AGENCY CONFIGURABLE	-	-	-	-
31*	2/B	15	-	AGENCY CONFIGURABLE	-	-	-	-
32*	2/B	16	-	AGENCY CONFIGURABLE	-	-	-	-

C. The frequencies listed on Channels 33-64 are recommended for placement on all ambulance provider response units' mobile and portable radios. Any ambulance provider units that respond to 911 calls shall have a minimum of one mobile radio and one portable radio (mobile or portable) programmed with these frequencies for mutual aid purposes.

33	3/C	1	DISP RPT	Dispatch - REPEAT	154.0100	100.0	156.0600	110.9
34	3/C	2	CMD2 RPT	East Command - REPEAT	154.3250	100.0	155.8350	110.9
35	3/C	3	VNC A/G	VNC Air-to-Ground	154.2350	CSQ	154.2350	CSQ
36	3/C	4	LAC T-19	LAC Air-to-Ground [T-19]	154.4000	CSQ	154.4000	151.4
37	3/C	5	CDF C-1	CDF Command 1	151.3550	CSQ	159.3000	136.5
38	3/C	6	CDF A/G	CDF Air-to-Ground	151.2200	CSQ	151.2200	CSQ
39	3/C	7	LPF A/G	USFS Air-to-Ground	170.0000	CSQ	170.0000	CSQ
40	3/C	8	LPF SIS	LPF Forest Net - Sisar	170.5500	CSQ	169.9000	123.0
41	3/C	9	LPF TOR	LPF Forest Net - Torrey	170.5500	CSQ	169.9000	156.7
42	3/C	10	LPF FRA	LPF Forest Net - Frazier	170.5500	CSQ	169.9000	110.9
43	3/C	11	LPF ABEL	LPF Forest Net - Abel	170.5500	CSQ	169.9000	167.9
44	3/C	12	KRN Ch. 1	Kern Co FD - Dispatch	155.8800	167.9	158.9400	167.9
45	3/C	13	KRN Ch. 3	Kern Co FD - Lockwood Valley	155.6250	167.9	158.8500	167.9
46	3/C	14	LCWD 1	Lockwood Vly VSO 1 - REPEAT	159.2100	100.0	154.0550	67.0
47	3/C	15	LCWD 11	Lockwood Vly VSO 11 - REPEAT	158.7300	100.0	154.0550	77.0
48	3/C	16	AIRGUARD	Air Guard	168.6250	CSQ	168.6250	110.9
49	4	1	SEMS 1	SEMS 1 [VCSD Ch. 1]	159.2100	110.9	159.2100	110.9
50	4	2	SEMS 2	SEMS 2 [VCSD Ch. 3]	156.1500	123.0	156.1500	123.0
51	4	3	SEMS 3	SEMS 3 [VNC Ch. 1]	154.0100	100.0	154.0100	100.0
52	4	4	SEMS 4	SEMS 4 [VCSD Car-to-Car]	158.7300	100.0	158.7300	100.0
53	4	5	SEMS 5	SEMS 5 [VCSD Ch. 2]	155.5350	114.8	155.5350	114.8
54	4	6	SEMS 7	SEMS 7 [MEDNET 1]	155.2050	103.5	155.2050	103.5
55	4	7	SEMS 8	SEMS 8 [VCSD SAR]	155.1600	CSQ	155.1600	CSQ
56	4	8	SEMS 9	SEMS 9 [COUNTYWIDE LAW]	156.0150	100.0	156.0150	100.0
57	4	9	SEMS 11	SEMS 11 [VEN. CO. PUB. WRKS]	151.0250	CSQ	156.2400	141.3
58	4	10	SEMS 12	SEMS 12 [CALCORD]	156.0750	CSQ	156.0750	CSQ
59	4	11	VCSD RED	V.C.S.D. M/A - RED	153.8450	CSQ	158.9400	110.9
60	4	12	VCSD SOU	V.C.S.D. M/A - SOUTH	153.8450	CSQ	158.9400	100.0
61	4	13	VCSD RIN	V.C.S.D. M/A - RINCON	153.8450	CSQ	158.9400	88.5
62	4	14	VCSD ROC	V.C.S.D. M/A - ROCKETDYNE	153.8450	CSQ	158.9400	97.4
63	4	15	MED 4	MEDNET 4	155.1750	103.5	155.1750	103.5
64	4	16	MED 5	MEDNET 5	155.0250	103.5	155.0250	103.5

D. Ambulance providers will post a list of frequency channel assignments in each response unit.

E. A list of frequency channel assignments will be submitted to VCEMS by each ambulance provider.

Ventura County EMS Sepsis Alert

Sepsis Alert Criteria

Temp >38°C (100.4°F) or < 36°C (96.8°F)?

Heart Rate > 90?

Respiratory Rate > 20

Suspected or Present Source of Infection? Look for wounds or recent antibiotics

If yes to all above notify receiving hospital of a possible sepsis patient

Severe Sepsis Criteria

Hypotension or Hypo-perfusion?

SBP <90 or SBP Drop >40 mm Hg of normal, etc

Septic Shock Criteria

Severe Sepsis with Hypotension, despite adequate fluid resuscitation?

Notify base of additional findings listed above if found

Pain Control

ADULT	PEDIATRIC
BLS Procedures	
Place patient in position of comfort Administer oxygen as indicated	Place patient in position of comfort Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
IV access **Morphine** • IV – 2-4 mg over 1-2 min o Repeat q 3 min as needed for pain relief o Max 10 mg • IM – 0.1 mg/kg o Max 10 mg Recheck vital signs before and after each administration • Hold if SBP < 100 mmHg *If patient has significant injury to head, chest, abdomen or is hypotensive, **DO NOT** administer pain control unless ordered by ED Physician*	IV access **Morphine** – given for burns and isolated extremity injuries only • IV – 0.1 mg/kg over 1-2 min o May repeat x 1 after 3 min as needed for pain relief o Max 0.2 mg/kg or 10 mg • ~~IM – 0.2 mg/kg~~ • IM – 0.1mg/kg o Max 10 mg Recheck vital signs before and after each administration *If patient has significant injury to head, chest, abdomen or is hypotensive, **DO NOT** administer pain control unless ordered by ED Physician*
Communication Failure Protocol	
If significant pain continues: • **Morphine** o IV – 2-4 mg over 1-2 min • Max repeat dose of 10 mg • Max total dosage of 20 mg o IM – 0.1 mg/kg • Max repeat dose of 10 mg	If significant pain continues: • **Morphine** o IV – 0.1 mg/kg over 1-2 min • May repeat x 1 after 3 min as needed for pain relief • Max repeat dose of 10 mg • Max total dosage of 0.4 mg/kg or 20 mg o IM – 0.2 mg/kg • Max repeat dose of 10 mg
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures

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.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMS Aircraft Classification		Policy Number 1204
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:	May 1999 July 9, 2007 June 11, 2009 July 31, 2011	Effective Date: December 1, 2007

I. PURPOSE:

To determine the types of aircraft available to provide emergency air transport for a patient in Ventura County.

II. POLICY:

All EMS Aircraft shall be classified as an Air Ambulance, a Rescue Aircraft or an Auxiliary Rescue Aircraft.

III. PROCEDURE:

A. EMS aircraft classifications shall be limited to the following categories:

1. Air Ambulance. An air ambulance is an aircraft specially constructed, modified or equipped, and used for the primary purposes of responding to emergency calls and transporting critically ill or injured patients whose medical flight crew has at a minimum two (2) attendants certified or licensed in advanced life support.
2. Rescue Aircraft. A rescue aircraft is an aircraft whose usual function is not prehospital emergency patient transport but which may be utilized, in compliance with local EMS policy, for prehospital emergency patient transport when use of an air or ground ambulance is inappropriate or unavailable. Rescue aircraft includes ALS rescue aircraft, BLS rescue aircraft and Auxiliary rescue aircraft.
   a. Advanced Life Support Rescue Aircraft. An Advanced Life Support (ALS) rescue aircraft is a rescue aircraft whose medical flight crew has at a minimum one attendant certified or licensed in advanced life support.
   b. Basic Life Support Rescue Aircraft. A Basic life Support Rescue aircraft is a rescue aircraft whose medical flight crew has at a minimum one attendant certified as an EMT-I, or an EMT-I with at least eight (8) hours of hospital clinical training and whose field/clinical experience specified in Section

100074 (c) of Title 22, California Code of Regulations, is in the aeromedical transport of patients.

3. Auxiliary Rescue Aircraft. Auxiliary rescue aircraft is a rescue aircraft which does not have a medical flight crew.

B. EMS Aircraft classification shall be reviewed at 2 year intervals. Reclassification shall occur if there is a transfer of ownership or a change in the aircraft's category. A request from a designated dispatch center shall be deemed as authorization of aircraft operated by the California Highway Patrol, Department of Forestry, National Guard or the Federal Government

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMT-I Administration of Oral Glucose		Policy Number 620
APPROVED: Administration:	Barry R. Fisher, MPPA	Date: December 1, 2008
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: December 1, 2008
Origination Date: Date Revised: Date Last Reviewed: Next Review Date:	November 18, 1982 March 9, 2006 October 9, 2008 October, 2011	Effective Date: December 1, 2008

I. PURPOSE: To define the indications and use of oral glucose by EMTs.

II. AUTHORITY: Health and Safety Code 1798, 1797.220. California Code of Regulations, Title 22, Section 100063.

III. POLICY:

A. Oral glucose is to be used only if the patient meets the following criteria:

1. The patient has a history of diabetes controlled by medication
2. Shows signs or symptoms of altered mental status.
3. The patient is conscious, able to swallow and protect their airway (intact gag reflex).

IV. PROCEDURE:

A. The following instructions should be followed:

1. Check the expiration date of the oral glucose
2. Monitor patient's airway closely during administration
3. Administer the entire tube in small increments
   a. Squeeze small portions of the oral glucose into the mouth between the cheek and gum or
   b. Place small portions f the oral glucose on a tongue depressor and deposit the medication between the cheek and gum
4. Lightly massage the cheek to increase absorption; the medication should not be swallowed.
5. If the patient loses consciousness or seizes, stop administration, consider suctioning.

6. Reassess the patient for improvement in mental status
7. Document the patient's assessment, the time and amount of medication administered and patient's reassessment.

VCEMS General Patient Guidelines

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

A. Initial response

1. Review dispatch information with crew members and dispatch center as needed
2 Consider other potential issues (location, time of day, weather, etc.)

B. Scene arrival and Size-up

1. Address Body Substance Isolation/Personal Protection Equipment (BSI/PPE)
2. Evaluate scene safety
3. Determine the mechanism of injury (if applicable) or nature of illness
4. Determine the number of patients
5. Request additional help if necessary (refer to VCEMS Policy 131)
6. Consider spinal precautions (refer to VCEMS Policy 614)

C. Initial assessment

1. Airway
   a. Open airway as needed, maintaining inline cervical stabilization if trauma is suspected
   b. Insert appropriate airway adjunct if indicated
   c. Suction airway if indicated
   d. If a partial or complete Foreign Body Airway Obstruction (FBAO) is present, utilize appropriate interventions
2. Breathing
   a. Assess rate, depth, and quality of respirations
   b. Assess lung sounds
   c. If respiratory effort inadequate, assist ventilations with BVM
   d. Initiate airway management and oxygen therapy as indicated
3. Circulation
   a. Assess skin color, temperature, and condition
   b. Check distal/central pulses, including capillary refill time
   c. Control major bleeding
   d. Initiate shock management as indicated
4. Disability
   a. Determine level of consciousness
   b. Assess pupils
   c. Assess Circulation, Sensory, Motor (CSM)
5. Exposure
   a. If indicated, remove clothing for proper assessment/treatment of injury location. Attempt to maintain patient dignity

b. Maintain patient body temperature at all times

D. Determine chief complaint. Initiate treatment per VCEMS policies/protocols

II. History of Present Illness – including pertinent negatives and additional signs/symptoms

1. Onset of current illness or chief complaint
2. Provoking factors
3. Quality
4. Radiation
5. Severity – 1 to 10 on pain scale
6. Time

III. Vital Signs

1. Blood Pressure and/or Capillary Refill
2. Heart Rate
3. Respirations
4. ALS assessments shall include:
   a. Cardiac rhythm
   b. 12-lead ECG as indicated per VCEMS Policy 726
   c. Pulse Oximetry
   d. Capnography (after advanced airway placement)

IV. Obtain history, including pertinent negatives

1. Signs/Symptoms leading up to the event
2. Allergies
3. Medications taken
4. Past medical history
5. Last oral intake (as indicated)
6. Events leading up to present illness

V. Perform Detailed Physical Examination per Trauma Assessment/Treatment Guidelines

VI. Base Hospital contact shall be made for all ALS patients in accordance with VCEMS Policy 704

VII. Transport to appropriate facility per VCEMS guidelines

1. Transport and Destination Guidelines – Policy 604
2. STEMI Receiving Center Standards – Policy 430
3. Post VF/VT with ROSC – Policy 705 (Cardiac Arrest VF/VT)
4. Trauma Triage and Destination Criteria – Policy 1405
5. Hospital Diversion – Policy 402

VII. Continuously monitor vital signs and document all findings. Continue appropriate treatments and reassess throughout transport to assess for changes in patient status

IX. Documentation

1. Completion of patient care documentation per VCEMS Policy 1000

2. Document all assessment findings, pertinent negatives, vital signs, interventions/treatments (both initial and ongoing), responses to treatments, and all changes in patient status
3. Submit ECG strips for all ALS patients
4. Maintain patient confidentiality at all times

Allergic/Adverse Reaction and Anaphylaxis

ADULT

BLS Procedures

Assist with prescribed **Epi-Pen**
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

Allergic Reaction or Dystonic Reaction
- **Benadryl**
  - IV/IM – 50 mg

If Wheezing is present
- **Albuterol**
  - Nebulizer – 5 mg/6 mL
    - Repeat as needed

Anaphylaxis without Shock
- **Epinephrine 1:1,000**
  - IM –
    - Less than 40 years old – 0.5 mg
    - 40 years old and greater – 0.3 mg
      - Only if severe respiratory distress is present
- IV access
- **Benadryl**
  - IV/IM – 50 mg
    - May repeat x 1 in 10 min

Anaphylaxis with Shock
- Treatment as above for Anaphylaxis without Shock
- Initiate 2nd IV
- **Normal Saline**
  - IV bolus – 1 Liter

For Profound Shock
- **Epinephrine 1:10,000**
  - Slow IVP – 0.1 mg (1 mL) increments
    - Max 0.3 mg (3 mL) over 1-2 min

Communication Failure Protocol

Anaphylaxis without Shock
- *Repeat* **Epinephrine 1:1,000**
  - IM – 0.3 mg q 5 min x 2 as needed

Anaphylaxis with Shock
- For continued shock
  - *Repeat* **Normal Saline**
    - IV bolus – 1 Liter
  - *Repeat* **Epinephrine 1:1,000**
    - IM – 0.3 mg q 5 min x 2 as needed

Base Hospital Orders only

Consult with ED Physician for further treatment measures

PEDIATRIC

BLS Procedures

Assist with prescribed **Epi-Pen Jr.**
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

Allergic Reaction or Dystonic Reaction
- **Benadryl**
  - IV/IM – 1 mg/kg
    - Max 50 mg

If Wheezing is present
- **Albuterol**
  - Less than 2 years old
    - Nebulizer – 2.5 mg/3 mL
      - Repeat as needed
  - 2 years old and greater
    - Nebulizer – 5 mg/6 mL
      - Repeat as needed

Anaphylaxis without Shock
- **Epinephrine 1:1,000**
  - IM – 0.01 mg/kg
    - Max 0.3 mg
- IV access
- **Benadryl**
  - IV/IM – 1 mg/kg
    - May repeat x 1 in 10 min
    - Max 50 mg

Anaphylaxis with Shock
- Treatment as above for Anaphylaxis without Shock
- Initiate 2nd IV if possible or establish IO
- **Normal Saline**
  - IV/IO bolus – 20 mL/kg

For Profound Shock
- **Epinephrine 1:10,000**
  - Slow IVP – 0.01 mg/kg (0.1 mL/kg) increments
    - Max 0.3 mg (3 mL) over 1-2 min

Communication Failure Protocol

Anaphylaxis without Shock
- *Repeat* **Epinephrine 1:1,000**
  - IM – 0.01 mg/kg q 5 min x 2 as needed

Anaphylaxis with Shock
- For continued shock
  - *Repeat* **Normal Saline**
    - IV/IO bolus – 20 mL/kg
  - *Repeat* **Epinephrine 1:1,000**
    - IM – 0.01 mg/kg q 5 min x 2 as needed

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Altered Neurologic Function

ADULT	PEDIATRIC
BLS Procedures	
If suspected stroke, perform Cincinnati Stroke Scale Administer oxygen as indicated If low blood sugar suspected • **Oral Glucose** o PO – 15 gm	If suspected stroke, perform Cincinnati Stroke Scale Administer oxygen as indicated If low blood sugar suspected • **Oral Glucose** o PO – 15 gm
ALS Prior to Base Hospital Contact	
IV access Determine Blood Glucose level If < 60 • **D_{50}** o IV – 25 mL • **Glucagon** (if no IV access) o IM – 1 mg Recheck Blood Glucose level 5 min after D_{50} or 10 min after Glucagon administration If still < 60 • **D_{50}** o IV – 25 mL	Consider IV/IO access Determine Blood Glucose level If < 60 • Less than 2 years old o **D_{25}** • IV – 2 mL/kg o **Glucagon** (if no IV access) • IM – 0.1 mg/kg o Max 1 mg • 2 years old and greater o **D_{50}** • IV – 1 mL/kg o **Glucagon** (if no IV access) • IM – 0.1 mg/kg o Max 1 mg Recheck Blood Glucose level 5 min after D_{50} or 10 min after Glucagon administration If still < 60 • Less than 2 years old o **D_{25}** • IV – 2 mL/kg • 2 years old and greater o **D_{50}** • IV – 1 mL/kg
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures

Additional Information:

- Certain oral hypoglycemic agents (e.g. - sulfonylureas) and long-acting insulin preparations have a long duration of action, sometimes up to 72 hours. Patients on these medications who would like to decline transport MUST be warned about the risk of repeat hypoglycemia for up to 3 days, which can occur during sleep and result in the patient's death. If the patient continues to decline further care, every effort must be made to have the patient speak to the ED Physician prior to leaving the scene.
- If stroke is suspected and the last time known to be without signs/symptoms was < 3 hours prior to EMS arrival, expedite treatment and transport

Behavioral Emergencies

ADULT	PEDIATRIC
ALS Prior to Base Hospital Contact	
IV Access For Extreme Agitation • **Midazolam** o IV – 2 mg • Repeat 1 mg q 2 min as needed • Max 5 mg o IM – 0.1 mg/kg • Max 5 mg 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 When safe to perform, determine blood glucose level	For Extreme Agitation • **Midazolam** o IM – 0.1 mg/kg • Max 5 mg When safe to perform, determine blood glucose level
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures

Additional Information:

- If patient refuses care and transport, and that refusal is because of "mental disorder", consider having patient taken into custody according to Welfare and Institutions Code Section 5150. "Mental disorders" do not generally include alcohol or drug intoxication, brain injury, hypoxemia, hypoglycemia, or similar causes.
- Refer to VC EMS pre-hospital provider fact sheet for suspected excited delirium patients. Be sure to consider and rule out other possible causes or behavior (traumatic or medical).
- Use of restraints (physical or chemical) shall be documented and monitored in accordance with VCEMS policy 732
- Welfare and Institutions Code Section 5150:
  - A patient may be taken into custody if, as a result of a mental disorder, there is a danger to self and others or is gravely disabled. A California peace officer, a California licensed psychiatrist in an approved facility, Ventura County Health Officer or other County-designated individuals, can take the individual into custody, but it must be enforced by the police in the field.
- Patients shall be medically cleared prior to transporting to a psychiatric facility if patient is placed on 5150 hold by law enforcement.
- Patient may be transported directly to a psychiatric facility if evaluated by Crisis Team or PAT Team in the field.
- All patients that are deemed medically unstable shall be transported to the most accessible Emergency Department.

Ventura County Mental Health Crisis Team: (866) 998-2243

Bites and Stings

BLS Procedures

Animal/insect bites:

- Flush site with sterile water
- Control bleeding
- Apply bandage

Snake bites/envenomations:

- Remove rings and constrictions
- Immobilize the affected part in dependent position
- Avoid excessive activity

Bee stings:

- If present, remove stinger
- Apply ice pack

Jellyfish stings:

- Rinse thoroughly with normal saline
  - DO NOT:
    - Rinse with fresh water
    - Rub with wet sand
    - Apply heat

All other marine animal stings:

- If present, remove barb
- Immerse in hot water if available

Administer oxygen as indicated

All bites other than snake bites may be treated as a BLS call

ALS Prior to Base Hospital Contact

IV access for snake bites

Monitor for allergic reaction or anaphylaxis

Morphine – per Policy 705 - Pain Control

Base Hospital Orders only

Consult with ED Physician for further treatment measure

Heat Emergencies

ADULT	PEDIATRIC
BLS Procedures	
Place patient in cool environment Initiate active cooling measures Administer oxygen as indicated	Place patient in cool environment Initiate active cooling measures Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
Determine Blood Glucose IV access **Normal Saline** • IV bolus – 1 Liter o Caution with cardiac and/or renal history	Determine Blood Glucose IV/IO access **Normal Saline** • IV/IO bolus – 20 mL/kg o Caution with cardiac and/or renal history
Communication Failure Protocol	
If hypotensive after initial IV fluid bolus: • *Repeat* **Normal Saline** o IV bolus – 1 Liter	If hypotensive after initial IV fluid bolus: • *Repeat* **Normal Saline** o 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

Hypothermia

BLS Procedures

Monitor vital signs for 1 minute
- *Acceptable ranges for severe hypothermia*
  - Respiratory Rate: 4-6/minute
  - Heart rate: 20-30/minute

Gently move patient to warm environment
Remove wet clothing and replace with dry blankets
Insulate head
Begin passive rewarming
STAT transport if no shivering (indicates core temp below 90º)
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

IV access (if needed for medication or fluid administration)
- If administering fluid, avoid administering cold fluids.

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Neonatal Resuscitation

BLS Procedures

Newly Born Infant

Provide warmth, dry briskly and discard wet linen
- Suction ONLY if secretions, including meconium, cause airway obstruction

Assess while drying infant
1. Full term?
2. Crying or breathing?
3. Good muscle tone?

If "YES" to all three
- Place skin-to-skin with mother
- Cover both with dry linen
- Observe breathing, activity, color

If "NO" to any of three
- Stimulate briefly (<15 seconds)
  - Flick soles of infant's feet
  - Briskly rub infant's back
- Provide warm/dry covering
- Continue to assess

Infant up to 48 hours old

Provide warmth
- Suction ONLY if secretions cause airway obstruction
- Stimulate briefly (<15 seconds)
  - Flick soles of infant's feet
  - Rub infant's back with towel

Provide warm/dry covering
Continue to assess

Assess Breathing
- If crying or breathing, assess circulation
- If apneic or gasping
  - Positive pressure ventilations (PPV) with BVM and ROOM AIR at 40-60 breaths per minute for 30 seconds
    - Continue PPV, reassessing every 30 seconds, until infant is breathing adequately
  - Reassess breathing, assess circulation

Assess Circulation
- If HR between 60 and 100 bpm
  - PPV with BVM and ROOM AIR at 40-60 breaths per minute for 30 seconds
    - Continue PPV, reassessing every 30 seconds, until infant maintains HR >100 bpm
- If HR < 60 bpm
  - CPR at 3:1 ratio for 30 seconds
    - 90/min compressions
    - 30/min ventilations
    - Continue CPR, reassessing every 30 seconds, until HR > 60 bpm
  - If no improvement after 90 seconds of ROOM AIR CPR, add supplemental O_2 until HR > 100

ALS Prior to Base Hospital Contact

Establish IO line only in presence of CPR

Asystole OR Persistent Bradycardia < 60 bpm

- **Epinephrine 1:10,000**
  - IO – 0.01mg/kg (0.1mL/kg) q 3-5 min

PEA

- **Epinephrine 1:10,000**
  - IO – 0.01mg/kg (0.1mL/kg) q 3-5 min
- **Normal Saline**
  - IO bolus – 10mL/kg

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:
- Resuscitation efforts may be withheld for extremely preterm infants (< 21 weeks or < 9 inches long). Sensitivity to the desires of the parent(s) may be considered. If uncertain as to gestational age, begin resuscitation.

Overdose/Poisoning

BLS Procedures

ADULT

Decontaminate if indicated and appropriate
Administer oxygen as indicated

PEDIATRIC

Decontaminate if indicated and appropriate
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

ADULT

IV access

Oral ingestion within 1 hour and gag reflex present:
- **Activated Charcoal**
  - PO – 1 gm/kg
    - Max 50 gm

Suspected opiate overdose with respirations less than 12/min:
- **Narcan**
  - IM – 2 mg
  - IV – 0.4 mg q 1 min
    - Initial max 2 mg
  - May repeat as needed to maintain respirations greater than 12/min

PEDIATRIC

IV/IO access
- IO access only if pt in extremis

Oral ingestion within 1 hour and gag reflex present:
- **Activated Charcoal**
  - PO – 1 gm/kg
    - Max 25 gm

Suspected opiate overdose with respirations less than 12/min:
- **Narcan**
  - IV/IM/IO – 0.1 mg/kg
    - Initial max 2 mg
  - May repeat as needed to maintain respirations greater than 12/min

Base Hospital Orders only

ADULT

Tricyclic Antidepressant Overdose
- **Sodium Bicarbonate**
  - IV – 1 mEq/kg

Beta Blocker Overdose
- **Glucagon**
  - IV – 2 mg
    - May give up to 10 mg if available

Calcium Channel Blocker Overdose
- **Calcium Chloride**
  - IV – 1 gm over 1 min
- **Glucagon**
  - IV – 2 mg
    - May give up to 10 mg if available

Stimulant/Hallucinogen Overdose
- **Midazolam**
  - IV – 2 mg
    - Repeat 1 mg q 2 min as needed
    - Max 5 mg
  - IM – 0.1 mg/kg
    - Max 5 mg

Organophosphate Poisoning
- **Atropine**
  - IV – 2 mg q 1 min
    - Repeat until symptoms are relieved

Consult with ED Physician for further treatment measures

PEDIATRIC

Tricyclic Antidepressant Overdose
- **Sodium Bicarbonate**
  - IV/IO – 1 mEq/kg

Beta Blocker Overdose
- **Glucagon**
  - IV/IO – 0.1 mg/kg
    - May give up to 10 mg if available

Calcium Channel Blocker Overdose
- **Calcium Chloride**
  - IV/IO – 20 mg/kg over 1 min
- **Glucagon**
  - IV/IO – 0.1 mg/kg
    - May give up to 10 mg if available

Stimulant/Hallucinogen Overdose
- **Midazolam**
  - IM – 0.1 mg/kg
    - Max 5 mg

Organophosphate Poisoning
- **Atropine**
  - IV/IO – 0.02 mg/kg q 1 min
    - Minimum dose – 0.1mg
    - Repeat until symptoms are relieved

Consult with ED Physician for further treatment measures

Additional Information:
- For Caustic/Corrosive or petroleum distillate ingestions, DO NOT GIVE CHARCOAL OR INDUCE VOMITING
- For Tricyclic Antidepressant Overdose, DO NOT GIVE CHARCOAL
- If chest pain present, refer to chest pain policy. DO NOT GIVE ASPIRIN
- Organophosphate poisoning – SLUDGE
  - S – Salivation
  - L – Lacrimation
  - U – Urination
  - D – Defecation
  - G – Gastrointestinal Distress
  - E – Elimination (vomiting)
- Narcan – it is not necessary that the patient be awake and alert. Administer until max dosage is reached **or** RR greater than 12/min. When given to chronic opioid patients, withdrawal symptoms may present. IM dosing is the preferred route of administration.

Effective Date: December 1, 2010
Next Review Date: December, 1, 2011
Date Revised: August, 2010
Last Reviewed: August, 2010
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VCEMS Medical Director

Seizures

ADULT

BLS Procedures

Protect from injury
Maintain/manage airway as indicated
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

IV access

Determine Blood Glucose level

If < 60

- **D_{50}**
  - IV – 25 mL
- **Glucagon** (if no IV access)
  - IM – 1 mg

Persistent Seizure Activity

- **Midazolam**
  - IV – 2 mg
    - Repeat 1 mg q 2 min as needed
    - Max 5 mg
  - IM – 0.1 mg/kg
    - Max 5 mg

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

3rd Trimester Pregnancy & No Known Seizure History

- **Magnesium Sulfate**
  - IVPB – 2 gm in 50 mL D_5W infused over 5 min
    - MUST Repeat x 1
    - Slow or stop infusion if bradycardia, heart block, or decreased respiratory effort occur

Recheck Blood Glucose level 5 min after D_{50} or 10 min after Glucagon administration

If still < 60

- *Repeat* **D_{50}**
  - IV – 25 mL

Base Hospital Orders only

Consult with ED Physician for further treatment measures

PEDIATRIC

BLS Procedures

Protect from injury
Maintain/manage airway as indicated
For suspected febrile seizures, begin passive cooling measures. If seizure activity persists, see below
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

Consider IV/IO access

Determine Blood Glucose level

If < 60

- Less than 2 years old
  - **D_{25}**
    - IV – 2 mL/kg
  - **Glucagon** (if no IV access)
    - IM – 0.1 mg/kg
      - Max 1 mg
- 2 years old and greater
  - **D_{50}**
    - IV – 1 mL/kg
  - **Glucagon**
    - IM – 0.1 mg/kg
      - Max 1 mg

Persistent Seizure Activity

- **Midazolam**
  - IM – 0.1 mg/kg
    - Max 5 mg

Recheck Blood Glucose level 5 min after D_{50} or 10 min after Glucagon administration

If still < 60

- Less than 2 years old
  - *o* **D_{25}**
    - IV – 2 mL/kg
- 2 years old and greater
  - *o* **D_{50}**
    - IV – 1 mL/kg

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:

- Treatment with Midazolam as indicated in the following:
  - Continuous seizures > 5 min (or > 2 min in pregnancy)
  - Repetitive seizures without regaining consciousness
- Patients with a known seizure disorder or uncomplicated, apparent pediatric febrile seizures, no longer seizing and with a normal postictal state, may be treated as a BLS call

Shortness of Breath – Wheezes/Other

BLS Procedures

ADULT

Assist patient with prescribed Metered Dose Inhaler if available
Administer oxygen as indicated

PEDIATRIC

Assist patient with prescribed Metered Dose Inhaler if available
Administer oxygen as indicated

ALS Prior to Base Hospital Contact

ADULT

Perform Needle Thoracostomy if indicated per Policy 715

Moderate Distress
- **Albuterol**
  - Nebulizer – 5 mg/6 mL
    - Repeat as needed

Severe Distress
- Treatment for moderate distress
- Less than 40 years old
  - **Epinephrine 1:1,000**
    - IM – 0.3 mg

Consider CPAP for both moderate and severe distress

IV access

PEDIATRIC

Perform Needle Thoracostomy if indicated per Policy 715

Moderate Distress
- Less than 2 years old
  - **Albuterol**
    - Nebulizer – 2.5 mg/3 mL
      - Repeat as needed
- 2 years old and greater
  - **Albuterol**
    - Nebulizer – 5 mg/6 mL
      - Repeat as needed

Severe Distress
- Treatment for moderate distress
- **Epinephrine 1:1,000**
  - IM – 0.01 mg//kg
    - Max 0.3 mg

Suspected Croup
- **Normal Saline**
  - Nebulizer/Aerosolized Mask – 5 mL

Consider CPAP if age 8 years old and greater

IV access

Communication Failure Protocol

ADULT

Severe Distress
- Less than 40 years old
  - If no change is apparent 10 minutes after first Epinephrine administration:
    - *Repeat* **Epinephrine 1:1,000**
      - IM – 0.3 mg
- 40 years old and greater
  - **Epinephrine 1:1,000**
    - IM – 0.3 mg
      - Only if apparent asthma
      - Only if age less than 60 years old
      - Only if no improvement with initial therapies

PEDIATRIC

Severe Distress
- If no change is apparent 10 minutes after first Epinephrine administration
  - *Repeat* **Epinephrine 1:1,000**
    - IM – 0.01 mg/kg
      - Max 0.3 mg

Base Hospital Orders only

ADULT

Consult with ED Physician for further treatment measures

PEDIATRIC

Suspected Croup and no improvement with Normal Saline nebulizer
- Less than 2 years old
  - **Epinephrine 1:1,000**
    - Nebulizer/Aerosolized Mask – 2.5 mL
- 2 years old and greater
  - **Epinephrine 1:1,000**
    - Nebulizer/Aerosolized Mask – 5 mL

Consult with ED Physician for further treatment measures

Additional Information:
- High flow O_2 is indicated for severe respiratory distress, even with a history of COPD
- COPD patients have a higher susceptibility to spontaneous pneumothorax due to disease process
- If suspected Arterial Gas Embolus/Decompression Sickness secondary to SCUBA emergencies, transport patient in supine position on 15L/min O_2 via mask. Early BH contact is recommended to determine most appropriate transport destination.

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