Public Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA93036	Pre-hospital Services Committee Agenda	September 11, 2014 9:30 a.m.

I.	**Introductions**		
II.	**Approve Agenda**		
III.	**Minutes**		
IV.	**Medical Issues**		
	A.	Other	
V.	**New Business**		
	A.	627 – Fireline Medic	Mark Komins requested that we update this policy to reflect the current standards set forth by FireScope.
	B.	402 – Patient Diversion/Emergency Department Closures – Karen	Adding new language on page 2, #5.
	C.	628 – Rescue Task Force Operations – Chris	New policy for review.
	D.	Pharmacology Manual – Tom O'Conner	Manual needs to be updated. Develop a working group to address changes.
	E.	Other	
VI.	**Old Business**		
	A.	705.26 – Suspected Stroke – Karen	Returned to PSC with suggested language changes.
	B.	451 – Stroke System Triage and Destination – Karen	Returned to PSC with suggested language changes.
	C.	PRESTO Trial Update - Angelo	
	D.	air-Q Study Update - Angelo	
	E.	CAM/ART – Mark Komins and Chad Panke	Returned to PSC after researching questions.
	F.	Spinal Motion Restriction	Returned to PSC. Discuss a "train the trainer "course.
	G.	Other	
VII.	**Informational/Discussion Topics**		
	A.	Ebola infection control guidance for EMS with California modifications - Angelo	
VIII.	**Policies for Review**		
	A.	105 - Prehospital Services Committee Operating Guidelines	
	B.	110 - County Ord. No. 4099 Ambulance Business License Code	
	C.	112 - Ambulance Rates	
	D.	210 - Child, Dependent Adult, or Elder Abuse Reporting	
	E.	319 - Paramedic Preceptor	
	F.	324 - Mobile Intensive Care Nurse: Authorization Reactivation	
	G.	606 - Withholding or Termination of Resuscitation and Determination of Death	
	H.	612 - Notification of Exposure to a Communicable Disease	
	I.	622 - ICE - In Case of Emergency for Cell Phones	
	J.	705.02 - Allergic/Adverse Reaction and Anaphylaxis	
	K.	705.06 – Burns	Scott Zeller requested we look at this policy. The policy does not address BLS care of burns for 10% or greater BSA.
	L.	705.07 - Cardiac Arrest - Asystole/Pulseless/PEA	
	M.	705.09 - Chest Pain - Acute Coronary Syndrome	
	N.	705.11 - Crush Injury/Syndrome	

	O.	705.18 - Overdose/Poisoning
	P.	705.21 - Shortness of Breath - Pulmonary Edema
	Q.	705.23 - Supraventricular Tachycardia
	R.	717 - Pediatric Intraosseous Infusion
	S.	732 - Use of Restraint
	T.	1001 - EMT-P/BH Communication Record
	U.	1105 - MICN Developmental Course and Exam
	V.	1132 - Continuing Education: Attendance Roster
IX.	**Agency Reports**	
	A.	Fire Departments
	B.	Ambulance Providers
	C.	Base Hospitals
	D.	Receiving Hospitals
	E.	Law Enforcement
	F.	ALS Education Program
	G.	TAG
	H.	EMS Agency
	I.	Other
X.	**Closing**	

Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Minutes	July 10, 2014 9:30 a.m.

Topic	Discussion	Action	Assigned
II. Approve Agenda			Approved by Ira Tilles Seconded by David Chase
III. Minutes	.		Approved by Ira Tilles Seconded by David Chase
IV. Medical Issues			
A. Spinal Motion Restriction	Angelo – People are spending too much time on long boards that don't need to be.	Contact L.A. County and ask if they can teach a "Train the Trainer" program in Ventura County.	
B. Other –Saline Shortage	Mark Komins stated that they are unable to get the 500 bags of NS anymore. Concerned about pediatric patients getting too much fluid with 1000cc bags.	Use 500cc bags already in stock on peds only. Use 1000cc on adults. Develop a training memo on how to give fluids to 3y/o and younger.	
V. New Business			
A. 705.26 – Suspected Stroke (Revision)	Karen presented the language change. The committee suggested additional changes that should be made.	Policy will come back to next PSC after additional changes.	
B. 451 – Stroke System Triage and Destination (Revision)	Karen presented the language change. The committee suggested additional changes that should be made.	Policy will come back to next PSC after additional changes.	
C. Other			
VI Old Business			
A. CAM/ART & ACLS/BLS	Angelo asked the committee if we should consider adopting CAM and ART	Mark and Chad will research details: -Can ART cross state lines? -Does ACLS cover more than ART?	
B. PRESTO Trial	Trial received IRB approval from VCMC. Meet with Cedars in a few weeks to discuss blood testing.	Update only	
C. Cardiac Arrest Survivor Interview	Working to ID more survivors and interview them about their history and event.	Update only	
D. air-Q Study	Waiting for IRB approval. Hoping to start trial in December 2014. Only	Update only	

		paramedics will be trained.		
VII.	**Informational/Discussion Topics**			
	A. Elderly Fall Prevention Coalition (EFPC)	Chris gave an overview of this program. Katy will take the lead. Responders will have to fill out questions. Patients will be asked to take part in the study. Fire agencies will hand out educational flyers to patients.		
	B. Policy 1404 Revision	Language added to page 2-A, #16	Approved with change.	
	C. Sidewalk CPR	Randy will forward the stats from neighboring counties when they are available. He also thanked everyone for all their work/participation on the last event.		
	D. Bariatric Rescue Training Suit and Mannequin	After a brief discussion, most agencies did not feel this equipment was necessary.		
VIII.	**Policies for Review**			
XI	**TAG Report**	-We have Data on 6 of the 10 measures. -Goal: every citizen of Ventura County should know CPR as a basic life skill.	The committee agrees with working toward the goal of all citizens knowing CPR.	
X.	**Agency Reports**			
	A. Fire departments	**VCFPD** – Scott stated that FCC is short handed. They have 7 new trainees starting soon. **VCFD** – Dede stated that they are busy with Fall Prevention Program training. The crews are receptive and excited to be a part of the program. **OFD** – Steph reported that Sta. 8 is planned to open in 2015. They have 3 retirements and new promotions. **FFD** – Bob shared that the golf tournament was a success. **Fed. Fire** – Purchasing a new engine. **SPFD** – Bill wanted to thank everyone involved in his rescue and treatment after the rattlesnake bite.		
	B. Transport Providers	**LMT –** Personnel have been trained on Fall Prevention Program. **AMR/GCA** – Working to get approval on Community Projects. The Hygiene		

		Improvement Project is moving forward.	
	C. Base Hospitals	**SVH – none** **LRRMC** – They are coordinating a Survivor Celebration. Received OK to open a 4 bed PICU. Debbie has a Smartman and would like Chad to teach CAM to ER staff. **SJRMC –** Dr. Russell's baby is expected today. They survived Cerner, smooth transition. **VCMC** – Construction continues! Helicopter will land at Bard and Lifeline will transport patient to VCMC.	
	D. Receiving Hospitals	**CMH** – Construction continues! Please advise if there are access issues. Nurses Assoc. is conducting a study on "Violence in the ER". Someone will be contacting VC ER's. **PVH – none** **OVCH** – They have improved the entrance to the hospital.	
	D. Law Enforcement	**VCSO -** Air Unit has been involved in a 2 week search for lost camper. **CSUCI PD –** PD used AED on campus and patient survived.	
	F. ALS Education Programs	**Ventura College** – 8 students passed Internship. 12 students signed up for next semester.	
	G. EMS Agency	**Angelo –** none **Steve** – There is a Homeland Security meeting coming up. We have extra money because we could not purchase duodote's. We currently have Doxy (to treat 5000) that will expire. Should we purchase Cipro (for 1800) with avail. funds. Comm. agrees with Cipro purchase. **Chris** – Looking to purchase new MCI tags and equipment. Steve and Chris will decide how it will be distributed. EMS purchased 1500 CAT Tourniquets for MCI trailers. **Katy -** none **Julie** – none **Randy** – none **Karen** – none	
	H. Other	**Mike T. –** They are ready to start wrapping the ambulances. LRRMC will be the first to partner with AMR/GCA. Contact Mike ASAP if you are interested in doing this. The cost is $1000 per rig to "wrap" it. They will rotate the message every 6 to 8 months.	
XI.	**Closing**	**Meeting adjourned at 1145**	

Prehospital Services Committee 2014

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/9/2014	2/13/2014	3/13/2014	4/10/2014	5/8/2014	6/12/2014	7/10/2014	8/14/2014	9/11/2014	10/9/2014	11/13/2014	12/11/2014	%
AMR	Stefansen	Adriane			AS		AS		AS						
AMR	Panke	Chad	CP		CP				CP						
CMH - ER	Canby	Neil	NC		NC		NC		NC						
CMH/OVCH-ER	Cobb	Cheryl	CC		CC		DP		CC						
OVCH	Patterson	Betsy	BP		BP				BP						
CSUCI PD	Drehsen	Charles	CD		CD				CD						
CSUCI PD	Rice	Al	AR		AR		AR		AR						
FFD	Herrera	Bill			BH		BH		BH						
FFD	Scott	Bob			BS		BS		BS						
GCA	Norton	Tony	TN		TN				TN						
GCA	Shultz	Jeff	JS		JS		JS		JS						
Lifeline	Rosolek	James	JR		JR		JR		JR						
Lifeline	Winter	Jeff	JW		JW		JW		JW						
LRRMC - ER	Beatty	Matt	MB		MB				MB						
LRRMC - ER	Licht	Debbie	DL		DL		DL		DL						
OFD	Carroll	Scott	SC		SC		KDS		SC						
OFD	Huhn	Stephanie	SH		SH		SH		SH						
SJPVH	Hamilton	Shay													
SJPVH	Davies	Jeff					JD								
SJRMC	Russell	Mark	MR		MR		MR								
SJRMC	McShea	Kathy	KM		KM		KM		KM						
SPFD	Dowd	Andrew	AD		AD				AD						
SVH - ER	Tilles	Ira	IT		IT		IT		IT						
SVH - ER	Hoffman	Jennie	JH		JH				JH						
V/College	O'Connor	Tom	TO		TO		TO								
VCFD	Tapking	Aaron	AT				AT		AT						
VCFD	Utley	Dede	DU		DU		DU		DU						
VNC	Zeller	Scott	NP		NP		SZ		SZ						
VNC	Dullam	Joe	JD		JD										
VNC - Dispatch	Shedlosky	Robin	RS		RS		RS		RS						
VCMC - ER	Chase	David	DC		DC		DC		DC						
VCMC - ER	Gallegos	Tom	TG		TG		TG		TG						

Agency	LastName	FirstName	1/9/2014	2/13/2014	3/13/2014	4/10/2014	5/8/2014	6/12/2014	7/10/2014	8/14/2014	9/11/2014	10/9/2014	11/13/2014	12/11/2014	%
VCMC-SPH	Gautam	Pai	MD												
VCMC-SPH	Melgoza	Sarah	SM												
VCSO SAR	Hadland	Don													
VCSO SAR	Golden	Jeff	JG						JG						
VFF	Rhoden	Crystal													
VFF	Jones	Brad													
Eligible to Vote	**Date Change/cancelled - not counted against member for attendance**														
Non Voting Members															
AMR	Whitmore	Geneva													
AMR	Taigman	Mike	MT		MT				MT						
CSUCI PD	Rice	Lynn	LR		LR		LR		LR						
EMS	Carroll	Steve	SC		SC		SC		SC						
EMS	Buhain	Ruth													
EMS	Frey	Julie	JF		JF		JF		JF						
EMS	Hadduck	Katy	KH		KH				KH						
EMS	Perez	Randy	RP		RP		RP		RP						
EMS	Rosa	Chris	CR		CR		CR		CR						
EMS	Salvucci	Angelo	AS		AS		AS		AS						
EMS	Beatty	Karen	KB		KB		KB		KB						
LMT	Frank	Steve			SF		SF								
VCMC	Duncan	Thomas					TD		TD						
VNC	Gregson	Erica	EG												
VNC	Komins	Mark	MK		MK		MK		MK						

TEMPORARY
PARKING PASS
Expires September 11, 2014

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

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

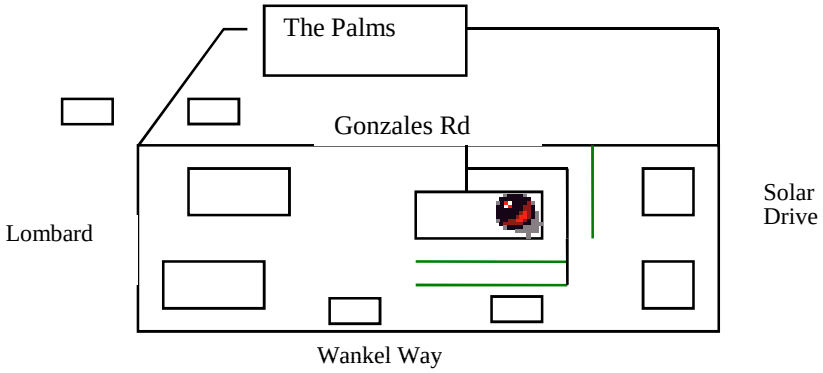
Parking Instructions: Parking at workshop venue is limited. Arrive early to allow for offsite parking if venue parking lot is full.

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.



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COUNTY OF VENTURA HEALTH CARE AGENCY			EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Fireline Medic			Policy Number 627
APPROVED: Administration:	Steven Carroll, Paramedic		Date: December 1, 2012
APPROVED: Medical Director	Angelo Salvucci, M.D.		Date: December 1, 2012
Origination Date: Date Revised: Date Last Reviewed: Review Date:	October 5, 2011 October 11, 2012 October 11, 2012 October 31, 2014	Effective Date:	December 1, 2012

I. PURPOSE: To establish procedures for a fireline paramedic (FEMP) response from and toagencies within or outside local EMS agency (LEMSA) jurisdiction when requested through thestatewide Fire and Rescue Mutual Aid System, to respond to and provide advanced life support (ALS) care on the fireline at wildland fires.

II. AUTHORITY:California Health and Safety Code, Division 2.5, Sections 1797.204, 1797.220; California Code of Regulations, Title 22, Division 9, Sections 100165 and 100167

III. POLICY:

A. County accredited paramedics shall carry the ALS/BLS inventory consistent with the FIRESCOPE FEMP position description. Reasonable variations may occur; however, any exceptions shall have prior approval of the VCEMSA. The equipment lists are a scaled down version of standard inventory in order to meet workable/packable weight limitations (45 lbs including wildland safety gear, divided between a two person team. Weight limit to include the Personal Pack Inventory as outlined in FireScope).

1. It will not be possible to maintain standard ALS minimums on the fireline.The attached ALS inventory essentially prioritizes critical and probable firelineneeds.
2. VCEMS accredited paramedics may function withintheir scope of practice, when serving in an authorized capacity assignment, as an agentof their authorized ALS fire agency.

IV. PROCEDURE:

A. Under the authority of State regulations, a paramedic may render ALS care during emergency operations as long as the following conditions are met:

1. The paramedic is currently licensed by the State of California and is accredited by the Ventura County EMS Agency.
2. The paramedic is currently employed with a Ventura County ALS provider and possesses the requisite wildland fireline skills and equipment.
3. The paramedic practices within the treatment guidelines set forth in VCEMSA policies and procedures manual. Paramedics operating in the capacity of a fireline paramedic (FEMP) shall follow VCEMSA communication failure protocol.
4. The FEMP is expected to check in and obtain a briefing from the Logistics SectionChief, or the Medical Unit Leader (MEDL) if established at the Wildfire Incident.
5. Documentation of patient care will be completed as per VCEMSA policy 1000.
    a. Documentation of patient care will be submitted to incident host agencies. A VCePCR shall be completed for all ALS patients contacted, and shall be completed by the FEMP upon return to camp, or as soon as practical.
6. Continuous Quality Improvement activities shall be in accordance with VCEMSA standards.

APPENDIX A

FIRELINE EMERGENCY MEDICAL TECHNICIAN

BASIC LIFE SUPPORT (BLS) PACK INVENTORY

	Airway, NPA Kit (1)		Mask, Face, Disposable w/eye shield (1)
	Airway, OPA Kit (1)		Mylar Thermal Survival Blanket (2)
	Bag Valve Mask (1)		Pad, Writing (1)
	Bandage, Sterile 4 x 4 (6)		Pen and Pencil (1 ea.)
	Bandage, Triangular (2)		Pen Light (1)
	Biohazard Bag (2)		Petroleum Dressing (2)
	Burn Sheet (2)		Shears (1)
	Cervical Collar, Adjustable (1)		Sphygmomanometer (1)
	Coban Wraps/Ace Bandage (2 ea.)		Splint, Moldable (1)
	Cold Pack (3)		Splinter Kit (1)
	Commercially Available Tourniquet (1)		
	Dressing, Multi-Trauma (4)		Stethoscope (1)
	Exam Gloves		Suction, Manual Device (1)
	Eye Wash (1 bottle)		Tape, 1 inch, Cloth (2 rolls)
	Glucose, Oral (1 Tube)		Triage Tags (6)
	Kerlix, Kling, 4.5, Sterile (2)		Triangular Dressing with Pin (2)
	Digital Thermometer (1)		

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APPENDIX B

FIRELINE EMERGENCY MEDICAL TECHNICIAN

PARAMEDIC (ALS) PACK INVENTORY **IN ADDITION TO THE BASIC LIFE SUPPORT INVENTORY, THE FOLLOWING ADDITIONAL ITEMS OR EQUIVALENTS SHALL BE CARRIED BY THE FEMP

ALS AIRWAY EQUIPMENT:

	Endotracheal Intubation Equipment (6.0, 7.5 ET – Mac 4, Miller 4, stylette and handle)		ETT Verification Device
	End Tidal CO2 Detector		Needle Thoracostomy Kit (1)
			Pulse Oximeter (Optional)
	ETT Restraint		Rescue Airway (1)

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IV/MEDICATION ADMIN SUPPLIES:

	1 ml TB Syringe (2)		20 ga. IV Catheter (2)
	10 ml Syringe (2)		IV Site Protector (2)
	18 ga. Needle (4)		IV Administration Set-Macro-Drip (2)
	25 ga. Needle (2)		Alcohol Preps (6)
	Adult EZ-IO Kit (1)		Betadine Swabs (4)
			E-Z IO Stabilizer
	EZ Connect tubing (2)		Glucometer Test Strips (4)
	25 mm EZ-IO Needle (1)		Lancet (4)
	45 mm EZ-IO Needle (1)		Razor (1)
	14 ga. IV Catheter (2)		Tape (1)
	16 ga. IV Catheter (2)		Tourniquet (2)
	18 ga. IV Catheter (2)		

MISCELLANEOUS:

	AMA Paper Forms (3)		PCR Paper Forms (6)
	FEMP Pack Inventory Sheet (1)		Sharps Container – Small(1)
	Narcotic Storage (per agency policy)		

BIOMEDICAL EQUIPMENT:

	Defibrillator Electrodes (2)		Glucometer (1)
	Defibrillator with ECG waveform display (1)		

MEDICATIONS:

	Amiodarone 50 mg/ml 3 ml (2)		Epinephrine 1:1,000 1 mg (4)
	Albuterol – 90mcg/puff (1 MDI) with Spacer Device		Glucagon 1 mg/unit (1)
	Aspirin-Chewable (1 Bottle)		Midazolam 20 mg
	Atropine Sulfate 1mg (2)		Morphine Sulfate 10 mg/ml (6)
			Naloxone – 2mg (2)
	Dextrose 50% 25 G. Pre-Load (1)		Nitroglycerin 1/150 gr (1)
	Diphenhydramine 50 mg (4)		Saline 0.9% IV 1,000 ml – Can be configured into two 500 ml or four 250 ml
	Epinephrine 1:10,000 1mg (2)		5% Dextrose in Water, 50 ml (1)

DRAFT

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title Patient Diversion/Emergency Department Closures	Policy Number: 402
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: October 1, 2003
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: October 1, 2003
Origination Date: January 1990 Revised Date: March 2003 Date Last Reviewed: December 13, 2012 Review Date: November 30, 2014	Effective Date:November 1, 2003

I. PURPOSE: To define the procedures by which Emergency Medical Services (EMS) providers and/or Base Hospitals (BH) may:

A. Transport emergency patients to the most accessible medical facility that is staffed, equipped, and prepared to administer emergency care appropriate to the needs of the patient.

B. Provide a mechanism for a hospital in the Ventura County (VC) EMS system to have patients diverted away from its emergency department when it has been determined that the hospital is not staffed, equipped, and/or prepared to care for additional or specific types of patients.

C. Assure that Advanced Life Support (ALS) units are not unreasonably removed from their area of primary response when transporting patients to a medical facility.

II. AUTHORITY: California Administrative Code, Title 13, Section 1105(c): "In the absence of decisive factors to the contrary, ambulance drivers shall transport emergency patients to the most accessible medical facility equipped, staffed, and prepared to receive emergency cases and administer emergency care appropriate to the needs of the patient".

III. POLICY: Hospitals may divert patients according to the conditions described below. This policy shall not negate prearranged interhospital triage and transport agreements approved by VC EMS Basic Life Support (BLS) patients will be transported to the nearest unless it is closed by internal disaster.

IV. DEFINITIONS:

A. ALS Patient: A patient who meets the criteria for base hospital contact.

B. BLS Patient: A patient whose illness or injury requires BLS care or a patient in a BLS unit, irrespective of the level of care required for the patient's illness or injury.

V. PROCEDURE

A. DIVERSION REQUEST CATEGORIES

A hospital may request that ambulances be diverted for the following reasons using the following terminology:

1. Internal Disaster

   Hospital's emergency department cannot receive any patients because of a physical plant breakdown (e.g. fire, bomb threat, power outage, safety issues in the ED, etc.).

   NOTE: Activation of a hospital's internal plan to handle diversions (see Section IV.D) does NOT constitute an internal disaster.

2. Emergency Department Saturation

   The hospital's emergency department resources are fully committed to critically and/or seriously ill patients and are not available for additional ALS patients.

3. Lack of Neurosurgical coverage

   Hospital is unable to provide appropriate care due to unavailability of a neurosurgeon, and is therefore not an ideal destination for patients likely to require these services.

4. Intensive Care Unit (ICU) / Critical Care Unit (CCU) Saturation

   Hospital's ICUs do not have any available licensed beds to care for additional patients, and is therefore not an ideal destination for patients likely to require these services.

5. CT Scanner Inoperative

   Hospital's CT scanner is not functioning and therefore not the ideal destination for patients with blunt or penetrating head trauma, truncal trauma, or a "StrokeAlert" patient.

B. PATIENT DESTINATION

1. Internal Disaster
   a. A hospital on diversion due to internal disaster shall not receive patients.
   b. Base hospitals shall not direct ALS units to transport patients to any medical facility that has requested diversion of ALS patients due to aninternal disaster.
2. Diversion requests will be honored provided that:
   a. The involved ALS unit estimates that it can reach an "open" facility without compromising the patient's condition by extending the Code 3 en route time from the incident location for hospitals on diversion due to:
      1) ICU/CCU saturation,

2) Emergency Department saturation, or

3) Neuro/CT scanner limitations for appropriately selected patients.

b. The patient does not exhibit an uncontrollable problem in the field. An "Uncontrollable Problem" is defined as:

1) Unstable vital signs

2) Cardiac Arrest

3) Severe Respiratory Distress

4) Unstable Airway

5) Profound Shock

6) Status Epilepticus

7) OB patient with imminent delivery

8) Life threatening arrythmia

9) Any Patient that the paramedic on scene or the BH MD feels would likely deteriorate due to diversion.

3. Destination while adjacent hospitals are on diversion

a. If adjacent hospitals within an area grouping are on diversion for the same diversion category, patients cannot be diverted for that reason, and the patient will be transported to the closest medical facility.

b. Guidelines for potential diversion destination when a hospital is on diversion based on patient location and estimated transport times are as follows:

Hospital Groupings/Areas

1. **Area 1** (Ojai): OjaiValleyCommunityHospital, CommunityMemorialHospital, VenturaCountyMedicalCenter, Santa PaulaMemorialHospital

2. **Area 2** (Santa Paula/Fillmore): Santa PaulaMemorialHospital, VenturaCountyMedicalCenter, CommunityMemorialHospital, Ojai ValleyCommunityHospital

3. **Area 3** (Simi Valley): Simi ValleyHospital, LosRoblesRegionalMedicalCenter, St. Johns Pleasant ValleyHospital

4. **Area 4** (Thousand Oaks): LosRoblesRegionalMedicalCenter, Simi ValleyHospital, St. Johns Pleasant ValleyHospital

5. **Area 5** (Camarillo): St. Johns Pleasant Valley Hospital, St. Johns Regional Medical Center, Los Robles Regional Medical Center, Simi Valley Hospital, Ventura County Medical Center, Community Memorial Hospital
6. **Area 6** (Oxnard): St. JohnsRegionalMedicalCenter, VenturaCountyMedicalCenter, CommunityMemorialHospital, St. Johns Pleasant ValleyHospital
7. **Area 7** (Ventura): Ventura County Medical Center, Community Memorial Hospital, St. Johns Regional Medical Center, Ojai Valley Community Hospital, Santa Paula Memorial Hospital.

As needed, an MICN may divert a patient to a hospital outside of VenturaCounty.

BLS ambulances shall notify receiving hospitals of their impending arrival.

4. Notwithstanding any other provisions of this policy, and in accordance with VCEMS Policy 604, Patient Transport and Destination, final authority for patient destination rests with the BaseHospital.

C. PROCEDURE FOR REQUESTING DIVERSION OF ALS PATIENTS

1. The hospital administrator or his/her designee must authorize the need for diversion.
2. To initiate, update or cancel a diversion, the Administrator or his/her designee shall make the status change via the ReddiNet system.
   a. Hospitals on diversion status shall immediately update their status via the ReddiNet system.
   b. Problems with policy and procedure related to diversion notification will be directed to VC EMS during normal business hours or the on-call VC EMS administrator after normal business hours
   c. Problems arising during a diversion, requiring immediate action should be directed to VC EMS during normal business hours or the on-call VC EMS administrator after normal business hours.
3. VC EMS staff will perform unannounced site visits to hospitals on diversion status to ensure compliance with these guidelines.

D. Hospitals shall develop internal policies and procedures for authorizing diversion of patients in accordance with this policy. These policies shall include internal activation of backup procedures. These policies and procedures shall be approved according to the hospital policy approval procedure and shall be available to the EMS staff for review.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Rescue Task Force Operations	Policy Number 628
APPROVED:	Date:
APPROVED: Medical Director:	Date:
Origination Date: September 3, 2014 Date Revised: Date Last Reviewed: Review Date:	Effective Date:

I. PURPOSE: To establish procedures for Rescue Task Force operations at the scene of an emergency.

II. AUTHORITY: California Health and Safety Code, Division 2.5, sections 1797.204 and 1797.220; California Code of Regulations, Title 22, Division 9, Sections, 100063, 100146, and 100148

~~II.~~III. DEFINITION:

1. The Rescue Task Force (RTF) is a team or teams of trained fire personnel deployed with armed law enforcement personnel to provide rapid care and rescue in areas where there is an ongoing indirect threat (ballistic, explosive, etc.). Teams provide this care and rescue only while under the protection of armed law enforcement personnel.
   A. RTF can/should be deployed for the following reasons:
      i. Treatment of victims in a warm zone
      ii. Removal of victims from the warm zone to a Casualty Collection Point (CCP) and/or to the Cold Zone
      iii. Movement of equipment/supplies from the cold zone to the warm zone.
      iv. Any other activities within the warm zone that are deemed necessary for a successful RTF operation.
2. Hot Zone is the area of the incident where there is an imminent and direct threat to the lives of the victims and responders. Operations in the hot zone are reserved for armed law enforcement personnel only.
3. Warm Zone is the area of the incident where the threat has been reduced or otherwise mitigated by law enforcement personnel. RTF operations are conducted in the warm zone, and shall be done so under the cover of armed law enforcement personnel.

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4. Cold Zone is the area of the incident where victims shall be moved to after rescue. The cold zone is also where transport resources and additional personnel will remain to support triage, treatment, and transport operations in accordance with VCEMS Policy 131 – Multi Casualty Incident Response.

~~III.~~IV. ~~III.~~ POLICY:

1. Rescue task force operations shall be conducted in accordance with current Incident Command System (ICS) standards, and the primary fire agency conducting RTF operations shall establish unified command with law enforcement as soon as feasible, ideally prior to the first RTF team making entry with law enforcement.
2. Once rescue operations are complete, all rescued victims shall be transitioned from the hazard area(s), to a cold zone where they can be treated and prepared for transport in accordance with VCEMS Policy 131.
3. Only fire personnel, trained in RTF operations, who are wearing appropriate personal protective equipment, shall make entry into the warm zone as part of an RTF. All others shall remain in the cold zone.
4. Equipment utilized for the purposes of medical care, rescue, and personal protection are outlined in Appendix A of this policy.
5. Treatment (basic or advanced) performed as part of RTF operations will be in line with current VCEMS treatment protocols.
   A. Medical care should be focused on stabilizing life/limb threatening injuries and should be centered around: 1) maintaining a patent airway and adequate respirations; 2) needle decompression of tension pneumothorax, and; 3) controlling extremity hemorrhage, including the application of tourniquet(s).
   B. Utilize SCAB-E mnemonic that highlights the principles of RTF medical care within the warm zone: Situation, Circulation, Airway, Breathing, and Evacuation.

~~IV.~~V. PROCEDURE:

1. Preparatory Phase
   A. Arrive and report to staging or designated location in a secure area.
      i. First arriving command officer (or company officer on single resource incidents) should seek to establish unified command with law enforcement as soon as possible.
      ii. First arriving command officer (or company officer on single resource incidents) should maintain physical contact with law enforcement IC at all times.
   B. Don PPE (fire helmet, ballistic vest, wildland jacket, EMS Jacket, etc.), based on departmental requirements and guidelines.

C. Report to Incident Command / Unified Command that rescue group / team is ready and awaiting an assignment.
D. Ensure there is clear identification of RTF personnel.
E. Prepare RTF medical bags
F. Perform brief intelligence and threat assessment with law enforcement personnel and Incident Command / Unified Command.
    i. Identify hot, warm, and cold zone(s)
    ii. Identify movement path(s), and entry/exit points, rally points, etc.
    iii. If the size and complexity of the incident, as well as the number of victims warrants it, static and dynamic CCP(s) should be pre-determined.
G. Perform communications check with other RTF personnel and rescue group.
    i. Fire/EMS resources and law enforcement personnel will remain on their assigned frequencies unless specifically directed to a separate channel by incident command / unified command.
H. Develop incident objectives for RTF (fire) personnel that are in line with the objectives outlined by law enforcement personnel.

2. Warm Zone Operations
A. Coordinate movements and maintain cover as directed by law enforcement members of RTF.
B. Perform rapid assessment and treatment of victims
    i. Apply red ribbon for treated victims, and black/white for deceased.
C. Move patients to CCP and/or cold zone treatment area.
    i. Transfer care to appropriate treatment area manager and ensure medical group supervisor is aware of new patients.
D. Establish RTF medical caches / re-supply points as needed.
E. Re-stock RTF medical bags and prepare for re-entry into the warm zone.
F. Transition RTF personnel to MCI operations in cold zone once rescue of victims from the warm zone is complete.

3. Post Incident Phase
A. Ensure accountability for all RTF personnel
B. Collect any/all RTF documents or unit logs
C. Perform incident de-brief / hot wash with all incident personnel
D. Assess mental and physical health of RTF personnel and conduct CISD and rehabilitation as needed.

4. Non-RTF Prehospital Personnel

A. Utilizing current ICS concepts, establish key roles for the purposes of MCI management that focus on the triage, treatment, and transport of victims.
B. Identify key locations in the cold zone for equipment staging, treatment area(s), and ambulance loading zone(s).
C. Ensure Incident Command / Unified Command is aware of the location of this area and of the personnel staffing key MCI management roles.
D. All MCI operations (where applicable) shall be conducted in accordance with VCEMS Policy 131.

5. Documentation of patient care shall be in accordance with procedure(s) outlined in VCEMS Policy 1000 – Documentation of Prehospital Care, or with VCEMS Policy 131 (if an MCI declaration is applicable.

Common Terms and Definitions Associated with Rescue Task Force Programs

Acts of Violence

Includes but is not limited to large scale complex incidents such as school shootings, workplace violence, active shooter and terrorist activities, as well as smaller scale and/or less complex incidents such as suicide attempts, single patient shootings and stabbings, domestic violence injuries, and assaults.

Active Shooter

A suspect who's activity is immediately causing death and serious bodily injury. The activity is not contained and there is immediate risk of death and serious injury to potential victims.

Barricaded Suspect

A suspect who is in a position of advantage, usually barricaded in a room or building, and is armed and has displayed violence. May or may not be holding hostages and there is no indication that the subject's activity is immediately causing death or serious bodily injury.

Contact Team

Contact teams are used by law enforcement to rapidly deploy to the active shooter incident. It is usually comprised of the first few officers on scene. Primary objective is to stop the shooter from inflicting death or injury. Contact Teams will bypass dead, wounded and panicked citizens to neutralize the active threat.

Rapid Deployment

The swift and immediate deployment of law enforcement resources to on-going, life threatening situations where delayed deployment could otherwise result in death or great bodily injury to innocent persons.

Cold Zone

Areas where there is no threat either by geography to threat, or has been cleared and secured by Law. These areas are where support functions will be established such as: ICP, treatment areas, and staging. May also be classified as the outer perimeter by law enforcement.

Warm Zone

Areas that have been cleared by Law Enforcement where there is minimal or mitigated threat. These areas can be considered clear but not secure. These areas are where Rescue Task

Forces (RTF) deploy. RTFs rapidly stabilize life threating injuries where victims are found, and/or in Casualty Collections Points (CCP), followed by evacuation to treatment areas. Only Fire personnel being provided Force Protection by law enforcement as part of an RTF will enter the Warm Zone. Law Enforcement has sole authority to determine warm zones.

Hot Zone

Areas wherein a direct and immediate threat exists. A direct and immediate threat is very dynamic and is determined by complexity and circumstances of the incident. Examples of direct and immediate threat are active shooters and unexploded ordinances. These areas are where Law Enforcement has deployed contact teams to isolate or neutralize the threat. Fire personnel will not operate in a Hot Zone. May also be classified as the inner perimeter by law enforcement.

Force Protection

Actions taken by law enforcement to prevent or mitigate hostile actions against personnel, resources, facilities and critical infrastructure.

Cover

Anything that will stop a bullet.

Concealment

Anything that prevents you from being seen but will not stop a bullet.

Violent Incident Personnel Protective Equipment (PPE)

The required PPE for violent incidents will be body armor, structure helmet and brush coat or EMS jacket. All personnel will wear the required PPE while on scene regardless of their assignment or work locations. PPE not only protects on scene personnel it is used as an identification method while working on a very dynamic multi-discipline response.

Rescue Group

At violent incidents Rescue Group is responsible for the medical care and evacuation of patients located in the Warm Zone. This is accomplished by assigning firefighters to a Rescue Task Force (s) (RTF). The firefighter members of the RTF report to the Rescue Group Supervisor, but work for and at the direction of the lead law enforcement officer of the RTF to which they are

assigned. Rescue Group may also be responsible for other operations that will take place within the Warm Zone. This can include objectives such as fire suppression, forcible entry, and fire alarm system activation/deactivation.

Force Protection Group

A law enforcement group with the responsibility to prevent or mitigate hostile actions against personnel, resources, facilities and critical infrastructure. Coordinates with Rescue Group in establishing Rescue Task Forces (RTF).

Rescue Task Force

Rescue Task Forces (RTF) deploy in the Warm Zone. RTFs rapidly stabilize life threating injuries where victims are found, and/or in Casualty Collection Points (CCP). After providing rapid lifesaving medical care, RTFs will evacuate patients to treatment areas and/or Casualty Collection Points. An RTF is comprised of law enforcement personnel providing force protection and fire personnel providing medical care. Comprised of a minimum of one law enforcement officer (LEO) and two firefighters. The Task Force Leader (TFLD) will be a LEO. The firefighter RTF members report to the Rescue Group Supervisor but are assigned to the RTF TFLD.

Casualty Collection Point

The Casualty Collection Point (CCP) is a forward location where victims can be assembled for movement from areas of high risk to the triage/treatment areas. It is a temporary location to stage patients while awaiting further treatment. Based on incident dynamics, multiple CCPs may be required. Law enforcement may evacuate patients out of the Hot Zone to the Warm Zone border for RTF management or, RTFs may evacuate patients to the Warm/Cold zone border for transport to treatment area(s).

Tactical Emergency Casualty Care (TECC)

Forward deployment of stabilizing medical interventions in civilian disaster scenarios. TECC guidelines are based on the military Tactical Casualty Combat Care (TCCC) principles. TECC guidelines take into account the specific needs of civilian EMS providers serving civilian populations. These principles focus on the three most common cause of preventable death in combat (active shooting) situations; 1) extremity hemorrhage, 2) tension pneumothorax, and 3) airway obstructions. All of these are treatable in the field with minimal equipment.

SCAB-E

SCAB-E: Situation, Circulation, Airway, Breathing, Evacuation. Mnemonic used to describe medical treatment process that is to be used in a hazardous area. Goal is to rapidly stabilize life threatening injuries where patient lies and evacuate.

Appendix A – Rescue Task Force Equipment
Mandatory Minimum Requirements

Personal Protective Equipment

1 – Fire Helmet, Agency and Rank Specific

1 – Ballistic Vest

1 – Wildland “Brush” Jacket or EMS Jacket, Agency Issued.

Individual RTF Kit – BLS

1 – StatPacks Brand “Competitor” Pack - Black

3 – Combat Application Tourniquet (C.A.T.)

2 – HyFin Vent Chest Seal

5 – Petrolatum Gauze 5x9

1 – 2” Cloth Adhesive Tape

2 – 4” Flat Emergency Trauma Dressing (ETD)

2 – 5x9 Sterile Combine Dressing

2 – 3” Stretch Gauze

6 – Pair, Nitrile Gloves

1 – Each, Nasopharyngeal Airways Size 28, 30, 32 French

3 – Packets, Sterile Lubricant

1 – Roll, 100 yard White/Black Striped Flagging Tape

1 – Roll, 100 yard Red Flagging Tape

1 – Trauma Shears

1 – Safety Goggles

Individual RTF Kit – ALS

1 – StatPacks Brand “Competitor” Pack – Black with ‘ALS’ Markings

1 – Cook Emergency Pneumothorax Set

3 – Combat Application Tourniquet (C.A.T.)

2 – HyFin Vent Chest Seal

5 – Petrolatum Gauze 5x9

1 – 2” Cloth Adhesive Tape

2 – 4” Flat Emergency Trauma Dressing (ETD)

2 – 5x9 Sterile Combine Dressing

2 – 3” Stretch Gauze

6 – Pair, Nitrile Gloves

1 – Each, Nasopharyngeal Airways Size 28, 30, 32 French

3 – Packets, Sterile Lubricant

1 – Roll, 100 yard White/Black Striped Flagging Tape

1 – Roll, 100 yard Red Flagging Tape

1 – Trauma Shears

1 – Safety Goggles

Suspected Stroke

ADULT

BLS Procedures

Cincinnati Stroke Scale (CSS)
Administer oxygen as indicated

- Administer oxygen if SpO2 less than 94% or unknown
- If low blood sugar suspected, refer to VC EMS Policy 705.03 – Altered Neurologic Function

ALS Prior to Base Hospital Contact

IV/IO access

Cardiac monitor – document initial and ongoing rhythm strips

Determine Blood Glucose level, treat according to VC EMS policy 705.03 – Altered Neurologic Function

If patient meets Stroke Alert Criteria, as defined in VC EMS Policy 451, expedite transport to nearest Acute Stroke Center (ASC)

Base Hospital Orders only

Consult with ED Physician for further treatment measure

Aditional Information

- **Cincinnati Stroke Scale (CSS).**
  Facial Droop
  Normal: Both sides of face move equally
  Abnormal: One side of face does not move normally
  Arm Drift
  Normal: Both arms move equally or not at all
  Abnormal: One arm does not move, or one arm drifts down compared with the other side
  Speech
  Normal: Patient uses correct words with no slurring
  Abnormal: Slurred or inappropriate words or mute
- Patients meeting Stroke Alert Criteria, as defined in VC EMS Policy 451, shall be transported to the nearest Acute Stroke Center (ASC).
- Document name and phone number in ePCR of person who observed patient's Time Last Known Well (TLKW), and take this information to the hospital.
- Stroke patients in cardiac arrest with sustained ROSC (>30 seconds) shall be transported to the nearest STEMI Receiving Center (SRC).
- For seizure activity, refer to VC EMS Policy 705.20 Seizure.
- ~~Minimize scene time and transport Code 3 if symptoms present for 4.5 hours or less.~~; Remove

DRAFT

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Stroke System Triage and Destination	Policy Number 451
APPROVED: Administration: Steven L. Carroll, EMT-P	Date:
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date:
Origination Date: October 11, 2012 Date Revised: Date Last Reviewed: Review Date:	Effective Date:

I. PURPOSE: To outline the process of prehospital triage and transport of suspected acute stroke patients to facilities designated as an Acute Stroke Center (ASC).

II. AUTHORITY: California Health and Safety Code Sections 1797.220 and 1798, California Code of Regulations, Title 22, Division 9, Sections 100147, and 100169

III. DEFINITIONS:

Acute Stroke Center (ASC): Hospitals that are designated as an Acute Stroke Center, as defined in VCEMS Policy 450

Stroke Alert: An early notification by prehospital personnel to the base hospital that a patient is suffering a possible acute stroke.

Time Last Known Well (TLKW): The date/time at which the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.

IV. POLICY: (Changed the order of a, b, c)

1. **Stroke System Triage:** A patient meetingcriteria in each of the following sections (a, b, c) shall be triaged into the VCEMS stroke system and transported to the nearest ASC.
    a. Patient's TLKW is within 4.5 hours.
    b. Blood Glucose is greater than sixty (60) OR patient continues to exhibit signs and symptoms of an acute stroke after prehospital treatment of abnormal blood glucose levels.
    c. Identification of *any* abnormal finding of the Cincinnati Stroke Scale (CSS).
        Facial Droop
            Normal: Both sides of face move equally
            Abnormal: One side of face does not move normally
        Arm Drift
            Normal: Both arms move equally or not at all
            Abnormal: One arm does not move, or one arm drifts down compared with the other side

Speech

Normal: Patient uses correct words with no slurring

Abnormal: Slurred or inappropriate words or mute

2. Stroke Alert: Upon identification of a patient meeting stroke system criteria, Base Hospital Contact (BHC) will be established and a Stroke Alert will be activated.

The base hospital will determine the closest appropriate ASC using the following criteria:

1. Patients condition
2. ASC availability
3. Transport time
4. Patient request

~~based on several factors including patient presentation, hospital availability, and transport time. Upon receipt of the StrokeAlert,~~TheBase Hospital will notify the appropriate ASC of the Stroke Alert patient.~~unless the base hospital receiving theStroke Alert will also be the receiving the patient.~~

b. You *may* be asked to take your patient directly to the CT scanner.

- Give report to the nurse, transfer your patient from your gurney onto the CT scanner platform, and then return to service.
- If there is any delay, such as the CT scanner not being readily available, or a nurse not immediately available, you will not be expected to wait. You will take your patient to a monitored bed and give report as usual.

3. Destination Decision: patients meeting stroke system criteria shall be transported to the nearest ASC, except in the following cases:

a. Stroke patients in cardiac arrest shall be transported to the nearest receiving hospital. Patients who have greater than thirty seconds of return of spontaneous circulation (ROSC) shall be transported to the nearest STEMI Receiving Center (SRC).

b. The nearest ASC is incapable of accepting a stroke alert patient due to anydiversion status except neurosurgical diversion.~~to CT or neurodiversion.In the event ofCT or neurodiversion~~,In this event,the patient shall be transported to the next closest ASC.

c. The patient requests transport to an alternate facility, not extending transport by more than twenty (20) minutes, and approved by the Base Hospital.

4. Documentation

a. Care and findings related to an acute stroke patient shall be documented in the Ventura County electronic patient care reporting (VCePCR) system in accordance with VCEMS policy 1000.

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: December 1, 2012
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: December 1, 2012
Origination Date: March, 1999 Date Revised: August 9, 2012 Date Last Reviewed: August 9, 2012 Review Date: August, 2014	Effective Date: December 1, 2012

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. 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. VCEMS Deputy Administrator
7. VCEMS Trauma Coordinator

C. 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.

D. Voting Rights

Designated voting members shall have equal voting rights.

E. 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: County Ordinance No. 4099: Ambulance Business License Code			Policy Number 110
APPROVED: Administration	Steven L. Carroll, EMT-P		Date: 12/01/07
APPROVED: Medical Director	Angelo Salvucci, M.D.		Date: 12/01/07
Origination Date: Revised Date: Last Reviewed: Review Date:	July 10, 1994 September 13, 2007 June 9, 2011 June 30, 2014	Effective Date:	December 1, 2007

See following pages.

ORDINANCE NO. 4099

AN ORDINANCE AMENDING SPECIFIED PROVISIONS OF THE VENTURA COUNTY ORDINANCE CODE RELATING TO REGULATION OF EMERGENCY MEDICAL SERVICES.

The Board of Supervisors of the County of Ventura does ordain as follows:

Section 2421 - DEFINITIONS - Unless otherwise specified, the term:

(a) "AMBULANCE" shall mean any privately or publicly owned motor vehicle that is specifically designed or constructed and equipped to transport persons in need of emergency medical care and is licensed as an ambulance by the California Highway Patrol.

(b) "AMBULANCE COMPANY LICENSE" shall mean a certificate from the County of Ventura which verifies that the company has met the procedural requirements of the Ventura County Emergency Medical Services Agency (VCEMSA) Policies and Procedures Manual for a license and is permitted to establish a base of ambulance operations in a designated ambulance service area.

(c) "AMBULANCE SERVICE AREA" shall mean those geographical areas established for the County of Ventura and shown on the Ambulance Service Map in the VCEMSA P/P Manual, and shall mean the area in which a holder of an ambulance company license may establish a base of operations.

(d) "BOARD" shall mean the Board of Supervisors of the County of Ventura.

(e) "COUNTY" or "VC" shall mean County of Ventura.

(f) "EMCC" shall mean the Ventura County Emergency Medical Care Committee appointed by the Board of Supervisors in accordance with the mandate in the California Health and Safety Code.

(g) "EMERGENCY CALL" shall mean any of the following:

1) A request from an individual who is experiencing or who believes he is experiencing a life threat. Lights and sirens are used.

2) A request from public safety agencies for individuals who are or may be experiencing a life threat; or a sudden and unforeseen need for basic life support or first aid. Lights and sirens are used if needed.

3) A request to transport hospitalized patients to and from another facility for special emergency or urgently needed diagnostic services which the requesting hospital cannot provide. Lights and sirens are used if needed.

(h) "VCEMSA" shall mean the Ventura County Emergency Medical Services Agency.

(i) "VCEMSA Admin" shall mean the Administrator of the VCEMSA.

(j) "VCEMSA MedDir" shall mean the Medical Director of the VCEMSA.

(k) "EMT-IA" shall mean Emergency Medical Technician-IA, who is a person who has successfully completed a basic EMT-IA course which meets State requirements and who has been certified by the VCEMSA MedDir.

(l) "EMT-P". An Emergency Medical Technician-Paramedic is a person who has successfully completed a paramedic training program which meets State requirements and who has been certified by the VCEMSA MedDir.

(m) "EMERGENCY SERVICE" shall mean the service performed in response to an emergency call.

(n) "PATIENT" shall mean a wounded, injured, sick, invalid, dead or incapacitated person who is evaluated or treated by personnel of any provider of emergency medical care Basic Life Support or Advanced Life Support.

(o) "VENTURA COUNTY EMERGENCY MEDICAL SERVICES AGENCY (VCEMSA) POLICIES AND PROCEDURES (P/P) MANUAL" shall include the County Ambulance Ordinance and the policies and operating procedures which are approved by the Ventura County VCEMSA Medical Director and/or Administrator.

Section 2423 - GENERAL PROVISIONS

Section 2423-l - Ambulance Company License Required - No person, either as owner, agent. or otherwise, shall operate an ambulance or conduct, advertise, or otherwise be engaged in or profess to be engaged in the provision of emergency or non-emergency ambulance service upon the streets or any public way or place of the County, unless he holds a current valid license for an ambulance issued pursuant to this ordinance. An ambulance operated by or contracted for by an agency of the United States or the State of California shall not be required to be licensed hereunder.

Section 2423-1.1 - Application for Ambulance Company License -An application for an ambulance company license shall be submitted and processed pursuant to the procedures set forth in the VCEMSA P/P Manual.

Section 2423-1.2 - Insurance - It shall be unlawful for any owner to operate an ambulance or cause or permit the same to be driven or operated, unless there is in full force and effect at all times while such ambulance is being operated, insurance covering the owner of such ambulance against loss by reason of injury or damage that may result to persons or property from negligent operation of such ambulance.
Insurance requirements as specified in the "Agreement for Emergency Ambulance Service and Transport of Indigent Persons" shall be complied with at all times, including but not limited to providing Certificates of Insurance to and naming the County of Ventura as Additional Insured.

Section 2423-1.3 - Exception - Licensing requirements of this article - Licensing requirements of this article shall not apply to an ambulance company or to the EMT-IAs or EMT-Ps who are:

(a) Rendering assistance to licensed ambulances in the case of a major catastrophe or emergency with which the licensed ambulances of County are insufficient or unable to cope.

(b) Operating from a location or headquarters outside of County to transport patients picked up beyond the limits of County to locations within County, or to transport patients picked up at licensed hospitals, nursing homes or extended care facilities within County to locations beyond the limits of County.

(c) Operating from a location or headquarters outside of County and providing emergency ambulance services at the request of and according to the conditions of the County of Ventura, or with the approval of the County of Ventura.

(d) Stationing an ambulance outside the service area for which the company is licensed in order to provide special ambulance service for an activity or event in accordance with a written agreement with the sponsor of the event. If the ambulance company is a prime contractor for emergency service, such an agreement may not cause the usual level of service to be lowered. The VCEMSA Admin shall be notified by ambulance companies when contracts are made for special ambulance service outside the service area of the licensee.

Section 2423-2 - Ambulance Operators and Personnel

Section 2423-2.1 - Ambulance EMT-IA and EMT-P Certification - Ventura County Requirements - Ambulance personnel in Ventura County shall be certified as EMT-IA or EMT-P pursuant to the procedures set forth in the VCEMSA P/P Manual.

Section 2423-2.2 - Ambulance Operations Requirements - No vehicle shall be operated for ambulance purposes and no person shall drive, attend or permit to be operated for such purpose on the streets, or any public way or place of County unless it shall be under the immediate supervision and direction of two (2) people who are at least EMT-IA certified and authorized by the Ventura County, except under conditions cited in Section 2423-1.3. Applications shall be submitted and processed pursuant to the procedures set forth in the VCEMSA P/P Manual.

Section 2423-2.3 - EMT-IA AND EMT-P Certification and California State Ambulance Driving Certificate requirements - No person shall drive an ambulance vehicle unless he or she is holding a currently valid California State Ambulance Driver's Certificate and is also at least EMT-IA certified.

Section 2423-2.4 - Certification Fees - The VCEMSA may charge a certification fee, the rate for which is to be established by the Board of Supervisors.

Section 2423-3 - Rate Schedule - The Board, on its own motion or upon application of a license, may set, establish, change, modify or amend the schedule of rates that may be charged by a licensee.

(a) No rates shall be set, established, changed, modified or amended without a hearing before the Board, except as hereinafter specified.

(b) Notice of such hearing shall be given to each licensee by the VCEMSA Admin.

(c) Maximum fees for "Supplies and Equipment" and "Disposable Items" have been established in the existing approved Rates Schedule (EMS P/P 112). Maximum fees for these, and any added, items may, in the future, be set, established, changed, modified, or amended by the VCEMSA. The VCEMSA may delete items from these categories or may add to these categories additional items which are medically indicated and approved by the VCEMSA.

(1) Prior to making changes as permitted by this subsection (c), the VCEMSA shall notify Ventura County EMS agencies and the public and shall provide an appropriate opportunity for public input at an Emergency Medical Care Committee meeting.

(2) The VCEMSA shall notify the Board of Supervisors via the Informational Agenda of any changes made pursuant to this subsection (c). The Board of Supervisors, after public hearing, may overrule any changes made by the VCEMSA pursuant to this subsection (c).

Section 2424 - SUSPENSION AND REVOCATION - Any license or permit issued pursuant to the provisions of this Article may be suspended or revoked by the Director of the Health Care Agency upon grounds and after following the procedures outlined in the VC EMSD P/P Manual.

Section 2424-1 - Mandatory License Denial, Suspension or Revocation - The DIR-HCA shall deny, suspend or revoke the license of an ambulance company if the operator:

(a) Is required to register as a sex offender under the provisions of Section 290 of the Penal Code; or

(b) Habitually or excessively uses or is addicted to the use of narcotics, dangerous drugs, or alcohol, or has been convicted of any offense relating to the use, sale, possession or transportation of narcotics or habit-forming or dangerous drugs; or

(c) Has falsified or failed to disclose a material fact in his application; or

(d) Has held a license and abandons ambulance operation for a period of seven (7) days. Acts of God and other acts beyond the control of the licensee shall not be abandonment within the meaning of this section; or

(e) Has been convicted of any offense punishable as a felony during the proceeding ten (10) years.

Section 2424-2 - Discretionary License Denial, Suspension or Revocation - The DIR-HCA may deny, revoke or suspend the license of an ambulance company if the operator has violated the standards and regulations set out in the VCEMSA P/P Manual.

Ordinance Code, County of Ventura
Division 2, Chapter 1, Article 1 - General Provisions

Section 2120-1 - Hearing - A license issued pursuant to the provisions of this division may be suspended or revoked only after complying with the following procedures.

Section 2120-1.1 - Statement of Charges - Upon an alleged violation of any of the regulations set forth in the VCEMSA P/P Manual, the VCEMSA Admin/MedDir shall file with the Clerk of the Board a statement of charges.

Section 2120-1.2 - Acts or Omissions Charged - It shall specify the ordinance code sections, policies or regulations allegedly violated.

Section 2120-1.3 - Notice and Request for Hearing - Upon the filing of a statement of charges, the Clerk of the Board shall serve a copy thereof upon the respondent named therein in a manner provided by Ordinance Code Section 14. It shall be accompanied by a statement that respondent may request a hearing by filing a written request with the Clerk of the Board within ten (10) days after service.

Section 2120-1.4 - Waiver of Hearing - If no request for a hearing is received, the hearing is deemed waived and the VC EMSD may proceed with suspension or revocation. Notice shall be sent respondent of suspension or revocation.

Section 2120-1.5 - Hearing Officer - The Tax Collector or his deputy is hereby designated as hearing officer for any hearing conducted pursuant to this article. The hearing officer shall hear all evidence presented and at the conclusion of the hearing, rule on the charges presented.

Section 2120-1.6 - Time, Place and Notice of Hearing - Upon receipt of request for hearing, the Clerk of the Board shall contact the hearing officer and arrange a date, time and place for the hearing. Notice thereof shall be given all parties at least ten (10) days prior to the hearing.

Ordinance Code, County of Ventura
Division 2, Chapter 1, Article 1 - General Provisions
Section 2133 - Appeals

Any person whose application for a license is disapproved or whose license is suspended or revoked after a hearing, may appeal to the Board of Supervisors within thirty (30) days after the date of such denial, suspension or revocation by filing with the Clerk of the Board of Supervisors a request that the Board review denial, suspension or revocation. The appeal shall be in the form of a written notice filed with the Clerk of the Board of Supervisors and signed by the appellant. The notice shall have attached a copy of the written application, suspension or revocation, and shall state clearly and concisely the reasons upon which the appellant relies for his appeal. The Clerk of the Board of Supervisors shall set the matter for hearing within fifteen (15) days after the notice is filed, and shall notify the appellant and VC EMSD of the setting. At the hearing, the appellant shall have the burden of establishing to the satisfaction of the Board that he is entitled to relief, or otherwise the denial of the application, the suspension, or revocation of the license or permit shall stand.

Ord. 4033/215/227.1 April 27, 1993

AN ORDINANCE OF THE COUNTY OF VENTURA
AMENDING VENTURA COUNTY ORDINANCE CODE
SECTION 2423-3 RELATING TO SETTINGS OF AMBULANCE RATES

The Board of Supervisors of the County of Ventura does ordain as follows:

Section 1. Section 2423-3 of the Ventura County Ordinance Code is hereby amended to read as follows:

"Section 2423-3 - Rate Schedule - The Board, on its own motion or upon application of a licensee, may set, establish, change, modify or amend the schedule of rates that may be charged by a licensee.

(a) No rates shall be set, established, changed, modified or amended without a hearing before the Board, except for consumer price index or other changes as provided for in ambulance provider agreements or as hereinafter specified.

(b) Notice of such hearing shall be given to each licensee by the VCEMSA Admin.

(c) Maximum fees for "Supplies and Equipment" and "Disposable Items" have been established in the existing approved Rates Schedule (EMS P/P 112). Maximum fees for these, and any added, items may, in the future, be set, established, changed, modified, or amended by the VCEMSA except that consumer price index or other changes provided for in ambulance provider agreements shall be in accordance with such agreements. The VCEMSA may delete items from these categories or may add to these categories additional items which are medically indicated and approved by the VCEMSA.

    (1) Prior to making changes as permitted by this subsection (c), the VCEMSA shall notify Ventura County EMS agencies and the public and shall provide an appropriate opportunity for public input at an Emergency Medical Care Committee meeting.

    (2) The VCEMSA shall notify the Board of Supervisors via the informational Agenda of any changes made pursuant to this subsection (c). the Board of Supervisors, after public hearing, may overrule any changes made by the VCEMS pursuant to this subsection (c).

Section 2. This Ordinance shall take effect thirty (30) days following final passage and adoption.
PASSED AND ADOPTED this day of , 1996, by the following vote:

AYES: Supervisors

NOES: Supervisors

ABSENT: Supervisors

CHAIR, BOARD OF SUPERVISORS

ATTEST:
RICHARD D. DEAN, County Clerk
County of Ventura, State of
California, and ex officio
Clerk of the Board of Supervisors
thereof:

By
Deputy Clerk

COUNTY OF VENTURA
2013/14 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, 2013

NON-EMERGENCY & ADVANCED LIFE SUPPORT RATES

Charge	2013-14	Definition
Non-Emergency Base Rate	$846.00	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	$1,620.25	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.
Specialty Care Transport Nurse Hourly Rate (Two hour minimum)	$250.00	Rate per hour for providing a specially trained nurse to accompany a critically injured or ill patient during transport by a ground ambulance vehicle, which includes the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic.
Mileage	$33.75	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	$105.75	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.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Child, Dependent Adult, Or Elder Abuse Reporting		Policy Number 210
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 Review: Review Date:	June 14, 1984 September 11, 2003 June 9, 2011 June 30, 2014	Effective Date: November 1, 2003

I. PURPOSE: To define child, dependent adult and elder abuse and outline the required reporting procedure for prehospital care personnel in all cases of suspected child, dependent adult and elder abuse.

II. AUTHORITY: Welfare and Institutions code Section 15630-15632

III. POLICY: EMS Provider will report all suspected cases of abuse.

IV. DEFINITIONS:

A. "Abuse of an elder or a dependent adult" means physical abuse, neglect, intimidation, cruel punishment, fiduciary abuse, abandonment, isolation, or treatment with resulting physical harm or pain or mental suffering, or the deprivation by a care custodian of goods and services which are necessary to avoid physical harm or mental suffering.

1. "Isolation" means any of the following:

a. Acts intentionally committed for the purpose of preventing, and that do serve to prevent, an elder or dependent adult from receiving his or her mail or telephone calls.

Telling a caller or prospective visitor that an elder or dependent adult is not present, or does not wish to talk with the caller, or does not wish to meet with the visitor, where the statement is false, is contrary to the express wishes of the elder or the dependent adult, whether he or she is competent or not, and is made for the purpose of preventing the elder or dependent adult from having contact with family, friends, or concerned persons.

False imprisonment, as defined in Section 236 of the Penal Code.

Physical restraint of an elder or dependent adult for the purpose of preventing the elder or dependent adult from meeting with visitors.

b. The acts set forth in paragraph a. shall be subject to a rebuttal presumption that they do not constitute isolation if they are

performed pursuant to the instructions of a physician licensed to practice medicine in the State of California, who is caring for the elder or dependent adult at the time the instructions are given, and who gives the instructions as part of his or her medical care.

c. The acts set forth in paragraph a. shall not constitute isolation if they are performed in response to a reasonably perceived threat of danger to property or physical safety.

2. "Child" means any person under the age of 18 years.
3. "Child abuse" means physical injury which is inflicted by other than accidental means on a child by another person....sexual assault of a child....neglect of a child or abuse in out-of-home care.
4. "Dependent Adult" means any person residing in this state between the ages of 18 and 64, who has physical or mental limitations which restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age.
5. “Dependent adult” includes any person between the ages of 18 and 64 years who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.
6. "Elder" means any person residing in this state, 65 years of age or older"
7. “Health practitioner” means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision © of Section 4980.03 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner.

8. "Physical abuse means all of the following:
    a. Assault, as defined in Section 240 of the Penal Code
    b. Battery, as defined in Section 242 of the Penal Code
    c. Assault with a deadly weapon or force likely to produce great bodily injury, as defined by Section 245 of the Penal Code
    d. Unreasonable physical constraint or prolonged or continual deprivation of food or water.
    e. Sexual Assault, which means any of the following:
        1) Sexual battery, as defined in Section 243.4 of the Penal Code
        2) Rape, as defined in Section 261 of the Penal Code
        3) Rape in concert, as described in Section 264.1 of the Penal Code
        4) Incest, as defined in Section 285 of the Penal Code
        5) Sodomy, as defined in Section 286 of the Penal Code
        6) Oral copulation, as defined in Section 288a of the Penal Code
        7) Penetration of a genital or anal opening by a foreign object, as defined in Section 289 of the Penal Code.
    f. Use of a physical or chemical restraint or psychotropic medication under any of the following conditions:
        1) For punishment
        2) For a period significantly beyond that for which the restraint or medication was authorized pursuant to the instructions of a physician licensed in the State of California, who is providing medical care to the elder or dependent adult at the time the instructions are given.
9. "Reasonable suspicion" means that it is objectively reasonable for a person to entertain such a suspicion based upon facts that could cause a reasonable person in a like position, drawing when appropriate, on his or her training and experience, to suspect child abuse.

V. PROCEDURE:

1. Report by telephone to a county child or adult protective agency (Ventura County Human Services Agency at (805-654-3200) or to a local law enforcement agency immediately or as soon as possible. The telephone report shall include the following:

a. Name, address, telephone number, and occupation of the person making the report
b. Name and address of the victim
c. Date, time and place of the incident
d. Other details, including the reporter's observations and beliefs concerning the incident
e. Any statement relating to the incident made by the victim
f. The name of any individuals believed to have knowledge of the incident
g. The name of the individuals believed to be responsible for the incident and their connection to the victim.
h. Present location of the child
i. Nature and extent of the injury
j. Information that led such person to suspect child abuse

2. Report in writing to the agency contacted by telephone within two working days of receiving the information concerning the incident.
3. When two (2) or more persons who are required to report are present and jointly have knowledge of a suspected instance of child, dependent adult or elder abuse, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by such selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so, shall thereafter make such report.
4. The reporting duties are individual, and no supervisor or administrator may impede or inhibit such reporting duties and no person making such report shall be subject to any sanction for making such report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established provided that they are not inconsistent with the provisions of this article.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Paramedic Preceptor	Policy Number: 319
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: December 1, 2008
APPROVED: Medical Director Angelo Salvucci, MD	Date: December 1, 2008
Origination Date: June 1, 1997 Date Revised: July 10, 2008 Last Date Reviewed: June 9, 2011 Next Review Date: June 30, 2014	Effective Date December 1, 2008

I. PURPOSE: To establish minimum requirements for designation as a Ventura County Paramedic Preceptor.

II. AUTHORITY: Health and Safety Code, Sections 1797.214 and 1798.

III. POLICY:

A. A Paramedic may be designated a Paramedic preceptor upon completion of the following:

1. 6 months, (minimum 1440 hours) practice in Ventura County as a Level II Paramedic.
2. Written approval submitted to VC EMSA by employer.
3. Written approval submitted to VC EMSA by the Prehospital Care Coordinator at the base hospital of the area where the Paramedic practiced the majority of the time.
4. Successful completion of The Ventura County Emergency Medical Services Agency (VC EMSA) Paramedic Preceptor Training course.
5. Written notification of intent to practice as a Paramedic Preceptor shall be submitted to VC EMSA prior to preceptor working in this capacity.

B. The Paramedic Preceptor will be responsible for the training, supervision and evaluation of personnel in Ventura County who are preparing for accreditation or completion of requirements for Level I, Level II or EMT ALS Assist authorizations, and Paramedic Interns.

C. A preceptor shall not precept or evaluate more than one person at a time.

D. Paramedic Interns: Preceptors must directly observe the performance of all “Critical Procedures” and must be located in a position to immediately assume control of the procedure. The preceptor may not be functioning in any other capacity during these procedures.

1. Critical Procedures:
    a. Endotracheal Intubation
        1) Paramedic Intern shall be limited to one attempt in difficult intubations (e.g., morbidly obese patients, neck or facial trauma, active vomiting, massive oropharyngeal bleeding). The intern will not make a second attempt.
    b. Needle Thoracostomy
    c. Intraosseous needle insertion
    d. Childbirth
    e. Drug Administration
    f. PVAD
    g. Intravenous Access when patient requires immediate administration of fluids and/or medication(s).

E. Paramedics acting as preceptors for paramedic interns need to meet State of California, Title XXII requirements and successfully complete the Ventura County Preceptor Training course.

F. Each preceptor will be evaluated by their intern or candidate at the end of their training period. This evaluation will be forwarded to the preceptor's employer

Recommendation Form

Employer: Please instruct the Paramedic to complete the requirements in the order listed. Upon employer approval the employer will contact the PCC prior to Paramedic contacting PCC for approval.

_____, Paramedic has been evaluated and is approved to provide EMS Prehospital Care in the following instances. S/he has met all criteria as defined in Ventura County EMS policies. I have reviewed documentation of such and it is attached to this recommendation.

Please initial the appropriate box

Paramedic Preceptor

_____ All the requirement of level II met.
_____ 6 months (minimum 1440 hrs.) practice in Ventura County as a Level II Paramedic.
_____ Successful completion of the VC EMS Preceptor Training course.
_____ Approval by employer
_____ Approval by the PCC at the base hospital of the area where the Paramedic practiced the majority of the time during the previous year.
_____ Notification of VC EMS
_____ Completion of Curriculum Vitae

Please sign and date below for approval.

Employer Date:

PCC, BH Date:

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: MOBILE INTENSIVE CARE NURSE AUTHORIZATION REACTIVATION	Policy Number 324
APPROVED: Administration Steven L. Carroll, EMT-P	Date: December 1, 2008
APPROVED: Medical Director Angelo Salvucci, MD	Date: December 1, 2008
Origination Date: December 1991 Revised: August 14, 2008 Date Last Reviewed: June 9, 2011 Next Review Date: June 30, 2014	Effective Date: December 1, 2008

I. Purpose: To define the procedure for reactivating a lapsed or inactive authorization.

II. Authority: Health and Safety Code 1797.56 and 1797.58, 1797.213 and 1798.

III. Policy: An individual may reactivate his/her authorization upon completion of the following requirements.

V. Procedure: An individual whose Mobile Intensive Care Nurse (MICN) authorization has become inactive or lapsed shall be eligible for reauthorization when the following have been met:

A. MICN Authorization has lapsed due to failure to meet continuous service requirements and date on authorization has not expired.

1. Notify VCEMS of intent to reactivate authorization.
2. Within six (6) months of notification of intent to reactivate, complete a minimum of six- (6) hours of lecture/seminar and six (6) hours field care audit. These hours will be applied to continuing education requirements for reauthorization.
3. Demonstrate competence to practice as an MICN by satisfactorily providing medical direction to a field unit under the direction of an authorized MICN or MD during minimum of five (5) ALS call-ins requiring ALS care.
4. Submit recommendations for reactivation of authorization from Base Hospital.

B. MICN authorization expired for 1-31 days:

1. Notify VCEMS of intent to reactivate.
2. Meet the requirements for authorization reactivation as defined in Policy 322.

C. MICN authorization expired less than one (1) year.

1. Notify VCEMS of intent to reactivate. Complete the following in order and within six (6) months.
2. Prior to assignment on a radio:
    a Meet the requirements for reauthorization as defined in Policy 322.
    b Complete additional continuing education consisting of six (6) hours lecture/seminar and six (6) hours field care audit.
    c Complete eight (8) hours of Field Observation on a Ventura County Base ALS unit.
3. Demonstrate competence to practice as an MICN by satisfactorily rendering the medical direction, while under the supervision of the BH PCC, MICN or MD, during a minimum of five (5) ALS responses. An ALS response is defined as the performance, by the EMT-P one or more of the skills listed in the VC EMS Scope of Practice.
4. Submit recommendations for reactivation of MICN authorization from the Base Hospital to VC EMS.

D. MICN authorization expired between one (1) and two (2) years.
1. Notify VC EMS of intent to reactivate. In the following order, and within six (6) months:
2. Prior to assignment on a radio:
    a. Meet the requirements for reauthorization as defined in Policy 322.
    b. Complete additional continuing education consisting of nine (9) hours lecture/seminar and nine (9) hours field care audit.
    c. Complete twelve (12) hours of field observation on a Ventura County ALS unit.
3. Demonstrate competence to practice as an MICN by satisfactorily rendering medical direction, while under the supervision of the BH PCC, MICN or MD, during minimum of ten ALS responses. An ALS response is defined as the performance, by the EMT-P one or more of the skills listed in the VC EMS Scope of Practice.
4. Submit recommendations for reactivation of MICN authorization from ALS employer and Base Hospital to VC EMS.

E. Authorization expired for two (2) years or more
1. Notify VC EMS of intent to reactivate. Criteria must be met in the following order and within six (6) months.

2. Prior to assignment on a radio:
    a. Meet the requirements for reauthorization as defined in Policy 322
    b. Complete additional continuing education consisting of an additional twelve (12) hours field care audit and twelve (12) hours lecture/seminar.
    c. Complete twelve (12) hours of field observation on a Ventura County ALS unit.
3. Demonstrate competence to practice as an MICN by satisfactorily rendering medical direction, while under the supervision of the BH PCC, MICN or MD, during a minimum of ten (10) ALS responses. An ALS response is defined as the performance, by the EMT-P one or more of the skills listed in the VC EMS Scope of Practice.
4. Submit recommendations for reactivation of MICN authorization from ALS employer and Base Hospital to VC EMS.

F. EMS Agency Responsibilities

VC EMS shall issue an authorization card upon successful completion of the requirements for reactivation.

LETTER OF RECOMMENDATION
AUTHORIZATION REACTIVATION

_____ is recommended for Reactivation of Mobile Intensive Care Nurse Authorization in Ventura County.

We have reviewed the attached Mobile Intensive Care Nurse Application and verify that the applicant:

_____ Holds a valid California Registered Nurse License.

_____ Has met the requirements for reactivation of Mobile Intensive Care Nurse Authorization.

_____
Emergency Department Medical Director/
Paramedic Liaison Physician

_____
Emergency Department Nursing Supervisor

_____
Prehospital Care Coordinator

Date: _____

REACTIVATION OF AUTHORIZATION APPLICATION

Attach the following:

1. Facsimile of California RN License
2. Facsimile of ACLS Certification
3. Continuing Education Requirements
4. Letter of Recommendation
5. Verification of Field Observation

Signatures: _____
MICN Candidate

_____
Prehospital Care Coordinator

Date: _____

COMMUNICATION EQUIPMENT PERFORMANCE EVALUATION FORM

Candidate's Name:	MICN Exam Date:	Base Hospital:
MICN Evaluator: Please evaluate this MICN candidate for the following, to include but not be limited to: Proper operation of radio equipment; recommended radio protocols used; correct priorities set; additional info requested as needed; appropriate, complete, specific orders given; able to explain rationale for orders, notification of other agencies involved; and ability to perform alone or with assistance.		

Date	Incident # (and Pt # of Total as needed)	Chief Complaint	Treatment	Evaluator's Comments	Evaluator's Signature	PCC's Comments
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

VERIFICATION OF INTERNSHIP COMPLETION

_____, employed at _____, is/is not recommended for Authorization as a Mobile Intensive Care Nurse. S/He has achieved the following rating in the following categories:

Category	Rating	Comments
Understands and operates equipment properly		
Sets correct priorities		
Requests additional information as needed		
Orders are specific, complete and appropriate		
Understands treatment rationale		

NOTE:
In order to qualify for recommendation, a candidate must receive at least a rating of 3 in each category. Ratings are as follows:

1. Poor
2. Fair
3. Average
4. Good
5. Excellent

ATTACH COMMUNICATION EQUIPMENT PERFORMANCE EVALUATION FORM

Signatures:

_____
BH Medical Director/Paramedic Liaison Physician

_____
Prehospital Care Coordinator

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 toe 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.**

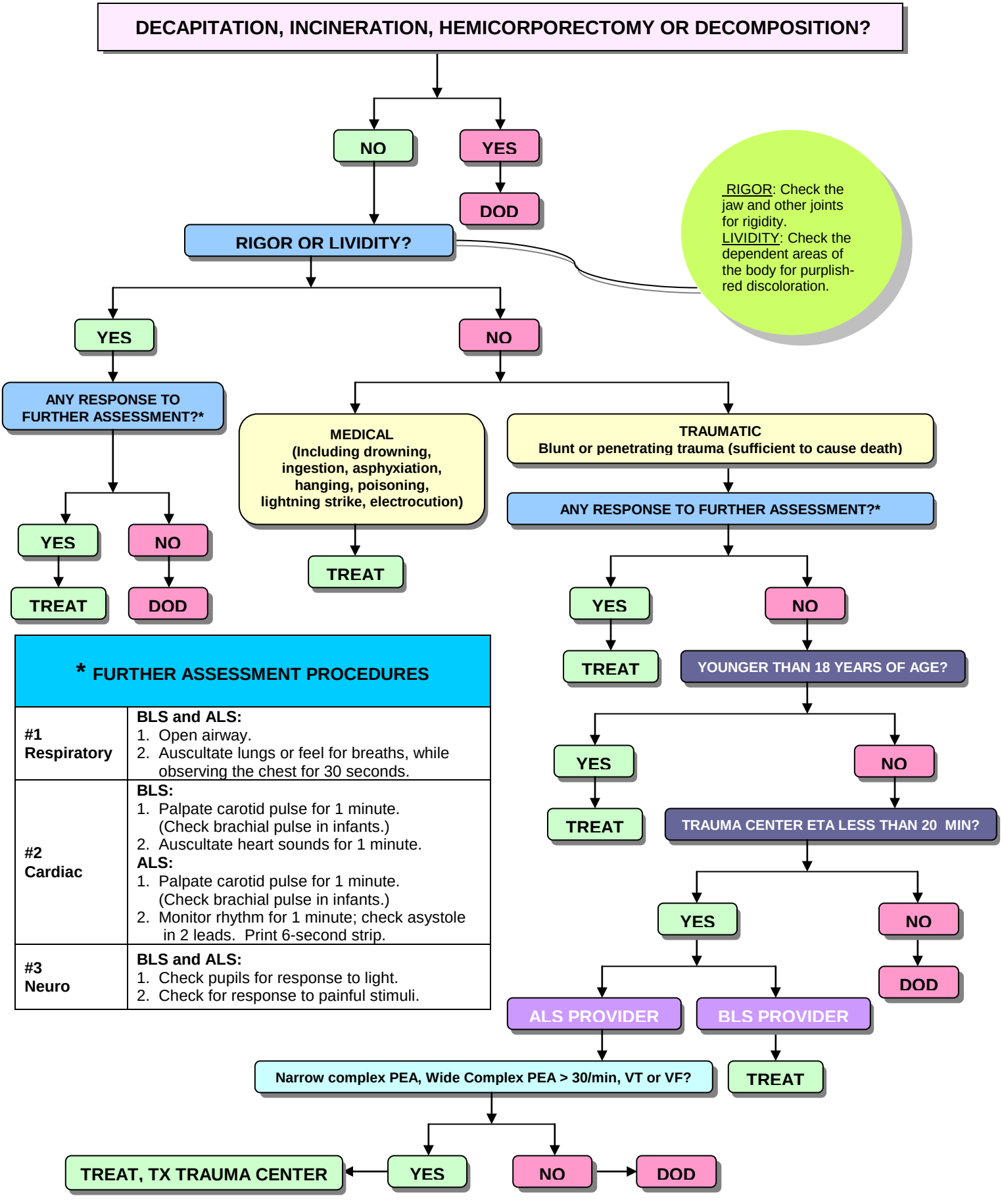
E. Documentation

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.

Ventura County EMS Determination of Death



* FURTHER ASSESSMENT PROCEDURES	
#1 Respiratory	**BLS and ALS:** 1. Open airway. 2. Auscultate lungs or feel for breaths, while observing the chest for 30 seconds.
#2 Cardiac	**BLS:** 1. Palpate carotid pulse for 1 minute. (Check brachial pulse in infants.) 2. Auscultate heart sounds for 1 minute. **ALS:** 1. Palpate carotid pulse for 1 minute. (Check brachial pulse in infants.) 2. Monitor rhythm for 1 minute; check asystole in 2 leads. Print 6-second strip.
#3 Neuro	**BLS and ALS:** 1. Check pupils for response to light. 2. Check for response to painful stimuli.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Notification of Exposure to a Communicable Disease	Policy Number 612
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: June 1, 2011
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: June 1, 2011
Origination Date: April 27, 1990 Date Revised: April 14, 2011 Date Last Reviewed: April 14, 2011 Review Date: June, 2014	Effective Date: June 1, 2011

I. PURPOSE:

To provide a protocol for communication between health facility and prehospital providers in the event an emergency responder has been exposed to bloodborne pathogens, aerosol transmissible pathogens or other reportable or communicable diseases or illnesses

II. AUTHORITY:

- Health and Safety Code, Division 2.5, Section 1797.188
- CA Code of Regulations, Title 17, Section 2500
- Public Health and Safety Act, Title 26, Section 1793
- CA CFR 1910.1030
- CCR, Title 8, Section 5199, Aerosol Transmissible Diseases
- CCR, Title 8, Section 5193, Bloodborne Pathogens

III. DEFINITIONS:

A. Aerosol Transmissible Exposure Incident – an event in which all of the following have occurred:

1. An employee who has been exposed to an individual who is a case or suspected case of a reportable ATD,
2. The exposure occurred without the benefit of applicable exposure controls
3. It reasonably appears from the circumstances of the exposure that transmission of disease is sufficiently likely to require medical evaluation

B. Bloodborne Exposure Incident – a specific eye, mouth, other mucous membranes, non-intact skin, or parenteral (needle-stick) contact with blood or other potentially infectious materials that result from the performance of an employee's duties

C. Communicable Disease - an illness due to a specific infectious agent which arises through transmission of that agent from an infected person, animal or objects to a susceptible host, either directly or indirectly

D. Contact Exposure – coming in touch with an object or surface that has been contaminated with a communicable disease

E. Designated Officer (DO)– an official, or their designee, designated to evaluate and respond to possible infectious disease exposures of their employees

F. Emergency Responder - paramedic, EMT, firefighter, peace officer, lifeguard and other public safety personnel

G. Health Care Facility – any hospital which provides emergency medical care and which receives patients following care by emergency responders

H. Infection Preventionist (IP) – a person , often an RN, who is assigned responsibility for surveillance and infection prevention, education and control activities

I. OPIM – other potentially infectious material such as amniotic fluid, semen, vaginal secretions, CSF, synovial fluid, peritoneal fluid

K. Reportable Disease – an infectious disease required to be reported to the Ventura County Communicable Disease Division pursuant to CCR, Title 17, Section 2500

IV. POLICY:

It shall be the policy of all emergency responders to wear appropriate personal protective equipment during patient care

It shall be the policy of the Emergency Medical Services Agency to insure that emergency responders are notified if they have been exposed to a reportable or communicable disease or illness in a manner which could transmit the disease. This notification shall follow the procedures outlined below. The name of the patient infected with the communicable disease will be not released during this notification process.

In the event the patient dies and the county medical examiner determines the presence of a communicable disease, they will notify the County EMS Agency Duty Officer. The Duty Officer will determine which, if any, emergency responders were involved and will notify the Designated Officer at those departments.

V. PROCEDURE:

A. Field Exposure to Blood or Other Potentially Infectious Material (OPIM) or airborne transmissible disease

When an emergency responder has a **known or suspected** bloodborne, airborne transmissible disease or infectious disease exposure the following procedure shall be initiated (Appendix B):

1. All emergency responders who know or suspect they have had a bloodborne exposure should immediately:
   a. Initiate first aid procedures (wash, irrigate, flush) to diminish exposure potential
   b. Notify their supervisor
2. Report the exposure by contacting their department's Designated Officer (DO),
3. The DO shall determine if an exposure has occurred and complete the appropriate documentation.
4. If it is determined that an exposure occurred, the DO shall initiate a Prehospital Exposure Tracking/Request Form (Appendix A) and obtain the information regarding the source patient and their location.
5. The DO will make contact with the appropriate person (e.g. ED charge nurse, Prehospital Care Coordinator, infection control preventionist or coroner) at the source patient's location to confirm the presence of a communicable disease and/or request any needed source patient testing.
6. The DO will fax a request for source patient information utilizing the Prehospital Exposure Tracking/Request Form (Appendix A) to their contact at the patient's location.
7. The source patient shall be tested as soon as feasible based on the type of communicable disease or illness exposure:
   a. Bloodborne Exposure – Hepatitis B, Hepatitis C, Rapid HIV, Syphilis
      (If the source patient is known to be HIV positive or the Rapid HIV test is positive, a viral load test shall be done)
   b. Airborne Exposure – appropriate testing as indicated
   c. Contact Exposure – appropriate testing as indicated
8. Results of the source patient's testing shall be released to the DO, who will notify the exposed emergency responder(s) and facilitate any required medical treatment or follow-up.
9. The DO will arrange for the exposed emergency responder(s) to receive appropriate follow-up which may include a confidential medical examination, including vaccination history and baseline blood collection. (CA CFR 1910.1030)

B. Hospital Notification of a Communicable Disease or Illness

When a health care facility diagnoses an airborne transmissible disease (Appendix D) or communicable disease or illness the following procedure will be initiated (Appendix C):

1. The Infection Control Preventionist or Emergency Department Personnel will notify Ventura County Public Health Officer or designee **AND** contact the DO of the involved department directly.
2. The Ventura County Public Health Officer will notify the Emergency Medical Services Agency (EMSA) Duty Officer.
3. The EMSA Duty Officer will determine if emergency responders were involved in the patient's care. If emergency responders were possibly exposed to the recently diagnosed patient, the Duty Officer will contact the involved department's DO with the date, time and location of the incident and the nature of the exposure
4. The DO will investigate the circumstances of the possible exposure and arrange for the exposed emergency responder(s) to receive appropriate follow-up which may include a confidential medical examination, including vaccination history and baseline blood collection. (CA CFR 1910.1030)

Appendix A

Pre Hospital Exposure Tracking/ Request Form

Hospital Receiving Request							
☐	CMH	☐	LRHMC	☐	OVCH	☐	SJPVH
☐	SJRMC	☐	SPH	☐	SVH	☐	VCMC

Name of Person Receiving Request
Name:

Requestor Information		
Date/Time of Request:		Fire Incident #:
Name of Requestor:	Title:	Contact Number:
Signature of Requestor:		

Agency Making Request					
AMR		GCA		FLM	
LMT		OXD			
SPA		SAR		VEN	
VFF		VNC		Other:	

Source Patient Information		
Source Patient:	DOB:	MR#
Symptoms:		

Description of Bloodborne Exposure					
***Description of Exposure**:*					
Hollow Needle Stick		Mucous Membrane Splash		Non-intact skin	

Description of Airborne Exposure					
***Description of Exposure**:*					
Aerosol Transmissible		Disease		TB	

Recommended Source Patient Blood Work					
Hepatitis B Antigen		Hepatitis C Antibody		Rapid HIV	
RPR				Viral Load (if HIV +)	
Other:					

Diagnosis: Bloodborne Pathogen Exposure: V15.85
Exposed Employee's Name:

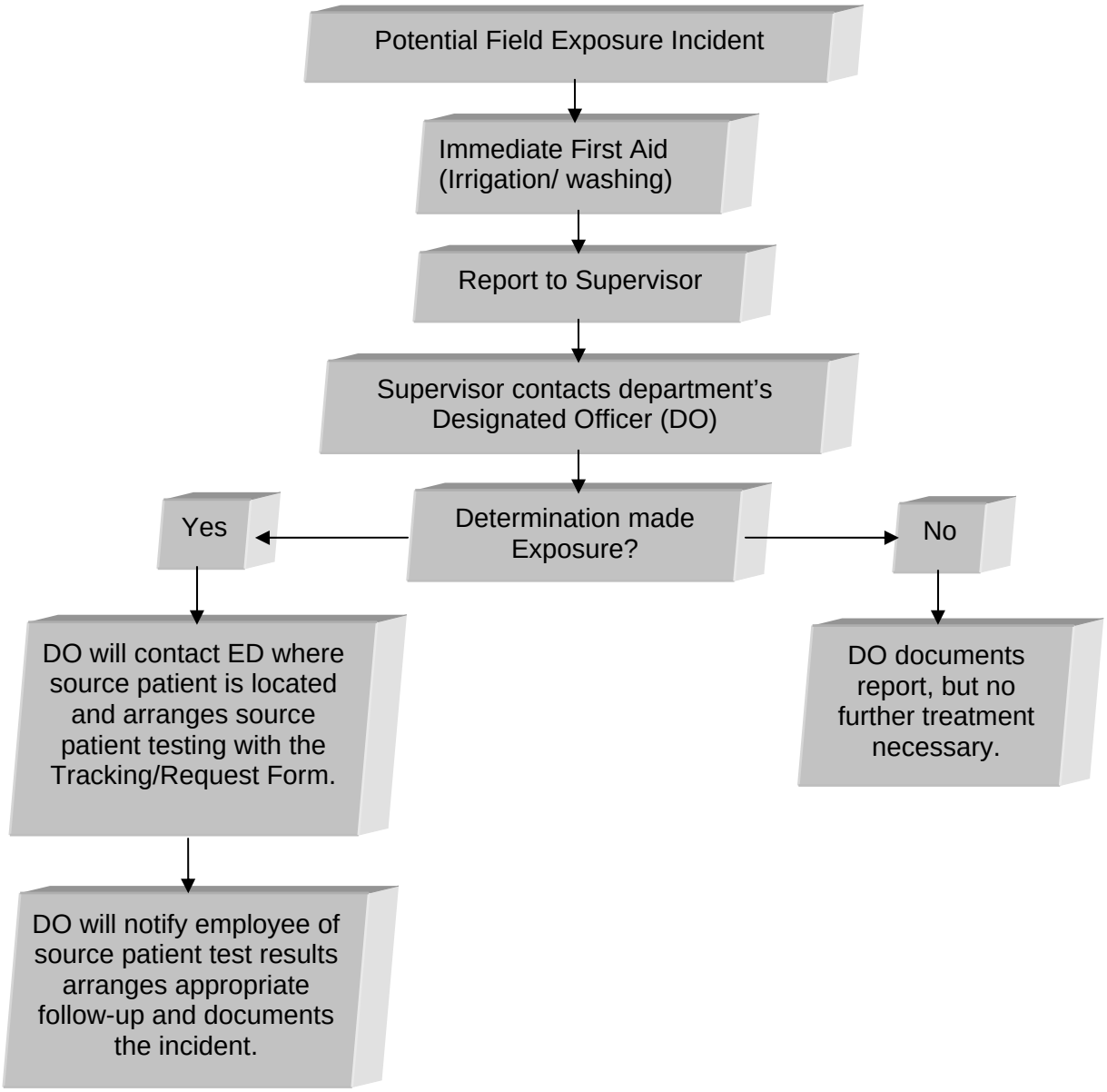
DOB:	Date of Injury/Exposure:

Billing Information	
Workers Compensation Carrier:	
Name of Employer:	
Name:	
Address:	
Phone Number:	
FAX number:	

Release of Source Patient Results		
Release Results To:	**Phone #:**	**FAX #:**
Date/Time Results Released:		

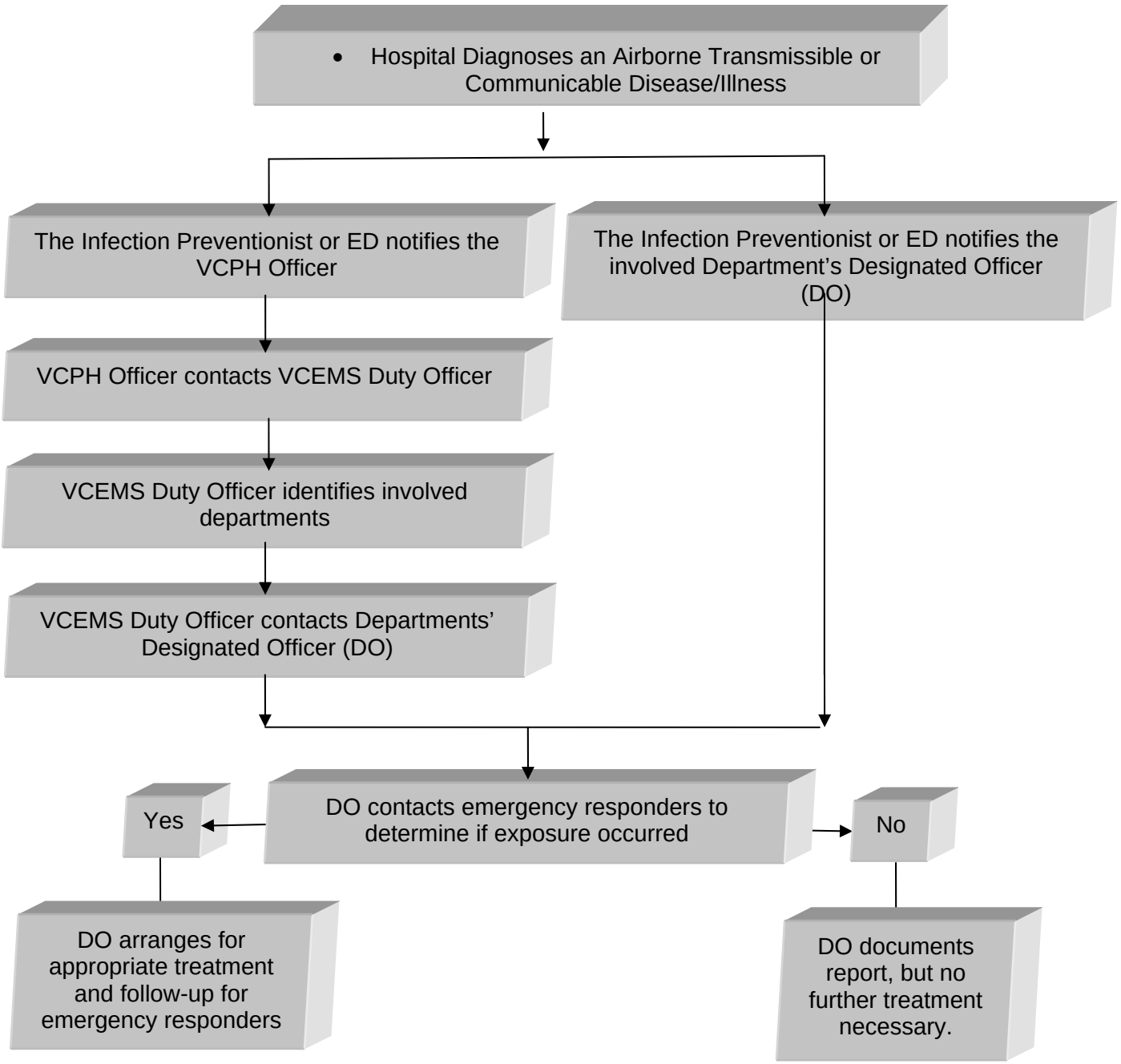
Appendix B

Policy 612 Algorithm: Field Exposure to Blood, Other Potentially Infectious Material or Airborne Transmissible Disease



Appendix C

Policy 612 Algorithm: Hospital Notification of an Airborne Transmissible or Communicable Disease/Illness



Appendix D

Aerosol Transmissible Diseases/Pathogens (Mandatory)
California Code of Regulation, Title 8, Section 5199

This appendix contains a list of diseases and pathogens which are to be considered aerosol transmissible pathogens or diseases for the purpose of Section 5199. Employers are required to provide the protections required by Section 5199 according to whether the disease or pathogen requires airborne infection isolation or droplet precautions as indicated by the two lists below.

Diseases/Pathogens Requiring Airborne Infection Isolation
Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. Anthrax/*Bacillus anthracis*
Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out
Measles (rubeola)/Measles virus
Monkeypox/Monkeypox virus
Novel or unknown pathogens
Severe acute respiratory syndrome (SARS)
Smallpox (variola)/Varioloa virus
Tuberculosis (TB)/*Mycobacterium tuberculosis* -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected
Any other disease for which public health guidelines recommend airborne infection isolation

Diseases/Pathogens Requiring Droplet Precautions
Diphtheria pharyngeal
Epiglottitis, due to *Haemophilus influenzae* type b
Haemophilus influenzae Serotype b (Hib) disease/*Haemophilus influenzae* serotype b -- Infants and children
Influenza, human (typical seasonal variations)/influenza viruses
Meningitis
Haemophilus influenzae, type b known or suspected
Neisseria meningitidis (meningococcal) known or suspected
Meningococcal disease sepsis, pneumonia (see also meningitis)
Mumps (infectious parotitis)/Mumps virus
Mycoplasmal pneumonia
Parvovirus B19 infection (erythema infectiosum)
Pertussis (whooping cough)
Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,
Pneumonia
Adenovirus
- Haemophilus influenzae Serotype b, infants and children
- Meningococcal
- *Mycoplasma, primary atypical*
- *Streptococcus Group A*

Pneumonic plague/*Yersinia pestis*
Rubella virus infection (German measles)/Rubella virus
Severe acute respiratory syndrome (SARS)
Streptococcal disease (group A streptococcus)

- Skin, wound or burn, Major
- Pharyngitis in infants and young children
- Pneumonia
- Scarlet fever in infants and young children
- Serious invasive disease

Viral hemorrhagic fevers due to Lassa, Ebola, Marburg, Crimean-Congo fever viruses (airborne infection isolation and respirator use may be required for aerosol-generating procedures)
Any other disease for which public health guidelines recommend droplet precautions

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: ICE – In Case of Emergency for Cell Phones		Policy Number 622
APPROVED: Administration:	Steven L. Carroll, EMT-P	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:	May 11, 2006 May 11, 2006 June 9, 2011 June 30, 2014	Effective Date: December 1, 2008

I. PURPOSE: To inform EMS providers of the ICE (In Case of Emergency) program that is promoted for personal cell phones. This is described as a universally-recognized mechanism to provide prompt notification to a family member or other designated contact of an ill or injured patient, and perhaps obtain information about a patient's medical history.

II. AUTHORITY: Division 2.5 of the Health and Safety Code, Sections 1797.214 and 1798

III. DEFINITIONS: "ICE" is an acronym for "In Case of Emergency".

IV. PROCEDURE: It may be practical for EMS Providers to briefly search for a cell phone or other identification when working with a patient that is unable to provide this information. These items could then be provided to law enforcement or transported with the patient to the hospital. EMS providers are not usually the ones who make emergency notifications to family members or other third parties. This is normally done by law enforcement, hospitals or others involved in the situation. Searching for cell phones or making notifications, whether to an ICE contact or other third party, should never delay patient assessment, treatment, or transport. Currently, there are no applicable federal laws that *require* an EMS provider to check a patient's cell phone and attempt to make contact with the patient's ICE designee. If the EMS Provider attempts to make a notification, they should only disclose personal health information about the patient that is directly relevant to their involvement with the patient's health care. This notification should be documented on the approved Ventura County documentation system.

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

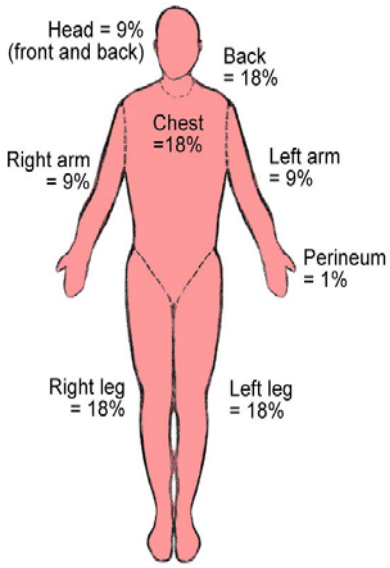
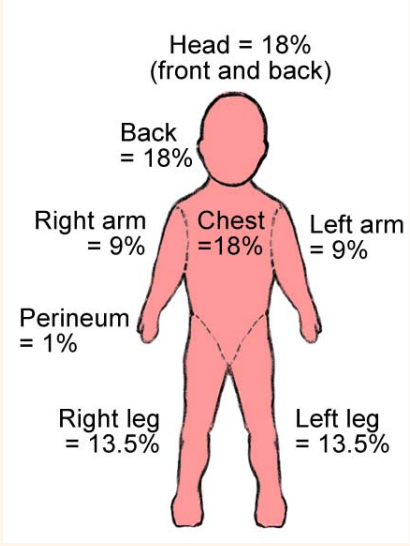
Anaphylaxis with Shock
- For continued shock
  - *Repeat* **Normal Saline**
    - IV/IO bolus – 20 mL/kg
  - *Repeat* **Epinephrine 1:1,000**
    - IM – 0.01 mg/kg q 5 min x 2 as needed

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Effective Date: June 1, 2011
Next Review Date: August, 2014
Date Revised: April 14, 2011
Last Reviewed: August 9, 2012

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	• 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** o IV bolus – 1 Liter	IV/IO access **Morphine** – per Policy 705 - Pain Control If TBSA > 10% or hypotension is present: • **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

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. 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.

Chest Pain – Acute Coronary Syndrome

BLS Procedures

Administer oxygen if dyspnea, signs of heart failure or shock, or SAO2 < 94%
Assist patient with prescribed Nitroglycerin as needed for chest pain
- Hold if SBP < 100 mmHg

ALS Prior to Base Hospital Contact

Perform 12-lead ECG
- If "***ACUTE MI SUSPECTED***" is present, expedite transport to closest STEMI Receiving Center
- Document all initial and ongoing rhythm strips and ECG changes

For continuous chest pain consistent with ischemic heart disease:
- **Nitroglycerin**
  - SL or lingual spray – 0.4 mg q 5 min for continued pain
    - No max dosage
    - Maintain SBP > 100 mmHg
      - If normal SBP < 100 mmHg, then maintain SBP > 90 mmHg
- **Aspirin**
  - PO – 324 mg

IV access
- 3 attempts only prior to Base Hospital contact

If pain persists and not relieved by NTG:
- **Morphine** – per policy 705 - Pain Control
  - Maintain SBP > 100 mmHg

If patient presents or becomes hypotensive:
- Elevate legs
- **Normal Saline**
  - IV bolus – 250 mL
    - Unless CHF is present

Communication Failure Protocol

One additional IV attempt if not successful prior to initial BH contact
- 4 attempts total per patient

If hypotensive and signs of CHF are present or no response to fluid therapy:
- **Dopamine**
  - IVPB – 10 mcg/kg/min

Base Hospital Orders only

Consult ED Physician for further treatment measures

ED Physician Order Only: For ventricular ectopy [PVC's > 10/min, multifocal PVC's, or unsustained V-Tach], consider amiodarone 150 mg IVPB.

Additional Information:
- Nitroglycerin is contraindicated when erectile dysfunction medications (Viagra, Levitra, and Cialis) have been recently used (Viagra or Levitra within 24 hours; Cialis within 48 hours). NTG then may only be given by ED Physician order

Crush Injury/Syndrome

ADULT

BLS Procedures

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

Communication Failure Protocol

Actual crush syndrome
- Initiate 2nd IV access
- **Normal Saline**
  - IV bolus – 1 Liter
    - Caution with cardiac and/or renal history
- **Sodium Bicarbonate**
  - IV mix – 1 mEq/kg
    - Added to 1st Liter of Normal Saline
- **Albuterol**
  - 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:
  - **Calcium Chloride**
    - IV – 1 gm over 1 min

For continued shock
- *Repeat* **Normal Saline**
  - IV bolus – 1 Liter

Base Hospital Orders only

For ongoing extended entrapment and no response to fluid therapy:
- **Dopamine**
  - IVPB – 10 mcg/kg/min

Consult with ED Physician for further treatment measures

PEDIATRIC

BLS Procedures

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

Communication Failure Protocol

Actual crush syndrome
- Initiate 2nd IV access if possible or establish IO
- **Normal Saline**
  - IV/IO bolus – 20 mL/kg
    - Caution with cardiac and/or renal history
- **Sodium Bicarbonate**
  - IV mix– 1 mEq/kg
    - Added to 1st Liter of Normal Saline
- **Albuterol**
  - Less than 2 years old
    - Nebulizer – 2.5 mg/3 mL
      - Repeat x 2
  - 2 years old and greater
    - Nebulizer – 5 mg/6 mL
      - Repeat x 2
- Maintain body heat
- Release compression
- Monitor for cardiac dysrhythmias
- For cardiac dysrhythmias:
  - **Calcium Chloride**
    - IV/IO – 20 mg/kg over 1 min

For continued shock
- *Repeat* **Normal Saline**
  - IV/IO bolus – 20 mL/kg

Base Hospital Orders only

For ongoing extended entrapment and no response to fluid therapy:
- **Dopamine**
  - 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

Effective Date: December 1, 2010
Next Review Date: July, 2014
Date Revised: August, 2010
Last Reviewed: August, 2012
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VCEMS Medical Director

Overdose/Poisoning

ADULT	PEDIATRIC
BLS Procedures	
Decontaminate if indicated and appropriate Administer oxygen as indicated	Decontaminate if indicated and appropriate Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
IV/IO access (IO per Policy 717) Oral ingestion less than 1 hour, AND GCS greater than or equal to 14, AND expected transport interval greater than 15 min: • **Activated Charcoal** o PO – 1 gm/kg • Max 50 gm Suspected opiate overdose with respirations less than 12/mi and significant ALOC: • **Narcan** o IM – 2 mg o IV – 0.4 mg q 1min • Initial max 2 mg o May repeat as needed to maintain respirations greater than 12/min Organophosphate Poisoning • **Mark I or DuoDote Antidote Kit** o Mild Exposure: IM x 1 o Moderate Exposure: IM x1 • May repeat in 10 minutes if symptoms persist o Severe Exposure: IM x 3 in rapid succession, rotating injection sites	IV/IO access (IO per Policy 717) Oral ingestion less than 1 hour, AND GCS greater than or equal to 14, AND expected transport interval greater than 15 min: • **Activated Charcoal** o PO –1 gm/kg • Max 50 gm Suspected opiate overdose with respirations less than 12/min: • **Narcan** o IV/IM/IO – 0.1 mg/kg • Initial max 2 mg o May repeat as needed to maintain respirations greater than 12/min Organophosphate Poisoning • Mark I or DuoDote Antidote Kit x 1 o May repeat x 1 in 10 minutes for patients greater than 40kg if symptoms persist • May use Atropen 0.5mg IM for patients up to 25kg or Atropen 1.0 mg IM for patients up to 50kg o Repeat until symptoms are relieved o Atropen requires a CHEMPACK deployment
Base Hospital Orders only	
Tricyclic Antidepressant Overdose • **Sodium Bicarbonate** o IV – 1 mEq/kg Beta Blocker Overdose • **Glucagon** o IV – 2 mg • May give up to 10mg if available Calcium Channel Blocker Overdose • **Calcium Chloride** o IV – 1 gm over 1 min • **Glucagon** o IV – 2 mg • May give up to 10 mg if available Stimulant/Hallucinogen Overdose • **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	Tricyclic Antidepressant Overdose • **Sodium Bicarbonate** o IV/IO – 1 mEq/kg Beta Blocker Overdose • **Glucagon** o IV/IO – 0.1 mg/kg • May give up to 10 mg if available Calcium Channel Blocker Overdose • **Calcium Chloride** o IV/IO – 20 mg/kg over 1 min • **Glucagon** o IV/IO – 0.1 mg/kg • May give up to 10 mg if available Stimulant/Hallucinogen Overdose • **Midazolam** o IM – 0.1 mg/kg • Max 5 mg
ED Physician Order Only: Ondansetron Consult with ED Physician for further treatment measures	**ED Physician Order Only: Ondansetron** Consult with ED Physician for further treatment measure

Additional Information:
- Refer to VCEMS Policy 705-17-Nerve Agent Poisoning for nerve agent exposure treatment guidelines.
- 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.

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

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

ADULT	PEDIATRIC
BLS Procedures	
Administer oxygen as indicated	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	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** o IV – 6 mg rapid push immediately followed by 10-20 mL NS flush No conversion or rate control • **Adenosine** o 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** o 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 • IO Access for unstable adults only. • **Synchronized Cardioversion** o Use the biphasic energy settings that have been approved by service provider medical director.	Stable • **Adenosine** o IV – 0.1 mg/kg (max dose 6 mg) rapid push immediately followed by 10-20 mL NS flush No conversion or rate control • **Adenosine** o IV – 0.2 mg/kg (max dose 12 mg) rapid push immediately followed by 10-20 mL NS flush May repeat x 1 if no conversion or rate control Unstable • **Synchronized Cardioversion** o 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.
- Prior to administering Adenosine in pediatric patients, evaluate for possible underlying causes of tachycardia (infection, dehydration, trauma, etc.)
- Document all ECG strips during adenosine administration and/or synchronized cardioversion.

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: December 1, 2012
APPROVED: Medical Director: Angelo Salvucci, MD	Date: December 1, 2012
Origination Date: September 10, 1992 Date Revised: July 12, 2012 Date Last Reviewed: July 12, 2012 Review Date: July, 2014	Effective Date: December 1, 2012

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. EZ-IO 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 arm band and place on patient's wrist.

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

C. 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 in the Ventura County Electronic Patient Care Report (VCePCR) system.
2. The site and number of attempts, success, complications, and any applicable comments related to attempting an IO infusion shall be documented on the VCePCR. Any medications administered shall also be documented in the appropriate manner on the VCePCR.

E. Quality Assurance

Each use of an IO infusion will be reviewed by EMS. Data related to IO attempts will be collected and analyzed directly from the VCePCR system.

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: Use of Restraints		Policy Number 732
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: December 1, 2012
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: December 1, 2012
Origination Date: Date Revised: Date Last Reviewed: Review Date:	April 1, 2011 July 12, 2012 July 12, 2012 July, 2014	Effective Date: December 1, 2012

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

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 July 12, 2012 July 31, 2014	Effective Date: December 1, 2007

I. PURPOSE: To define the use of the "Paramedic/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: Mobile Intensive Care Nurse Developmental Course and Examination Procedure	Policy Number 1105
APP ROVED: Administration: Steven L. Carroll, EMT-A	Date: December 1, 2011
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: December 1, 2011
Origination Date: July 2, 1984 Date Revised: June 9, 2006 Date Last Reviewed: June 9, 2011 Next Review Date: June 30, 2014	Effective Date: December 1, 2011

I. PURPOSE: To prepare nurses for their role in directing the prehospital care activities of paramedics. In order for the nurse to attain these necessary skills, practical as well as didactic (including field care audit) sessions shall be provided. Only nurses who fulfill the criteria in Policy 321 are eligible to take the course. The Ventura County EMS Agency shall approve all programs.

II. AUTHORITY: Health and Safety Code 1797.56 and 1797.58

III. COURSE REQUIREMENTS:

A. Minimum of 40 hours in length

B. Topics will include:

1. VCEMS Overview
2. MICN Role
3. Communication Protocol/Terminology
4. Legal Issues
5. Documentation
6. Paramedic Reporting
7. Hazmat
8. OD/Seizures
9. EMS Overview
10. Hypothermia/Heat Emergencies
11. SOB (Pulmonary Edema & Wheezes/Other)
12. Pharmacology
13. Chest Pain – Acute Coronary Syndrome

14. "STEMI"
15. "Ventura County Trauma System/Trauma Triage/Trauma Treatment Guidelines
16. Burns
17. Nausea/Vomiting
18. Allergic/Adverse Reaction and Anaphylaxis
19. AED/Dispatch
20. Pain Control
21. Hypovolemic Shock/Shock/Crush Injuries
22. Altered Neurologic Function/Behavioral
23. CISM
24. Cardiac Arrest/Dysrhythmias
25. ART/BART
26. Childbirth/Neonatal Resuscitation
27. Homework Review
28. MICN Practice
29. MCI/Triage
30. Nerve Agents
31. Diversion/ReddiNet
32. Pediatrics (may be presented as its own topic or incorporated into each of the above)
33. Weapons of Mass Destruction

C. Course shall be coordinated by a Prehospital Care Coordinator (PCC) from a Ventura County Base Hospital, in consultation with an Emergency Department Physician involved in prehospital care.

D. Individual topics may be taught by medical/nursing personnel with recent Advanced Life Support prehospital care and teaching experience. The course coordinator must approve all instructors.

E. Each topic shall have predetermined behavioral objectives which clearly specify the relevancy of the material to the MICN's role.

F. The course shall be reviewed and revised annually to keep up with additions and/or changes to policies and protocol.

G. There shall be a final examination with an overall passing score of 80%. This exam shall be based on the topics presented and on the course objectives.

IV. COUNTY EXAMINATION:

A. Only those candidates who successfully pass the MICN Course and Final Exam will be eligible to sit for the County Examination for purposes of working as an MICN in a Base Hospital.

B. The exam shall consist of 100 questions covering all of the topics listed above in III.B.

C. Candidates shall pass the exam with an overall score of 80%.

D. The exam shall be compiled and reviewed by the EMS Medical Director and the PCC's. The Course Coordinator or individual instructors may submit questions for the exam. Each question shall be correlated to the Objectives, and be based on current standards of care in ALS services.

E. The Exam shall be given as needed. Scheduling of the exam shall be the responsibility of the Course Coordinator. The EMS Agency will administer the test.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Continuing Education Attendance Roster	Policy Number 1132
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: December 1, 2008
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: December 1, 2008
Origination Date: January 1, 1993 Date Revised: March 9, 2006 Date Last Reviewed: June 9, 2011 Review Date: August, 2013	Effective Date: December 1, 2008

I. PURPOSE: To define the use of a continuing education attendance roster.

II. AUTHORITY: Health and Safety Code 1797.208, and California Code of Regulations, Division 9, Chapter 11.

II. POLICY: A continuing education attendance roster shall be completed for all approved lectures or field care audits.

III. PROCEDURE:

The form will be completed by an approved continuing education provider. The attendance roster will be retained by the approved continuing education provider for a minimum of four years.

A. The following information will be completed by the sponsoring agency or designated liaison:

1. Sponsoring agency name (Base Hospital, CE Provider, etc.)
2. Lecture Title - .Name of program/lectures, or field care audit
3. Lecturer(s):
   a. Name of person(s) presenting lecture, including title(s), or
   b. Name of person presenting field care audit
4. Date
5. Hours approved for CE presentation
6. Instructor or non instructor based
7. Continuing education provider number

B. The MICN, 'Paramedic or EMT name, employer, and certification number will be entered on the attendance roster by each MICN/ Paramedic or EMT. Each MICN, Paramedic or EMT shall sign his/her name.

C. The roster for continuing education, which is mandatory (i.e., EMS update, paramedic skills refresher, airway lab refresher) shall be faxed to the EMS Agency within 24 hours of completion by the sponsoring agency.