

Public Health Administration
Large Conference Room
2240 E. Gonzales, 2nd Floor
Oxnard, CA 93036

Pre-hospital Services Committee
Agenda

October 9, 2014
9:30 a.m.

I. Introductions	
II. Approve Agenda	
III. Minutes	
IV. Medical Issues	
A. Ebola Virus – Dr. Levin, Ventura County Health Officer	
V. New Business	
A. 704 – Guidelines for Base Hospital Contact - Chris	
B. 625 – Physician Order for Life Sustaining Treatment (POLST) Mark Komins updated to reflect new State changes.	
C. Other	
VI. Old Business	
A. 210 - Child, Dependent Adult, or Elder Abuse Reporting - Karen	
B. 451 – Stroke System Triage and Destination – Karen	Returned to PSC with suggested language changes.
C. 705.02 - Allergic/Adverse Reaction and Anaphylaxis	Need further discussion. Carried over from Sept. meeting.
D. 705.06 – Burns	Need further discussion. Carried over from Sept. meeting.
E. 705.11 - Crush Injury/Syndrome	Need further discussion. Carried over from Sept. meeting.
F. 705.18 - Overdose/Poisoning	Need further discussion. Carried over from Sept. meeting.
G. 717 - Pediatric Intraosseous Infusion	Need further discussion. Carried over from Sept. meeting.
H. 802 – EMD AED Medical Director	New Language
I. 803 - EMT AED Service Provider Program Standards	New Language
J. 805 - EMT Medical Cardiac Arrest	New Language
K. 808 - EMT Integration with Public AED Operation	New Language
L. PRESTO Trial Update - Angelo	
M. air-Q Study Update - Angelo	
N. CAM/ART – Mark Komins and Chad Panke	Returned to PSC after research.
O. CAM/CARES - Angelo	
P. Other	
VII. Informational/Discussion Topics	
A. Enterovirus D68	
VIII. Policies for Review	
A. 507 – Critical Care Transports	
B. 705.00 – General Patient Guidelines	
C. 705.12 – Heat Emergencies	
D. 725 – Patients after Taser Use	
E. 726 – 12 Lead ECG	
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	

Topic	Discussion	Action	Assigned
II. Approve Agenda			Approved by Kathy McShea Seconded by Bob Scott
III. Minutes	Correction: Bob Scott pointed out that Chief Herrera is with Fillmore Fire, not Santa Paula Fire.		Approved by Kathy McShea Seconded by Bob Scott
IV. Medical Issues			
A.			
V. New Business			
A. 627 – Fireline Medic	Mark Komins requested changes in this policy to reflect the current FireScope standards. IO Stabilizer was added to reflect local policy.	Approved with changes.	Approved by Tom O’Conner Seconded by Bob Scott
B. 402 – Patient Diversion/Emergency Department Closures		Approved with changes.	Approved by Stephanie Huhn Seconded by James Rosolek
C. 628 – Rescue Task Force Operations	Committee requested the addition of hot zone and warm zone. Remove the definition from page 1.	Approved with changes.	Approved by Dave Chase Seconded by Bill Herrera
D. Pharmacology Manual	V.C. College PM program needs to update the Pharm. Manual.	Tom will be contacting agencies to develop a working group. James Rosolek was kind enough to be the first volunteer.	
VI Old Business			
A. 705-26 – Suspected Stroke		Approved with changes.	Approved by James Rosolek Seconded by Kathy McShea
B. 451 – Stroke System Triage and Destination	Committee had concerns about the language on Page 2, 3:b	Make changes and bring back.	
C. PRESTO Trial	The trial will begin in Dec. Katy is researching how the tubes of blood will be taken to their final destination. There will be a “Train the Trainer” class		

	at the end of Oct. or early Nov. Only transport agencies are involved with trial.		
D. Air-Q Study	Angelo presented part of the training video to committee members. There are 2 sizes only, smallest pt. is 95 lbs., he is researching a device that will secure the airway.		
E. CAM/ART	Mark Komins requested that we bring this back again after additional research.	Tabled until Oct.	
F. Spinal Motion Restriction		Tabled	
VII. Informational/Discussion Topics			
A. Ebola infection control guidance for EMS with California Modifications	State EMSA sent out an informational bulletin on Ebola. Angelo stressed that it is not pertinent to Ventura County, there is no increased risk and no changes to our policies.		
VIII. Policies for Review			
A. 105 - Prehospital Services Committee Operating Guidelines		Approved with changes on page 2,B.	
B. 110 - County Ord. No. 4099 Ambulance Business License Code		Approved	
C. 112 - Ambulance Rates			
D. 210 - Child, Dependent Adult, or Elder Abuse Reporting	Karen will check to see if the language that states "EMT I or II" needs to be updated. Consider adding e-mail or on-line for reporting methods.	Bring back in Oct.	
E. 319 - Paramedic Preceptor		Approved	
F. 324 - Mobile Intensive Care Nurse: Authorization Reactivation		Approved with changes.	
G. 606 - Withholding or Termination of Resuscitation and Determination of Death		Approved with changes.	

H.	612 - Notification of Exposure to a Communicable Disease		Approved with changes.	
I.	622 - ICE - In Case of Emergency for Cell Phones		Approved	
J.	705.02 - Allergic/Adverse Reaction and Anaphylaxis			
K.	705.06 – Burns		Bring back to Oct. PSC for additional discussion.	
L.	705.07 - Cardiac Arrest - Asystole/Pulseless/PEA		Approved with changes.	
M.	705.09 - Chest Pain - Acute Coronary Syndrome		Approved with changes.	
N.	705.11 - Crush Injury/Syndrome	Why was “60 min.” removed?	Make changes and bring back to Oct. meeting.	
O.	705.18 - Overdose/Poisoning	Committee reps will check with their facilities regarding the removal of Charcoal.	Discuss at Oct. meeting.	
P.	705.21 - Shortness of Breath - Pulmonary Edema		Approved	
Q.	705.23 - Supraventricular Tachycardia		Approved	
R.	717 - Pediatric Intraosseous Infusion		Bring back to Oct. PSC for additional discussion.	
S.	732 - Use of Restraint		Approved	
T.	1001 - EMT-P/BH Communication Record		Move to Oct. Agenda	
U.	1105 - MICN Developmental Course and Exam		Move to Oct. Agenda	
V.	1132 - Continuing Education: Attendance Roster		Move to Oct. Agenda	
XI	TAG Report	Increased data “core measures” from 6 to 8. Will start to chart projects for		

		improvement next month.	
X.	Agency Reports		
A.	Fire departments	VCFPD –Dispatch is doing well. Waiting to see if additional is needed. VCFD – none OFD –Training on new tablets. Hiring 9 to 10 FF’s. New Truck. Fed. Fire – none SPFD – none FFD - Getting a new engine.	
B.	Transport Providers	LMT – James Rosalek was promoted to Administrative Paramedic. AMR/GCA – none	
C.	Base Hospitals	SVH – Jennie shared that there were 75 people at the Sidewalk CPR event. LRRMC – Debbie and Survivors from Ventura County spoke about their experiences and the Cardiac Arrest stats in Ventura County. SJRM – Dr. Russell is leaving PSC. Dr. Larsen is taking his place. (<i>Thank you to Dr. Russell and we look forward to working with Dr. Larsen.</i>) VCMC – Helicopter is still landing at Bard until Sept. 19 th .	
D.	Receiving Hospitals	SPH – Sarah Melgoza will be representing SPH. CMH – Construction is on-going. PVH – Elaina Hall is new E.R. Manager OVCH – The new entrance is great, please come by and check it out.	
E.	Law Enforcement	VCSO - none CSUCI PD – none	
F.	ALS Education Programs	Ventura College – On 10/11/14, there will be a 5k event and Health Fair.	
G.	EMS Agency	Angelo – none Steve – none Chris – none Katy – none Julie – none Randy – none Karen – none	
H.	Other		
XI.	Closing	Meeting adjourned at 1245	

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		AS				
AMR	Panke	Chad	CP		CP				CP						
CMH - ER	Canby	Neil	NC		NC		NC		NC		NC				
CMH - ER	Cobb	Cheryl	CC		CC		DP		CC		CC				
OVCH - ER	Popescu	Dan							DP		DP				
OVCH - ER	Patterson	Betsy	BP		BP				BP		BP				
CSUCI PD	Drehesen	Charles	CD		CD				CD		CD				
CSUCI PD	Rice	Al	AR		AR		AR		AR						
FFD	Herrera	Bill			BH		BH		BH		BH				
FFD	Scott	Bob			BS		BS		BS		BS				
GCA	Norton	Tony	TN		TN				TN		TN				
GCA	Shultz	Jeff	JS		JS		JS		JS		JS				
Lifeline	Rosolek	James	JR		JR		JR		JR		JR				
Lifeline	Winter	Jeff	JW		JW		JW		JW		JW				
LRRMC - ER	Beatty	Matt	MB		MB				MB						
LRRMC - ER	Licht	Debbie	DL		DL		DL		DL		DL				
OFD	Carroll	Scott	SC		SC		KDS		SC		SC				
OFD	Huhn	Stephanie	SH		SH		SH		SH		SH				
SJPVH - ER	Hall	Elaina													
SJPVH - ER	Davies	Jeff					JD								
SJRMCM - ER	Russell	Mark	MR		MR		MR								
SJRMCM - ER	McShea	Kathy	KM		KM		KM		KM		KM				
SPFD	Dowd	Andrew	AD		AD				AD						
SVH - ER	Tilles	Ira	IT		IT		IT		IT		IT				
SVH - ER	Hoffman	Jennie	JH		JH				JH		JH				
V/College	O'Connor	Tom	TO		TO		TO				TO				
VCFD	Tapking	Aaron	AT				AT		AT						
VCFD	Utley	Dede	DU		DU		DU		DU		DU				
VNC	Zeller	Scott	NP		NP		SZ		SZ		SZ				
VNC	Dullam	Joe	JD		JD										
VNC - Dispatch	Shedlosky	Robin	RS		RS		RS		RS		RS				
VCMC - ER	Chase	David	DC		DC		DC		DC		DC				

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 - ER	Gallegos	Tom	TG		TG		TG		TG		TG				
VCMC-SPH	Gautam	Pai	MD												
VCMC-SPH	Melgoza	Sarah	SM								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		MT				
CSUCI PD	Rice	Lynn	LR		LR		LR		LR						
EMS	Carroll	Steve	SC		SC		SC		SC		SC				
EMS	Buhain	Ruth													
EMS	Frey	Julie	JF		JF		JF		JF		JF				
EMS	Haddock	Katy	KH		KH				KH		KH				
EMS	Perez	Randy	RP		RP		RP		RP		RP				
EMS	Rosa	Chris	CR		CR		CR		CR		CR				
EMS	Salvucci	Angelo	AS		AS		AS		AS		AS				
EMS	Beatty	Karen	KB		KB		KB		KB		KB				
LMT	Frank	Steve			SF		SF				SF				
VCMC	Duncan	Thomas					TD		TD						
VNC	Gregson	Erica	EG								EG				
VNC	Komins	Mark	MK		MK		MK		MK		MK				



**TEMPORARY
PARKING PASS
Expires October 9, 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.

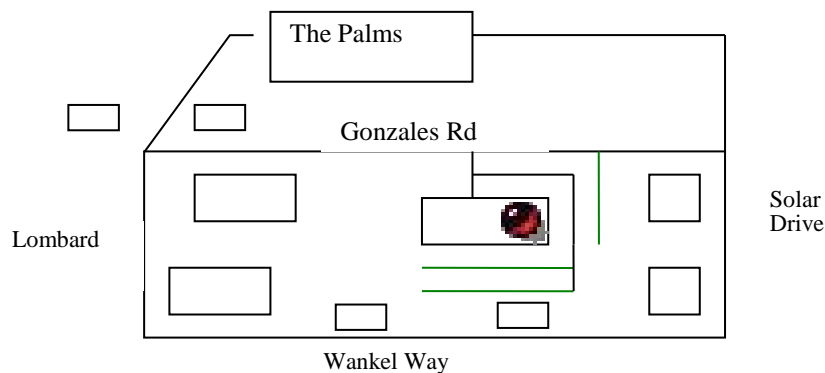
2100 Solar Drive

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.





EMERGENCY MEDICAL SERVICES

2220 E. Gonzales Road, Suite 130, Oxnard, CA 93036-0619

Phone: 805-981-5301

Fax: 805-981-5300

www.vchca.org/ph/ems

STEVEN L. CARROLL, EMT-P


EMS Administrator

ANGELO SALVUCCI, M.D., F.A.C.E.P.

Medical Director

MEMORANDUM

To: All Ventura County Prehospital Provider Personnel

From: Angelo Salvucci, MD, FACEP 
Ventura County EMS Agency Medical Director

Re: EMS Response to Suspected Ebola Cases

Date: October 3, 2014

As you are all aware, the first patient in the United States infected with the Ebola Virus has been confirmed and is currently receiving medical treatment in the Dallas, Texas area. In addition, it has been reported that the Centers for Disease Control and other health officials are tracking up to 100 additional people that have or may have come into contact with this infected individual. Some of these individuals have been quarantined for 21 days, but none of these individuals are exhibiting signs or symptoms of the Ebola virus at this time. Also, out of an abundance of caution, three prehospital personnel who treated and transported this patient are currently under home quarantine, although none of these individuals are showing any signs of illness.

Below are some facts about the Ebola Virus, as well as some guidance/reminders related to importance of utilizing personal protective equipment (PPE) and cleaning/maintaining equipment.

Assessment

- Ebola is a disease that initially causes non-specific symptoms like fever, chills, muscle ache, loss of strength and fatigue. As the disease progresses patients develop high fever (greater than 101.5 F), diarrhea, vomiting and abdominal pain. Ebola can only be transmitted through direct contact with blood or body fluids (urine, fecal material, sputum or spit) of an individual who is SICK with the disease: individuals without symptoms cannot transmit the disease.
- Patients who present with any of the above symptoms should have recent (past 21 days) travel patterns questioned, focusing on recent visits to the West African region (Guinea, Liberia, Nigeria, Senegal, Sierra Leone, and Democratic Republic of the Congo).
 - This information should be reported to the receiving hospital prior to the patient arriving at the destination, so that appropriate infection control precautions may be prepared in advance. This information shall be documented in the narrative section of the ePCR.
 - Also included in this pattern of questioning should be whether or not the patient physically handled, or otherwise came into contact with, any bats or non-human primates during their travel to the West African region.
- If the patient has any symptom of Ebola AND has travelled to one of the above countries within 21 days before onset of symptoms, the individual should be treated as a suspected patient infected with the Ebola virus.

- For public safety dispatchers, there will be no change in caller interrogation procedures. However, if the reporting party volunteers that: 1) s/he is concerned about possible Ebola, or 2) that the patient has traveled from West Africa in the previous 21 days, that information should be noted in the comment section of the CAD ticket and the crew notified over the radio to check the comments before the crews arrive on scene.
- The Ventura County EMS Agency Duty Officer shall be notified of any patient who presents with any of the above symptoms who has traveled to the West African region in the past 21 days.

Exposure Prevention

- The best way to prevent exposure to Ebola is to avoid coming in contact with blood and body fluids. Protection is provided through standard, contact, and droplet precautions which include:
 - Gloves, goggles, mask, and a fluid resistant or impermeable gown when caring for patients with suspected Ebola or when cleaning/disinfecting the ambulance or equipment after a patient encounter.
- During resuscitation procedures (intubation, open suctioning of airways, cardiopulmonary resuscitation), in addition to above PPE, respiratory protection that is at least as protective as a NIOSH-certified fit-tested N95 filtering facepiece respirator or higher should be worn instead of a facemask.
- In addition, always wash your hands before and after every patient encounter using soap and warm water or clean your hands with an alcohol-based hand cleaner.
- If blood, body fluids, secretions, or excretions from a patient with suspected Ebola come into direct contact with the EMS provider's skin or mucous membranes, then the EMS provider should immediately stop working. They should wash the affected skin surfaces with soap and water and report exposure to an occupational health provider or supervisor for follow-up and notify the EMS Agency Duty Officer.

While it remains unlikely that Ebola will present in a patient in Ventura County, the possibility cannot be completely ruled out. Providers are reminded to maintain adequate personal protection and body substance isolation at all times, and to be diligent in gathering information and ruling out pertinent negatives when assessing patients that present with signs or symptoms listed above.

Additional information related to this topic can be found on the Centers for Disease Control and Prevention website at the link below:

<http://www.cdc.gov/vhf/ebola/hcp/interim-guidance-emergency-medical-services-systems-911-public-safety-answering-points-management-patients-known-suspected-united-states.html>

Questions or concerns can be forwarded to Chris Rosa, VCEMS Deputy Administrator, at 805-981-5308 or chris.rosa@ventura.org.



Detailed Emergency Medical Services (EMS) Checklist for Ebola Preparedness

The U.S. Department of Health and Human Services (DHHS) Centers for Disease Control and Prevention (CDC) and Office of the Assistant Secretary for Preparedness and Response (ASPR), in addition to other federal, state, and local partners, aim to increase understanding of Ebola and encourage U.S.-based EMS agencies and systems to prepare for managing patients with Ebola and other infectious diseases. Every EMS agency and system, including those that provide non-emergency and/or inter-facility transport, should ensure that their personnel can detect a person under investigation (PUI) for Ebola, protect themselves so they can safely care for the patient, and respond in a coordinated fashion. Many of the signs and symptoms of Ebola are non-specific and similar to those of other common infectious diseases such as malaria, which is commonly seen in West Africa. Transmission of Ebola can be prevented by using appropriate infection control measures.

This checklist is intended to enhance collective preparedness and response by highlighting key areas for EMS personnel to review in preparation for encountering and providing medical care to a person with Ebola. The checklist provides practical and specific suggestions to ensure the agency is able to help its personnel **detect** possible Ebola cases, **protect those** personnel, and **respond** appropriately.

Now is the time to prepare, as it is possible that individuals infected with Ebola virus in West Africa may travel to the U.S., develop signs or symptoms of Ebola, and seek medical care from EMS personnel.

EMS agencies, in conjunction with their medical directors, should review infection control policies and procedures and incorporate plans for administrative, environmental, and communication measures.

The checklist format is not intended to set forth mandatory requirements or establish national standards. It is a list of activities that can help each agency prepare. Each agency is different and should adapt this document to meet its specific needs. In this checklist, EMS personnel refers to all persons, paid and volunteer who provide pre-hospital emergency medical services and have the potential for direct contact exposure (through broken skin or mucous membranes) with an Ebola patient's blood or body fluids, contaminated medical supplies and equipment, or contaminated environmental surfaces.

This detailed checklist for EMS is part of a suite of HHS checklists. This guidance is only for EMS agencies and systems; the CDC's [Interim guidance for EMS](#) includes information for individual providers and for 9-1-1 Public Safety Answering Points.

CDC is available 24/7 for consultation by calling the CDC Emergency Operations Center (EOC) at 770-488-7100 or via email at eocreport@cdc.gov.

C=Completed; IP=In Progress; NS=Not Started

PREPARE TO DETECT	C	IP	NS
Train all EMS personnel on how to identify signs and symptoms of Ebola infections and to avoid risk of exposure.			
Review CDC Ebola case definition for guidance on who meets the criteria for a PUI for Ebola.			
Ensure EMS personnel are aware of current guidance: Interim Guidance Emergency Medical Services Systems .			
Review patient assessment and management procedures and ensure they include screening criteria (e.g. relevant questions: travel within 21 days from affected West African country, exposure to case) for use by EMS personnel to ask individuals during the triage process for patients presenting with compatible symptoms.			
Post screening criteria in conspicuous locations in EMS units, at EMS stations, and in other locations frequented by EMS personnel (see suggested screening criteria in Attachment A).			
Designate points of contact within their EMS organization/system responsible for communicating with state and local public health officials. Remember: Ebola must be reported to local, state, and federal public health authorities.			
Ensure that all personnel are familiar with the protocols and procedures for notifying the designated points of contact regarding a PUI for Ebola.			
Conduct spot checks and reviews for staff to ensure they are incorporating Ebola screening into their patient assessment and management procedures and are able to initiate notification, isolation, and PPE procedures.			

PREPARE TO PROTECT	C	IP	NS
Consider travelers with fever, fatigue, vomiting and/or diarrhea and returning from affected West African countries as potential cases, and obtain additional history.			
Conduct a detailed inventory of available supplies of PPE suitable for standard, contact, and droplet precautions. Ensure an adequate supply, for EMS personnel, of: <ul style="list-style-type: none"> • Fluid resistant or impermeable gowns, • Gloves, • Shoe covers, boots, and booties, and • Appropriate combination of the following: <ul style="list-style-type: none"> ○ Eye protection (face shield or goggles), ○ Facemasks (goggles or face shield must be worn with facemasks), ○ N95 respirators (for use during aerosol-generating procedures) • Other infection control supplies (e.g. hand hygiene supplies). 			
Ensure that PPE meets nationally-recognized standards as defined by the Occupational Safety & Health Administration (OSHA), National Institute for Occupational Safety and Health (NIOSH), Food and Drug Administration (FDA), or Interagency Board for Equipment Standardization and Interoperability .			
Review plans, protocols, and PPE purchasing with community/coalition partners that promote interoperability and inter-agency/facility coordination.			
Ensure Ebola PPE supplies are maintained in all patient care areas (transport unit and in bags/kits).			
Verify all EMS personnel: <ul style="list-style-type: none"> • Meet all training requirements in PPE and infection control, 			

<ul style="list-style-type: none"> • Are able to use PPE correctly, • Have proper medical clearance, • Have been properly fit-tested on their respirator for use in aerosol-generating procedures or more broadly as desired, and • Are trained on management and exposure precautions for PUI for Ebola. 			
Encourage EMS personnel to use a “buddy system” when putting on and removing PPE .			
Review CDC guidelines for isolation precautions and share with EMS personnel.			
Frequently spot-check (for example through quality assurance/quality improvement) to be sure standard, contact and droplet infection control and isolation guidelines are being followed, including safely putting on and removing PPE.			
Ensure procedures are in place to require that all EMS personnel accompanying a patient in a transport unit are wearing (at minimum): gloves, gown (fluid resistant or impermeable), eye protection (goggles or face shield), and a facemask.			
Ensure procedures are in place to limit EMS personnel exposure to PUI for Ebola during treatment and transport.			
Review and update, as necessary, EMS infection control protocols/procedures.			
Review your policies and procedures for screening, isolation, medical consultation, and monitoring and management of EMS personnel who may have Ebola exposure and/or illness.			
Review and update, as necessary, all EMS agency protocols and procedures for isolation of PUI for Ebola .			
Review the agency’s infection control procedures to ensure adequate implementation for preventing the spread of Ebola.			
Review protocols for sharps injuries and educate EMS personnel about safe sharps practices to prevent sharps injuries.			
Emphasize the importance of proper hand hygiene to EMS personnel.			
Develop contingency plans for staffing, ancillary services, vendors, and other business continuity plans.			
Review plans for special handling of linens, supplies, and equipment from PUI for Ebola.			
Review environmental cleaning procedures and provide education/refresher training to appropriate personnel.			
Provide education and refresher training to EMS personnel on healthcare personnel sick leave policies.			
Review policies and procedures for screening and work restrictions for exposed or ill EMS personnel, and develop sick leave policies for EMS personnel that are non-punitive, flexible, and consistent with public health guidance.			
Ensure that EMS personnel have ready access, including via telephone, to medical consultation.			

PREPARE TO RESPOND	C	IP	NS
Review, implement, and frequently exercise the following elements with EMS personnel: <ul style="list-style-type: none"> • Appropriate infectious disease procedures and protocols, including putting on and taking off PPE. 			

<ul style="list-style-type: none"> • Appropriate triage techniques and additional Ebola screening questions, • Disease identification, testing, specimen collection and transport procedures, • Isolation, quarantine and security procedures, • Communications and reporting procedures, and • Cleaning and disinfection procedures. 			
Review plans and protocols, and exercise/test the ability to appropriately share relevant health data between key stakeholders, coalition partners, public health, emergency management, etc.			
Review, develop, and implement plans for: adequate respiratory support, safe administration of medication, and sharps procedures; and reinforce proper biohazard containment and disposal precautions.			
Ensure that EMS agency leaders are familiar with their responsibilities during a public health emergency.			
<p>Consider identifying a Communications/Public Information Officer who:</p> <ul style="list-style-type: none"> • Develops appropriate literature and signage for posting (topics may include definitions of low-risk, high-risk and explanatory literature for patient, family members and contacts), • Coordinates with public health on targeted risk communication messages for use in the event of a PUI for Ebola. • Requests appropriate Ebola literature for dissemination to EMS personnel, patients, and contacts, • Prepares written and verbal messages, ahead of time, that have been approved, vetted, rehearsed and exercised, and • Works with internal department heads and clinicians to prepare and vet internal communications to keep EMS personnel informed. 			
<p>Plan for regular situational briefs for decision-makers, including:</p> <ul style="list-style-type: none"> • PUI for Ebola who have been identified and reported to public health authorities, • Isolation, quarantine and exposure reports, • Supplies and logistical challenges, • Personnel status, and • Policy decisions on contingency plans and staffing. 			
Maintain situational awareness of reported Ebola case locations, travel restrictions, and public health advisories, and update patient assessment and management guidelines accordingly.			
Incorporate Ebola information into educational activities (e.g. initial/ refresher training, drills, and exercises).			
Implement, as needed, a multijurisdictional, multidisciplinary exchange of public health and medical-related information and situational awareness between EMS; the health care system; local, state, federal, tribal, and territorial levels of government; and the private sector.			

Quick Resources List

The CDC has produced several resources and references to help agencies prepare for Ebola, and more resources are in development. Information and guidance posted on these resources may change as experts learn more about Ebola. Frequently monitor the [CDC's Ebola Homepage](#), and review CDC's Ebola response guide checklists for:

- [Clinician and healthcare workers](#),
- [Patient Management for US Hospitals](#), and

- [Healthcare facilities.](#)

Stay informed! Subscribe to the following sources to receive updates about Ebola:

- [CDC Health Alert Network \(HAN\).](#)
- [CDC Clinician Outreach and Communication Activity \(COCA\).](#)
- [CDC National Institute for Occupational Safety and Health,](#) and
- [U.S. Department of Labor's Occupational Safety & Health Administration \(OSHA\) Newsletter.](#)

Below are a few of the resources most relevant to healthcare preparedness:

- [Interim Guidance for Emergency Medical Services Systems and 9-1-1 PSAPs.](#)
- [Ebola Virus Disease Information for Clinicians in U.S. Healthcare Settings.](#)
- [Case Definition for Ebola Virus Disease.](#) This case definition should be used for screening patients and should be implemented in all healthcare facilities.
- [Safe Management of Patients with Ebola Virus Disease in US Hospitals.](#)
- [Infection Prevention and Control Recommendations for Hospitalized Patients with Known or Suspected Ebola Hemorrhagic Fever in U.S. Hospitals.](#) This document provides a summary of the proper Personal Protective Equipment (PPE).
- [Interim Guidance for Specimen Collection, Transport, Testing, and Submission for Patients with Suspected Infection with Ebola Virus Disease.](#)
- [Sequence for Removing Personal Protective Equipment \(PPE\)](#)
- [National Guidance for Healthcare System Preparedness' Capabilities,](#) with particular emphases on Capability #6 (*Information Sharing*) and Capability #14 (*Responder Safety and Health*)

Check CDC's *Ebola Hemorrhagic Fever* website regularly for the most current information. State and local health departments with questions should contact the CDC Emergency Operations Center (770-488-7100 or eocreport@cdc.gov).



Attachment A

Ebola Virus Disease (EVD) Awareness for EMS

EMS patient assessment criteria for isolation/hospital notification are likely to be:

- 1.** Fever, headache, joint and muscle aches, weakness, fatigue, diarrhea, vomiting, stomach pain and lack of appetite, and in some cases bleeding.

AND

- 2.** Travel to West Africa (Guinea, Liberia, Sierra Leone, Senegal, Nigeria or other countries where Ebola transmission has been reported by WHO) within 21 days (3 weeks) of symptom onset.

If both criteria are met, then the patient should be isolated and STANDARD, CONTACT, and DROPLET precautions followed during further assessment, treatment, and transport.

IMMEDIATELY Report Suspected Ebola Case(s) to Receiving Facility.

If patient is not transported (refusal, pronouncement, etc.):

1. Inform Local and State Public Health Authorities: **(Name), (Email), (Phone)**
2. Inform the U.S. Centers for Disease Control and Prevention (CDC), available 24/7, at 770-488-7100, or via the CDC Emergency Operations Center (EOC) at eocreport@cdc.gov.

Sources: <http://www.cdc.gov/vhf/ebola/hcp/case-definition.html>, <http://www.bt.cdc.gov/han/han00364.asp>,
<http://www.cdc.gov/vhf/ebola/hcp/infection-prevention-and-control-recommendations.html>.

Media centre

What we know about transmission of the Ebola virus among humans

Ebola situation assessment - 6 October 2014

The Ebola virus is transmitted among humans through close and direct physical contact with infected bodily fluids, the most infectious being blood, faeces and vomit.

The Ebola virus has also been detected in breast milk, urine and semen. In a convalescent male, the virus can persist in semen for at least 70 days; one study suggests persistence for more than 90 days.

Saliva and tears may also carry some risk. However, the studies implicating these additional bodily fluids were extremely limited in sample size and the science is inconclusive. In studies of saliva, the virus was found most frequently in patients at a severe stage of illness. The whole live virus has never been isolated from sweat.

The Ebola virus can also be transmitted indirectly, by contact with previously contaminated surfaces and objects. The risk of transmission from these surfaces is low and can be reduced even further by appropriate cleaning and disinfection procedures.

Not an airborne virus

Ebola virus disease is not an airborne infection. Airborne spread among humans implies inhalation of an infectious dose of virus from a suspended cloud of small dried droplets.

This mode of transmission has not been observed during extensive studies of the Ebola virus over several decades.

Common sense and observation tell us that spread of the virus via coughing or sneezing is rare, if it happens at all. Epidemiological data emerging from the outbreak are not consistent with the pattern of spread seen with airborne viruses, like those that cause measles and chickenpox, or the airborne bacterium that causes tuberculosis.

Theoretically, wet and bigger droplets from a heavily infected individual, who has respiratory symptoms caused by other conditions or who vomits violently, could transmit the virus – over a short distance – to another nearby person.

This could happen when virus-laden heavy droplets are directly propelled, by coughing or sneezing (which does not mean airborne transmission) onto the mucus membranes or skin with cuts or abrasions of another person.

WHO is not aware of any studies that actually document this mode of transmission. On the contrary, good quality studies from previous Ebola outbreaks show that all cases were infected by direct close contact with symptomatic patients.

No evidence that viral diseases change their mode of transmission

Moreover, scientists are unaware of any virus that has dramatically changed its mode of transmission. For example, the H5N1 avian influenza virus, which has caused sporadic human cases since 1997, is now endemic in chickens and ducks in large parts of Asia.

That virus has probably circulated through many billions of birds for at least two decades. Its mode of transmission remains basically unchanged.

Speculation that Ebola virus disease might mutate into a form that could easily spread among humans through the air is just that: speculation, unsubstantiated by any evidence.

This kind of speculation is unfounded but understandable as health officials race to catch up with this fast-moving and rapidly evolving outbreak.

To stop this outbreak, more needs to be done to implement – on a much larger scale – well-known protective and preventive measures. Abundant evidence has documented their effectiveness.

Related links

[Ebola situation assessments](#)

[Frequently asked questions on Ebola virus disease](#)

[Fact sheet on Ebola](#)

[Ebola virus disease - web site](#)

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Guidelines For BaseHospital Contact		Policy Number: 704	
APPROVED: Administration: Steven L. Carroll, EMT-P		Date: December 1, 2010	
APPROVED: Medical Director: Angelo Salvucci, MD		Date: December 1, 2010	
Origination Date: October 1984		Effective Date: December 1, 2010	
Date Revised: October 14, 2010 September 12, 2014			
Date Last Reviewed: September 12, 2013			
Review Date: September, 2016			

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- I. PURPOSE: To define patient conditions for which EMT-Ps shall establish BH contact.
- II. AUTHORITY: Health and Safety Code Sections 1798, 1798.102 and 1798.2
- III. POLICY: A paramedic shall contact a BaseHospital in the following circumstances:
 - A. Any patient to which ALS care is rendered under VCEMS Policy 705: County Wide Protocols.
 - B. Patients with traumatic injuries who triage into steps 1-4 of VCEMS Policy 1405: Field Triage Decision Scheme.
 - C. General Cases
 - 1. ~~1.~~ Significant vaginal bleeding (OB or non-OB related).
 - 2. ~~2.~~ Pregnant female in significant distress (e.g., symptoms of placenta previa, placenta abruptio, toxemia, retained placenta, etc.).
 - 3. ~~3.~~ Syncope / Near Syncope
 - 4. Any safely surrendered baby.
 - 5. ~~4.~~ AMA involving any of the conditions listed in this policy.
 - 6. ~~5.~~ AMA including suspected altered level of consciousness
 - 7. ~~6.~~ AMA involving an actual/suspected ALTE patient.
 - 8. Any patient who, in paramedic's opinion, would benefit from base hospital consultation.

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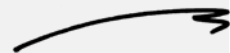
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COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Physician Orders for Life-Sustaining Treatment (POLST)		Policy Number 625	
APPROVED Administrator: Steven L. Carroll, EMT-P		Date:	
APPROVED: Medical Director: Angelo Salvucci, M.D.		Date:	
Origination Date: January 7, 2009		Effective Date:	
Date Revised:			
Date Last Reviewed:			
Review Date:			

- I. PURPOSE: To permit Ventura County Emergency Medical Services personnel to honor valid POLST forms and provide end-of-life care in accordance with a patient's wishes.
- II. AUTHORITY: California Health and Safety Code, Sections 1798 and 7186. California Probate Code, Division 4.7 (Health Care Decisions Law).
- III. DEFINITIONS:
 - A. "EMS Personnel": All EMTs-1s, EMT-Ps Paramedics and RNs caring for prehospital or interfacility transfer patients as part of the Ventura County EMS system.
 - B. Valid Physician Orders for Life-Sustaining Treatment (POLST). A completed and signed physician order form, according to California Probate Code, Division 4.7 and approved by the California Emergency Medical Services Authority.
- IV. POLICY:
 - A. A POLST form must be signed by the patient or surrogate and physician to be valid.
 - B. Although an original POLST form is preferred, a copy or FAX is valid.
 - C. When a valid POLST form is presented, EMS personnel will follow the instructions according to the procedures below.
 - D. The POLST form is intended to supplement, not replace, an existing Advance Health Care Directive. If the POLST form conflicts with the Advance Health Care Directive, the most recent order or instruction of the patient's wishes governs.
- V. PROCEDURE:
 - A. Confirm that:
 1. The patient is the person named in the POLST.

Barry R.



2. The POLST form, Section D, is signed by the patient or surrogate and physician. The form is not valid if not signed by both.
- B. POLST form - Section A:
1. If the patient has no pulse and is not breathing AND “Do Not Attempt Resuscitation/DNR” is selected, refer to VC EMS Policy 613 – Do Not Resuscitate.
 2. If the patient has no pulse and is not breathing AND EITHER “Attempt Resuscitation/CPR” is selected OR neither option is selected then begin resuscitation. (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- C. POLST Form – Section B: This section applies if the patient has a pulse and/or is breathing.
1. If “Full Treatment” is selected, the following treatments may be done as indicated:
 - a. All items included in Selective and Comfort-Focused Treatment
 - b. Intubation and other advanced airway interventions
 - c. Mechanical Ventilation
 - d. Cardioversion / Defibrillation
 2. If “Selective Treatment” is selected, the following treatments may be done as indicated:
 - a. All items included in Comfort-Focused Treatment
 - b. General Medical Treatment
 - c. IV Antibiotics
 - d. IV Fluids
 - e. Non-Invasive positive airway pressure
 3. If “Comfort-Focused Treatment” is selected, the following treatments may be done as indicated:
 - a. Relieve pain and suffering with medication by any route as needed
 - b. Oxygen
 - c. Suctioning
 - d. Manual treatment of airway obstruction

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Do not use treatments listed in Full and/or Selective Treatment unless consistent with comfort goal. Request transfer to hospital **only** if comfort needs cannot be met in current location.

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1. If **“Comfort Measures Only”** is selected, the following treatments may be done as indicated to relieve pain and suffering:

- a. Patient positioning
- b. Oxygen
- c. Airway suctioning
- d. Relief of airway obstruction (including Magill Forceps)
- e. Pain control per VC EMS Policy 705

2. If **“Limited Additional Interventions”** is selected, in addition to the above “Comfort Measures Only” items, the following treatments may be done as indicated:

- a. IV fluids
- b. bag-mask ventilation
- c. CPAP
- d. **DO NOT INTUBATE**

If the “Do Not Transfer to hospital for medical interventions” option is selected, contact the base hospital. Generally the patient will be transported.

3. If **“Full Treatment”** is selected the patient will be treated with all medically indicated medications and/or procedures. If a patient has selected both “Do Not Attempt Resuscitation/DNR” in Section A and “Full Treatment” in Section B, if the patient is witnessed to go into a shockable rhythm and still has agonal respirations, defibrillate once and begin bag-mask ventilations, but do not begin chest compressions.

D. If there is any conflict between the written POLST orders and on-scene individuals, contact the base hospital.

E. Take the POLST form with the patient.

VI. DOCUMENTATION:

For all cases in which a patient has been treated according to a POLST form, the following documentation is required in the narrative section of the AVCDS.:

- A. A statement that the orders on a POLST form were followed..
- B. The section of the POLST form that was applicable.

DRAFT



EMSA #111 B
(Effective 10/1/2014)*

Physician Orders for Life-Sustaining Treatment (POLST)

First follow these orders, then contact physician.
A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

A Check One	CARDIOPULMONARY RESUSCITATION (CPR): <i>If patient has no pulse and is not breathing.</i> <i>If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.</i>
	<input type="checkbox"/> Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B) <input type="checkbox"/> Do Not Attempt Resuscitation/DNR (Allow Natural Death)

B Check One	MEDICAL INTERVENTIONS: <i>If patient is found with a pulse and/or is breathing.</i>
	<input type="checkbox"/> Full Treatment – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. <input type="checkbox"/> Trial Period of Full Treatment. <input type="checkbox"/> Selective Treatment – goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. <input type="checkbox"/> Request transfer to hospital only if comfort needs cannot be met in current location. <input type="checkbox"/> Comfort-Focused Treatment – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location. Additional Orders: _____ _____

C Check One	ARTIFICIALLY ADMINISTERED NUTRITION: <i>Offer food by mouth if feasible and desired.</i>
	<input type="checkbox"/> Long-term artificial nutrition, including feeding tubes. Additional Orders: _____ <input type="checkbox"/> Trial period of artificial nutrition, including feeding tubes. _____ <input type="checkbox"/> No artificial means of nutrition, including feeding tubes. _____

D	INFORMATION AND SIGNATURES:
	Discussed with: <input type="checkbox"/> Patient (Patient Has Capacity) <input type="checkbox"/> Legally Recognized Decisionmaker
	<input type="checkbox"/> Advance Directive dated _____, available and reviewed → Healthcare Agent if named in Advance Directive: <input type="checkbox"/> Advance Directive not available Name: _____ <input type="checkbox"/> No Advance Directive Phone: _____
	Signature of Physician My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.
	Print Physician Name: _____ Physician Phone Number: _____ Physician License Number: _____
	Physician Signature: (required) _____ Date: _____
	Signature of Patient or Legally Recognized Decisionmaker I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.
	Print Name: _____ Relationship: (write self if patient) _____
	Signature: (required) _____ Date: _____
	Mailing Address (street/city/state/zip): _____ Phone Number: _____ Office Use Only: _____

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009 or 4/1/2011 are also valid

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle):	Date of Birth:	Gender: M F
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Healthcare Provider Assisting with Form Preparation

N/A if POLST is completed by signing physician

Name:	Title:	Phone Number:
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Additional Contact

None

Name:	Relationship to Patient:	Phone Number:
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Directions for Healthcare Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a healthcare provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- POLST must be signed by a physician and the patient or decisionmaker to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force.

For more information or a copy of the form, visit www.caPOLST.org.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

RESOURCES | FREQUENTLY ASKED QUESTIONS FOR PROVIDERS

What does 'POLST' stand for?

POLST stands for Physician Orders for Life-Sustaining Treatment.

What is the POLST form?

POLST is a physician order that helps give seriously ill patients more control over their care during serious illness. Produced on a distinctive bright pink form and signed by both the doctor and patient, POLST specifies the types of medical treatment that a patient wishes to receive towards the end of life. As a result, POLST can prevent unwanted or medically ineffective treatment, reduce patient and family suffering, and help ensure that patients' wishes are honored.

What information is included on the POLST form?

The decisions documented on the POLST form include whether to:

- Attempt cardiopulmonary resuscitation,
- Use high intensity treatments,
- Use intubation and mechanical ventilation, and
- Provide artificial nutrition.

Why was POLST developed?

POLST was developed in response to seriously ill patients receiving medical treatments that were not consistent with their wishes. The goal of POLST is to provide a framework for healthcare professionals so they can provide the treatments patients DO want, and avoid those treatments that they DO NOT want.

Is POLST mandated by law?

Filling out a POLST form is entirely voluntary. However, California law requires that the physician orders in a POLST be followed by healthcare professionals, and provides immunity from civil or criminal liability to those who comply in good faith with a patient's POLST requests. [Reference: AB 3000, Part 4, Section 7, Probate Code Section 4782.]

Who should have a POLST form?

POLST is designed for seriously ill patients, those with chronic, progressive illness, or those who are medically frail, regardless of their age. A helpful tool for determining who would benefit from POLST is the question, "Would you be surprised if this patient died within the next year."

Does the POLST form replace traditional Advance Directives?

The POLST form complements an Advance Directive and is not intended to replace that document. An Advance Directive is still necessary to appoint a legal healthcare decisionmaker, and is recommended for all adults, regardless of their health status.

If someone has a POLST form and an Advance Directive that conflict, which takes precedence?

If there is a conflict between the documents, the more recent document would be followed.

Who should discuss and complete the POLST form with patients?

Having a conversation with a patient about care during serious illness and end-of-life issues is an important and necessary part of good medical care. The law allows anyone who is a healthcare provider* to assist with the completion of a POLST form. In many cases, physicians will initiate conversations with their patients to understand their wishes and goals of care. Depending on the situation and setting, other trained staff members – such as nurses, nurse practitioners, social workers, or chaplains – may also play a role in starting the POLST conversation. However, physicians are responsible for confirming POLST choices are consistent with the patient's medical condition and preferences, and signing the POLST form.

*The term "healthcare provider" is defined by law as "an individual licensed, certified, or otherwise authorized or permitted by the law of this state to provide health care in the ordinary course of business or practice of a profession."

Can a POLST form be completed for patients who can no longer communicate their treatment wishes?

Yes. A healthcare professional can complete the POLST form based on family members' understanding of their loved one's wishes. The appointed decisionmaker can then sign the POLST form on behalf of their loved one.

What should be done with the form after it is completed and signed?

The original POLST form, on bright pink paper, stays with the patient at all times. If the patient is transferred to another setting, the POLST form goes with them.

- In the acute care or long-term care setting, the form should be kept in the patient’s medical record or file.
- At home, patients should be instructed to place the form in a visible location so it can be found easily by emergency medical personnel – usually on a table near the patient’s bed, or on the refrigerator.

Can a patient’s POLST form be changed?

Yes, the POLST can be modified or revoked by a patient, verbally or in writing, at any time. Changes may also be made by a physician, or requested by a patient’s decisionmaker, based on new information or changes in the patient’s condition.

When should a patient’s POLST form be reviewed?

It is good clinical practice to review a patient’s POLST form when any of the following occur:

- The patient is transferred from one medical or residential setting to another;
- There is a significant change in the person’s health status, or there is a new diagnosis;
- The patient’s treatment preferences change.

It is recommended to complete a 2014 POLST when a 1/1/2009 or 4/1/2011 POLST form is reviewed or modified.

How can I obtain copies of the POLST form to use with patients/clients?

Healthcare providers may download the California POLST form at www.caPOLST.org. In order to maintain continuity throughout California, the form should be copied or printed on 65# Ultra Pink card stock, available at most office supply stores. POLST forms may be purchased in bulk from MedPass at <http://med-pass.com>.

Are faxed copies and/or photocopies valid? Must pink paper be used?

Faxed copies and photocopies are valid. Ultra Pink paper is preferred and used to distinguish the form from other forms in the patient’s medical record; however, the form will be honored on any color paper.

Is the POLST form available in other languages?

Many translations of the form are available to assist healthcare providers in explaining the form, including Armenian, Chinese, Farsi, Hmong, Japanese, Korean, Pashto, Russian, Spanish, Tagalog, Vietnamese and Braille. However, the English version of the POLST form must be completed and signed so that emergency medical personnel and healthcare providers can follow the orders. All translations, with instructions, are available at www.caPOLST.org.

Where is POLST being used now?

POLST was originally developed in Oregon. There are a number of states which have established POLST programs or are currently developing programs. For more information on the national POLST effort, including published research and a complete listing of states using POLST, visit www.POLST.org.

When was POLST authorized in California?

California State POLST Legislation (AB 3000 (Statutes 2008, Chapter 266)) went into effect on January 1, 2009.

Will a patient's POLST form be valid when traveling to another state?

The California POLST form is valid in California. If patients are traveling outside California, it is a good idea for them to take both their Advance Directive and POLST form with them. Both documents, even if not legally binding, will help healthcare providers know and honor their wishes.

Which organizations support the use of the POLST form?

California POLST is part of a national effort. For a complete listing of California organizations that support the use of POLST visit www.POLST.org.

Who is leading the POLST initiative in California?

The Coalition for Compassionate Care of California (CCCC) provides leadership and oversight for POLST outreach activities in California, with support from the California HealthCare Foundation.

Is there additional clinical information about POLST?

Yes, Frequently Asked Clinical Questions for Providers is available at www.caPOLST.org.

How can I find out more about POLST?

Visit the California POLST website at www.caPOLST.org for additional information and resources.

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: June 14, 1984		Effective Date: November 1, 2003	
Date Revised: September 11, 2003			
Last Review: June 9, 2011			
Review Date: June 30, 2014			

- 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 and **fax to (805-654-5597)** ~~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: 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		Effective Date:	
Date Revised:			
Date Last Reviewed:			
Review 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 meeting criteria 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 Stroke Alert, The~~ Base Hospital will notify the appropriate ASC of the Stroke Alert patient. ~~unless the base hospital receiving the Stroke 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 ED, CT or Internal Disaster diversion, transport to the ~~In the event of CT or neuroneurosurgical diversion, 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.

Allergic/Adverse Reaction and Anaphylaxis	
ADULT	PEDIATRIC
BLS Procedures	
Assist with prescribed Epi-Pen Administer oxygen as indicated	Assist with prescribed Epi-Pen Jr. Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
<p>Allergic Reaction or Dystonic Reaction</p> <ul style="list-style-type: none"> • Benadryl <ul style="list-style-type: none"> ○ IV/IM – 50 mg <p>If Wheezing is present</p> <ul style="list-style-type: none"> • Albuterol <ul style="list-style-type: none"> ○ Nebulizer – 5 mg/6 mL <ul style="list-style-type: none"> • Repeat as needed <p>Anaphylaxis without Shock</p> <ul style="list-style-type: none"> • Epinephrine 1:1,000 <ul style="list-style-type: none"> ○ IM – <ul style="list-style-type: none"> • Less than 40 years old – 0.5 mg • 40 years old and greater – 0.3 mg <ul style="list-style-type: none"> ○ Only if severe respiratory distress is present • IV access • Benadryl <ul style="list-style-type: none"> ○ IV/IM – 50 mg <ul style="list-style-type: none"> • May repeat x 1 in 10 min <p>Anaphylaxis with Shock</p> <ul style="list-style-type: none"> • Treatment as above for Anaphylaxis without Shock • Initiate 2nd IV • Normal Saline <ul style="list-style-type: none"> ○ IV bolus – 1 Liter <p>For Profound Shock</p> <ul style="list-style-type: none"> • Epinephrine 1:10,000 <ul style="list-style-type: none"> ○ Slow IVP – 0.1 mg (1 mL) increments <ul style="list-style-type: none"> • Max 0.3 mg (3 mL) over 1-2 min 	<p>Allergic Reaction or Dystonic Reaction</p> <ul style="list-style-type: none"> • Benadryl <ul style="list-style-type: none"> ○ IV/IM – 1 mg/kg <ul style="list-style-type: none"> • Max 50 mg <p>If Wheezing is present</p> <ul style="list-style-type: none"> • Albuterol <ul style="list-style-type: none"> ○ Less than 2 years old <ul style="list-style-type: none"> • Nebulizer – 2.5 mg/3 mL <ul style="list-style-type: none"> ○ Repeat as needed ○ 2 years old and greater <ul style="list-style-type: none"> • Nebulizer – 5 mg/6 mL <ul style="list-style-type: none"> ○ Repeat as needed <p>Anaphylaxis without Shock</p> <ul style="list-style-type: none"> • Epinephrine 1:1,000 <ul style="list-style-type: none"> ○ IM – 0.01 mg/kg <ul style="list-style-type: none"> • Max 0.3 mg • IV access • Benadryl <ul style="list-style-type: none"> ○ IV/IM – 1 mg/kg <ul style="list-style-type: none"> • May repeat x 1 in 10 min • Max 50 mg <p>Anaphylaxis with Shock</p> <ul style="list-style-type: none"> • Treatment as above for Anaphylaxis without Shock • Initiate 2nd IV if possible or establish IO • Normal Saline <ul style="list-style-type: none"> ○ IV/IO bolus – 20 mL/kg <p>For Profound Shock</p> <ul style="list-style-type: none"> • Epinephrine 1:10,000 <ul style="list-style-type: none"> ○ Slow IVP – 0.01 mg/kg (0.1 mL/kg) increments <ul style="list-style-type: none"> • Max 0.3 mg (3 mL) over 1-2 min
Communication Failure Protocol	
<p>Anaphylaxis without Shock</p> <ul style="list-style-type: none"> • Repeat Epinephrine 1:1,000 <ul style="list-style-type: none"> ○ IM – 0.3 mg q 5 min x 2 as needed <p>Anaphylaxis with Shock</p> <ul style="list-style-type: none"> • For continued shock <ul style="list-style-type: none"> ○ Repeat Normal Saline <ul style="list-style-type: none"> • IV bolus – 1 Liter ○ Repeat Epinephrine 1:1,000 <ul style="list-style-type: none"> • IM – 0.3 mg q 5 min x 2 as needed 	<p>Anaphylaxis without Shock</p> <ul style="list-style-type: none"> • Repeat Epinephrine 1:1,000 <ul style="list-style-type: none"> ○ IM – 0.01 mg/kg q 5 min x 2 as needed <p>Anaphylaxis with Shock</p> <ul style="list-style-type: none"> • For continued shock <ul style="list-style-type: none"> ○ Repeat Normal Saline <ul style="list-style-type: none"> • IV/IO bolus – 20 mL/kg ○ Repeat Epinephrine 1:1,000 <ul style="list-style-type: none"> • IM – 0.01 mg/kg q 5 min x 2 as needed
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	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	
<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Normal Saline <ul style="list-style-type: none"> IV bolus – 1 Liter 	IV/IO access Morphine – per Policy 705 - Pain Control If TBSA > 10% or hypotension is present: <ul style="list-style-type: none"> Normal Saline <ul style="list-style-type: none"> 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



Crush Injury/Syndrome	
ADULT	PEDIATRIC
BLS Procedures	
Perform spinal precautions as indicated Determine Potential vs. Actual Crush Syndrome Administer oxygen as indicated	Perform spinal precautions as indicated Determine Potential vs. Actual Crush Syndrome Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
Potential crush injury <ul style="list-style-type: none"> • IV access • Maintain body heat • Release compression • Monitor for cardiac dysrhythmias 	Potential crush injury <ul style="list-style-type: none"> • IV access • Maintain body heat • Release compression • Monitor for cardiac dysrhythmias
Communication Failure Protocol	
Actual crush syndrome <ul style="list-style-type: none"> • Initiate 2nd IV access • Normal Saline <ul style="list-style-type: none"> ○ IV bolus – 1 Liter <ul style="list-style-type: none"> • Caution with cardiac and/or renal history • Sodium Bicarbonate <ul style="list-style-type: none"> ○ IV mix – 1 mEq/kg <ul style="list-style-type: none"> • Added to 1st Liter of Normal Saline • Albuterol <ul style="list-style-type: none"> ○ Nebulizer – 5 mg/6 mL <ul style="list-style-type: none"> • Repeat x 2 • Morphine – Per Policy 705 - Pain Control • Maintain body heat • Release compression • Monitor for cardiac dysrhythmias • For cardiac dysrhythmias: <ul style="list-style-type: none"> ○ Calcium Chloride <ul style="list-style-type: none"> • IV – 1 gm over 1 min 	Actual crush syndrome <ul style="list-style-type: none"> • Initiate 2nd IV access if possible or establish IO • Normal Saline <ul style="list-style-type: none"> ○ IV/IO bolus – 20 mL/kg <ul style="list-style-type: none"> • Caution with cardiac and/or renal history • Sodium Bicarbonate <ul style="list-style-type: none"> ○ IV mix– 1 mEq/kg <ul style="list-style-type: none"> • Added to 1st Liter of Normal Saline • Albuterol <ul style="list-style-type: none"> ○ Less than 2 years old <ul style="list-style-type: none"> • Nebulizer – 2.5 mg/3 mL <ul style="list-style-type: none"> ○ Repeat x 2 ○ 2 years old and greater <ul style="list-style-type: none"> • Nebulizer – 5 mg/6 mL <ul style="list-style-type: none"> ○ Repeat x 2 • Maintain body heat • Release compression • Monitor for cardiac dysrhythmias • For cardiac dysrhythmias: <ul style="list-style-type: none"> ○ Calcium Chloride <ul style="list-style-type: none"> • IV/IO – 20 mg/kg over 1 min
For continued shock <ul style="list-style-type: none"> • Repeat Normal Saline <ul style="list-style-type: none"> ○ IV bolus – 1 Liter 	For continued shock <ul style="list-style-type: none"> • Repeat Normal Saline <ul style="list-style-type: none"> ○ IV/IO bolus – 20 mL/kg
Base Hospital Orders only	
For ongoing extended entrapment and no response to fluid therapy: <ul style="list-style-type: none"> • Dopamine <ul style="list-style-type: none"> ○ IVPB – 10 mcg/kg/min 	For ongoing extended entrapment and no response to fluid therapy: <ul style="list-style-type: none"> • Dopamine <ul style="list-style-type: none"> ○ IVPB – 10 mcg/kg/min
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures
Additional Information: <ul style="list-style-type: none"> • 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



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: <ul style="list-style-type: none"> • Activated Charcoal <ul style="list-style-type: none"> ○ PO – 1 gm/kg <ul style="list-style-type: none"> • Max 50 gm Suspected opiate overdose with respirations less than 12/mi and significant ALOC: <ul style="list-style-type: none"> • Narcan <ul style="list-style-type: none"> ○ IM – 2 mg ○ IV – 0.4 mg q 1min <ul style="list-style-type: none"> • Initial max 2 mg ○ May repeat as needed to maintain respirations greater than 12/min Organophosphate Poisoning <ul style="list-style-type: none"> • Mark I or DuoDote Antidote Kit <ul style="list-style-type: none"> ○ Mild Exposure: IM x 1 ○ Moderate Exposure: IM x1 <ul style="list-style-type: none"> • May repeat in 10 minutes if symptoms persist ○ 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: <ul style="list-style-type: none"> • Activated Charcoal <ul style="list-style-type: none"> ○ PO – 1 gm/kg <ul style="list-style-type: none"> • Max 50 gm Suspected opiate overdose with respirations less than 12/min: <ul style="list-style-type: none"> • Narcan <ul style="list-style-type: none"> ○ IV/IM/IO – 0.1 mg/kg <ul style="list-style-type: none"> • Initial max 2 mg ○ May repeat as needed to maintain respirations greater than 12/min Organophosphate Poisoning <ul style="list-style-type: none"> • Mark I or DuoDote Antidote Kit x 1 <ul style="list-style-type: none"> ○ 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 <ul style="list-style-type: none"> ○ Repeat until symptoms are relieved ○ Atropen requires a CHEMPACK deployment
Base Hospital Orders only	
Tricyclic Antidepressant Overdose <ul style="list-style-type: none"> • Sodium Bicarbonate <ul style="list-style-type: none"> ○ IV – 1 mEq/kg Beta Blocker Overdose <ul style="list-style-type: none"> • Glucagon <ul style="list-style-type: none"> ○ IV – 2 mg <ul style="list-style-type: none"> • May give up to 10mg if available Calcium Channel Blocker Overdose <ul style="list-style-type: none"> • Calcium Chloride <ul style="list-style-type: none"> ○ IV – 1 gm over 1 min • Glucagon <ul style="list-style-type: none"> ○ IV – 2 mg <ul style="list-style-type: none"> • May give up to 10 mg if available Stimulant/Hallucinogen Overdose <ul style="list-style-type: none"> • Midazolam <ul style="list-style-type: none"> ○ IV – 2 mg <ul style="list-style-type: none"> • Repeat 1 mg q 2 min as needed • Max 5 mg ○ IM – 0.1 mg/kg <ul style="list-style-type: none"> • Max 5 mg 	Tricyclic Antidepressant Overdose <ul style="list-style-type: none"> • Sodium Bicarbonate <ul style="list-style-type: none"> ○ IV/IO – 1 mEq/kg Beta Blocker Overdose <ul style="list-style-type: none"> • Glucagon <ul style="list-style-type: none"> ○ IV/IO – 0.1 mg/kg <ul style="list-style-type: none"> • May give up to 10 mg if available Calcium Channel Blocker Overdose <ul style="list-style-type: none"> • Calcium Chloride <ul style="list-style-type: none"> ○ IV/IO – 20 mg/kg over 1 min • Glucagon <ul style="list-style-type: none"> ○ IV/IO – 0.1 mg/kg <ul style="list-style-type: none"> • May give up to 10 mg if available Stimulant/Hallucinogen Overdose <ul style="list-style-type: none"> • Midazolam <ul style="list-style-type: none"> ○ IM – 0.1 mg/kg <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> ○ S – Salivation ○ L – Lacrimation ○ U – Urination ○ D – Defecation ○ G – Gastrointestinal Distress ○ E – Elimination (vomiting) • Narcan – it is not necessary that the patient be awake and alert. Administer until max dosage is reached or RR greater than 12/min. When given to chronic opioid patients, withdrawal symptoms may present. IM dosing is the preferred route of administration. 	

Effective Date: June 1, 2014
Next Review Date: April 30, 2016

Date Revised: May 8, 2014
Last Reviewed: May 8, 2014

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	Effective Date: December 1, 2012	
Date Revised:	July 12, 2012		
Date Last Reviewed:	July 12, 2012		
Review Date:	July, 2014		

- 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.



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: Emergency Medical Technician Automatic External Defibrillation (AED) Service Provider Medical Director		Policy Number: 802	
APPROVED: Administration: Steven L. Carroll, EMT-P		Date: 10/10/2002	
APPROVED: Medical Director: Angelo Salvucci, M.D.		Date: 10/10/2002	
Origination Date: November 1988		Effective Date: November 30, 2002	
Date Revised: June, 2002			
Date Last Reviewed: April 14, 2011			
Review Date: April 2014			

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- I. PURPOSE: To define the qualifications and responsibilities of the EMT AED Medical Director.
- II. AUTHORITY: Health and Safety Code 1797.107, 1797.170, 1797.220, 1798 and California Code of Regulations, Title 22, Division 9, Sections 100063 and 100063.1.
- III. DEFINITION: "Defibrillation Medical Director" means a physician and surgeon licensed in the State of California who is certified by the American Board of Emergency Medicine and is designated by the local EMS medical director to be responsible for the EMT Automatic External Defibrillation program, including medical control, under his/her jurisdiction. Waiver of the board certified requirement may be granted by the local EMS medical director if such physicians are not available for designation. (22CCR100059.1)
- IV. POLICY: An EMT AED Service Provider Medical Director in Ventura County shall meet the qualifications and perform the functions defined in this policy.
- V. PROCEDURE: The EMT AED Medical Director shall:
 - A. Either:
 1. Be certified by the American Board of Emergency Medicine or
 2. Maintain current ACLS certification
 - B. Have skills in cardiac rhythm interpretation
 - C. Possess a working knowledge of the prehospital EMS system and EMT AED systems.
 - D. Make sufficient time commitment to actively participate in the review of individual cases and in the development and approval of all periodic reports.
 - E. Approve and monitor training programs, including refresher training

- F. Establish policies and procedures for demonstration of continued competency in defibrillation.
- G. Require documented demonstration of skills proficiency
 - ~~1. Monthly for manual defibrillation~~
 - 2. ~~At~~ at least every 6 months for automatic or semi-automatic defibrillation.
- H. Rescind accreditation if an EMT fails to show continued competency
- I. Establish policies and procedures for temporary suspension, as needed, by EMS Medical Director, EMT AED medical director or Base Hospital medical director and submit these policies to the EMS Medical Director for approval.
- J. Submit reports to the EMS Medical Director according to policies and procedures established by the local EMS agency.

The EMT AED medical director may delegate specific field care audits, training and clinical experience/demonstration of competency to the medical director of a Base Hospital, physician, registered nurse, physician assistant or ~~Paramedic~~EMT-P licensed or certified in the State of California. An EMT may assist an instructor in demonstration of competency and training.

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COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Emergency Medical Technician (EMT) Automatic External Defibrillation (AED) Service Provider Program Standards		Policy Number: 803	
APPROVED: Administration: Steven L. Carroll, EMT-P		Date: 04-24-06	
APPROVED: Medical Director: Angelo Salvucci, M.D.		Date: 04-24-06	
Origination Date: November 1988		Effective Date: June 1, 2006	
Date Revised: March 2006			
Date Last Reviewed: April 14, 2011			
Review Date: April 30, 2014			

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- I. PURPOSE: To establish criteria for approval and oversight of EMT AED Service Provider programs.
- II. AUTHORITY: Health and Safety Code 1797.107, 1797.170, 1798 and California Code of Regulations, Title 22, 100063.1.
- III. DEFINITION: An EMT AED service provider is an agency or organization that employs individuals as defined in Section 100060, and who obtain AEDs for the purpose of providing AED services to the general public.
- IV. POLICY:
 - A. An AED Service Provider shall be approved by Ventura County Emergency Medical Services (VC EMS) prior to beginning service. In order to receive and maintain EMT AED Service Provider approval, an EMT AED Services Provider shall comply with the requirements of this policy.
 - B. An EMT AED Service Provider shall:
 1. Have a written agreement with a physician who meets requirements in VCEMS Policy 802 to serve as Medical Director.
 2. Provide orientation of AED authorized personnel to the AED
 3. Ensure maintenance of AED equipment.
 4. Ensure continued competency of AED authorized personnel
 - a. Demonstration of skills competence at least every six months to the EMT Medical Director or his/her designee as identified to the EMS office.
 - b. Use of AEDs ~~shall~~ will be incorporated into each fire station's quarterly drills.
 - c. Attendance records shall be maintained.
 - d. Continuing Education Lecture: The EMT (AED) shall attend one (1) hour lecture per six months to total four (4) per two year certification period with content in cardiac arrest management.
 5. Ensure that EMT personnel complete a first responder BLS [Electronic](#)

- Prehospital Care Record ([or electronic ePCR](#)) for all patient contacts, ~~and submit to VC EMS.~~
6. Authorize personnel and maintain a current listing of all EMT AED Service Provider authorized personnel and provide a listing upon request by the VC EMS Agency. Authorized personnel means EMT personnel trained to operate an AED and authorized by an approved EMT AED Service Provider.
 7. Train all EMTs who have not already been trained in use of AED. Training shall include the following:
 - a. Perform emergency cardiac care in accordance with protocols developed and/or approved by the EMS Agency Medical Director.
 - b. Recognize that a patient is in cardiac arrest and that CPR and immediate application of the automated external defibrillator or manual defibrillator is required.
 - ~~c. If collapse before call to 9-1-1, 2 minutes of CPR before first analysis.~~
 - ~~cd.~~ Set up the automated defibrillator correctly.
 - ~~de.~~ Correctly apply the defibrillator pads.
 - ~~ef.~~ Ensure that rescuers or bystanders are not in contact with the patient while the AED is analyzing or delivering a shock.
 - ~~fg.~~ ~~If collapse after call to 9-1-1, d~~ Deliver shocks for ventricular fibrillation in the shortest time possible following their arrival at the patient side, ideally within 90 seconds.
 - ~~gh.~~ Recognize that a shock was delivered to the patient.
 - ~~hi.~~ Provide supportive care to a patient who has been successfully defibrillated.
 - ~~ij.~~ Immediately recognize and respond to patients who rebrillate either at the scene or during transport, in accordance with protocols.
 - ~~jk.~~ Deliver no more than the number of shocks allowed in the standing orders.
 - ~~kl.~~ Record the pertinent events of the emergency response on ~~an~~ ePCR.
 - ~~lm.~~ Maintain the monitor/defibrillator and voice/ECG recorder or other documentation device in accordance with manufacturer's recommendations.
 8. Develop and maintain a quality improvement program, approved by the VC EMS Medical Director that contains the following:
 - a. Assure timely and competent review of EMT managed cardiac arrest cases, accurate logging of required data, and timely, accurate and

informative statistical summaries of system performance over time, as well as recommendations, as indicated, for modifications of system design, performance protocols, or training standards designed to improve patient outcome.

- b. Collect, store and analyze, at a minimum, the following data related to EMT management of cardiac arrest patients:
 - (1) Patient Data:
 - a) Age,
 - b) Sex,
 - c) Whether arrest was witnessed or unwitnessed,
 - d) Distance of collapse from EMT responding unit, and
 - e) Initial cardiac rhythm.
 - (2) EMS System Data:
 - a) Estimated time from collapse to call for help,
 - b) Estimated time from collapse to initiation of CPR,
 - c) EMT responding unit response time, and
 - d) Scene to hospital transport time.
 - (3) EMT Performance:
 - a) Accuracy of rhythm interpretation,
 - b) Time from arrival to actual defibrillation,
 - c) Time between defibrillation attempts,
 - d) Appropriateness of management for each rhythm encountered, and
 - e) General adherence to established protocol.
 - (4) Patient Outcome:
 - a) Rhythm after each shock.
 - b) Return of pulse and/or spontaneous respirations in the field.

7. EMT AED documentation submission

a. If EMTAED Service Provider has Ventura County Electronic Patient Care Record (ePCR) capabilities, documentation shall be consistent with VCEMS Policy 1000.

b. If EMT AED Service Provider does not have ePCR capabilities, documentation submission shall be as follows:
(1)a- EMT documentation (incident printout and prehospital care record (PCR) shall be submitted to the receiving hospital as soon as

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possible (not more than two hours after patient arrival).

(2)b- EMT documentation for all arrests (incident printout and PCR including times) shall be submitted by the provider to the involved base hospital within 30 days of the end of the calendar month of the occurrence.

(3)e- EMT documentation (incident printout, PCR including times, and audio recordingtape) shall be submitted to the EMTmedical director or designee within 10 working days of the occurrence.

8. The EMT AED Service Provider, in conjunction with its medical director, shall submit an annual written report to the EMS Agency to include as a minimum the following information.

- a. The total number of cases in which the AED was activated. The number of those cases where return of spontaneous circulation (ROSC) was achieved.
- b. The number of cases that presented in Ventricular Fibrillation (VF). The number of those cases where ROSC was achieved.
- c. The number of cases that presented in witnessed VF. The number of those cases where ROSC was achieved.
- d. The 90% fractile times from first notification to on-scene, to with patient and to first analysis, in case of secondary PSAP, time received.
- e. The number of cases of cardiac arrest responded to where the AED was not activated and the 90% fractile time from first notification to on-scene for those cases, in case of secondary PSAP, time received.

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COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Emergency Medical Technician (EMT) Medical Cardiac Arrest		Policy Number 805	
APPROVED Administrator	Steven L. Carroll, EMT-P	Date: 04/24/2006	
APPROVED Medical Director:	Angelo Salvucci, MD	Date: 04/24/2006	
Origination Date:	October 1, 1993	Effective Date: June 1, 2006	
Revised:	April 24, 2006		
Date Last Reviewed:	April 14, 2011		
Review Date:	April, 2014		

- I. PURPOSE: To define the protocol to be followed by non-transport unit EMT-s during a response to a medical cardiac arrest.
- II. AUTHORITY: Health and Safety Code 1797.107, 1797.170, 1797.220, 1798 and California Code of Regulations, Title 22, Division 9, Section 100063 and 100063.1.
- III. POLICY: The following protocol shall be used by EMT-s in a medical cardiac arrest.
- IV. PROCEDURE: EMT-s shall:
 - A. CONFIRM: Patient is unconscious, non-breathing or has agonal respiration and pulseless.
 1. Arrest not secondary to trauma (if trauma, follow trauma protocol)
 2. If AED has demonstrated a high specificity for pediatric shockable rhythms, as determined by the service provider medical director, patient is 1 year of age or older. If the AED has not demonstrated a high specificity for pediatric shockable rhythms, as determined by the service provider medical director, patient is 8 years of age or older.
 - B. Initiate CPR/set up defibrillator.
 1. ~~If collapse before call to 9-1-1, 2 minutes of CPR (1 or 2+ rescuers) before first analysis.~~
 2. ~~If collapse after call to 9-1-1:~~
 - a1. If alone, do not start CPR. Start defibrillator immediately and analyze.
 - 2b. For 2 or more rescuers, CPR while setting up defibrillator, then analyze immediately.
 - C. Clear personnel prior to analyzing rhythm. Re-clear and visually clear prior to administering shock.
 - D. Have machine analyze rhythm
 1. ~~If the AED is not in compliance with the 2005 AHA Guidelines~~
 - a. ~~If machine determines that a shock is necessary, press button to shock patient (360J monophasic)*.~~
 - b. ~~Analyze rhythm: If machine determines that a shock is necessary, press button to shock patient (360J monophasic)*.~~
 - c. ~~Analyze rhythm: If machine determines that a shock is necessary, press button to shock patient (360 J monophasic)*. Check carotid pulse.~~

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* Or monophasic or biphasic energy level approved by service provider medical director.

- d. ~~If the patient remains unconscious and pulseless after the third shock, perform CPR for 1 minute and repeat the series of up to three shocks.~~
- e. ~~Continue cycles of CPR and assessment until turning over care to ALS responders or to the hospital.~~
- f. ~~If after any of the shocks, the rhythm has changed and there is a pulse, maintain the airway and breathing, monitor pulse, and check blood pressure. If pulse is less than 30 and patient remains unconscious, do CPR for 1 minute and reevaluate patient.~~

2. ~~If the AED is compliant with the 2005 AHA Guidelines:~~

- a. If machine determines that a shock is necessary, press button to shock patient (360J)*, then immediately begin CPR.
- b. Perform CPR for 2 minutes, reassess, and shock if necessary.
- c. Continue cycles of CPR and assessment until turning over care to ALS responders or to the hospital.

E. Patient Transportation

- 1. If the transport unit is an Advanced Life Support unit, the care of the patient will be turned over to the ~~EMT-Ps~~ Paramedics. The EMTs ~~+~~ may accompany the patient to the hospital.
- 2. If the transport unit is a Basic Life Support unit, CPR shall be continued and the patient transported to the nearest (in terms of time) hospital.
 - a. The EMT ~~+~~ shall accompany the patient in the BLS unit.
 - b. If the patient transiently regains pulses as a result of previous defibrillation, and then patient loses pulses, the unit may pull over for machine evaluation of the patient's rhythm and deliver further shocks.

F. If the initial rhythm is not shockable or any time that the machine indicates a non-shockable rhythm and patient remains pulseless:

- 1. Do CPR for two minutes
- 2. ~~Have machine analyze rhythm~~
- 3. If unshockable rhythm remains, check pulse. If pulseless, do CPR for 2 minutes. If pulse is absent, reanalyze. Repeat cycle until transport unit arrives, patient resumes pulse, or a shockable rhythm presents.
- 4. If a shockable rhythm presents, follow shock series as above.

* Or monophasic or biphasic energy level approved by service provider medical director.

5. If pulse returns, maintain airway and breathing, monitor pulse, and check blood pressure. Except in cases of hypothermia, if pulse is less than 30 and patient remains unconscious, do CPR for 2minutes and reevaluate patient.
- F. When repeating shocks on a patient who has converted and then refribrillates, administer shocks at the level that conversion occurred (e.g., if the patient converted at 360 J, begin new series of shocks at 360 J) *1.

Policy Title: Emergency Medical Technician (EMT) Defibrillation Integration With Public AED Operator		Policy Number 808
APPROVED Administrator	Steven L. Carroll, EMT-P	Date: 0/10/2002
APPROVED Medical Director:	Angelo Salvucci, MD	Date: 10/10/2002
Origination Date:	May 9, 2002	Effective Date: November 30, 2002
Date Revised:	August 2002	
Date Last Reviewed:	April 14, 2011	
Review Date:	April 2014	

- I. PURPOSE: To define criteria for EMS providers to integrate with public AED operations.
- II. AUTHORITY: Health and Safety Code 1797.107, 1797.170, 1798 and California Code of Regulation, Title 22 10063.1.
- III. POLICY: Ventura County EMS Agency will notify local EMS providers of known AED programs in their area, including type of AED device. EMS providers will attempt to integrate pre-arrival AED care with current Ventura County Policy.
- IV. PROCEDURE:
 - A. Obtain brief report from public AED operator, which shall include:
 1. Situation (patient age, sex, history, events occurring prior to arrival)
 2. Initial analysis – Shock or no shock? If shock - # of shocks delivered
 3. Time of last analysis or shock
 - B. Confirm patient is unconscious, non-breathing or agonal respirations and pulseless UNLESS public AED is in the process of analyzing or in the middle of a shocking sequence.
 - C. Determine need to switch to first responder's AED.
 1. Criteria for switching units to include:
 - a. Pads incorrectly positioned
 - b. Questionable or unsafe operation of public AED
 2. Criteria for continuing with public AED
 - a. Appropriate operation of AED
 - b. Pads correctly positioned
 3. If decision is made to switch to first responder AED, be sure to deactivate or turn off the public AED prior to removing pads.
 - D. Assume or take over ventilations and compressions from bystanders.
 - E. Follow EMT Protocol outlined in Policy 805.

1. In continuing with public AED, supervise and advise public AED operator for compliance with Policy 805.
 2. If switching to first responder AED, begin with initial analysis or rhythm and follow EMT protocol in Policy 805.
- F. If a pulse is obtained, stop CPR and continuously monitor the pulse. Immediately analyze if pulse is lost. (Not all public AEDs will sound an alert if the patient's rhythm changes to a shockable rhythm.)
- G. Switch to ALS agency (manual) defibrillator during CPR, not during analysis or shocking sequence.
- H. Obtain and document information for a complete cardiac arrest report to include:
1. Information listed in IV.A.1, 2, 3 and C.1, 2, 3.
 2. Time down
 3. Witnessed or non-witnessed arrest
 4. Presence of bystander CPR
 5. Type of public AED
 6. Contact person and phone number for the public AED program
- I. Acknowledge the public AED operator's and bystander's efforts in the resuscitation attempt.

COUNTY OF VENTURA EMERGENCY
MEDICAL SERVICES

HEALTH CARE AGENCY
POLICIES AND PROCEDURES

Policy Title: Critical Care Transports	Policy Number: 507
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: December 1, 2011
APPROVED: Medical Director Angelo Salvucci, M.D.	Date: December 1, 2011
Origination Date: October 31, 1995	
Date Revised: October 13, 2011	Effective Date: December 1, 2011
Date Last Reviewed: October 13, 2011	
Review Date: November 1, 2014	

- I. PURPOSE: To establish requirements for nurse-staffed ALS Units
- II. AUTHORITY: Health and Safety Code 1798.170.
- III. POLICY: An ALS Ambulance Company may be approved to employ or contract with Registered Nurses to staff ALS inter-facility transports providing the company adhere to the outlined conditions. This policy applies to interfacility ground transports only.
- IV. PROCEDURE:
 - A. Vehicle Staffing Requirements
 - 1. One registered nurse, currently licensed to practice in the State of California, shall be added to the BLS or ALS Support team, and shall meet the following requirements:
 - a. RN with a minimum of two (2) years experience in a critical care area within the previous three (3) years, prior to employment with the ambulance provider.
 - b. Current BLS and ACLS certification from the American Heart Association.
 - c. Successful completion of an in-house orientation program sponsored by the provider agency.
 - d. For pediatric CCT's only: Pediatric Advanced Life Support (PALS), Pediatric Education for Prehospital Providers (PEPP) or Emergency Nurses Pediatric Course (ENPC).
 - e. Certification in any one of the following: Certified Emergency Nurse (CEN); Critical Care Registered Nurse (CCRN); Mobile Intensive Care Nurse (MICN); Certified Flight Registered Nurse (CFRN), Certified Nurse Anesthetist; Post Anesthesia Recovery Nurse (PAR), Certified Transport Registered Nurse

(CTRN); may challenge/pass Ventura County MICN certification exam.

2. To maintain authorization as a CCT nurse, s/he will:
 - a. Work a minimum of 384 hours in a critical care area (including time worked as a CCT RN) per year, unless employed full time as a critical care transfer nurse.
 - b. Maintain current ACLS certification.
 - c. For pediatric CCT's only: PALS, PEPP or ENPC.
 3. Nurses used to provide ALS in accordance with this policy, may be employed by the ambulance provider or be sub-contracted, at the provider's option.
 4. Ambulance providers shall provide an internal orientation to all personnel participating in nurse-staffed ambulance transports.
- B. Equipment:
1. In addition of the items required by California Administrative Code, Title 13, the ambulance provider shall provide, at a minimum, the following equipment for nurse-staffed ALS units:
 - a. ASV equipment List
 - b. Manual defibrillator with external pacemaker
 - c. Infusion pump(s)
 - d. Back-up power source
 - e. Pulse oximeter
- C. Medical Direction: An agency providing CCTs shall have:
1. Medical protocols to be followed by the RN at the ALS level which have been approved and signed by a Physician, and
 2. Either a
 - a. Physician Director
Provider shall have either full or part-time Physician Director qualified by training and/or experience and recent practice in emergency or acute critical care medicine. The candidate for Physician Director must be approved by the Medical Director. The Physician Director shall:
 - 1) Ensure the ongoing training of all medical personnel involved.

- 2) Ensure the quality of patient transfers being conducted by the provider by conducting patient care audits.
 - 3) Be familiar with applicable patient transfer laws, or
 - b. Nursing Coordinator
Provider shall have either full or part-time RN employed as Nursing Coordinator qualified by training and/or experience and recent practice in emergency or acute critical care nursing. The Nursing Coordinator shall:
 - 1) Provide ongoing training of all medical personnel involved.
 - 2) Ensure quality of patient transfers being conducted by the provider by conducting patient care audits.
 - 3) Be familiar with applicable patient transfer laws
3. Procedures/Protocols
 - a. Each company providing nurse-staffed ALS units shall develop and maintain procedures for the hiring and training of nursing personnel and vehicle staffing.
 - b. Each provider must develop a manual clearly displaying:
 1. Malpractice insurance coverage.
 2. Identify and accessibility of the Physician Director and Nursing Coordinator.
 3. Vehicle inventory lists
 4. Copies of all related interfacility transfer paperwork
 5. Statement of responsibility of the sending physician for the patient during transfer and in accordance with COBRA and SB317 laws.
 6. Guidelines for change in patient destination due to patient condition
 7. Protocols (Standing Orders) based on ACLS, PALS/PEPP, or NALS guidelines.
 - c. Procedures and protocols shall be subject to review by the VC EMS.
4. CQI
 - a. The Physician Director and/or Nursing Coordinator shall be responsible for performing quality assurance outcome audits.

- b. Patient transport record review shall be performed at least quarterly and involve the use of pre-established criteria.
- c. All transports resulting in adverse patient outcome shall be reviewed and reported to the VC EMS Agency per Policy 150.
- d. Periodic staff conferences on audit and outcomes are required in order to improve or revise protocols.
- e. Records of all these activities shall be kept by the provider and be made available for inspection and audit by VC EMS.
- f. Report (quarterly) to VC EMS. Reports are to include general statistics (number of runs, types of runs, outcomes, intubation statistics, incidents during which paramedic assistance at ALS level is required).

5. Program Approval

Requests for approval must be made in writing sixty (60) days prior to anticipate service starting date, to the administrator of VC EMS, and must include:

- a. Proposed identification and location of the nurse-staffed unit.
- b. Procedures and protocols
- c. Documentation of qualifications of the proposed Physician Director (if applicable).
- d. Documentation of qualifications for the proposed Nursing Coordinator.
- e. Preliminary plan for quality assurance audits.
- f. Agreement to comply with all policies and procedures of VC EMS.

VC EMS shall notify the applicant in writing within ten (10) working days of lack of documentation. The applicant shall be notified in writing within thirty (30) days of receipt of complete package of approval or denial of the program.

6 Program Review

- a. VCEMS may perform periodic on-site audits of records to ensure compliance with this policy.
- b. Non-compliance with this policy may cause VC EMS to suspend or revoke approval to provide nurse-staffed ALS inter-facility transports.

VCEMS General Patient Guidelines

- I. Purpose: To establish a consistent approach to patient care
 - A. Initial response
 1. Review dispatch information with crew members and dispatch center as needed
 2. Consider other potential issues (location, time of day, weather, etc.)
 - B. Scene arrival and Size-up
 1. Address Body Substance Isolation/Personal Protection Equipment (BSI/PPE)
 2. Evaluate scene safety
 3. Determine the mechanism of injury (if applicable) or nature of illness
 4. Determine the number of patients
 5. Request additional help if necessary (refer to VCEMS Policy 131)
 6. Consider spinal precautions (refer to VCEMS Policy 614)
 - C. Initial assessment
 1. Airway
 - a. Open airway as needed, maintaining inline cervical stabilization if trauma is suspected
 - b. Insert appropriate airway adjunct if indicated
 - c. Suction airway if indicated
 - d. If a partial or complete Foreign Body Airway Obstruction (FBAO) is present, utilize appropriate interventions
 2. Breathing
 - a. Assess rate, depth, and quality of respirations
 - b. Assess lung sounds
 - c. If respiratory effort inadequate, assist ventilations with BVM
 - d. Initiate airway management and oxygen therapy as indicated
 3. Circulation
 - a. Assess skin color, temperature, and condition
 - b. Check distal/central pulses, including capillary refill time
 - c. Control major bleeding
 - d. Initiate shock management as indicated
 4. Disability
 - a. Determine level of consciousness
 - b. Assess pupils
 - c. Assess Circulation, Sensory, Motor (CSM)
 5. Exposure
 - a. If indicated, remove clothing for proper assessment/treatment of injury location. Attempt to maintain patient dignity

- b. Maintain patient body temperature at all times
 - D. Determine chief complaint. Initiate treatment per VCEMS policies/protocols
 - II. History of Present Illness – including pertinent negatives and additional signs/symptoms
 - 1. Onset of current illness or chief complaint
 - 2. Provoking factors
 - 3. Quality
 - 4. Radiation
 - 5. Severity – 1 to 10 on pain scale
 - 6. Time
 - III. Vital Signs
 - 1. Blood Pressure and/or Capillary Refill
 - 2. Heart Rate
 - 3. Respirations
 - 4. ALS assessments shall include:
 - a. Cardiac rhythm
 - b. 12-lead ECG as indicated per VCEMS Policy 726
 - c. Pulse Oximetry
 - d. Capnography (after advanced airway placement)
 - IV. Obtain history, including pertinent negatives
 - 1. Signs/Symptoms leading up to the event
 - 2. Allergies
 - 3. Medications taken
 - 4. Past medical history
 - 5. Last oral intake (as indicated)
 - 6. Events leading up to present illness
 - V. Perform Detailed Physical Examination per Trauma Assessment/Treatment Guidelines
 - VI. Base Hospital contact shall be made for all ALS patients in accordance with VCEMS Policy 704
 - VII. Transport to appropriate facility per VCEMS guidelines
 - 1. Transport and Destination Guidelines – Policy 604
 - 2. STEMI Receiving Center Standards – Policy 430
 - 3. Post cardiac arrest with ROSC – Policy 705 (Cardiac Arrest VF/VT)
 - 4. Trauma Triage and Destination Criteria – Policy 1405
 - 5. Hospital Diversion – Policy 402
 - VIII. Continuously monitor vital signs and document all findings. Continue appropriate treatments and reassess throughout transport to assess for changes in patient status
 - IX. Documentation
 - 1. Completion of patient care documentation per VCEMS Policy 1000

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

Effective Date: December 1, 2012
Next Review Date: December, 1, 2014

Date Revised: October, 2012
Last Reviewed: October, 2012

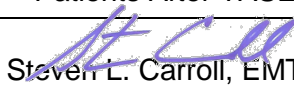



Heat Emergencies	
ADULT	PEDIATRIC
BLS Procedures	
Place patient in cool environment Initiate active cooling measures <ul style="list-style-type: none"> • Remove clothing • Fan the patient, or turn on air conditioner • Apply ice packs to axilla, groin, back of neck Administer oxygen as indicated	Place patient in cool environment Initiate active cooling measures Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
Determine Blood Glucose IV access Normal Saline <ul style="list-style-type: none"> • IV bolus – 1 Liter <ul style="list-style-type: none"> ○ Caution with cardiac and/or renal history 	Determine Blood Glucose IV/IO access Normal Saline <ul style="list-style-type: none"> • IV/IO bolus – 20 mL/kg <ul style="list-style-type: none"> ○ Caution with cardiac and/or renal history
Communication Failure Protocol	
If hypotensive after initial IV fluid bolus: <ul style="list-style-type: none"> • Repeat Normal Saline <ul style="list-style-type: none"> ○ IV bolus – 1 Liter 	If hypotensive after initial IV fluid bolus: <ul style="list-style-type: none"> • Repeat Normal Saline <ul style="list-style-type: none"> ○ 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

Effective Date: December 1, 2012
Next Review Date: October, 2014

Date Revised: October 11, 2012
Last Reviewed: October 11, 2012



COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Patients After TASER Use		Policy Number: 725	
APPROVED: Administration:	 Steven L. Carroll, EMT-P	Date: December 1, 2011	
APPROVED: Medical Director	 Angelo Salvucci, MD, FACEP	Date: December 1, 2011	
Origination Date:	August 10, 2006	Effective Date: December 1, 2011	
Date Revised:	August 11, 2011		
Date Last Reviewed:	August 11, 2011		
Next Review Date:	August 31, 2014		

- I. PURPOSE: To define the treatment and transportation of the patient on whom a TASER has been used.
- II. AUTHORITY: Health and Safety Code, Sections 1797.214, 1797.220, 1798, and 1798.200, California Code of Regulations, Title 22, Section 100169.
- III. POLICY: It is the policy of the Ventura County Sheriff's Department that all persons on whom a TASER is used be medically cleared prior to incarceration. Law enforcement officers may remove the TASER probes and may transport individuals in custody to an emergency department. On occasion, EMS personnel may be called to evaluate and transport patients with or without the probes in place.
 - A. TASER probes should not be removed by EMS personnel unless they interfere with the safe transportation of the patient.
 - B. Patients should be transported to the closest available hospital or the hospital requested by the law enforcement officer.
- IV. PROCEDURE:
 - A. When safe to do so, patients should be immediately evaluated, with particular attention to signs and symptoms of excited delirium.
 - B. Any injuries or medical conditions will be treated according to the appropriate treatment protocol.
 - C. These patients will be in the custody of law enforcement and will require transportation to an emergency department for medical clearance.
 - D. If the transporting paramedic determines that the patient is a risk to him/herself and/or the ambulance personnel, law enforcement officer(s) may be requested to accompany the patient.
 - E. Unless otherwise contraindicated, the patient should be adequately and safely restrained in an upright position prior to transport. Please see VCEMS Policy 732.
 - F. If one or both of the TASER probes requires removal for safe transportation:

1. Verify the wires to the probes have been severed.
 2. Use routine biohazard precautions.
 3. Place one hand on the patient in the area where the probe is embedded and stabilize the skin surrounding the puncture site between two fingers. Keep your hand several inches away from the probe. With your other hand, in one fluid motion pull the probe straight out from the puncture site.
 4. Reinsert TASER probes, point down, into the discharged air cartridge and hand it to the law enforcement officer.
 5. Apply direct pressure for bleeding, and apply a sterile dressing to the wound site.
- G. If the TASER may be in a dangerous area (e.g., face, neck, hand, bone, groin or spinal column), where it may injure bone, nerves, blood vessels, or an eye, do NOT remove the probe. Transport the patient to the ED in an appropriate position.
- H. Refer to Policy 705: Behavioral Emergencies if patient requires sedation.

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES		HEALTH CARE AGENCY POLICIES AND PROCEDURES	
Policy Title 12 Lead ECG		Policy Number: 726	
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: December 1, 2012	
APPROVED: Medical Director:	Angelo Salvucci, MD	Date: December 1, 2012	
Origination Date:	August 10, 2006		
Date Revised:	October 11, 2012	Effective Date:	December 1, 2012
Date Last Reviewed:	October 11, 2012		
Review Date:	December, 2014		

- I. Purpose: To define the indications, procedure and documentation for obtaining 12-lead ECGs.
- II. Authority: California Health and Safety Code, Sections 1797.220 and 1798, California Code of Regulations, Title 22, Section 100175.
- III. Policy: Paramedics will obtain 12-lead ECGs in patients demonstrating symptoms of acute coronary syndrome. Treatment of these patients shall be done in accordance with this policy. Only paramedics who have received training in this policy are authorized to obtain a 12-lead ECG on patients. EMTs who are specially trained may be authorized to set up the 12 lead.
- IV. Procedure:
 - A. Indications for a 12-lead ECG: Medical history and/or presenting complaints consistent with an acute coronary syndrome. Patients will have the acute (within the previous 12 hours) onset of one or more of the following symptoms that have no other identifiable cause:
 1. Chest, upper back or upper abdominal discomfort.
 2. Generalized weakness.
 3. Dyspnea.
 - B. Contraindications: Do NOT perform an ECG on these patients:
 1. Critical Trauma: There must be no delay in transport.
 2. Cardiac Arrest unless return of spontaneous circulation
 - C. ECG Procedure:
 1. Attempt to obtain an ECG during initial patient evaluation. Oxygen should be administered if patient is dyspneic, shows signs of heart failure or shock, or has SAO₂ < 94%. If the ECG can be completed without delay (less than 3 minutes after patient contact), and the patient is not in severe distress, perform ECG prior to medication administration.

2. The ECG should be done prior to transport.
 3. If the ECG is of poor quality (artifact or wandering baseline), or the patient's condition worsens, may repeat to a total of 3.
 4. Once an acceptable quality ECG is obtained, switch the monitor to the standard 3-lead function. Repeat the 12-lead ECG only if the original ECG interpretation is NOT *****ACUTE MI SUSPECTED*****, and patient's condition worsens.
 5. If interpretation is *****ACUTE MI SUSPECTED****, note underlying rhythm, and verify by history and physical exam that the patient does not have a pacemaker or ICD.
- D. Base Hospital Communication/Transportation:
1. If the ECG interpretation is **ACUTE MI SUSPECTED**; report that to MICN at the beginning of the report. If the ECG is of poor quality, or the underlying rhythm is paced, or atrial flutter, include that information in the initial report. All other information, except that listed in items 2, 4, and 5 below, is optional and can be given at the paramedic and MICN's discretion.
 2. Paramedics are to ask the patient if they have a cardiologist and report the information to the base hospital.
 3. If ECG Interpretation is **ACUTE MI SUSPECTED**, patients should be transported to the closest and most appropriate STEMI Receiving Center (SRC) depending on patient preference and cardiac catheterization lab availability. MICN may direct ambulance to alternative SRC if cardiac catheterization lab not available.
 4. If the ECG interpretation is ******ACUTE MI SUSPECTED******, and the underlying rhythm is Atrial Flutter the Base Hospital shall be notified at the beginning of the report. The Cath Lab will not be activated.
 5. If the ECG interpretation is *****ACUTE MI SUSPECTED***** and the patient has a pacemaker or the ECG is of poor quality (wandering baseline and/or artifact) report that to the MICN.
 6. If a first responder paramedic obtains an ECG that is **not ***ACUTE MI SUSPECTED***** and the patient is stable, patient care may be turned over to the transporting paramedic. The ECG will be turned over to the transporting paramedic.

7. Positive ECGs will be handed to the receiving medical practitioner. The receiving practitioner will initial, time and date the ECG to indicate they have received and reviewed the ECG.
- E. Patient Treatment:
1. Patient Communication: If the ECG interpretation is ***ACUTE MI SUSPECTED***, the patient should be told that “according to the ECG you may be having a heart attack”. If the ECG interpretation is anything else, the patient should NOT be told the ECG is normal or “you are not having a heart attack”. If the patient asks what the ECG shows, tell him/her that it will be read by the emergency physician.
- F. Other ECGs
1. If an ECG is obtained by a physician and the physician interpretation is Acute MI, the patient will be treated as an ***ACUTE MI SUSPECTED***. Do not perform an additional ECG unless the ECG is of poor quality, or the patient's condition worsens.
 2. If there is no interpretation of another ECG then repeat the ECG.
 3. The original ECG performed by physician shall be obtained and accompany the patient.
- G. Documentation
1. Approved Ventura County Documentation System (AVCDS) documentation will be completed per VCEMS policy. The original ECG will be turned in to the base hospital and ALS Service Provider.
- H. Reporting
1. False Positive ECGs not recognized and called in as such to the Base Hospital, will be reported to VC EMS as an Unusual Occurrence in accordance with VC EMS Policy 150.

*** ACUTE MI SUSPECTED ***

