

Ventura County Fire Dept. Classroom A and B 165 Durley Ave Camarillo, CA 93010	Pre-hospital Services Committee Agenda	January 16, 2020 9:30 a.m.
<b>I. Introductions</b>		
<b>II. Approve Agenda</b>		
<b>III. Minutes</b>		
<b>IV. Medical Issues</b>		
A. Other		
<b>V. New Business</b>		
A. Fentanyl Related Policies		Dr. Shepherd
1. 310 – Paramedic Scope of Practice		Dr. Shepherd
2. 504 – ALS and BLS Equipment		Dr. Shepherd
3. 705.06 – Burns		Dr. Shepherd
4. 705.09 – Chest Pain		Dr. Shepherd
5. 705.19 – Pain Control		Dr. Shepherd
6. 710 – Airway Management		Dr. Shepherd
7. 705.24 – Bradycardia		Dr. Shepherd
B. Naloxone Policy		Chris Rosa
<b>VI. Old Business</b>		
A. Other		
<b>VII. Informational/Discussion Topics</b>		
A. 452 – TCASC Standards		Karen Beatty
<b>VIII. Policies for Review</b>		
A. 705.28 – Smoke Inhalation		
B. 1602 – PSFA Optional Skills Approval and Training		
C. 1605 – PSFA Optional Skills Naloxone Administration		
<b>IX. Agency Reports</b>		
A. Fire Departments		
B. Ambulance Providers		
C. Base Hospitals		
D. Receiving Hospitals		
E. Law Enforcement		
F. ALS Education Program		
G. EMS Agency		
H. Other		
<b>X. Closing</b>		

Health Administration  
 Large Conference Room  
 2240 E. Gonzales, 2<sup>nd</sup> Floor  
 Oxnard, CA 93036

Pre-hospital Services Committee  
 Minutes

October 10, 2019  
 9:30 a.m.

Topic	Discussion	Action	Approval
<b>II. Approve Agenda</b>		Approved	Motion: Ira Tilles Seconded: Tom Gallegos Passed unanimous
<b>III. Minutes</b>		Approved	Motion: Adriane Stefansen Seconded: Kathy McShea Passed unanimous
<b>IV. Medical Issues</b>			
A. None			
<b>V. New Business</b>			
A. 131 – MCI Response Plan	Chris discussed the changes that were made to meet the “FOG” Guidelines.	MCI Committee will continue to work on additional changes to 131 as needed.	
B. 132 – EMS Coverage for Special Events or Mass Gathering	Chris presented this policy to the committee.	This is not a requirement, but it should be taken into consideration when planning special events.	Motion: Kathy McShea Seconded: Aaron Tapking Passed unanimous
C. 624 – Patient Medications	Patient medications should be left at home if possible.	Page 1: IV-D – Remove “and/or a dead body” and replace with “decedent”.  Training video will come out in January.	Motion: Kyle Brooks Seconded: Kathy McShea Passed unanimous
D. 705.XX – Traumatic Full Arrest		Take policy to TORC for approval. Report to PSC on next meeting date.	
E. Hospice	Andrew presented this policy that was developed in the Hospice Sub-committee.	Approved	Motion: Ira Tilles Seconded: Adriane Stefansen Passed unanimous
F. 715 – Needle Thoracostomy		Page 1: IV-C - 10 to 14 gauge for adults and 14 to 16 for pediatric patients.	
G. 1000 - Documentation		Add ETCO2 and O2 Sat to Attachment – A.  Approved with changes.	
<b>VI. Old Business</b>			

A. 705.07 – Cardiac Arrest Asystole and PEA		Approved with changes. 0.1 mg/ml removed	
B. 705.08 – Cardiac Arrest VF/VT		Approved with changes.  Bold - concentration for pediatric. Delete - over 1 minute/Calcium Chloride for pediatrics.	
<b>VII. Informational/Discussion Topics</b>			
A. Education Sub-Committee	Andrew will take the lead setting up an educational committee to discuss the direction of EMS Education.	Assigned to Andrew Casey.	
B. 310 – Paramedic Scope of Practice		Dopamine will be left in this policy.  Add Hydroxocobalamin. Fix formatting.	
<b>VIII. Policies for Review</b>			
A. 107 – Ventura County Stroke and STEMI Committee		Approved	Motion: Kathy McShea Seconded: Tom O’Conner Passed unanimous
<b>X. Agency Reports</b>			
A. Fire departments	<b>VCFPD</b> – none <b>VCFD</b> - none <b>OFD</b> – none <b>Fed. Fire</b> – none <b>SPFD</b> – none <b>FFD</b> – none		
B. Transport Providers	<b>LMT</b> – none <b>AMR/GCA</b> – Safe Talk at AMR on October 15, 2019. UCLA interns are currently at AMR. AMR received their High-Risk Ambulance. <b>AIR RESCUE</b> – none		
C. Base Hospitals	<b>SAH</b> – Joint Commission survey was last week. There is construction in the Cath. Lab. Planning Sexual Assault training for pre-hospital personnel.		

		<b>LRRMC</b> – Please remind staff that they need to be on time for EMS Update. <b>SJRM</b> C – On-going construction. <b>VCMC</b> – none	
D.	Receiving Hospitals	<b>PVH</b> – none <b>SPH</b> – none <b>CMH</b> – none <b>OVCH</b> – Continuing Care Center is opening soon.	
E.	Law Enforcement	<b>VCSO</b> –none <b>CSUCI PD</b> – none	
F.	ALS Education Programs	<b>Ventura</b> – Advisory Committee Meeting on November 1, 2019.	
G.	EMS Agency	<b>Steve</b> – Karen is currently working hard on the Stroke and Stemi contracts. PSPS: If power is shut down, it will be shut down until incident is over. <b>Dr. Shepherd</b> – none <b>Chris</b> – none <b>Katy</b> –none <b>Karen</b> – Dr. Duncan wants to thank everyone who worked at the Fall Prevention Conference. He will send a Gun violence video to the committee for review. <b>Julie</b> –none <b>Randy</b> – none	
H.	Other		
<b>XI.</b>	<b>Closing</b>	<b>Meeting adjourned at 11:30</b>	

Prehospital Services Committee 2019

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/10/2019	2/14/2019	3/14/2019	4/11/2019	5/9/2019	6/13/2019	7/11/2019	8/8/2019	9/12/2019	10/10/2019	11/14/2019	12/12/2019	%
AMR	Stefansen	Adriane	AS		AS				AS	AS		AS			
AMR	Casey	Andrew	AC												
CMH - ER	Levin	Ross			RL		RL		RL	RL		RL			
CMH - ER	Querol	Amy			AQ		AQ								
OVCH - ER	Pulido	Ed	EP						EP						
OVCH - ER	Ferguson	Catherine			CF		CF			CF		CF			
CSUCI PD	Drehesen	Charles	CD		CD		CD		CD	CD		CD			
CSUCI PD	Camp	Arnie													
FFD	Herrera	Bill							BH	BH					
FFD	Panke	Chad	CP				CP								
GCA	Villasenor	Alejandro	AV				AV		AV	AV		AV			
GCA	Sanders	Mike	MS		MS				MS	MS		MS			
Lifeline	Rosolek	James	JR		JR				JR	JR		JR			
Lifeline	Williams	Joey							JW	JW					
LRRMC - ER	Brooks	Kyle			KB		KB		KB	KB					
LRRMC - ER	Shaner	Meghan	MS				MS		MS	MS		MS			
OFD	Strong	Adam	AS		AS		AS		AS			AS			
OFD	Villa	Jaime	JV		JV		JV		JV	JV		JV			
SJPVH - ER	Hutchison	Stacy	SH		SH		SH		SH			SH			
SJPVH - ER	Sikes	Chris	CS		CS				CS			CS			
SJPMC - ER	Larsen	Todd	TL		TL		TL		TL	TL		TL			
SJPMC - ER	McShea	Kathy	KM		KM		KM		KM			KM			
SVH - ER	Tilles	Ira	IT		IT		IT		IT	IT		IT			
SVH - ER	Shorts	Kristen	NV		NV				JS	KS		KS			
V/College	O'Connor	Tom	TO		TO		TO		TO	TO		TO			
VCFD	Tapking	Aaron	AT		AT		AT			AT		AT			
VCFD	Ellis	Heather			HE				HE	HE		HE			
VNC	Parker	Barry			BP				BP	BP		BP			
VNC	Schwab	David			JD		DS		DS						
VNC - Dispatch	Gregson	Erica	EG		EG		EG			EG		EG			
VCMC - ER	Chase	David	DC		DC		DC			DC		DC			
VCMC - ER	Gallegos	Tom			TG		TG			TG		TG			



COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Paramedic Scope of Practice		Policy Number: 310	
APPROVED: Administration: Steven L. Carroll, Paramedic		Date: <del>December 1, 2019</del>	
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: <del>December 1, 2019</del>	
Origination Date: May, 1984		Effective Date: <del>December 1, 2019</del>	
Date Revised: <del>October 10, 2019</del>			
Date Last Reviewed: <del>October 10, 2019</del>			
Review Date: <del>October 31, 2021</del>			

- I. PURPOSE: To define the scope of practice of a Paramedic accredited and practicing in Ventura County.
- II. AUTHORITY: Health and Safety Code Section 1797.172 and 1797.185. California Code of Regulations, Division 9, Chapter 4, Section 100145.
- III. POLICY:
  - A. A paramedic may perform any activity identified in the Scope of Practice of an EMT or Advanced EMT (AEMT) as defined in regulations governing those certification levels.
  - B. A paramedic trainee or paramedic accredited in Ventura County, while caring for patients in a hospital as part of their training or continuing education, under the direct supervision of a physician, registered nurse, or physician assistant, or while at the scene of a medical emergency, during transport, or during inter-facility transfer when medical direction is maintained by a physician or an MICN according to the policies and procedures approved by the Ventura County Emergency Medical Services Medical Director, may:
    1. Utilize electrocardiographic devices and monitor electrocardiograms (ECG), including 12-lead ECG.
    2. Perform pulmonary ventilation by use of oral endotracheal intubation or a Ventura County EMS approved alternative ALS airway management device.
    3. Utilize mechanical ventilation devices for continuous positive airway pressure (CPAP).
    4. Institute intravenous (IV) catheters, saline locks, needles or other cannulae (IV) lines, in peripheral veins.
    5. Monitor and access pre-existing peripheral and central vascular access lines.
    6. Institute intraosseous (IO) needles or catheters.
    7. Administer IV or IO glucose solutions and Normal Saline solutions.
    8. Obtain venous blood samples.
    9. Administer the following drugs:
      - a. Adenosine
      - b. Amiodarone

- c. Aspirin
  - d. Atropine sulfate
  - e. Bronchodilators, Nebulized beta-2 specific
  - f. Calcium chloride
  - g. Dextrose, 5%, 10%, 25%, and 50%
  - h. Diazepam
  - i. Diphenhydramine hydrochloride
  - j. Dopamine hydrochloride
  - ~~k.~~ Epinephrine
  - ~~k.l.~~ Fentanyl
  - ~~l.m.~~ Heparin (Interfacility transfers only)
  - ~~m.n.~~ Glucagon hydrochloride
  - ~~n.o.~~ Hydroxocobalamin
  - ~~o.p.~~ Lidocaine hydrochloride
  - ~~p.q.~~ Magnesium sulfate
  - ~~q.r.~~ Midazolam
  - ~~r.s.~~ Morphine sulfate
  - ~~s.t.~~ Naloxone hydrochloride
  - ~~t.u.~~ Nitroglycerin preparations: oral, IV (interfacility transfers only)
  - ~~u.v.~~ Ondansetron
  - ~~v.w.~~ Pralidoxime Chloride
  - ~~w.x.~~ Sodium bicarbonate
  - ~~x.y.~~ Tranexamic Acid
10. Perform defibrillation
  11. Perform synchronized cardioversion
  12. Perform transcutaneous pacing
  13. Visualize the airway by use of the laryngoscope and remove foreign body(ies) with Magill forceps
  14. Perform Valsalva maneuver
  15. Monitor thoracostomy tubes
  16. Monitor and adjust IV solutions containing potassium  $\leq 20$  mEq/L.
  17. Monitor Capnography/Capnometry
  18. Perform needle thoracostomy
  19. Perform blood glucose level determination



COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: BLS And ALS Unit Equipment And Supplies		Policy Number: 504	
APPROVED: Administration: Steven L. Carroll, Paramedic		Date: <del>June 1, 2019</del>	
APPROVED: Medical Director Daniel Shepherd, MD		Date: <del>June 1, 2019</del>	
Origination Date: May 24, 1987		Effective Date: <del>June 1, 2019</del>	
Date Revised: <del>January 10, 2019</del>			
Last Reviewed: <del>January 10, 2019</del>			
Review Date: <del>January 30, 2022</del>			

- I. PURPOSE: To provide a standardized list of equipment and supplies for response and/or transport units in Ventura County.
- II. POLICY: Each response and/or transport unit in Ventura County shall be equipped and supplied according to the requirements of this policy.
- III. AUTHORITY: California Health and Safety Code Section 1797.178, 1797.204, 1797.218, 1797.221 and California Code of Regulations Sections 100148, 100306, 100404
- IV. PROCEDURE:  
 The following equipment and supplies shall be maintained on each response and/or transport unit in Ventura County.

Deviation from the standards outlined in this policy shall only be authorized with written approval (see attached Equipment/Medication Waiver Request form) from the VCEMS Medical Director. Mitigation attempts should be documented in the comment section on the waiver request form, such as what vendors were contacted, etc.

ALS / BLS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
<b>A. ALL BLS AND ALS RESPONSE AND/OR TRANSPORT UNITS</b>			
Clear masks in the following sizes:			
Adult	1 each	1 each	1 adult
Child			1 infant
Infant			
Neonate			
Bag valve units			
Adult	1 each	1 each	1 adult
Child			
Nasal cannula			
Adult	3	3	3
Nasopharyngeal airway (adult and child or equivalent)	1 each	1 each	1 each
Continuous positive airway pressure (CPAP) device	1 per size	1 per size	1 per size
Nerve Agent Antidote Kit	9	9	0
Blood glucose determination devices (optional for non-911 BLS units)			
Oral glucose 15gm unit dose	2	1	1
Oropharyngeal Airways	1	1	1
Adult			
Child			
Infant			
Newborn			
Oxygen with appropriate adjuncts (portability required)	1 each size	1 each size	1 each size
Portable suction equipment	10 L/min for 20 minutes	10 L/min for 20 mins.	10 L/min for 20 mins.
Transparent oxygen masks	1	1	1
Adult nonbreather	3	2	2
Child	3	2	2
Infant	2	2	2
Bandage scissors	1	1	1
Bandages			
4"x4" sterile compresses or equivalent	12	12	5
2",3",4" or 6" roller bandages	6	6	4
10"x30" or larger dressing		2	2
Blood pressure cuffs			
Thigh	1	1	1
Adult	1	1	1
Child	1	1	1
Infant	1	1	1
Emesis basin/bag	1	1	1
Flashlight	1	1	1
Traction splint or equivalent device	1	1	1
Pneumatic or rigid splints (capable of splinting all extremities)	4	4	4
Potable water or saline solution	4 liters	4 liters	4 liters
Cervical spine immobilization device	2	2	2
Spinal immobilization device			
KED or equivalent	1	1	1

	ALS / BLS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
60" minimum with at least 3 sets of straps	1	0	1	
Sterile obstetrical kit	1	1	1	1
Tongue depressor	4	4	4	4
Cold packs	4	4	4	4
Tourniquet	1	1	1	1
1 mL .5 mL, and 10 mL syringes with IM needles	4	4	4	4
Automated External Defibrillator (if not equipped with ALS monitor/defibrillator)	1	1	1	1
Personal Protective Equipment per State Guideline #216				
Rescue helmet	2	1	0	0
EMS jacket	2	1	0	0
Work goggles	2	1	0	0
Tyvek suit	2 L / 2 XXL	1 L / 1 XXL	0	0
Tychem hooded suit	2 L / 2 XXL	1 L / 1 XXL	0	0
Nitrile gloves	1 Med / 1 XL	1 Med / 1 XL	0	0
Disposable footwear covers	1 Box	1 Box	0	0
Leather work gloves	3 L Sets	1 L Set	0	0
Field operations guide	1	1	0	0
<b>OPTIONAL EQUIPMENT</b>				
Occlusive dressing or chest seal				
Hemostatic gauze per EMSA guidelines				
<b>B. TRANSPORT UNIT REQUIREMENTS</b>				
Ambulance cot and collapsible stretcher; or two stretchers, one of which is collapsible.	1	0	0	1
Straps to secure the patient to the stretcher or ambulance cot, and means of securing the stretcher or ambulance cot in the vehicle.	1 Set	0	0	1 Set
Soft Ankle and wrist restraints.	1	0	0	0
Sheets, pillow cases, blankets and towels for each stretcher or ambulance cot, and two pillows for each ambulance	1	0	0	0
Bedpan	1	0	0	0
Urinal	1	0	0	0

	ALS / BLS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
<b>C. ALS UNIT REQUIREMENTS</b>				
Cellular telephone	1	1	1	1
Alternate ALS airway device	2	1	1	1
Arm Boards 9" 18"	3 3	0 0	1 1	0 0
Cardiac monitoring equipment	1	1	1	1
CO <sub>2</sub> monitor	1	1	1	1
Colorimetric CO <sub>2</sub> Detector Device	1	1	1	1
Defibrillator pads or gel	3	3	3	1 adult – No Peds.
Defibrillator w/adult and pediatric paddles/pads	1	1	1	1
EKG Electrodes	10 sets	3 sets	3 sets	6 sets
Endotracheal intubation tubes, sizes 6.0, 6.5, 7.0, 7.5, 8.0 with stylets	1 of each size	1 of each size	1 of each size	4, 5, 6, 6.5, 7, 7.5, 8
EZ-10 intraosseous infusion system	1 Each Size	1 Each Size	1 Each Size	1 Each Size
Intravenous Fluids (in flexible containers)				
• Normal saline solution, 100 ml	2	1	1	1
• Normal saline solution, 500 ml	2	1	1	1
• Normal saline solution, 1000 ml	6	2	4	3
IV admin set - macrodrip	4	1	4	3
IV catheter, Sizes 14, 16, 18, 20, 22, 24	6 each 14, 16, 18, 20 3 each 22 3 each 24	2 each	2 each	2 each
Laryngoscope, replacement bulbs and batteries	1 set	1 set	1 set	1 set
Curved blade #2, 3, 4	1 each	1 each	1 each	1 each
Straight blade #1, 2, 3	1 each	1 each	1 each	1 each
Magill forceps Adult Pediatric	1 1	1 1	1 1	1 1
Nebulizer	2	2	2	2
Nebulizer with in-line adapter	1	1	1	1
Needle Thoracostomy kit	2	2	2	2
Pediatric length and weight tape	1	1	1	1
SpO <sub>2</sub> Monitor (if not attached to cardiac monitor)	1	1	1	1
<b>OPTIONAL ALS EQUIPMENT (No minimums apply)</b>				
Flexible intubation stylet				
Cyanide Antidote Kit				

	BLS Unit Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
<b>D. MEDICATION, MINIMUM AMOUNT</b>					
Adenosine, 6 mg		3	3	3	3
Albuterol 2.5mg/3ml		6	2	3	1
Aspirin, 81mg		4 ea 81 mg	4 ea 81 mg	4 ea 81 mg	4 ea 81 mg
Amiodarone, 50mg/ml 3ml		6	3	6	3
Atropine sulfate, 1 mg/10 ml		2	2	2	2
Diphenhydramine (Benadryl), 50 mg/ml		2	1	1	2
Calcium chloride, 1000 mg/10 ml		2	1	1	1
Dextrose					
• 5% 50ml, OR		2	1	2	1
• 10% 250 ml, OR		5	2	2	2
• 25% 2.5 GM 10ml, OR		1	1	1	1
• 50%, 25 GM/50		2	1	2	1
Epinephrine					
• Epinephrine, 1mg/ml	2	5	5	5	5
• 1 mL ampule / vial, OR	2	4	2	2	2
• Adult auto-injector (0.3 mg), AND	2	4	2	2	2
• Peds auto-injector (0.15 mg)					
• Epinephrine 0.1mg/ml (1 mg/10ml preparation)		6	3	6	4
Fentanyl, 100mcg/2ml ampule		2	2	2	2
Glucagon, 1 mg/ml		2	1	2	1
Lidocaine, 100 mg/5ml		2	2	2	2
Magnesium sulfate, 1 gm per 2 ml		4	4	4	4
Midazolam Hydrochloride (Versed)		5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials
Morphine sulfate, 10 mg/ml (Only required during a Fentanyl shortage)		2	2	2	2
Naloxone Hydrochloride (Narcan)					
• IN concentration - 4 mg in 0.1 mL (optional for ALS and non-911 BLS units), OR	2	5	5	5	5
• IM / IV concentration - 2 mg in 2 mL preload (optional for non-911 BLS units)	2	5	5	5	5
Nitroglycerine preparations, 0.4 mg		1 bottle	1 bottle	1 bottle	1 bottle
Normal saline, 10 ml		2	2	2	2
Ondansetron (Zofran)					
• 4 mg IV single use vial		4	4	4	4
• 4 mg oral		4	4	4	4
Sodium Bicarbonate, 1 mEq/mL		2	1	1	1
Tranexamic Acid (TXA) 1 gm/10 mL		2	1	1	1

<b>Burns</b>	
<b>ADULT</b>	<b>PEDIATRIC</b>
<b>BLS Procedures</b>	
<ul style="list-style-type: none"> <li>• Stop the burning process                             <ul style="list-style-type: none"> <li>○ Thermal                                     <ul style="list-style-type: none"> <li>▪ Put out fire using water or some other non-hazardous, non-flammable liquid. Fire extinguisher may be used.</li> </ul> </li> <li>○ Liquid Chemical                                     <ul style="list-style-type: none"> <li>▪ Flush area with water.</li> </ul> </li> <li>○ Powdered Chemical                                     <ul style="list-style-type: none"> <li>▪ Brush off as much as possible prior to flushing area with copious amounts of water.</li> </ul> </li> <li>○ Electrical                                     <ul style="list-style-type: none"> <li>▪ Turn off power source and safely remove victim from hazard area.</li> </ul> </li> </ul> </li> <li>• Remove rings, constrictive clothing and garments made of synthetic material</li> <li>• Assess for chemical, thermal, electrical, or radiation burns and treat accordingly</li> <li>• If less than 10% Total Body Surface Area (TBSA) is burned, cool with saline dressings.</li> <li>• For TBSA greater than 10%, cover burned area with dry sterile dressings first, followed by a clean dry sheet.</li> <li>• Once area is cooled, remove saline dressings and cover with dry, sterile burn sheets</li> <li>• Elevate burned extremities if possible</li> <li>• Maintain body heat at all times</li> <li>• Administer oxygen as indicated</li> </ul>	
<b>ALS Prior to Base Hospital Contact</b>	
<p>IV/IO access <b>Pain Control Fentanyl/Morphine</b> – per Policy 705.19 - <del>Pain Control</del></p> <p>If TBSA greater than 10% or hypotension is present:</p> <ul style="list-style-type: none"> <li>• <b>Normal Saline</b> <ul style="list-style-type: none"> <li>○ IV/IO bolus – 1 Liter</li> </ul> </li> </ul>	<p>IV/IO access <b>Pain Control Morphine</b> – per Policy 705.19 - <del>Pain Control</del></p> <p>If TBSA greater than 10% or hypotension is present:</p> <ul style="list-style-type: none"> <li>• <b>Normal Saline</b> <ul style="list-style-type: none"> <li>○ IV/IO bolus – 20 mL/kg</li> </ul> </li> </ul>
<b>Base Hospital Orders only</b>	
Consult with ED Physician for further treatment measures	
<p>Additional Information</p> <ul style="list-style-type: none"> <li>• Hypothermia is a concern in patients with large body surface area burns. As moist dressings increase the risk of hypothermia, Morphine Sulfate is the preferred method of pain control in these patients.</li> </ul>	

## Chest Pain – Acute Coronary Syndrome

### BLS Procedures

Administer oxygen if dyspnea, signs of heart failure or shock, or SpO2 < 94%  
Assist patient with prescribed Nitroglycerin as needed for chest pain

- Hold if SBP less than 100 mmHg

### ALS Standing Orders

#### Perform 12-lead ECG

- Expedite transport to closest STEMI Receiving Center if monitor interpretation meets the manufacturer guidelines for a positive STEMI ECG and/or physician states ECG is positive for STEMI.
- Notify Base hospital within 10 minutes of monitor interpretation of a positive STEMI ECG
- Document all initial and ongoing rhythm strips and ECG changes

#### Perform 12-lead ECG

- To reduce the time to reperfusion when STEMI criteria is identified on 12-lead ECG
  - Notify STEMI receiving center ASAP (within 10 minutes) of identifying STEMI
  - Minimize on scene time where possible

- Expedite transport to closest STEMI Receiving Center if monitor interpretation meets the manufacturer guidelines for a positive STEMI ECG and/or physician states ECG is positive for STEMI.
- Notify Base hospital within 10 minutes of monitor interpretation of a positive STEMI ECG
- Document all initial and ongoing rhythm strips and ECG changes

For continuous chest pain consistent with ischemic heart disease:

- **Aspirin**
  - PO – 324 mg
- **Nitroglycerin (DO NOT administer if ECG states inferior infarct)**
  - SL or lingual spray – 0.4 mg q 5 min for continued pain
    - No max dosage
    - Maintain SBP greater than 100 mmHg

IV/IO access

- 3 attempts only prior to Base Hospital contact

If pain persists and not relieved by NTG: For persistent pain not relieved by Nitroglycerin reference pain control policy 705.19

- **Morphine Fentanyl** – per policy 705 – Pain Control
- Maintain SBP greater than 100-90 mmHg

If patient presents or becomes hypotensive:

- Lay Supine
- **Normal Saline**
  - IV/IO bolus – 500 mL -may repeat x1 for total 1000 mL.
    - Unless CHF is present

If hypotensive (SBP less than 90 mmHg) and signs of CHF are present or no response to fluid therapy\*:

- **Epinephrine 10mcg/mL**
  - 1mL (10mcg) q 2 minutes, slow IV/IO push
  - Titrate to SBP of greater than or equal to 90mm/Hg

For ventricular ectopy [PVC's > 10/min, multifocal PVC's, or unsustained V-Tach], consider Amiodarone IV/IOPB - 150 mg in 50 mL D5W infused over 10 minutes

### Communication Failure Protocol

Effective Date: December 1, 2019  
Next Review Date: July 31, 2021

Date Revised: July 11, 2019  
Last Reviewed: July 11, 2019

VCEMS Medical Director

Formatted

Formatted: Indent: Left: 0.5", No bullets or numbering

Formatted: Indent: Left: 0.5"

Formatted: Font: 8 pt

Formatted: Indent: Left: 1", No bullets or numbering

Formatted: Normal, No bullets or numbering

Formatted: Font: (Default) Arial, 8 pt

One additional IV/IO attempt if not successful prior to initial BH contact

- 4 attempts total per patient

If hypotensive (SBP less than 90 mmHg) and signs of CHF are present or no response to fluid therapy:

- Epinephrine 10mcg/mL
  - 1mL (10mcg) q 2 minutes, slow IV/IO push
  - Titrate to SBP of greater than or equal to 90mm/Hg

**Base Hospital Orders only**

Consult with ED Physician when orders are needed for interventions within scope but not addressed in policy. Consult ED Physician for further treatment measures

ED Physician Order Only: For ventricular ectopy [PVC's > 10/min, multifocal PVC's, or unsustained V-Tach], consider Amiodarone IV/IOPB - 150 mg in 50 mL D5W infused over 10 minutes

Additional Information:

- Refer to VCEMS Policy 735 for additional information on preparing push dose epinephrine solution.
- Nitroglycerin is contraindicated in inferior infarct or when phosphodiesterase inhibitor medications [Sildenafil (Viagra and Revatio), Vardenafil (Levitra), and Tadalafil (Cialis)] have been recently used (Viagra or Levitra within 24 hours; Cialis within 48 hours). These medications are most commonly used to treat erectile dysfunction or pulmonary hypertension. NTG then may only be given by ED Physician order
- Appropriate dose of Aspirin is 324mg. Aspirin may be withheld if able to confirm that patient has received appropriate dose prior to arrival. If unable to confirm appropriate dose, administer Aspirin, up to 324mg.

Formatted: List Paragraph, Indent: Left: 0.49", Bulleted + Level: 5 + Aligned at: 2.25" + Indent at: 2.5", Tab stops: -1", Left

Formatted: Centered

Formatted Table

Effective Date: December 1, 2019  
Next Review Date: July 31, 2021

Date Revised: July 11, 2019  
Last Reviewed: July 11, 2019

VCEMS Medical Director



<b>Pain Control</b>	
<b>ADULT</b>	<b>PEDIATRIC</b>
<b>BLS Procedures</b>	
Place patient in position of comfort Administer oxygen as indicated	
<b>ALS Prior to Base Hospital Contact</b>	
<p>IV/IO access</p> <p>Cardiac Monitor</p> <p><b>Ondansetron</b></p> <ul style="list-style-type: none"> <li>• IV/IM/ODT – 4 mg</li> <li>• Repeat x 1 q 10 minutes for nausea or &gt; 2 doses of opiate pain control</li> </ul> <p><b>Pain 5 out of 10 or greater and SBP &gt; 90 mmHg</b></p> <p><b>Fentanyl IV / IO</b></p> <ul style="list-style-type: none"> <li>• 0.1 mcg/kg IV/IO over 1 minute</li> <li>• Max single dose 100 mcg</li> <li>• May repeat q 5 minutes for persistent pain</li> </ul> <p style="text-align: center;"><u>OR</u></p> <p><b>Fentanyl IN / IM</b></p> <ul style="list-style-type: none"> <li>• 0.1 mcg/kg IN or IM</li> <li>• May repeat q 10 minutes for persistent pain</li> <li>• Repeat doses should be administered IV/IO if vascular access available</li> </ul> <p><b>Morphine – Pain 5 out of 10 or greater</b> If Fentanyl unavailable;</p> <p><b>Morphine IV/IO</b></p> <ul style="list-style-type: none"> <li>• 0.1 mg/kg over 1 minute</li> <li>• Max single dose 10 mg</li> <li>• May repeat ½ initial dose x 2 q 5 min</li> </ul> <p><b>Initial IV Dose</b></p> <ul style="list-style-type: none"> <li>• Slow IVP – 0.1 mg/kg over 2 minutes<sup>+</sup></li> <li>• Maximum for <b>ANY</b> IV dose is 10 mg</li> </ul> <p style="text-align: center;"><u>OR</u></p> <p><b>Initial IM Dose Morphine IM</b></p> <ul style="list-style-type: none"> <li>• IM - 0.1 mg/kg<sup>+</sup></li> <li>• Maximum for <b>ANY</b> IM dose is 10 mg</li> <li>• Max single dose 10 mg</li> <li>• May repeat ½ initial dose x 2 q 15 min</li> </ul> <p><b>May give second IV/IM Dose, if pain persists</b> 5 minutes after IV morphine, or 15 minutes after IM morphine</p> <ul style="list-style-type: none"> <li>• Administer half of the initial morphine dose</li> </ul> <p><b>May give third IV/IM Dose, if pain persists</b> 5 minutes after 2<sup>nd</sup> IV morphine, or 15 minutes after 2<sup>nd</sup> IM morphine</p> <ul style="list-style-type: none"> <li>• <b>Ondansetron</b> (only if third dose of morphine needed)</li> <li>• IV/IM/ODT – 4 mg</li> </ul>	<p>IV/IO access</p> <p>Cardiac Monitor</p> <p><b>Ondansetron:</b> Patient 4 years of age or older</p> <ul style="list-style-type: none"> <li>• IV/IM/ODT – 4 mg</li> <li>• Repeat x 1 q 10 minutes for nausea or &gt; 2 doses of opiate pain control</li> </ul> <p><b>Morphine – Pain 5 out of 10 or greater</b> <b>Pain 5 out of 10 or greater and SBP &gt; 90 mmHg</b></p> <p><b>Fentanyl IV / IO</b></p> <ul style="list-style-type: none"> <li>• 0.1 mcg/kg IV/IO over 1 minute</li> <li>• Max single dose 100 mcg</li> <li>• May repeat q 5 minutes for persistent pain</li> </ul> <p style="text-align: center;"><u>OR</u></p> <p><b>Fentanyl IN / IM</b></p> <ul style="list-style-type: none"> <li>• 0.1 mcg/kg IN or IM</li> <li>• May repeat q 10 minutes for persistent pain</li> <li>• Repeat doses should be administered IV/IO if vascular access available</li> </ul> <p><b>If Fentanyl unavailable:</b></p> <p><b>Morphine IV/IO</b></p> <ul style="list-style-type: none"> <li>• 0.1 mg/kg over 1 minute</li> <li>• Max single dose 10 mg</li> <li>• May repeat ½ initial dose x 2 q 5 min</li> </ul> <p style="text-align: center;"><u>OR</u></p> <p><b>Morphine IM</b></p> <ul style="list-style-type: none"> <li>• IM - 0.1 mg/kg</li> <li>• Max single dose 10 mg</li> <li>• May repeat ½ initial dose x 2 q 15 min</li> </ul> <p><b>Morphine</b> – given for burns and isolated extremity injuries only. Consider early base contact for other pediatric complaints of pain (e.g. dog bite, cancer)</p> <p><b>Initial IV Dose</b></p> <ul style="list-style-type: none"> <li>• Slow IVP – 0.1 mg/kg over 2 minutes<sup>+</sup></li> <li>• Maximum for <b>ANY</b> IV dose is 10 mg</li> </ul> <p><b>Initial IM Dose</b></p> <ul style="list-style-type: none"> <li>• IM – 0.1 mg/kg<sup>+</sup></li> <li>• Maximum for <b>ANY</b> IM dose is 10 mg</li> </ul> <p><b>May give second IV/IM Dose, if pain persists</b></p>

Formatted Table

Formatted: Font: Bold

Formatted: Indent: Left: 1.5", No bullets or numbering

Formatted: Indent: Left: 0.5", No bullets or numbering

Formatted: Font: Not Bold

Formatted: Indent: Left: 0.5"

Formatted: Bulleted + Level: 1 + Aligned at: 0.28" + Indent at: 0.53"

Formatted: Indent: Left: 1.5"

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Effective Date: June 1, 2018  
Next Review Date: April 30, 2020

Date Revised: April 12, 2018  
Last Reviewed: April 12, 2018

VCEMS Medical Director

<ul style="list-style-type: none"> <li>• Administer half of the initial morphine dose</li> </ul> <p>Check and document vital signs before and after each administration</p> <ul style="list-style-type: none"> <li>• Hold if SBP less than 100 mmHg</li> </ul> <ul style="list-style-type: none"> <li>• <i>If patient has significant injury to head, chest, abdomen or is hypotensive, <b>DO NOT</b> administer pain control unless ordered by ED Physician</i></li> </ul>	<p>5 minutes after IV morphine, or 15 minutes after IM morphine</p> <ul style="list-style-type: none"> <li>• Administer half of the initial morphine dose</li> </ul> <p><b>May give third IV/IM Dose, if pain persists</b> 5 minutes after 2<sup>nd</sup> IV morphine, or 15 minutes after 2<sup>nd</sup> IM morphine</p> <ul style="list-style-type: none"> <li>• <b>Ondansetron</b> (only if third dose of morphine needed)             <ul style="list-style-type: none"> <li>• IV/IM/ODT = 4 mg</li> </ul> </li> <li>• Administer half of the initial morphine dose</li> </ul> <p>Check and document vital signs before and after each administration</p> <ul style="list-style-type: none"> <li>• Hold if SBP less than 100 mmHg</li> </ul> <p><i>If patient has significant injury to head, chest, abdomen or is hypotensive, <b>DO NOT</b> administer pain control unless ordered by ED Physician</i></p>
---	--

Formatted: Bulleted + Level: 1 + Aligned at: 0.25" + Indent at: 0.5"

Formatted: Font: Bold

Formatted: Tab stops: 2.38", Left

**Base Hospital Orders only**

Consult with ED Physician for further treatment measures. Consult with ED Physician when orders are needed for interventions within scope but not addressed in policy.

**Additional Information**

1. **Special considerations. Consider administering 0.05 mg/kg ½ normal dose of Opiate pain control:**
  - Consider lower dose for patients 65 years of age and older.
  - Patients with past adverse reaction to opiates
  - Chest pain not resolved by nitroglycerine (NTG)
  - Patient with history of adverse reaction to morphine
  - Symptomatic bradycardia for patients receiving transcutaneous pacing. Patients with suspected cardiac ischemia or active TCP
  - Patients with traumatic injuries who are at risk for hemodynamic decompensation

Effective Date: June 1, 2018  
Next Review Date: April 30, 2020

Date Revised: April 12, 2018  
Last Reviewed: April 12, 2018

\_\_\_\_\_  
VCEMS Medical Director

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Airway Management		Policy Number 710	
APPROVED: Administration: Steven L. Carroll, Paramedic		Date: July 1, 2018	
APPROVED: Medical Director: Daniel Shepherd, MD		Date: July 1, 2018	
Origination Date: June 1986		Effective Date: July 1, 2018	
Date Revised: June 14, 2018			
Date Last Reviewed: June 14, 2018			
Review Date: June 30, 2020			

- I. **PURPOSE:** To define the indications, procedure and documentation for airway management by Ventura County EMS personnel.
- II. **AUTHORITY:** California Health and Safety Code, §1798, §1798.2; §1798.160 and §1798.170 and California Code of Regulations, Title 22, §100145 and §100146.
- III. **Policy:** Airway management shall be performed on all patients that are unable to maintain their own airway. Paramedics may utilize oral endotracheal intubation on adult patients. Paramedics may utilize oral endotracheal intubation on pediatric patients who are longer than the standard pediatric weight and length tape. Pediatric patients who fit on a pediatric length and weight tape will not be intubated by pre-hospital personnel.
- IV. **Definitions:** Attempt: An interruption of ventilation, with, 1) laryngoscope insertion for the purpose of inserting an endotracheal tube (ETT), or 2) lifting of tongue for the purpose of insertion of the air-Q.
- V. **Procedure:**
  - A. **Bag-Valve-Mask (BVM) ventilations**
    1. **Indications**
      - a. Respiratory arrest or severe respiratory compromise
      - b. Cardiac arrest – according to VCEMS Policy 705
    2. **Contraindications**
      - a. None
  - B. **Endotracheal Intubation (ETI)**
    3. **Indications**
      - a. Cardiac arrest – according to VCEMS Policy 705 – ONLY if unable to adequately ventilate with BVM

- f. Withdraw the stylet to align the black mark with the teeth.
  - g. Have your assistant load and advance the ETT tip to the black mark.
  - h. Have your assistant grasp and hold steady the straight end of the stylet.
  - i. While maintaining laryngoscope blade position, advance the ETT.
  - j. At the glottic opening turn the ETT 90 degrees counter-clockwise to assist passage over the arytenoids.
  - k. Advance the ETT to 22 cm at the teeth.
  - l. While maintaining ETT position, withdraw the stylet.
- 2) One Person Technique (recommended when visualization is good but cords are too anterior to pass ET tube).
- a. Load the stylet into the ETT with the bent end approximately 4 inches (10 cm) past the distal end of the ETT.
  - b. Pinch the ETT against the stylet.
  - c. With the bent tip anterior, while visualizing the cords advance the stylet through the cords.
  - d. Maintain laryngoscope blade position.
  - e. When the black mark is at the teeth ease your grip to allow the tube to slide over the stylet. If available have an assistant stabilize the stylet.
  - f. At the glottic opening turn the ETT 90 degrees counter-clockwise to assist passage over the arytenoids.
  - g. Advance the ETT to 22 cm at the teeth.
  - h. While maintaining ETT position, withdraw the stylet.
- b. Tracheal stoma intubation
- 1. Select the largest endotracheal tube that will fit through the stoma without force (it should not be necessary to use lubricant).

- >5% exhaled CO<sub>2</sub> and tan 2-5% CO<sub>2</sub>. Yellow or tan indicates tube placement in the trachea. Purple indicates less than 2% CO<sub>2</sub> and in the patient with spontaneous circulation, is a strong indicator of esophageal intubation.
- d. Using information from auscultation and CO<sub>2</sub> measurement, determine the ETT position.
1. If breath sounds are equal, there are no sounds at the epigastrium, and the CO<sub>2</sub> measurement device indicates tracheal placement, secure the ETT using an ETT holder.
  2. If auscultation or the CO<sub>2</sub> measurement device indicates that the ETT may be in the esophagus, immediately reevaluate the patient. If you are not CERTAIN that the ETT is in the trachea, the decision to remove the ETT should be based upon the patients overall clinical status (e.g., skin color, respirations, pulse oximetry)
  3. If breath sounds are present but unequal, the ETT position may be adjusted as needed.
- e. Once ETT position has been confirmed, reassessment using CO<sub>2</sub> measurement, pulse oximetry (if able to obtain), and auscultation of breath sounds should be performed each time patient is moved.
- f. Continue to monitor the CO<sub>2</sub> measurement device during treatment and transportation. If a change occurs from positive (yellow/tan) to negative (purple), or the waveform diminishes or disappears, reassess the patient for possible accidental extubation or change in circulation status.
- f.g. The target quantitative value for end-tidal CO<sub>2</sub> is 40mmHg.
- g-h. After confirmation of proper ETT placement, and prior to movement, all intubated patients shall have their head and neck maintained in a neutral position with head supports. A cervical collar will only be used if a cervical spine injury is suspected.
1. Reconfirm ETT placement after any manipulation of the head or neck, including positioning of a head support, and after each change in location of the patient.

5. Auscultation results
6. Secured by what means
7. ETCO<sub>2</sub>, initial value
8. Support of the head or immobilization of the cervical spine.  
An electronic upload of Cardiac Monitor data, including ETCO<sub>2</sub> waveform "snapshots" the the VCePCR is required. In the event an upload cannot occur, a printed code summary, mounted and labeled, displaying capnography waveform at the key points noted above is required. This printed code summary shall be scanned and attached to the VCePCR.

C: ~~air-Q®~~

1. ~~Indications, contraindications, placement and documentation in accordance with~~ ← - - -

Formatted: Indent: Left: 0", First line: 0.5"

Policy 729.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: <u>Leave at Home Naloxone Program</u>		Policy Number <u>7XX</u>	
APPROVED: Administration: Steve L. Carroll, Paramedic		Date: <u>DRAFT</u>	
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: <u>DRAFT</u>	
Origination Date:			
Date Revised:		Effective Date: <u>DRAFT</u>	
Date Last Reviewed:			
Review Date:			

I. PURPOSE: To authorize ALS prehospital personnel to distribute naloxone kits to patients with suspected opioid misuse, or family/friends of these patients, with suspected opioid use disorder, that refuse transport, and to delineate the process for distribution of naloxone to Ventura County ALS provider agencies.

II. AUTHORITY: California Health and Safety Code, Sections 1797.220 and 1798; California Code of Regulations, Title 22, Sections 100146, 100169, 100170

III. POLICY: ALS prehospital personnel may distribute naloxone kits, with guidance and training on how to administer the medication, to any individual patients, or the friends/family of patients, with suspected opioid use disorder misuse. The appropriate training must be provided to the recipient at the time of distribution. or their family/friends, suffering from a suspected opioid overdose.

A. Indications

1. Suspected opiate/opioid use disorder misuse or self-reported dependence, and/or;

Opiate / opioid overdose requiring reversal, and;

2. Patient is not transported and left at scene alive

B. Contraindications

Suspected use disorder of substance other than an opiate/opioid, and/or;

Overdose on substance other than an opiate/opioid, and/or;

1. Patient is transported or determined to be dead and left at scene

IV. PROCEDURE:



A. Treat Patient in accordance with VCEMS policies and procedures

- B. Once it has been determined that patient will refuse transport, AMA shall be processed and documented in accordance with VCEMS Policy 603 – Refusal of EMS Services
- C. Once AMA process has been completed, the patient, or the patient’s family/friends (must be present on scene) will be offered a leave-at-home naloxone kit with clearly identified kit number and medication expiration date.
- D. Recipient Training and Education
1. If the naloxone kit is accepted, the patient and/or family and friends will be trained on the recognition of opioid overdose and on the administration of nasal naloxone.
  2. At a minimum, the training will consist of the following:
    - a) Signs and symptoms of an opioid overdose
    - b) Administration of nasal naloxone
    - c) Activating the 911 system
    - d) Hands-only CPR
  3. Printed training materials and resources related to ongoing drug treatment services, including the Behavioral Health Department’s 24/7 Access Line, will be left with patient or patient’s family/friends at the scene.
- E. Documentation
1. Information will be completed for both the patient contact, as well as the refusal of EMS services, in accordance with VCEMS Policy 1000 – Documentation of Patient Care.
  2. In addition to the standard ePCR documentation, additional fields related to the leave at home naloxone kit will also be documented via supplemental ePCR fields. At a minimum, these fields will include:
    - a) Name of Naloxone Kit Recipient
    - b) Recipient relationship to patient
    - c) Recipient phone number
    - d) Confirmation that training was provided to recipient and family/friends on scene
    - e) Kit number on Naloxone Kit provided
    - f) Confirmation that addiction resources were left with recipient



F. Inventory

1. Distribution of leave at home naloxone will be tracked through the ePCR system, which means documentation is very important.
2. Nasal naloxone should not be distributed through standard inventory that is part of the day-to-day equipment (i.e. jump bags, supply cabinets, etc). These kits will be specially marked and tracked outside of the standard inventory process.
3. As nasal naloxone inventory is depleted through the leave at home program, replacement kits will be supplied by VCEMS to agencies on a one-for-one basis.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Thrombectomy Capable Acute Stroke Center (TCASC) Standards		Policy Number 452	
APPROVED: Administration:	 Steven L. Carroll, Paramedic	Date: February 1, 2020	
APPROVED: Medical Director:	 Daniel Shepherd, MD	Date: February 1, 2020	
Origination Date:	July 26, 2017		
Date Revised:	December 11, 2019	Effective Date: February 1, 2020	
Last Review:	December 11, 2019		
Review Date:	December 31, 2022		

- I. PURPOSE: To define the criteria for designation as a Thrombectomy Capable Acute Stroke Center (TCASC) in Ventura County.
- II. AUTHORITY: California Health and Safety Code, Sections 1797.114, 1797.220, 1798, 1798.2, 1798.101, and California Code of Regulations, Title 22, Section 100147 and 100169.
- III. DEFINITIONS:
  - Acute Stroke Center (ASC):** Hospital designated as an Acute Stroke Center, as defined in VCEMS Policy 450.
  - ELVO Alert:** A pre-arrival notification by pre-hospital personnel to the base hospital that a patient is suffering a possible Emergent Large Vessel Occlusion (ELVO) ischemic stroke.
  - Thrombectomy Capable Acute Stroke Center: (TCASC)** Acute Stroke Center (ASC) that has the capability to perform neuroendovascular procedures for acute stroke including thrombectomy and intra-arterial thrombolysis.
- IV. POLICY:
  - A. A Thrombectomy Capable Acute Stroke Center (TCASC), approved and designated by Ventura County EMS (VC EMS), shall meet the following requirements:
    1. All the requirements of an Acute Stroke Center (ASC) as defined in Policy 450.
    2. Certified as a Thrombectomy-Capable Stroke Center (TSC) by The Joint Commission or a Primary Plus by Det Norske Veritas, or a

- Comprehensive Stroke Center (CSC) by either The Joint Commission or Det Norske Veritas
3. Neurointerventionist on call 24/7 and available on-site at TCASC within 45 minutes of notification of an ELVO alert.
  4. Neurosurgeon on call 24/7 and available to provide care as indicated.
  5. Neurologist, with hospital privileges to provide ICU level of care for acute stroke patients, on call 24/7 and available to provide care as indicated.
  6. An individual Neurointerventionist or Neurosurgeon may not be simultaneously on call for a separate hospital.
  7. Appropriate endovascular catheterization laboratory personnel available on-site within 45 minutes of notification of an ELVO alert
  8. Will create policies and procedures detailing how the TCASC will notify the appropriate personnel of an ELVO alert.
  9. Will accept all ELVO alert patients, regardless of ICU or ED saturation status, except in the event of internal disaster or no catheterization laboratory availability.
  10. Will create policies and procedures detailing how the TCASC will manage the presentation of concurrent ELVO alerts.
  11. Will create policies and procedures detailing how the TCASC plans to manage competing demands on the procedure suite (staffing, other cardiovascular procedures).
  12. Will create policies and procedures that allow the automatic acceptance of any ELVO patient from a Ventura County Hospital upon notification by the transferring physician.
  13. Ability to perform endovascular procedures as indicated for emergent large vessel occlusions.
  14. Have CT or MRI perfusion capabilities.
  15. Maintain appropriate staff and facility availability to address complications of emergent endovascular procedures.
  16. Will participate in the Ventura County Stroke Registry in accordance with policy 450.
-

B. Designation Process:

1. Application:  
Eligible hospitals shall submit a written request for TCASC designation to VC EMS no later than 30 days prior to the desired date of designation, documenting the compliance of the hospital with Ventura County TCASC Standards.
  2. Approval:
    - a. Upon receiving a written request for TCASC designation, VC EMS will arrange an on-site survey of the requesting hospital to assure compliance with stated requirements.
    - b. TCASC approval or denial shall be made in writing by VC EMS to the requesting hospital within two weeks after receipt of the request for approval and all required documentation and completion of the VC EMS site survey.
    - c. Certification as a TSC or Primary Plus, or a CSC by The Joint Commission or Det Norske Veritas shall occur no later than six months following designation as a TCASC by VC EMS.
  3. VCEMS may deny, suspend, or revoke the designation of an TCASC for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Ventura County Board of Supervisors for appropriate action.
  4. The VC EMS Medical Director may grant an exception to a portion of this policy upon substantiation of need by the TCASC that compliance with the regulation would not be in the best interests of the persons served within the affected area.
  5. TCASCs shall be reviewed on a biannual basis.
    - a. TCASCs shall receive notification of evaluation from the VCEMS.
    - b. TCASCs shall respond in writing regarding program compliance.
    - c. On-site TCASC visits for evaluative purposes may occur.
    - d. TCASCs shall notify VCEMS by telephone, followed by a letter or email within 48 hours, of changes in program compliance or performance.
-

C. Provisional Designation Process

VC EMS may grant provisional designation as a TCASC to a requesting hospital that has satisfied the requirements of a TCASC as outlined in section A of this policy but has yet to receive certification by an approving body. Only when the following requirements are satisfied will VC EMS grant a provisional designation:

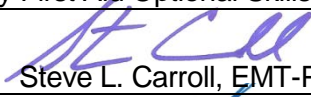

1. Application:  
Eligible hospitals shall submit a written request for provisional TCASC designation to VC EMS no later than 30 days prior to the desired date of provisional designation, documenting the compliance of the hospital with Ventura County TCASC Standards.
  2. Provisional Approval:
    - a. Upon receiving a written request for provisional TCASC designation, VC EMS will arrange an on-site survey of the requesting hospital to assure compliance with stated requirements.
    - b. Provisional TCASC approval or denial shall be made in writing by VC EMS to the requesting hospital within two weeks after receipt of the request for approval and all required documentation, as well as completion of the VC EMS site survey.
    - c. Certification as a Thrombectomy-capable Stroke Center, Primary Plus or Comprehensive Stroke Center by The Joint Commission or Det Norske Veritas shall occur no later than six months following provisional designation as an TCASC by VC EMS.
  3. VC EMS may deny, suspend, or revoke the designation of an TCASC for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Ventura County Board of Supervisors for appropriate action.
-

<b>Smoke Inhalation</b>	
<b>ADULT</b>	<b>PEDIATRIC</b>
<b>BLS Procedures</b>	
Remove individual from the environment	Remove individual from the environment
Consider gross decontamination	Consider gross decontamination
Assess ABCs	Assess ABCs
Assess for trauma and other acute medical conditions	Assess for trauma and other acute medical conditions
Administer high flow oxygen as indicated, or with evidence of smoke inhalation and ALOC or significant headache	Administer high-flow oxygen as indicated, or with evidence of smoke inhalation and ALOC or significant headache
<b>ALS Prior to Base Hospital Contact</b>	
Airway support in accordance with Policy 710 – Airway Management	Airway support in accordance with Policy 710 – Airway Management
IV/IO access as indicated	IV/IO access as indicated
If Wheezes present <ul style="list-style-type: none"> <li>• <b>Albuterol</b> <ul style="list-style-type: none"> <li>○ Nebulizer – 5 mg/6 mL               <ul style="list-style-type: none"> <li>▪ Repeat as needed</li> </ul> </li> </ul> </li> </ul>	If Wheezes present <ul style="list-style-type: none"> <li>• <b>Albuterol</b> <ul style="list-style-type: none"> <li>○ <b>Patient less than 30 kg</b> <ul style="list-style-type: none"> <li>• Nebulizer – 2.5 mg/3 mL               <ul style="list-style-type: none"> <li>○ Repeat as needed</li> </ul> </li> </ul> </li> <li>○ <b>Patient greater than 30 kg</b> <ul style="list-style-type: none"> <li>• Nebulizer – 5 mg/6 mL               <ul style="list-style-type: none"> <li>○ Repeat as needed</li> </ul> </li> </ul> </li> </ul> </li> </ul>
If smoke inhalation AND unconscious or ALOC <ul style="list-style-type: none"> <li>• <b>Hydroxocobalamin – If Available</b> <ul style="list-style-type: none"> <li>○ IV/IO – 5 g in 200 mL NS over 15 minutes</li> </ul> </li> </ul>	If smoke inhalation AND unconscious or ALOC <ul style="list-style-type: none"> <li>• <b>Hydroxocobalamin – If Available</b> <ul style="list-style-type: none"> <li>○ IV/IO – 70 mg/kg to a max of 5 g in 200 mL NS over 15 minutes</li> </ul> </li> </ul>
<b>Base Hospital Orders only</b>	
Continued unconscious/ALOC OR poor response to initial dose <ul style="list-style-type: none"> <li>• <b>Hydroxocobalamin</b> <ul style="list-style-type: none"> <li>○ IV/IO – 5 g in 200 mL NS over 15 to 120 minutes, depending on clinical presentation.</li> </ul> </li> </ul>	Continued unconscious/ALOC OR poor response to initial dose <ul style="list-style-type: none"> <li>• <b>Hydroxocobalamin</b> <ul style="list-style-type: none"> <li>○ IV/IO – 70 mg/kg to a max of 5 g in 200 mL NS over 15 to 120 minutes, depending on clinical presentation.</li> </ul> </li> </ul>
Consult with ED Physician for further treatment measures.	Consult with ED Physician for further treatment measures.
Additional Information: <ul style="list-style-type: none"> <li>• If monitoring equipment is available, the patient’s carboxyhemoglobin levels should be checked if smoke inhalation is suspected.</li> <li>• Evidence of smoke inhalation includes soot around mouth and/or nares, increased work of breathing, wheezing</li> <li>• If additional IV/IO medications are indicated, establish a second IV or IO. DO NOT administer other medications with hydroxocobalamin through the same IV/IO line.</li> <li>• DO NOT administer hydroxocobalamin if patient has a known allergy to hydroxocobalamin or cyanocobalamin</li> </ul>	

Effective Date: June 1, 2018  
Next Review Date: March 31, 2019

Date Revised:  
Last Reviewed:

  
VCEMS Medical Director

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Public Safety First Aid Optional Skills Approval and Training		Policy Number 1602	
APPROVED: Administration:  Steve L. Carroll, EMT-P		Date: July 28, 2017	
APPROVED: Medical Director:  Daniel Shepherd, M.D.		Date: July 28, 2017	
Origination Date: July 13, 2017			
Date Revised:		Effective Date: July 28, 2017	
Date Last Reviewed:			
Review Date: August, 2018			

- I. PURPOSE: To establish the application and approval process for the utilization of optional skills by Public Safety First Aid (PSFA) agency personnel in Ventura County, and to establish the requirements and responsibilities of the Ventura County EMS Agency (VCEMS) approved PSFA optional skill providers
    - A. The PSFA program shall be operated by approved providers in accordance with Title 22, Division 9, Chapter 1.5 of the California Code of Regulations and with all applicable VCEMS policies and procedures.
    - B. This program shall be implemented and maintained under the authority of the Ventura County EMS Medical Director.
  - II. AUTHORITY: California Health and Safety Code Sections 1797.220 and 1798; California Code of Regulations, Title 22, Section 100019
  - III. POLICY:
    - A. Any PSFA agency utilizing optional skills shall be approved by the VCEMS Medical Director, and continually meet all requirements outlined in the California Code of Regulations and VCEMS policies and procedures.
    - B. No entity may operate as a PSFA optional skills agency or provide optional skills unless authorized by the VCEMS Medical Director.
    - C. PSFA optional skills providers must be employed by a government public safety agency functioning within Ventura County as a part of the EMS system and may only provide optional skills while on duty.
    - D. Providers must meet the requirements and perform each optional skill as described in this policy.
    - E. The optional skills authorized for use by a PSFA agency shall be limited to:
      1. Administration of intranasal (IN) naloxone for suspected narcotic overdoses with respiratory depression.
-

2. Administration of epinephrine by auto-injector for suspected anaphylaxis
3. Administration of auto-injectors containing atropine and pralidoxime chloride for nerve agent exposure for self or peer care.

IV. PROCEDURE:

A. PSFA Optional Skills Application and Approval Process

1. Providers requesting to utilize PSFA optional skills shall submit an application to VCEMS for approval. A complete application shall include the following:
  - a. Identification of optional skill(s) being requested for authorization
  - b. A letter of intent to provide the PSFA optional skill(s) being applied for, signed by a chief officer of the agency, agreeing to adhere to all applicable VCEMS policies and procedures.
  - c. A description of the geographic area within which the PSFA Optional Skill(s) will be utilized (size, population, population distribution and any other unique characteristics associated with the area that may impact the program, such as; tourist impact, recreational activities, etc.).
  - d. A description of the need for use of the PSFA Optional Skill(s), including the number of patients that may have benefited from the use of PSFA optional skill(s) for the previous year.
  - e. A description of the plans for initial training and ongoing PSFA Optional Skills competency verification for authorized PSFA personnel.
  - f. Procedures for collection and retention of required medical records.
  - g. Written procedure for ongoing Quality Improvement activities specific to each skill utilized with a staff member assigned to complete this responsibility on a regular and on-going basis.
  - h. Identification of the individual at the agency responsible for program oversight and coordination of quality improvement.

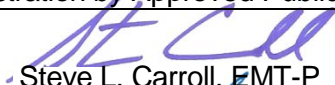

B. Program Notification

1. VCEMS shall notify the PSFA agency within seven (7) working days of receipt of the request for PSFA optional skills approval and shall specify what information, if any, is missing.
  2. PSFA optional skills approval or denial shall be made within thirty (30) calendar days of receipt of all required application materials.
-



3. PSFA Optional Skill(s) providers shall notify VCEMS of any Instructor change. Any new Instructor shall be approved by VCEMS prior to providing course instruction.
- C. PSFA Optional Skill(s) Provider Requirements and Responsibilities
1. Training Requirements  
PSFA optional skills provider agencies shall:
    - a. Provide initial PSFA Optional Skills training and testing utilizing curriculum approved and provided by VCEMS
    - b. Provide all necessary training equipment (manikins, audiovisual aids, training auto-injectors, etc.).
    - c. Ensure that each authorized PSFA individual demonstrates competency in the utilization of all approved optional skills, a minimum of once every twelve (12) months.
    - d. Maintain on file a course completion record for all personnel successfully completing the approved training, for a minimum of four (4) years. This record shall be made available to VCEMS upon request
  2. Records and Data Collection Requirements:
    - a. A PSFA Optional Skills Utilization Patient Care Report (Appendix A) shall be completed for each patient on whom any of the PSFA Optional Skill(s) are utilized and submitted within 24 hours to the EMS Agency via secure email or fax as specified on the form.
    - b. The provider shall develop procedures for collection, disposition, and retention of all pertinent medical records
    - c. The PSFA provider agency shall submit an annual report, no later than January 31<sup>st</sup> of each year that summarizes program activities and performance for the previous calendar year. At a minimum, this report shall include:
      - i. Competency records for all PSFA optional skill providers working within the agency
      - ii. An update of any and all program changes or updates that occurred within the PSFA optional skills provider agency over the previous twelve months, as it relates to the utilization of PSFA optional skills.
- D. Continuous Quality Improvement (CQI) Requirements
-

1. PSFA optional skills provider agencies shall maintain adequate program staff to ensure:
    - a. There is a timely and adequate review of each incident in which an optional skills has been utilized
    - b. There is adequate documentation of each incident in which an optional skill has been utilized
    - c. Each utilization of an optional skills has been in accordance with VCEMS policies and procedures.
  2. A monthly report outlining all utilizations of any PSFA optional skills over the previous calendar month shall be completed by the PSFA provider agency and submitted to VCEMS by the fifteenth (15<sup>th</sup>) day of each month.
- E. Denial, Revocation, or Suspension of Program Approval
1. Non-compliance with any criteria required for PSFA training program approval, use of any unqualified teaching personnel, or noncompliance with any other applicable provisions of the California Code of Regulations, may result in suspension, or revocation of PSFA program approval by VCEMS.
  2. VCEMS will notify PSFA program in writing of any deficiency and shall correct any identified problem within thirty (30) days.
  3. Failure to correct deficiencies and/or otherwise respond to directions will be cause for VCEMS to place the program on a probationary status with conditions for improvement, or deny, revoke, or suspend the program approval.
-

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Naloxone Administration by Approved Public Safety Agency Personnel		Policy Number 1605	
APPROVED: Administration:  Steve L. Carroll, EMT-P		Date: July 28, 2017	
APPROVED: Medical Director:  Daniel Shepherd, MD		Date: July 28, 2017	
Origination Date: July 13, 2017			
Date Revised:		Effective Date: July 28, 2017	
Date Last Reviewed:			
Review Date: August, 2018			

I. PURPOSE:

- A. To outline criteria for approved Public Safety First Aid (PSFA) administration of naloxone hydrochloride in cases of suspected acute opioid overdose.
- B. To provide medical direction and naloxone administration parameters for approved PSFA optional skills provider agencies and personnel in the County of Ventura.

II. AUTHORITY: California Health and Safety Code, Division 2.5; California Code of Regulations, Title 22, Division 9, Section 100019.

III. DEFINITIONS:

**Opioid Overdose:** The result of an individual's accidental or intentional exposure to narcotic substances e.g. heroin, morphine, oxycodone, hydrocodone, fentanyl, methadone, opium, hydromorphone (dilaudid), or Demerol.

**Naloxone Hydrochloride (Narcan):** An opioid antagonist that is only indicated for the reversal of opioid drug exposures. Naloxone will not reverse the effects of non-opioid drugs such as benzodiazepines, sedative hypnotics, alcohol, or other drug classifications.

IV. POLICY:

- A. Training shall be completed as outlined in California Code of Regulations, section 100019 and VCEMS Policy 1602 – PSFA Optional Skills Approval and Training
- B. The PSFA agency training program director shall be responsible for the following:
  - 1. Ensuring the agency's supply of nasal naloxone remains current and not expired at all times.
  - 2. Ensuring proper and efficient deployment of nasal naloxone for use within the agency.
  - 3. Prompt replacement of any nasal naloxone that is used in the course of care, expired, damaged, or otherwise deemed unusable.

4. Ensuring all personnel that will be using nasal naloxone has received appropriate training.
5. Maintain records of all documented use, restocking, damaged, expired or otherwise unusable naloxone.

V. PROCEDURE:

A. Indications

1. Suspected or confirmed opiate overdose
  - a. Environment indicates illegal or prescription use of opiate medication, AND
  - b. Victim is unconscious or poorly responsive and respiratory rate appears to slow (less than 8 per minute) or shallow/inadequate; or victim is unconscious and not breathing.
2. Need for complete or partial reversal of central nervous system and respiratory depression induced by opioids.
3. Decreased level of consciousness of unknown origin and opioid induced respiratory depression
4. Law enforcement or First Responders with known or suspected opiate exposure AND signs and symptoms of opiate overdose.

B. Contraindications

1. Known allergy to naloxone hydrochloride

C. Relative Contraindications

1. Use with caution in opiate-dependent patients and in neonates of opiate addicted mothers; opiate-dependent patients who receive naloxone may experience acute withdrawal reaction syndrome. Opiate withdrawal symptoms in the opiate-dependent patient include:
  - a. Agitation
  - b. Tachycardia
  - c. Hypertension
  - d. Seizures
  - e. Cardiac Rhythm Disturbances
  - f. Nausea, vomiting, and/or diarrhea
  - g. Profuse sweating

D. Intranasal (IN) Naloxone Administration

1. Ensure EMS personnel (fire and transport) have been responded to the scene through established communications channels.
-

2. Maintain standard body substance isolation precautions utilizing appropriate personal protective equipment.
  3. Check patient/victim for responsiveness
  4. Open airway using established Basic Life Support techniques
  5. Perform CPR as indicated.
  6. Administer intranasal naloxone
    - a. Naloxone 4mg IN
    - b. May repeat dose, if no improvement in patient condition, x 1 (total of 2 doses)
  7. If response to naloxone and patient is a suspected chronic opiate user, prepare for possible narcotic reversal behavior or withdrawal symptoms (agitation and vomiting)
  8. Notify fire and transport personnel of naloxone administration.
- E. On a monthly basis, law enforcement agencies that administer naloxone shall report all cases to the Ventura County EMS Agency using the established reporting form (Attachment A)
-



# Ventura County EMS Agency

## VCEMS Policy 1605 Attachment A Monthly PSFA Optional Skills UTILIZATION & UPDATE FORM

*Due the 15<sup>th</sup> of the following month*  
*(ex: Jan. 1-31, due Feb. 15)*

PSFA Agency Name: \_\_\_\_\_

Review Month: \_\_\_\_\_

Current Program Coordinator: \_\_\_\_\_

No Utilizations  
*(check here if applicable)*

\*\*\*OR\*\*\*

Date of Incident	Patient Initials	Provider Name	PCR Attached
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

Program Coordinator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Program Notes/Comments:  
\_\_\_\_\_  
\_\_\_\_\_

**For VCEMS Use Only**

Received Date	Reviewed Date	Reviewed By
/ /	/ /	