Virtual	Pre-hospital Services Committee Agenda	January 12, 2023 9:30 a.m.

I.	**Introductions**	
II.	**Approve Agenda**	
III.	**Minutes**	
IV.	**Medical Issues**	
	A. Coronavirus/Flu/Respiratory Virus	Dr. Shepherd/Steve Carroll
V.	**New Business or Policies for Review with Proposed Changes**	
	A. PSC Meeting February 9th- Virtual or In-Person	
	B. 124 – Hospital Emergency Services Reduction Impact Assessment	Steve Carroll
	C. 705.18 – Overdose/Poisoning	Andrew Casey
VI.	**Old Business**	
	A. Just Culture Training Update	Chris Rosa
VII.	**Informational/Discussion Topics or Policies Approved at Specialty Care Committees**	
	A. 107 – Stroke and STEMI Committee	Adriane Gil-Stefansen
	B. 452 – TCASC Standards	Adriane Gil-Stefansen
	C. 705.01 – Trauma Treatment Guidelines	Karen Beatty
VIII.	**Policies Due for Review (No proposed changes)**	
	A. 110 – County Ord. No. 4099 Ambulance Business License Code	Steve Carroll
	B. 626 – CHEMPACK Deployment	
	C. 705 – General Patient Guidelines	
	D. 705.15 – Nausea/Vomiting	
	E. 705.19 – Pain Control	
	F. 705.28 – Smoke Inhalation	
IX.	**Agency Reports**	
	A. Fire Departments	
	B. Ambulance Providers	
	C. Base Hospitals	
	D. Receiving Hospitals	
	E. Law Enforcement	
	F. ALS Education Program	
	G. EMS Agency	
	H. Other	
X.	**Closing**	

Virtual	Pre-hospital Services Committee Minutes	November 10, 2022 9:30 a.m.

Topic	Discussion	Action	Approval
II. Approve Agenda		Approved	Motion: Tom O'Connor Seconded: Dr. Tilles Passed: unanimous
III. Minutes		Approved	Motion: Dr. Larsen Seconded: Tom O'Connor Passed: unanimous
IV. **Medical Issues**			
A. Coronavirus/Flu/ Respiratory Virus Update	**Dr. Shepherd –** Resurgence of legacy seasonal illnesses, flood of ill people with flu in oct/nov, ems agencies are aware of increased strain on system. Monitoring. No serious action item as of yet. **Steve –** OC seeing well over 200% normal of peds. Normal census 150-175, 450+ are being seen in the ER daily, OC declared local state of emergency that the state does not agree with. We are meeting with our hospitals next week to prepare for surge, RSV, etc. Challenge is in years past there was money for covid supplies/staffing, now there is no federal/state funding available. We need to work within our own system as there will not be resources available. Keep a close eye on the situation. **Larsen** – state call mentioned EMS was still active under the current declaration. Most of it is RSV, flu, and 25% covid. **Rosa** – language in the paramedic is to assist with COVID surge.		
V. New Business			
A. 0111 – Ambulance Company Licensing Procedures	**Steve** – While reviewing All Town Ambulance application, it was determined that final approval it is not required by the BOS. Therefore, #7 on page 9 will be deleted. If denied for any reason, that would go to the BOS for appeal. This does not affect our 911 providers	Approved with changes	Motion: Dr. Canby Seconded: Dr. Larsen Passed: Unanimous
B. 0210 – Abuse Reporting Guidelines	Rosa – policy updated to reflect some of the codes and language. Definitions added to	Change ages to 18-59 and age 60+ for "elders" instead 65 yrs.	Motion: Tom Seconded: Dr. Sykes

	better understand terminology in this process. Hyperlinked the actual APS form, so that personnel can go directly to the section so there will be less room for ambiguity and assumptions. Separated child from adult procedures, flowchart added, links to reporting form and email address. Carroll stated "elder" has changed to 60 yrs, likewise dependent adults is 18-59 yrs.	Approved with changes	Passed: unanimous
C. 0300 – EMT Scope of Practice	**Beatty** – added BiPAP next to CPAP under letter "e" on page 2.	Approved	Motion: Dr. Larsen Seconded: Tom O'Connor Passed: unanimous
D. 0301 – EMT Certification	**Beatty** – Added clarification on page 2, #5 that "both cognitive and skills testing" must be completed for CPR. When referring to Policy 302 on page 3, there are only 9 requirements in Section 3 A instead of 10 CAM is accepted in place of CPR card for Recert, CPR card is required for initial Cert.	Approved	Motion: Tom O'Connor Seconded: Dr. Sykes Passed: unanimous
E. 0303 – EMT Optional Skills	Rosa – Adjusted policy to include Atropine auto injector training for optional skills as approved by the State.	Approved	Motion: Jaime Villa Seconded: Dr. Canby Passed: unanimous
F. 0304 – EMT Challenge Exam	**Beatty –** Added clarification on page 1, Sec III, A-1 that "both cognitive and skills testing" must be completed for CPR.	Approved	Motion: Tom O'Connor Seconded: Dr. Larsen Passed: unanimous
G. 0711 – Prehospital Capnography	**Casey** – proposing to add on page one, Sec. III, 5, language to include ETCO2 monitoring for suspected Sepsis patients.	Approved	Motion: Dr. Larsen Seconded: Dr. Blum Passed: unanimous
H. 0720 – Guidelines for LBC	**Rosa** – language update to reflect common practice, patient criteria clarified, page 2 chart updated, **Tom** – standardize using capital letters or lower-case letters throughout chart on page 2.	Approved with suggested changes	Motion: Tom O'Connor Seconded: Dr. Tilles Passed: unanimous
I. 1603 – PSFA Nerve Agent Antidote Administration	**Rosa** – for public safety personnel, added clarification that atropine auto injectors are not authorized. Larsen – Remove "prehospital personnel" for sentence in Sec III, B.	Approved with suggested changes	Motion: Dr. Larsen Seconded: Tom O'Connor Passed: unanimous
VI. Old Business			
A. 705.17 – Nerve Agent Organophosphate	**Rosa** – deadline is looming on duodote expiration dates. Figuring out what agencies are going with duodote or atropine. Atropine auto injectors were proposed in the policy, but committee decided to take atropine back out of policy.	Approved with suggested change to remove Atropine	
VII. Informational			

A. NREMT Pass Rates	**Rosa** – bring back at March PSC meeting initial report for EMT pass rates. 3-yr average at 80% after 3 attempts.		
B. Safety Event/UO/Med Error	Rosa – shift this to a safety event reporting process. Enforce this as a training and education approach instead of a punitive process. It will start including accommodations. More to follow at next meeting.		
VIII. Policies for review			
A. 1604 – Oxygen Administration and Basic Airway Adjuncts	Rosa – Clean up title of Policy Tom – fix periods	Approved with suggested changes	Motion: Tom O'Connor Seconded: Dr. Canby Passed: unanimous
B. 1606 – PSFA Epinephrine Administration	Rosa – PSFA dates were updated Tom – fix punctuation	Approved with suggested changes	Motion: Tom O'Connor Seconded: Dr. Canby Passed: unanimous
IX. Agency Reports			
A. Fire departments	**VCFD** – now has two nurses **VFD –** none **OFD** – none **Fed. Fire** – none **FFD** – none		
B. Transport Providers	**AMR/GCA/LMT** –.hired allejandro ? moving into field specialist position **AIR RESCUE –** none		
C. Base Hospitals	**AHSV** – volumes that they have never seen before even in the height of covid, please do not go on diversion. **LRRMC** – Two new pccs, two part time nurses co-filling the position, new ER expansion opening on the 15th. **SJRMC –** none **VCMC** – none		
D. Receiving Hospitals	**PVH** – none **SPH** – none **CMH** / **OVCH** – also seeing high volumes, rsv is seeing 200+ a day.		
E. Law Enforcement	**VCSO –**none **CSUCI PD –** none **Parks –** none		
F. ALS Education Programs	**Ventura College** –		
G. EMS Agency	Steve – ???		
H. Other			
X. Close	**Meeting adjourned at 10:34am**		Motion: Dr. Larsen Seconded: Dr. Canby Passed: unanimous

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Hospital Emergency Services Reduction Impact Assessment	Policy Number 124
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: June 1, 2023~~December 1, 2018~~
APPROVED: Medical Director Daniel Shepherd, M.D.	Date: June 1, 2023~~December 1, 2018~~
Origination Date: June 1999 Date Revised: May 13, 2004 Effective Date: June 1, 2023~~December 1, 2018~~ Date Last Reviewed: January 12, 2023~~September 13, 2018~~ Review Date: January 31, 2025~~September 30, 2021~~	

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I. PURPOSE: To provide a mechanism for Ventura County to evaluate and report on the potential impact on the Emergency Medical Services (EMS) system of the reduction or closure of emergency services in hospitals.

II. AUTHORITY: Health and Safety Code Section 1300 (c).

III. POLICY: Acute care hospitals intending to implement either a reduction or closure of emergency services must advise the EMS agency as soon as possible, but at least 90 days prior to the proposed change.

A. The notification of change proposal must include:

1. Reason for the proposed change(s).
2. Itemization of the services currently provided and the exact nature of the proposed change(s).
3. Description of the local geography, surrounding services, the average volume of calls.
4. Description of potential impact on the EMS community regarding patient volume and type of prehospital and emergency department services available. Include a pre/post comparison.
5. Description of potential impact on the public regarding accessibility of comparable alternative facilities or services. Include a pre/post comparison.

B. Evaluation Process

1. Upon receiving notification of a planned reduction or elimination of emergency medical services by a hospital or the California Department of Health Services, the Department, all local hospitals, fire departments, and ambulance providers, and all local planning and or zoning authorities will be notified.

2. Within thirty-five (35) days of notification, the EMS Agency, in consultation with emergency service providers and planning/zoning authorities, will complete and distribute a draft EMS Impact Evaluation utilizing the Impact Evaluation Instrument (Attachment A) and set a public hearing date. At a minimum, the Impact Evaluation report shall include:
   a. Assessment of community access to emergency medical care.
   b. Effect on emergency services provided by other entities.
   c. Impact on the local EMS system.
   d. System strategies for accommodating the reduction or loss of emergency services.
   e. Potential options, if known.
   f. Public and emergency services provider comments.
   g. Suggested/recommended actions.
3. Within fifty (50) days of notification, the EMS Agency will release the draft impact evaluation report to prehospital and hospital emergency services personnel, with a 10 working day comment period; and conduct at least one (1) public hearing, and incorporate the results of those hearings in the final Impact Evaluation. These public hearings may be incorporated with other public meetings held by the Public Health Department, Board of Supervisors and/or other government agencies, commissions, or committees.
4. Within sixty (60) days of receiving notice, the EMS Agency will prepare the final Impact Evaluation, and submit those findings to the California Department of Health Services, State EMS Authority, Board of Supervisors, all city councils, fire departments, ambulance services, hospitals, planning/zoning authorities, local EMS participants and other interested parties.
5. The hospital will serve notice of the public hearing to the community through standard and reasonable efforts (i.e. local newspapers and notices at hospitals) within the affected county.
6. The Department of Health Services will make the final determination as to the nature of emergency services to be provided by the hospital seeking reduction or closure.
7. The hospital proposing a reduction or closure of service(s) will be charged a $750.00 fee by Ventura County Emergency Medical Services for the impact evaluation.

Time Line (in calendar days) for Development of Report of Impact on the EMS System in the Event of Closure or Reduction of Emergency Department Services in Local Hospitals					
Day 0	By Day 7	By Day 35	By Day 50	By Day 60	By Day 90
VC EMS is notified of pending closure or reduction in emergency services	Hospital has formally received necessary information relating to impact study	1. Draft EMS Impact Evaluation Report completed and distributed. to prehospital and hospital emergency medical services personnel with a 10 working day comment period 2. Public Hearing Date set.	1. At least one public hearing has been conducted 2. Results of comments and hearing(s) are incorporated into the final Impact Evaluation.	VC EMS will prepare Final Impact Evaluation VC EMS will submit the report to agencies listed in Section III.4	The hospital will serve notice of the public hearings regarding closure / reduction of services and hold such hearings.

CLOSURE / REDUCTION IN SERVICES IMPACT EVALUATION
HOSPITAL ASSESSMENT CRITERIA
VENTURA COUNTY EMERGENCY MEDICAL SERVICES AGENCY

This tool provides a quantitative indication of the relative impact potential of an emergency service reduction/elimination by one or more of the listed facilities. The numeric value indicates the magnitude of the impact, not the "value" of the facility to its community or the EMS system. Values are for a 12 month period.

Hospitals (in alphabetical order)	GEOGRAPHIC ISOLATION B (# of Hospitals within 15 mile radius) (Maximum points – 30) < 2 30 2-4 20	911 ALS TRANSPORTS	911 BLS TRANSPORTS	TOTAL ED VOLUME 1 point per 1000	HOSPITAL SERVICES Base Hospital 25 Cardiovascular Surgery 10 Neuro 25 NICU 5 Psych. (5150) 10	ED DIVERSION Hours <50 30 50-99 25 100-199 20 200-299 15 300-399 10 400-499 5 >500 0	TOTAL
Adventist Health Simi Valley							
Los Robles Regional Medical Center							
St. John's Camarillo Hospital~~Pleasant Valley Hospital~~							
St. John's Regional Medical Center							
Ojai Valley Community Hospital							
Ventura County Medical Center							
Community Memorial Hospital							

Overdose

ADULT	PEDIATRIC
BLS Procedures	
Decontaminate if indicated and appropriate Administer oxygen and support ventilations as indicated Suspected opioid overdose with respirations less than 12/min and significant ALOC: • **Naloxone** o IN – 4 mg via pre-filed nasal spray, may repeat x 1 to a total of 8 mg o IN – 2 mg (1 mg per nostril) via nasal atomizer, may repeat x 1 to a total of 4 mg ~~o IN – 4 mg in 0.1 mL, may repeat X 1, Max of 8 mg~~ o IM – 2 mg, may repeat ~~x~~X ~~1, Max of 4 mg~~ to a total of 4 mg	
ALS Standing Orders	
IV/IO access Suspected opioid overdose with respirations less than 12/min and significant ALOC • **Naloxone~~, if not already administered by BLS personnel or if patient continues with decreased resp rate and significant ALOC~~** ~~o IN – 4 mg in 0.1 mL, may repeat x1, Max of 8 mg~~ ~~o IM – 2 mg q 5 min~~ o IV/IO – 0.4-5 mg q 1min ~~• Initial max 6 mg~~ o May repeat as needed to maintain respirations greater than 12/min Dystonic Reaction • **Benadryl** • **IV/IO/IM – 50 mg** Stimulant/Hallucinogen Overdose • **Midazolam** o IV/IO – 2 mg • Repeat 1 mg q 2 min as needed • Max 5 mg o IM – 0.1 mg/kg o Max 5 mg	IV/IO access Suspected opioid overdose with respirations less than 12/min and significant ALOC: • **Naloxone~~, if not already administered by BLS personnel or if patient continues with decreased resp rate and significant ALOC~~** o IM – 0.1 mg/kg • Initial max of 2 mg o IV/IO – 0.1 mg/kg • Initial max 2 mg o May repeat as needed to maintain respirations greater than 12/min Dystonic Reaction For patients ≥ 6 months of age • **Benadryl** o **IV/IO/IM – 1 mg/kg** ▪ **Max 50 mg** ▪ Stimulant/Hallucinogen Overdose • **Midazolam** o IM – 0.1 mg/kg • Max 5 mg o IV/IO – 0.1 mg/kg • Repeat q 2 min as needed • Max single dose 2 mg • Max total dose 5 mg
Base Hospital Orders Only	
Tricyclic Antidepressant Overdose • **Sodium Bicarbonate** o IV/IO – 1 mEq/kg o Repeat 0.5 mEq/kg x 2 q 5 min Beta Blocker Overdose • **Glucagon** o IV/IO – 2 mg • May give up to 10mg if available Calcium Channel Blocker Overdose • **Calcium Chloride** o IV/IO – 1 g over 1 min • **Glucagon** o IV/IO – 2 mg • May give up to 10 mg if available	Tricyclic Antidepressant Overdose • **Sodium Bicarbonate** o IV/IO – 1 mEq/kg o Repeat 0.5 mEq/kg x 2 q 5 min Beta Blocker Overdose • **Glucagon** o IV/IO – 0.1 mg/kg • May give up to 10 mg if available Calcium Channel Blocker Overdose • **Calcium Chloride** o IV/IO – 20 mg/kg over 1 min • **Glucagon** o IV/IO – 0.1 mg/kg • May give up to 10 mg if available
Additional Information: • If chest pain present, refer to chest pain policy. DO NOT GIVE ASPIRIN OR NITROGLYCERIN (Consult with ED Physician) • 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. ~~o If base hospital contact cannot be made, naloxone should be administered sparingly, in doses no more than 0.1 mg every 2-3 minutes.~~	

Effective Date: December 1, 2020
Next Review Date: October 31, 2022

Date Revised: October 8, 2020
Last Reviewed: October 8, 2020

VCEMS Medical Director

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COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Ventura County Stroke and STEMI Committees	Policy Number 107
APPROVED: Administration: Steve L. Carroll, Paramedic	Date: December 1, 2019
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: December 1, 2019
Origination Date: August 9, 2018 Date Revised: August 9, 2018 Date Last Reviewed: October 10, 2019 Review Date: October 31, 2022	Effective Date: December 1, 2019

I. Committee Name

The name of these committees shall be the Ventura County (VC) Stroke Committee and the VC STEMI Committee.

II. Committee Purpose

The purpose of these committees shall be to provide input to the VC Emergency Medical Services (EMS) Medical Director and VC EMS administration on matters pertaining to the VC Stroke Specialty System and the VC STEMI Specialty System.

III. Membership

A. Voting Membership

Voting membership in the committee shall be composed of 2 representatives (see chart below) Alternatives will be considered on a case by case basis.

Type of Organization	**Member**	**Member**
Acute Stroke Centers (ASC)	Stroke Coordinator	Physician
Non-ASC receiving centers	ED Manager or PCC	Physician
STEMI Receiving Centers	STEMI Coordinator	Physician
STEMI Referral Hospitals	ED Manager or PCC	Physician
Fire	Clinical manager or QI director	Senior Administrator or Medical Director

Ambulance Companies	Clinical manager or QI manager	Senior Administrator or Medical Director
VCEMSA	Administrator	Medical Director

B. Non-voting Membership

Non-voting members of the committee shall be composed of stakeholders from local agencies.

C. Membership Responsibilities

Representatives to the Stroke Committee and STEMI Committee represent the views of their agency. Representatives should ensure that agenda items have been discussed/reviewed by their agency prior to the meeting.

D. Voting Rights

Designated voting members shall have equal voting rights.

E. Attendance

1. Members shall remain as active voting members by attending 75% (Stroke) and 66% (STEMI) of the meetings in a (calendar) year. If attendance falls below these percentages, the organization administrator will be notified, and the member may lose the right to vote.
    (a) Members may have a single designated alternate attend in their place, no more than two times (Stroke) and one time (STEMI) per calendar year.
    (b) Agencies may designate one representative to be able to vote for both representatives, no more than two times (Stroke) and one time (STEMI) per calendar year.
2. The member whose attendance falls below these percentages, may regain voting status by attending two consecutive meetings.
3. If meeting dates are changed or cancelled, members will not be penalized for not attending.

IV. Officers

A. The chairperson of the Stroke Committee and the STEMI Committee is the VCEMSA Medical Director. The chairperson shall perform the duties prescribed by the guidelines outlined in this policy.

V. Meetings

A. Regular Meetings

The Stroke Committee will meet quarterly, and the STEMI Committee will meet once every 4 months. VCEMS will prepare and distribute the meeting agenda no later than one week prior to a scheduled meeting.

B. Special Meetings

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

C. Quorum

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

VI. Task Forces and Ad-hoc Committees

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

VII. Calendar Year

The Stroke and STEMI Committee will operate on a calendar year

VIII. Parliamentary Authority

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

IX. Submission of Agenda Items

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

A. Subject
B. Reason for request
C. Description/Justification
D. Supporting medical information/other research as applicable
E. List of affected VC EMS policies, if a requested policy change
F. Agenda Category:
    1. Operational
    2. Medical

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Thrombectomy Capable Acute Stroke Center (TCASC) Standards	Policy Number 452
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: ~~July 1, 2020~~June 1, 2023~~December 28, 2022~~
APPROVED: Medical Director: Daniel Shepherd, MD	Date: ~~July 1, 2020~~June 1, 2023~~Decemebr 28, 2022~~
Origination Date: July 26, 2017 Date Revised: December 28, 2022~~11, 2019~~ Last Review: ~~December 11, 2019~~December 28, 2022 Review Date: December 31, 2024~~2~~	Effective Date: ~~July 1, 2020~~June 1, 2023~~2~~

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.

~~E~~**LVO Alert:** A pre-arrival notification by pre-hospital personnel to the base hospital that a patient is suffering a possible ~~Emergent~~ Large Vessel Occlusion (~~E~~LVO) 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. Neurointerventionalist on call 24/7 and available on-site at TCASC within 45 minutes of notification of an ~~E~~LVO 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 Neurointerventionalist 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 ~~E~~LVO alert
8. Will create policies and procedures detailing how the TCASC will notify the appropriate personnel of an ~~E~~LVO alert.
9. Will accept all ~~E~~LVO 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 ~~E~~LVO 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 ~~E~~LVO 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. ~~16.~~ Will participate in the Ventura County Stroke Registry in accordance with policy 450.
17. ~~17.~~
18. ~~18.~~
19. ~~19.~~16.

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.

Trauma Assessment/Treatment Guidelines 705.01

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

A. Rapid trauma survey

1. Airway

a. Maintain inline cervical stabilization

1) Follow spinal precautions per VCEMS Policy 614

b. Open airway as needed

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

c. Suction airway if indicated

2. Breathing

a. Assess rate, depth and quality of respirations

b. If respiratory effort inadequate, assist ventilations with BVM

c. Insert appropriate airway adjunct if indicated

d. Assess lung sounds

e. Initiate airway management and oxygen therapy as indicated

1) Maintain SpO2 ≥ 94%

3. Circulation

a. Assess skin color, temperature, and condition

b. Check distal/central pulses and capillary refill time

c. Control major bleeding

d. Initiate shock management as indicated

4. Disability

a. Determine level of consciousness (Glasgow Coma Scale)

b. Assess pupils

5. Exposure

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

b. Maintain patient body temperature

B. Detailed physical examination

1. Head

a. Inspect/palpate skull

b. Inspect eyes, ears, nose and throat

2. Neck

a. Palpate cervical spine

b. Check position of trachea

c. Assess for jugular vein distention (JVD)

3. Chest

a. Visualize, palpate, and auscultate chest wall

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

C. Trauma care guidelines
   1. Fluid Administration
      a. Maintain SBP of ≥ 80 mmHg
         1) Patients 65 years and older, maintain SBP of ≥ 100 mmHg
         2) Pediatric patients, maintain minimum systolic for respective age in Handtevy.
         3) Isolated head injuries, maintain SBP of ≥ 100 mmHg
   2. Tranexamic Acid (TXA) Administration
      a. Patients 15 years of age and older as indicated in VCEMS Policy 734
   3. Head injuries
      a. General treatments
         1) Evaluate head and face – maintain high index of suspicion for injury if significant mechanism of injury is present or physical examination is remarkable for findings
         2) Elevate head 30° unless contraindicated
         3) Do not attempt to intubate head injured patients unless unable to manage with BLS airway measures
         4) Do not delay transport if significant airway compromise
      b. Penetrating injuries
         1) DO NOT REMOVE IMPALED OBJECT (unless airway obstruction is present)
         2) Stabilize object manually or with bulky dressings
      c. Facial injuries
         1) Assess airway and suction as needed
         2) Remove loose teeth or dentures if present
      d. Eye injuries

1) Remove contact lenses
2) Irrigate eye thoroughly with suspected acid/alkali burns
3) Avoid direct pressure
4) Place eye shield over injured eye only~~Cover both eyes~~
~~4)~~5) Ask patient to keep eyes closed
~~5)~~6) Stabilize any impaled object manually or with bulky dressing

4. Spinal cord injuries
   a. General treatments
      1) Evaluate spinal column – maintain high index of suspicion for injury if significant mechanism of injury is present or physical examination is remarkable for findings
      2) Place patient in supine position if hypotension is present
   b. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
      1) Stabilize object manually or with bulky dressings
      2) Control bleeding if present
      3) In the presence of isolated penetrating injuries, spinal motion restriction is contraindicated
   c. Neck injuries
      1) Monitor airway
      2) Control bleeding if present
5. Thoracic Trauma
   a. General treatments
      1) Evaluate chest – maintain high index of suspicion for internal injury if significant mechanism of injury is present or physical examination is remarkable for findings
      2) Keep patients sitting high-fowlers
         a. In the presence of isolated penetrating injuries, spinal motion restriction is contraindicated
   b. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT
      a) Remove object if CPR is interfered
      b) Stabilize object manually or with bulky dressings
      c) Control bleeding if present
   c. Flail Chest/Rib injuries
      a) Assist ventilations if respiratory status deteriorates
   d. Pneumothorax/Hemothorax
      a) Keep patient sitting high-fowlers
      b) Assist ventilations if respiratory status deteriorates1.

1) Suspected tension pneumothorax should be managed per VCEMS Policy 715

e. Open (Sucking) Chest Wound

a) Place an occlusive dressing to wound site, secure on 3 sides only or place a vented chest seal.

b) Assist ventilations if respiratory status deteriorates

f. Cardiac Tamponade – If suspected, expedite transport

a) Beck's Triad

1) Muffled heart tones

2) JVD

3) Hypotension

g. Traumatic Aortic Disruption

a) Assess for quality of radial and femoral pulses

b) If suspected, expedite transport

6. Abdominal/Pelvic Trauma

a. General Treatments

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

b. Blunt injuries

1) Place patient in supine position if hypotension is present

c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECT

1) Stabilize object manually or with bulky dressings

2) Control bleeding if present

d. Eviscerations

1) DO NOT REPLACE ABDOMINAL CONTENTS

a) Cover wound with saline-soaked dressings

2) Control bleeding if present

e. Pregnancy

1) Place patient in left-lateral position to prevent supine hypotensive syndrome

f. Pelvic injuries

1) Consider wrapping a bed sheet tightly around the pelvis and tying it together for use as a binder to help control internal bleeding

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

2) Control bleeding if present

3) If possible, avoid log rolling patient.

7. Extremity Trauma

a. General Treatments

1) Evaluate CSM distal to injury

a) If decrease or absence in CSM is present:

(1) Manually reposition extremity into anatomical position

(2) Re-evaluate CSM

b) If no change in CSM after repositioning, splint in anatomical position and expedite transport

c) Cover open wounds with sterile dressings

d) Place ice pack on injury area (if closed wound)

e) Splint/elevate extremity with appropriate equipment

f) Uncontrolled hemorrhage: Tranexamic Acid – For patients 15 years of age and older as indicated in VCEMS Policy 734

b. Dislocations

1) Splint in position found with appropriate equipment

c. Penetrating injuries – DO NOT REMOVE IMPALED OBJECTS

1) Stabilize object manually or with bulky dressings

2) Control bleeding if present

d. Femur fractures

1) Utilize traction splint only if isolated mid-shaft femur fracture is suspected

2) Assess CSM before and after traction splint application

e. Amputations

1) Clean the amputated extremity with NS

2) Wrap in moist sterile gauze

3) Place in plastic bag

4) Place bag with amputated extremity into a separate bag containing ice packs

5) Prevent direct tissue contact with the ice pack

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: County Ordinance No. 4099: Ambulance Business License Code		Policy Number 110
APPROVED: Administration	Steven L. Carroll, Paramedic	Date: June 1, 2023~~December 1, 2018~~
APPROVED: Medical Director	Daniel Shepherd, M.D.	Date: June 1, 2023~~December 1, 2018~~
Origination Date: Revised Date: Last Reviewed: ~~13, 2018~~ Review Date: ~~30, 2021~~	July 10, 1994 September 13, 2007 January 12, 2023~~September~~	Effective Date: June 1, 2023~~December 1, 2018~~

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See following pages.

ORDINANCE NO. 4099

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 2423 - GENERAL PROVISIONS

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

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

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

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

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

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

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

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

Section 2423-2 - Ambulance Operators and Personnel

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ord. 4033/215/227.1 April 27, 1993

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

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

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

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

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

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

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

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

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

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

AYES: Supervisors

NOES: Supervisors

ABSENT: Supervisors

CHAIR, BOARD OF SUPERVISORS

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

By
Deputy Clerk

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: CHEMPACK Deployment		Policy Number 626
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: June 1, 2023~~December 1, 2020~~
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: June 1, 2023~~December 1, 2020~~
Origination Date: Date Revised: Date Last Reviewed: Review Date:	February 2, 2010 August 13, 2020 January 12, 2023~~August 13, 2020~~ January 31, 2025~~August 31, 2022~~	Effective Date: June 1, 2023~~December 1, 2020~~

I. PURPOSE: This policy establishes guidelines for the deployment and use of the CHEMPACK by pre-hospital care providers in response to incidents involving suspected nerve agent exposure.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.220 & 1798.

III. DEFINITION: The Assistant Secretary for Preparedness and Response (ASPR) has established the "CHEMPACK" project for the forward placement of sustainable repositories of nerve agent antidotes in numerous locations throughout the United States, so that they can be immediately accessible for the treatment of exposed and affected persons.

There are two types of CHEMPACKs available. The "Hospital CHEMPACK" is designed for hospital and healthcare provider use, consisting mostly of single dose vials and a small quantity of auto-injectors. The "EMS CHEMPACK" is designed for field use and contains mostly auto-injectors. Ventura County has elected to only host EMS CHEMPACKs.

Content of CHEMPACKs			
Unit Pack	**Units**	**Cases**	**Quantity**
Pralidoxime 600 mg Auto-Injector	240	5	1200
Atropine Sulfate 0.4 mg/ml 20 ml	100	1	100
Pralidoxime 1 Gm inj. 20 ml	276	1	276
Atropen 0.5 mg	144	1	144

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Atropen 1.0 mg	144	1	144
Atropen 2 mg	136	5	680
Diazepam 5 mg/ml auto-injector	150	2	300
Midazolam 5mg/mL vial, 10mL	50	1	50
Sterile water for inj (SWFI) 20cc vials	100	2	200
Sensaphone®2050	1	1	1
Satco B DEA Container	1	1	1

IV. POLICY: Actual location of the CHEMPACK will be maintained as confidential. This policy outlines the responsibilities and the operational requirements to pre-position or utilize a cache within the Ventura County Operational Area.

In the case of an accidental or deliberate release of a nerve agent or potent organophosphate compound, time will be of the essence to minimize morbidity and mortality. This is a key consideration in cache placement, notification, transportation and administration.

V. PROCEDURE: CHEMPACK Deployment and Movement

A. Authorization to Open or Forward Deploy a CHEMPACK Container – Emergency Incident Based:

1. The Ventura County EMS Agency shall be contacted for authorization to open or forward deploy any CHEMPACK within the Ventura County Operational Area. The EMS Agency Duty Officer can be accessed on a 24-hour basis by calling the Ventura County Fire Department Fire Communications Center at 805-388-4279.
2. In the event that return contact by the EMS Agency Duty Officer is delayed and the situation clearly warrants immediate action, the CHEMPACK provider may elect to open or forward deploy the CHEMPACK for an emergency incident. Attempts to contact the EMS Agency Duty Officer shall be made in all cases through the Fire Communications Center.
3. The EMS Agency may request deployment of a CHEMPACK to a location within the Ventura County Operational Area or outside the operational area under a medical-health mutual aid request. The CHEMPACK provider shall make CHEMPACK resources immediately available upon request by the EMS Agency.

4. The EMS Agency shall immediately notify the Region 1 Regional Disaster Medical Health Specialist (RDMHS) of any CHEMPACK movement from fixed locations or opening of a CHEMPACK container. The RDMHS will ensure that California Department of Health Services / Emergency Preparedness Office (DHS/EPO) is notified promptly of any movement or deployment of CHEMPACK material. DHS/EPO will in turn notify ASPR.
5. Qualifying Events – Emergency Deployment: CHEMPACK material may be accessed, deployed or used only when it is determined that an accidental or intentional nerve agent or other organophosphate release has threatened the public health security of a community. A seal will be broken and material used only when it is determined that other means to save human life will not be sufficient. Authorization to deploy, break the seal on, or move a CHEMPACK container from its specified location will be limited to any of the following events:
    a. Release of a nerve agent or potent organophosphate with human effects or immediate threats too great to adequately manage with other pharmaceutical supplies available.
    b. Large or unusual occurrence of patients presenting with signs and/or symptoms consistent with nerve agent or organophosphate exposure or intoxication.
    c. A credible threat of an imminent event of a magnitude likely to require the assets of the CHEMPACK.
    d. An event with potential to create a nerve agent or organophosphate release with human exposure (e.g. a transportation accident with fire or loss of container integrity).
    e. Any mutual aid request from another region or neighboring state in which CHEMPACK assets are being deployed or staged.
    f. Any event which, in the judgment of the County Health Officer, EMS Agency Medical Director, or Medical & Health Operational Area Coordinator (MHOAC), justifies the deployment of CHEMPACK supplies.
    g. A physical threat to the CHEMPACK at the fixed location (i.e. fire, theft, flood).

B. Authorization to Forward Deploy a CHEMPACK Container – Event or Threat Planning:

1. The EMS Agency may authorize movement of a CHEMPACK container and contents to any location within the Ventura County Operational Area, or outside the area under a medical-health mutual aid request. The EMS Agency will notify the Region 1 RDMHS in advance of any pre-planned CHEMPACK container movement for a particular event or threat.
2. Qualifying Events – Pre-Emptive Deployment: Pre-emptive movement is the relocation of a sealed CHEMPACK container and its contents to a site providing for levels of environmental and security controls generally identical to those required for its regular placement site. Breaking the seal, removing any contents, or moving the cache to a location without those controls constitutes deployment, not pre-emptive movement, and must meet deployment conditions.
    a. Pre-emptive movements may be requested to the EMS Agency by any emergency medical, public health, emergency management, hazardous materials or other related agency in preparation for, or response to, a planned or occurring event deemed appropriate for forward CHEMPACK placement.
    b. Any such request must be made to the RDMHS for approval. Unless an imminent or ongoing emergency, each request must be made at least 48 hours before the movement. The RDMHS will refer any request to the RDMHC and to DHS/EPO for consideration. If an RDMHS is unavailable to take timely action on a movement request, that request may be made to DHS/EPO via the State Warning Center.

C. Post Event Actions:

1. Incident documentation should begin as soon as possible following any emergency operation involving CHEMPACK assets by the EMS Agency. The documentation must include the following:
    a. A thorough description of the incident or event involving CHEMPACK resources.
    b. A list of the approving officials.
    c. An inventory of used and unused CHEMPACK contents.

d. An after-action critique of CHEMPACK deployment effectiveness.

2. The CHEMPACK container and any unused contents will be returned to the CHEMPACK Provider and will be resealed. The EMS Agency will coordinate resupply with the Region 1 RDMHS, DHS/EPO and the ASPR as appropriate. Currently the CHEMPACK Project is not funded to replace CHEMPACK supplies used for an emergency event. However, requests for replenishment of CHEMPACK supplies should be made to the SNS Program as soon as possible after their use. The SNS Program will attempt to secure federal funding to replace and restock supplies used in response to an emergency event

VCEMS General Patient Guidelines 705.00

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 motion restrictions (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

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Effective Date: June 1, 2023~~December 1, 2019~~
Next Review Date: January 31, 2025~~August 31, 2021~~

Date Revised: August 8, 2019
Last Reviewed: January 12, 2023~~August 8, 2019~~

VCEMS Medical Director

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 are primary survey and secondary assessment performed by a Paramedic and may include:

a. Cardiac rhythm

b. 12-lead ECG as indicated per VCEMS Policy 726

c. Pulse Oximetry

d. Capnography

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. Stroke System Triage and Destination – Policy 451
4. Post cardiac arrest with ROSC – Policy 705 (Cardiac Arrest)
5. Trauma Triage and Destination Criteria – Policy 1405
6. Hospital Diversion – Policy 402

VIII. Regularly assess 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

Nausea/Vomiting

ADULT	PEDIATRIC
BLS Procedures	
Maintain airway and position of comfort Administer oxygen as indicated	Maintain airway and position of comfort Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
Indications for Ondansetron: 1. Moderate to severe nausea or vomiting. 2. Potential for airway compromise secondary to suspected/actual head injury when cervical immobilization is used. 3. Prior to MS administration • IV/IO access • Cardiac Monitor • **Ondansetron** ○ PO – 4 mg ODT • May repeat x 1 in 10 min ○ IV/IM/IO – 4 mg • May repeat x 1 in 10 min	Indications for Ondansetron: 1. Moderate to severe nausea or vomiting. 2. Potential for airway compromise secondary to suspected/actual head injury when cervical immobilization is used. 3. Prior to MS administration • IV/IO access • Cardiac Monitor **Ages 6 months up to 5 years** • **Ondansetron** ○ PO – 2 mg ODT ○ IV/IM/IO – 0.1 mg/kg **Ages ≥ 5 Years** • **Ondansetron** ○ PO – 4 mg ODT ○ IV/IM/IO – 0.1 mg/kg
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures

- The use of ondansetron should be avoided in patients with known congenital long QT syndrome
- Use caution in administration of ondansetron for patients with electrolyte imbalances, CHF, bradyarrhythmia, or patients taking medications known to prolong the QT interval

Effective Date: June 1, 2023
Next Review Date: January 31, 2025
Date Revised: October 8, 2020
Last Reviewed: January 12, 2023

VCEMS Medical Director

Pain Control

BLS Procedures

Place patient in position of comfort
Administer oxygen as indicated

ALS Standing Orders

IV/IO access

Cardiac Monitor

Pain 5 out of 10 or greater and SBP > 90 mmHg

Fentanyl
- IV/IO - 1 mcg/kg over 1 minute, OR IN/IM – 1mcg/kg
- Max single dose 100 mcg
- May repeat q 5 minutes for persistent pain to a max total dose 200 mcg
- Repeat doses should be administered IV/IO if vascular access obtained

If Fentanyl unavailable;

Ondansetron - Per 705.15 Nausea/Vomiting Policy
- Repeat x 1 in 10 minutes for nausea or > 2 doses of Morphine

Morphine
- **IV/IO** - 0.1 mg/kg over 1 minute
- Max single dose 10 mg
- May repeat ½ initial dose x 2 q 5 min

OR

Morphine
- IM - 0.1 mg/kg
- Max single dose 10 mg
- May repeat ½ initial dose x 2 q 15 min

Base Hospital Orders only

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

Additional Information

1. **Consider administering ½ normal dose of Opiate pain control;**
   - Patients 65 years of age and older
   - Patients with past adverse reaction to opiates
   - Patients with suspected cardiac ischemia or active TCP
   - Patients with traumatic injuries who are at risk for hemodynamic decompensation

Smoke Inhalation

BLS Procedures

Remove individual from the environment
Consider gross decontamination
Assess ABCs
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

ALS Standing Orders

ADULT

Airway support in accordance with Policy 710 – Airway Management

IV/IO access as indicated

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

If smoke inhalation AND unconscious, ALOC, or cardiac arrest:
- **Hydroxocobalamin – If Available**
  - IV/IO – 5 g in 200 mL NS over 15 minutes

PEDIATRIC

Airway support in accordance with Policy 710 – Airway Management

IV/IO access as indicated

If Wheezes present
- **Albuterol**
  - **Patient ≤ 30 kg**
    - Nebulizer – 2.5 mg/3 mL
      - Repeat as needed
  - **Patient > 30 kg**
    - Nebulizer – 5 mg/6 mL
      - Repeat as needed

If smoke inhalation AND unconscious, ALOC, or cardiac arrest:
- **Hydroxocobalamin – If Available**
  - IV/IO – 70 mg/kg to a max of 5 g in 200 mL NS over 15 minutes

Base Hospital Orders Only

ADULT

Continued unconscious/ALOC OR poor response to initial dose
- **Hydroxocobalamin**
  - IV/IO – 5 g in 200 mL NS over 15 to 120 minutes, depending on clinical presentation.

PEDIATRIC

Continued unconscious/ALOC OR poor response to initial dose
- **Hydroxocobalamin**
  - IV/IO – 70 mg/kg to a max of 5 g in 200 mL NS over 15 to 120 minutes, depending on clinical presentation.

Consult with ED Physician for further treatment measures.

Additional Information:
- If monitoring equipment is available, the patient's carboxyhemoglobin levels should be checked if smoke inhalation is suspected.
- Evidence of smoke inhalation includes soot around mouth and/or nares, increased work of breathing, wheezing
- 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.
- DO NOT administer hydroxocobalamin if patient has a known allergy to hydroxocobalamin or cyanocobalamin