

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

Pre-hospital Services Committee
Agenda

August 9, 2018
9:30 a.m.

I. Introductions

II. Approve Agenda

III. Minutes

IV. Medical Issues

A. Other

V. New Business

A. 400 – Ventura County Emergency Departments

Katy Haddock

B. 410 – ALS Base Hospital Standards

Katy Haddock

C. 420 - Receiving Hospital Standards

Katy Haddock

D. XXX – Ventura County Stroke and STEMI Committee

Dr. Shepherd

VI. Old Business

A. 715 – Needle Thoracotomy

Dr. Shepherd

B. 731 – Tourniquet Policy

Katy Haddock

C. 504 (page 1) / Equipment/Medication Waiver Form

Dr. Shepherd

VII. Informational/Discussion Topics

A. VT/VF Alarms after ROSC

Providers will report findings

B. 318 – ALS Response Unit Staffing

Steve Carroll

C. 705.16 – Neonatal Resuscitation

Dr. Shepherd

VIII. Policies for Review

A. 605 – Interfacility Transfer Patients

B. 612 – Notification of Exposure to a Communicable Disease

C. 705.23 – Supraventricular Tachycardia

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

Topic	Discussion	Action	Approval
II. Approve Agenda		Approved	Motion: Tom O'Connor Seconded: Ira Tilles Passed unanimous
III. Minutes	Tom O'Connor's name was misspelled.	Approved	Motion: Ira Tilles Seconded: Chris Sikes Passed unanimous
IV. Medical Issues			
A. 504 – BLS and ALS Unit Equipment and Supplies	Following a lengthy discussion, the committee decided not to make any changes to the mag sulfate dose in policy 705.20 as requested by Mr. Jelin, therefore the only change to 504 was the Epi dose.	Change Epi Unit minimum amounts due to the different delivery methods.	
B. 705.20 - Seizures	Following a lengthy discussion, the committee decided not to make any changes to the mag sulfate dose in as requested by Mr. Jelin.	No changes	
V. New Business			
A. 318 – ALS Response Unit Staffing		Page 10 of 10: Add "Provider Number" as a 4 th check off category in the EMS Update section #3. In section #6, remove "Endotracheal Intubations" and replace with "Airway Lab". Approved with changes.	Motion: Heather Ellis Seconded: Kyle Brooks Passed unanimous
B. 618 – Unaccompanied Minor		In section A, remove "consider using their cellular phone" and replace with "attempt to". Take out "603" and add "per policy 1000" in section "B". Approved with changes.	Motion: Kathy McShea Seconded: Tom Gallegos Passed unanimous
C. 705.12 – Heat Emergencies		Approved with changes	Motion: Kathy McShea Seconded: Nicole Vorzimer

			Passed unanimous
D. 705.13 - Hypothermia		Change Hypothermia to "Cold Emergencies". Approved with changes	Motion: Kathy McShea Seconded: Joe Dullam Passed unanimous
E. 705.16 – Neonatal Resuscitation		Approved with changes	Motion: Heather Ellis Seconded: Joe Dullam Passed unanimous
F. 715 – Needle Thoracotomy		The committee asked that this policy go to the July TORC meeting and presented to PSC in August.	Motion: Tom O’Conner Seconded: Kathy McShea Passed unanimous
G. 731 – Tourniquet Policy		The committee asked that this policy go to the July TORC meeting and presented to PSC in August.	
H. 1000 - Documentation		Remove the proposed changes.	Motion: Erica Gregson Seconded: Kathy McShea Passed unanimous
I. VT/VF Alarms after ROSC		Tabled until August	Motion: James Rosolek Seconded: Jaime Villa Passed unanimous
J. Ambulance Transport of Children	Restraining a child should reflect the Providers internal policy.	EMS will forward the DOT standard for safe transport of children to each provider.	Motion: Tom O’Conner Seconded: Heather Ellis Passed unanimous
VI. Old Business			
A.			Motion: Nicole Vorzimer Seconded: Tom O’Conner Passed unanimous
VII. Informational/Discussion Topics			
A. Air-Q		Tabled	
B. Pediatric Intubation	As of July 1, 2018, you will no longer be allowed to intubate most children.	Refer to policy 710, 705.07, 705.08 for details.	
C. Cardiac Arrest Data 2018	Katy presented the 2018 data. Dr. Chase is concerned we are trending down with full arrest saves.	Look at developing a sub committee to study the cardiac arrest data.	
D. Trauma Destinations Report	Katy presented the 2018 trauma data which includes January – May.		

VIII. Policies for Review		
A. 615 – Organ Donor Information Search		No changes. Approved
B. 703 – Medical Control at Scene, Physicians on Scene	Update the physician cards that is in the policy. Match the card language to the policy.	
C. 705.11 – Crush Injury		Remove Dopamine and replace with Epi.
X. Agency Reports		
A. Fire departments	<p>VCFPD – Don't forget CE day on June 21st. Flyers have been distributed and food will be provided for attendees.</p> <p>VCFD - none</p> <p>OFD – Dr. Larsen is the new Medical Director for their ALS program. The program is anticipated to start in the fall with a full-time squad and a medic engine as needed</p> <p>Fed. Fire – none</p> <p>SPFD – none</p> <p>FFD – none</p>	
B. Transport Providers	<p>LMT – none</p> <p>AMR/GCA – none</p> <p>AIR RESCUE –none</p>	
C. Base Hospitals	<p>SVH – The hospital is now a Chest Pain Center.</p> <p>LRRMC – June 21st the hospital is having a Stop the Bleed Class.</p> <p>SJRM – Construction is ongoing. Ambulance entrance is open.</p> <p>VCMC – Sarah Melgoza is no longer at VCMC. A new replacement will be chosen for PSC.</p>	
D. Receiving Hospitals	<p>PVH – The new hospital will open in the Fall.</p> <p>SPH – none</p> <p>CMH - none</p> <p>OVCH – none</p>	
E. Law Enforcement	<p>VCSO – none</p> <p>CSUCI PD – none</p>	
F. ALS Education Programs	Ventura College – The paramedic graduation is tomorrow, June 15 th . There is a total of 17 medics graduating.	
G. EMS Agency	<p>Steve – Thank you to Randy for all his hard work on the Narcan training throughout the county.</p> <p>Dr. Shepherd - none</p> <p>Chris – VCEMS is developing a local curriculum for the “Stop the Bleed” campaign. Thank you to Mark Komins for developing the packet for the scope changes.</p>	

	<p>Katy –</p> <p>Karen – October 29th is World Stroke day. The Mission Lifeline Awards will be presented at the August PSC meeting.</p> <p>Julie – none</p> <p>Randy – There is a total of 1,431 people who have been trained to do “Hands Only CPR” in Ventura County this year.</p>	
H. Other		
XI. Closing	Meeting adjourned at 12:00	



**TEMPORARY
PARKING PASS
Expires August 9, 2018**

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

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

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

2240 Gonzales Rd. location

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

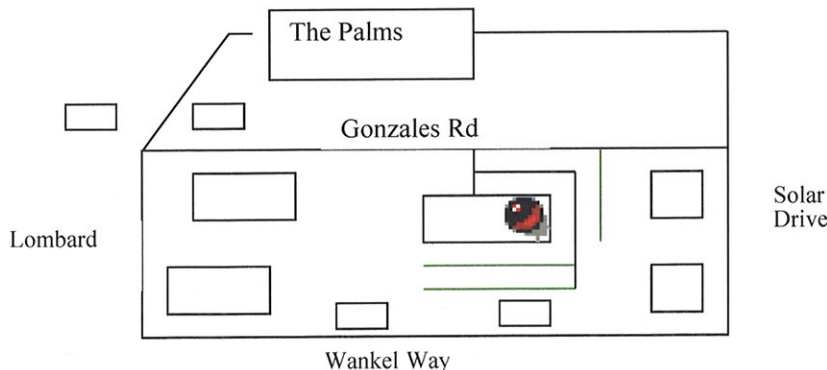
2100 Solar Drive

An additional amount of "Green Permit Parking" spaces (only 30) are available in adjacent parking lot, those that back-up against venue parking area, (Enter this parking lot off of Gonzales[3rd driveway] or Solar Drive). **Place this flyer on your dash.** If all of those stalls are occupied, overflow parking is available at The Palms shopping area or side streets.

The Palms - shopping mall

Enter The Palms at Lombard and Gonzales. Allow for a ten minute walk to venue location.

Additional parking is available on side streets, Lombard, Solar and Wankel Way.



Prehospital Services Committee 2018

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/11/2018	2/8/2018	3/8/2018	4/12/2018	5/10/2018	6/14/2018	7/12/2018	8/9/2018	9/13/2018	10/11/2018	11/8/2018	12/11/2018	%
AMR	Stefansen	Adriane				AS									
AMR	Casey	Andrew	YC					AC							
CMH - ER	Levin	Ross	NC		RL	RL		RL							
CMH - ER	Querol	Amy													
OVCH - ER	Pulido	Ed	EP		EP	EP									
OVCH - ER	Ferguson	Catherine	CF		CF	CF									
CSUCI PD	Drehesen	Charles	CD		CD	CD		CD							
CSUCI PD	DeBoni	Curtis	AC												
FFD	Herrera	Bill	BH		BH	BH		BH							
FFD	Panke	Chad						CP							
GCA	Villasenor	Alejandro						AV							
GCA	Sanders	Mike			MS	MS		MS							
Lifeline	Rosolek	James	JR			JR									
Lifeline	Williams	Joey			JW										
LRRMC - ER	Brooks	Kyle	KB			KB		KB							
LRRMC - ER	Shaner	Meghan	MS		MS	MS		MS							
OFD	Martin	Blair				SM									
OFD	Villa	Jaime	JV		JV	JV		JV							
SJPVH - ER	Hutchison	Stacy	SD			SD		SH							
SJPVH - ER	Sikes	Chris	JD		CS	CS		CS							
SJRMCM - ER	Larsen	Todd	TL		TL	TL		TL							
SJRMCM - ER	McShea	Kathy	KM		KM	KM		KM							
SPFD	Zeller	Tyler	TZ			TZ									
SVH - ER	Tilles	Ira	IT		IT	IT		IT							
SVH - ER	Vorzimer	Nicole	NV		NV	NV		NV							
V/College	O'Connor	Tom	TO		TO	TO		TO							
VCFD	Tapking	Aaron			AT	AT									
VCFD	Ellis	Heather			JH	HE		HE							
VNC	Parker	Barry			SZ			BP							
VNC	Dullam	Joe	JT			JT		JD							
VNC - Dispatch	Gregson	Erica			EG	EG		EG							
VCMC - ER	Chase	David			DC	DC		DC							

Agency	LastName	FirstName	1/11/2018	2/8/2018	3/8/2018	4/12/2018	5/10/2018	6/14/2018	7/12/2018	8/9/2018	9/13/2018	10/11/2018	11/8/2018	12/11/2018	%
VCMC - ER	Gallegos	Tom	TG		TG	TG		TG							
VCMC-SPH	Holt	Carrie	SM		SM	SM									
VCSO SAR	Hadland	Don	DH			DH									
VCSO SAR	Tolle	Jonathon													
VFF	Santillo	Dave													
VFF	Ruppert	Kent													
Below names a			Date Change/cancelled - not counted against member for attendance												
EMS	Carroll	Steve	SC		SC	SC		SC							
EMS	Frey	Julie	JF		JF	JF		JF							
EMS	Haddock	Katy	KH		KH	KH		KH							
EMS	Perez	Randy			RP	RP		RP							
EMS	Shepherd	Daniel			DS	DS		DS							
EMS	Rosa	Chris	CR		CR	CR		CR							
EMS	Salvucci	Angelo													
EMS	Hansen	Erik													
EMS	Beatty	Karen	KB		KB	KB		KB							
EMS	Garcia	Martha				MG		MG							
LMT	Winter	Jeff	JW		JW	JW									
LMT	Frank	Steve													
State Parks	Futoran	Jack			JF	JF									
VCMC	Hill	Jessica													
VCMC	Duncan	Thomas				TD		TD							
CMH	Hall	Elaina				EH		EH							
VNC	James	Lauri						LJ							
VNC	Shedlosky	Robin	RS		RS	RS		RS							
VNC	Komins	Mark	MK		MK	MK		MK							

COUNTY OF VENTURA HEALTH CARE AGENCY		POLICIES AND PROCEDURES EMERGENCY MEDICAL SERVICES	
Policy Title: Ventura County Emergency Departments		Policy Number: 400	
APPROVED: Administration: Steven L. Carroll, Paramedic		Date:	
APPROVED: Medical Director: Daniel Shepherd, MD		Date:	
Origination Date:	October, 1984	Effective Date:	DRAFT
Date Revised:	August 10, 2006		
Date Last Reviewed:	May 14, 2015		
Next Review Date:	May 31, 2018		

Base Hospitals

Basic Emergency Departments

Los Robles Hospital Medical Center
215 W. Janss Road
Thousand Oaks, CA 91360
(805) 370-4435

St. John's Regional Medical Center
1600 N. Rose Ave.
Oxnard, CA 93030
(805) 988-2663

Simi Valley Hospital
2975 N. Sycamore Dr
Simi Valley, CA 93065
(805) 955-6100

Ventura County Medical Center
3291 Loma Vista Road
Ventura, CA 93003
(805) 652-6165

Receiving Hospitals

Basic Emergency Departments

Community Memorial Hospital
147 No. Brent
Ventura, CA 93003
(805) 652-5018

St. John's Pleasant Valley Hospital
2309 Antonio Avenue
Camarillo, CA 93010
(805) 389-5811

VCMC/Santa Paula Hospital
825 N. 10th Street
Santa Paula, CA 93060
(805) 933-8663

Receiving Hospital

Standby Emergency Department

Ojai Valley Community Hospital
1306 Maricopa Highway
Ojai, CA 93023
(805) 640-2260

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title ALS Base Hospital Standards		Policy Number: 410	
APPROVED Administration: Steven L. Carroll, Paramedic		Date:	
APPROVED Medical Director: Daniel Shepherd, MD		Date:	
Origination Date: August 22, 1986		Effective Date: DRAFT	
Date Revised: December 5, 2016			
Date Last Reviewed: December 5, 2016			
Review Date: December 2019			

- I. PURPOSE: To define the criteria, which shall be met by an acute care hospital in Ventura County for Base Hospital (BH) designation.
- II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798, 1798.101, 1798.105, 1798.2 and California Code of Regulations, Title 22, Section 100175.
- III. POLICY:
 - A. An Advanced Life Support (ALS) BH, approved and designated by the Ventura County Emergency Medical Services (VCEMS), shall:
 1. Meet all requirements of an ALS Receiving Hospital (RH) per VCEMS Policy 420.
 2. Have an average emergency department (ED) census of 1200 or more visits per month.
 3. Have the capability to provide, at all times, operational phone with the capability to record the communications, between the BH and paramedics.
 - a. If the communications capability of the BH is interrupted, the ALS provider and the nearest BH shall be notified immediately by telephone.
 - b. ALS calls shall be routed to the nearest BH until communication capability is restored and telephone notification of the ALS provider and nearest BH is made.
 - c. All equipment used for ALS communications shall operate within the frequency requirements of the Ventura County Communications Department. At the time that a countywide communication system is implemented, all ALS providers shall comply with the Ventura County Communications Department ALS communications plan.
 4. Assure that communication between the BH and ALS Unit for each ALS call shall be provided only by the BH ED physician or Ventura County authorized Mobile Intensive Care Nurse (MICN) by radio or telephone.
 5. Designate a Prehospital Liaison Physician (PLP) who shall be a physician on the hospital staff, licensed in the State of California and have experience in emergency medical care. The PLP shall:

- a. Be regularly assigned to the ED.
 - b. Have experience in and knowledge of BH operations.
 - c. Be responsible for overall medical control and supervision of the ALS program within the BH's area of responsibility including review of patient care records and critique of personnel involved.
 - d. Be responsible for reporting deficiencies in patient care to VCEMS.
 - e. Coordinate BH activities with RH, Prehospital Services Committee (PSC) and VCEMS policies and procedures.
 - f. Attend PSC meetings.
 - g. Provide ED staff education.
 - h. Evaluate paramedics for clinical performance and makes recommendation to VCEMS.
 - j. Evaluate MICNs for authorization/reauthorization and makes recommendation to VCEMS.
6. Have on duty, on a 24-hour basis, one (1) MICN who meets the criteria in VCEMS Policy 321.
 7. Identify an MICN with experience in, and knowledge of, BH communications operations and VCEMS policies and procedures as a Prehospital Care Coordinator (PCC) to assist the PLP in the medical control, supervision, and continuing education (CE) of prehospital care personnel. The PCC shall be a full-time or full-time equivalency employee whose responsibility is dedicated to the oversight and management of the prehospital / EMS duties of the BH.
 8. Provide for the CE of prehospital care personnel, paramedics MICNs, EMTs, and first responders, in accordance with VCEMS:
 9. Cooperate with and assist the PSC and the VCEMS medical director in the collection of statistics and review of necessary records for program evaluation and compliance.
 10. Assure that paramedics perform medical procedures only under medical direction of a physician or Ventura County authorized MICN except for approved standing orders.
 11. Agree to maintain all recorded communications and prehospital data in a manner consistent with hospital data requirements. Prehospital data includes, but is not limited to, the recording of the prehospital communication, prehospital care record, paramedic BH communications form and documentation of telephone communication with the RH (if utilized). All prehospital data except the recording will be integrated with the patient chart.
 12. Resident physicians shall attend BH Physician course.

- B. There shall be a written agreement between the BH and VCEMS indicating the commitment of hospital administration medical staff, and emergency department staff to meet requirements for ALS program participation as specified by State regulations and VCEMS policies and procedures.
- C. The VCEMS shall review its agreement with each BH at least every two years.
- D. The VCEMS may deny, suspend, or revoke the approval, of a BH for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the PSC and Board of Supervisors for appropriate action.
- E. A hospital wishing to become an ALS BH in Ventura County must meet Ventura County BH Criteria and agree to comply with Ventura County regulations.
 - 1. Application:
Eligible hospitals shall submit a written request for BH approval to VCEMS documenting the compliance of the hospital with the Ventura County BH Criteria.
 - 2. Approval:
 - a. Program approval or disapproval shall be made in writing by the VCEMS to the requesting BH within a reasonable period of time after receipt of the request for approval and all required documentation. This time period shall not exceed three (3) months.
 - b. The VCEMS shall establish the effective date of program approval in writing upon the satisfactory documentation of compliance with all the program requirements.
 - 3. Withdrawal of Program Approval:
Non-compliance of any criterion associated with program approval, use of non-certified personnel, or non-compliance with any other Ventura County regulation applicable to a BH, may result in withdrawal, suspension or revocation of program approval by the VCEMS.
- F. Advanced Life Support BHs shall be reviewed ~~on an annual basis~~ every two years.
 - 1. All BH's shall receive notification of evaluation from the VCEMS.
 - 2. All BH's shall respond in writing regarding program compliance.
 - 3. On-site visits for evaluative purposes may occur.
 - 4. Any BH shall notify the VCEMS by telephone, followed by a letter within 48 hours of changes in program compliance or performance.

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

BASE HOSPITAL
CRITERIA COMPLIANCE CHECK LIST

Base Hospital: _____

Date: _____

	YES	NO
An Advanced Life Support (ALS) Base Hospital (BH), approved and designated by the Ventura County Emergency Medical Services (VCEMS), shall:		
1. Meet all requirements of an ALS Receiving Hospital (RH) per (VCEMS) Policy 420.		
2. Have the capability to provide, at all times, operational phone with the capability to record the communications, between the BH and paramedics. If the communications capability of the BH is interrupted, the ALS provider and the nearest BH shall be notified immediately by telephone. All equipment used for ALS communications shall operate within the frequency requirements of the Ventura County Communications Department. At the time that a countywide communication system is implemented, all ALS providers shall comply with the Ventura County Communications Department ALS communications plan.		
3. Have the capability to provide, at all times, operational phone with the capability to record the communications, between the BH and paramedics.		
4. Designate a Prehospital Liaison Physician (PLP) who shall be a physician on the hospital staff, licensed in the State of California, and have experience in emergency medical care. The PLP shall:		
• Be regularly assigned to the Emergency Department (ED).		
• Have experience in and knowledge of BH operations.		
• Be responsible for overall medical control and supervision of the ALS program within the BH's area of responsibility including review of patient care records and critique of personnel involved.		
• Be responsible for reporting deficiencies in patient care to VCEMS.		
• Coordinate BH activities with RH, Prehospital Services Committee (PSC) and VCEMS policies and procedures.		
• Attend PSC meetings.		
• Provide ED staff education.		
• Evaluate MICNs for authorization/reauthorization and make recommendation to VCEMS.		
5. All BH MICN's shall:		
• Be authorized in Ventura County by the VCEMS MD <u>medical director (MD)</u> .		
• Be assigned only to the ED while functioning as an MICN.		
• Maintain current ACLS certification.		
• Be a BH employee.		

	YES	NO
6. Identify an MICN with experience in and knowledge of BH communication operations and VCEMS policies and procedures as a Prehospital Care Coordinator (PCC) to assist the PLP in the medical control, supervision, and continuing education (CE) of prehospital care personnel. The PCC shall be a full-time or full-time equivalency employee whose responsibility is dedicated to the oversight and management of the prehospital / EMS duties of the BH.		
7. Provide for the CE of prehospital care personnel (paramedics MICN's, EMTs, and first responders), in accordance with VCEMS Policy 1131:		
8. Cooperate with and assist the Prehospital Services Subcommittee (PSC) and the VCEMS MD in the collection of statistics and review of necessary records for program evaluation and compliance.		
9. Assure that paramedics perform medical procedures only under medical direction of a physician or Ventura County authorized MICN except for approved standing orders and medical procedures.		
10. Agree to maintain all recorded communications and prehospital data in a manner consistent with hospital data requirements. Prehospital data includes, but is not limited to the tape of the prehospital communication, prehospital care record paramedic BH communications form, documentation of telephone communication with the RH (if utilized). All prehospital data except the tape recording will be integrated with the patient chart.		
11. Submit a letter to VCEMS indicating the commitment of hospital administration medical staff, and emergency department staff to meet requirements for program participation as specified by State regulations and VCEMS policies and procedures.		
12. Assure that resident physicians shall attend BH Physician course.		

COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES		HEALTH CARE AGENCY POLICIES AND PROCEDURES	
Policy Title: Receiving Hospital Standards		Policy Number 420	
APPROVED Administration: Steven L. Carroll, Paramedic		Date:	
APPROVED Medical Director: Daniel Shepherd, MD		Date:	
Origination Date: April 1, 1984		Effective Date: DRAFT	
Date Revised: July 12, 2012			
Date Last Reviewed: July 12, 2012			
Review Date: July, 2015			

- I. PURPOSE: To define the criteria, which shall be met by an acute care hospital in Ventura County for Receiving Hospital (RH) designation.
- II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1798, 1798.101, 1798.105, 1798.2 and California Code of Regulations, Title 22, Section 100175.
- III. POLICY:
 - A. A RH , approved and designated by the Ventura County, shall:
 1. Be licensed by the State California as an acute care hospital.
 2. Meet the requirements of the Health and Safety Code Sections 1250-1262 and Title 22, Sections 70411, 70413, 70415, 70417, 70419, 70649, 70651, 70653, 70655 and 70657 as applicable.
 3. Be accredited by a CMS accrediting agency.
 4. Operate an emergency department (ED) that is designated by the State Department of Health Services as a “Comprehensive Emergency Department,” “Basic Emergency Department” or a “Standby Emergency Department.”
 5. Operate an Intensive Care Unit.
 6. Have the following specialty services available at the hospital or appropriate referral hospital (at the discretion of the Emergency Department Physician. and consultant Physician.) within 30 minutes:

Cardiology	Anesthesiology	Neurosurgery
Orthopedic Surgery	General Surgery	General Medicine
Thoracic Surgery	Pediatrics	Obstetrics
 7. Have operating room services available within 30 minutes.
 8. Have the following services available within 15 minutes.

X-ray	Laboratory	Respiratory Therapy
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9. Evaluate all ambulance transported patients promptly, either by RH Physician, Private Physician or other qualified medical personnel designated by hospital policy.
10. Have the capability at all times to communicate with the ambulances and the Base Hospital (BH).
11. Designate a ED Medical Director who shall be a physician on the hospital staff, licensed in the State of California and have experience in emergency medical care. The Medical Director shall:
 - a. Be regularly assigned to the ED.
 - b. Have knowledge of VCEMS policies and procedures.
 - c. Coordinate RH activities with BH, Prehospital Services Committee (PSC), and VCEMS policies and procedures.
 - d. Attend, or have designee attend, PSC meetings.
 - e. Provide ED staff education.
 - f. Schedule medical staffing for the ED on a 24-hour basis.
12. Agree to provide, at a minimum, on a 24-hour basis, a physician and a registered nurse (RN) that meets the following criteria:
 - a. All Emergency Department physicians shall:
 - 1) Be immediately available to the Emergency Department at all times.
 - 2) Be certified by the American Board of Emergency Medicine or be board eligible or have all of the following:
 - a) Have and maintain current Advanced Cardiac Life Support (ACLS) certification.
 - b. Have and maintain current Advanced Trauma Life Support (ATLS) certification.
 - c) Complete at least 25 Category I CME hours per year with content applicable to Emergency Medicine.
 - 3) Full-time resident physicians working in their own institution's Emergency Departments whose function as backup to Advanced Life Support (ALS) personnel shall fulfill Section 11.a and shall be senior (second and third year) residents.
 - b. RH EDs shall be staffed by:
 - 1) Full-time staff: those physicians who practice emergency medicine 120 hours per month or more, and/or

- 2) Regular part-time staff: those physicians who see 90 patients or more per month in the practice of emergency medicine.
 - a) Formula: Average monthly census of acute patients divided by 720 hours equals average number of patients per hour. This figure multiplied by average hours worked by physician in emergency medicine equals patients per physician per month.
 - b) Physicians working in more than one hospital may total their hours.
 - c) Acute patients exclude scheduled and return visits, physicals, and patients not seen by the ED Physician.
 - d) During period of double coverage, the whole shall be met if one of the physicians meets the above standards.
 - c. All RH RNs shall:
 - 1) Be regular hospital staff assigned solely to the ED for that shift.
 - 2) Maintain current ACLS certification.
 - d. All other nursing and clerical personnel for the Emergency Department shall maintain current Basic Cardiac Life Support certification.
 - e. Sufficient licensed personnel shall be staffed to support the services offered.
13. Cooperate with and assist the PSC and EMS Medical Director in the collection of statistics for program evaluation.
 14. Agree to maintain all prehospital data in a manner consistent with hospital data requirements and provide that the data be integrated with the patient's chart. Prehospital data shall include the ~~Prehospital Care Record~~ [Ventura County Electronic Patient Care Report \(VCePCR\)](#), Paramedic Base Hospital communication form (from the BH), and documentation of a BH telephone communication with the RH.
 15. Participate with the BH in evaluation of paramedics for reaccreditation.
 16. Permit the use of the hospital helipad as an emergency rendezvous point if a State-approved helipad is maintained on hospital premises.
- B. There shall be a written agreement between the RH and EMS indicating the commitment of hospital administration, medical staff, and emergency department staff to meet requirements for ALS program participation as specified by EMS policies and procedures.

- C. EMS shall review its agreement with each RH at least every two years.
- D. EMS may deny, suspend, or revoke the approval of a RH for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Board of Supervisors for appropriate action.
- E. The EMS Medical Director may grant an exception to a portion of this policy upon substantiation of need by the PSC that, as defined in the regulations, compliance with the regulation would not be in the best interests of the persons served within the affected local area.
- F. A hospital that applies to become a RH in Ventura County must meet Ventura County RH Criteria and agree to comply with Ventura County regulation.
 - 1. Application:
Eligible hospital shall submit a written request for RH approval to the VCEMS, documenting the compliance of the hospital with the Ventura County RH.
 - 2. Approval:
Program approval or denial shall be made in writing by EMS to the requesting RH within a reasonable period of time after receipt of the request for approval and all required documentation. This period shall not exceed three (3) months.
- G. ALS RHs shall be reviewed ~~on an annual basis~~ **every two years**.
 - 1. All RH shall receive notification of evaluation from the EMS.
 - 2. All RH shall respond in writing regarding program compliance.
 - 3. On-site visits for evaluative purposes may occur.
 - 4. Any RH shall notify the EMS by telephone, followed by a letter within 48 hours, of changes in program compliance or performance.
- H. A RH with a comprehensive or basic emergency department should be the destination for patient who would likely require admission to an acute care hospital. Examples of these patients would include, but are not limited to, patients with:
 - 1. Sustained abnormal vital signs
 - 2. Patients with seizure of new onset, multiple seizures within a 24-hour period, or sustained alteration in level of consciousness
 - 3. Chest pain or discomfort of known or suspected cardiac origin
 - 4. Sustained respiratory distress not responsive to field treatment
 - 5. Suspected pulmonary edema not responsive to field treatment
 - 6. Potentially significant cardiac arrhythmias

7. Orthopedic emergencies having deformity, open fractures, or alterations of distal neurovascular status
 8. Suspected spinal cord injury of new onset
 9. Toxic exposure or overdose.
 10. Burns greater than 10% body surface area
 11. Drowning or suspected barotrauma with any history of loss of consciousness, unstable vital signs, or respiratory problems
 12. Criteria that meet stroke, STEMI, or trauma criteria for transport to a specialty care hospital
- I. A RH with a standby emergency department only, offering “standby emergency medical service,” is considered to be an alternative receiving facility. Patients may be transported to a standby emergency department when the use of the facility is in the best interest of patient care. EMS providers and paramedics may transport patients to a RH with a standby emergency department when the paramedic reasonably believes the patient will be discharged from the emergency department.
1. Patients that require emergent stabilization at an emergency department may be transported to a standby emergency department if a basic emergency facility is not within a reasonable distance. These would include patients:
 - a. In cardiac arrest with NO return of spontaneous circulation (ROSC) in the field
 - b. With bleeding that cannot be controlled
 - c. Without an effective airway
 2. Patients who would likely require admission to an acute care hospital should not be transported to a standby emergency department. When the paramedic reasonably believes the patient’s condition is likely to require hospital admission, this information should be included in prehospital report to the Base Hospital MICN. The MICN should then direct the patient to the most appropriate hospital.
 3. During hours of peak traffic, the Base Hospital MICN should make destination determinations based on predicted travel time and patient condition. Patients who meet criteria for trauma, stroke, or STEMI, or will likely require admission, in the absence of a condition that meets I. 1. above, will be directed to the appropriate destination.

4. A RH with a standby emergency department shall report to Ventura County EMS Agency any change in status regarding its ability to provide care for emergency patients.

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

RECEIVING HOSPITAL
CRITERIA COMPLIANCE CHECKLIST

Receiving Hospital: _____

Date: _____

		YES	NO
A.	Receiving Hospital (RH), approved and designated by the Ventura County, shall:		
1.	Be licensed by the State of California as an acute care hospital.		
2.	Meet the requirements of the Health and Safety Code Section 1250-1262 and Title 22, Sections 70411, 70413, 70415, 70417, 70419, 70649, 70651, 70653, 70655 and 70657 as applicable.		
3.	Be accredited by a CMS accrediting agency		
4.	Operate an Intensive Care Unit.		
5.	Have the following specialty services available at the hospital or appropriate referral hospital (at the discretion of the Emergency Department (ED) Physician. and consultant Physician.) within 30 minutes:		
	• Cardiology		
	• Anesthesiology		
	• Neurosurgery		
	• Orthopedic Surgery		
	• General Surgery		
	• General Medicine		
	• Thoracic Surgery		
	• Pediatrics		
	• Obstetrics		
6.	Have operating room services available within 30 minutes.		
7.	Have the following services available within 15 minutes.		
	• X-Ray		
	• Laboratory		
	• Respiratory Therapy		
8.	Evaluate all ambulance transported patients promptly, either by RH Physician, Private Physician or other qualified medical personnel designated by hospital policy.		
9.	Have the capability at all times to communicate with the ambulances and the BH.		
10.	Designate an Emergency Department Medical Director who shall be a physician on the hospital staff, licensed in the State of California and have experience in emergency medical care. The Medical Director shall:		
a.	Be regularly assigned to the Emergency Department.		
b.	Have knowledge of VC EMS policies and procedures.		

		YES	NO
c.	Coordinate RH activities with Base Hospital, Prehospital Services Committee (PSC), and VCEMS policies and procedures.		
d.	Attend or have designee attend PSC meetings.		
e.	Provide Emergency Department staff education.		
f.	Schedule medical staffing for the ED on a 24-hour basis.		
11.	Agree to provide, at a minimum, on a 24-hour basis, a physician and a registered nurse that meets the following criteria:		
a.	All Emergency Department physicians shall:		
1).	Be immediately available to ED at all times.		
2).	Be certified by the American Board of Emergency Medicine or be board eligible or have all of the following:		
a).	Have and maintain current Advanced Cardiac Life Support (ACLS) certification.		
b).	Have and maintain current Advanced Trauma Life Support (ATLS) certification.		
c).	Complete at least 25 Category I CME hours per year with content applicable to Emergency Medicine.		
3).	Full-time resident physician working in their own Institution's ED. Resident physicians who function, as backup to ALS personnel shall fulfill Section 11.a and shall be senior (second and third year) residents.		
b.	RH EDs shall be staffed by:		
1).	Full-time staff: those physicians who practice emergency medicine 120 hours per month or more, and/or		
2).	Regular part-time staff: those physicians who see 90 patients or more per month in the practice of emergency medicine.		
a).	Formula: Average monthly census of acute patients divided by 720 hours equals average number of patients per hour. This figure multiplied by average hours worked by physician in emergency medicine equals patients per physician per month		
b).	Physicians working in more than one hospital may total their hours		

		YES	NO
	c) Acute patients exclude scheduled and return visits, physicals, and patients not seen by the ED Physician		
	d) During period of double coverage, the whole shall be met if one of the physicians meets the above standards.)		
	c. All RH RNs shall:		
	1) Be regular hospital staff assigned solely to the ED for that shift.		
	2) Maintain current ACLS certification.		
	d. All other nursing and clerical personnel for the ED shall maintain current Basic Cardiac Life Support certification.		
	e. Sufficient licensed personnel shall be utilized to support the services offered.		
12.	Cooperate with and assist the PSC and EMS Medical Director in the collection of statistics for program evaluation.		
13.	Agree to maintain all prehospital data in a manner consistent with hospital data requirements and provide that the data be integrated with the patient's chart. Prehospital data shall include the VCePCR, paramedic Base Hospital communication form (from the BH), and documentation of a BH telephone communication with the RH.		
14.	Participate with the BH in evaluation of paramedics for reaccreditation.		
15.	Permit the use of the hospital helipad as an emergency rendezvous point if a State-approved helipad is maintained on hospital premises.		
B.	There shall be a written agreement between the RH and EMS indicating the commitment of hospital administration, medical staff, and emergency department staff to meet requirements for employment as specified by EMS policies and procedures.		

Physician Name: _____

Date: _____

All Emergency Department physicians shall:		YES	NO
1.	Be immediately available to the RH ED at all times.		
2.	Be certified by the American Board of Emergency Medicine or have the following:		
	a. Have and maintain current ACLS certification.		
	b. Complete at least 25 Category I CME hours per year with content applicable to Emergency Medicine.		
	c. It is recommended that RH physicians be ATLS certified.		
3.	Full-time resident physician working in their own Institution's EDs. Resident physicians who function, as backup to ALS personnel shall fulfill Section 14.a and shall be senior (second and third year) residents.		

The above named physician is:

1)	Full-time staff: A physician who practices emergency medicine 120 hours per month or more, and/or		
2)	Regular part-time staff: A physician who see 90 patients or more per month in the practice of emergency medicine (Average monthly census of acute patients divided by 720 hours equals average number of patients per hour. This figure multiplied by average hours worked by physician in emergency medicine equals patients per physician per month, Physicians working in more than one hospital may total their hours, Acute patients exclude scheduled and return visits, physicals, and patients not seen by the ED Physician)		

COUNTY OF VENTURA
EMERGENCY MEDICAL SERVICES

RECEIVING HOSPITAL
STANDBY EMERGENCY DEPARTMENT
ADDITIONAL CRITERIA COMPLIANCE
CHECKLIST

Receiving Hospital w/Standby ED: _____ Date: _____

	<u>EMS REVIEW</u>	
	<u>YES</u>	<u>NO</u>
<u>The RH with standby ED has:</u>		
<u>A. Medical staff, and the availability of the staff at various times to care for patients requiring emergency medical services.</u>		
<u>B. Ability of staff to care for the degree and severity of patient injuries or condition.</u>		
<u>C. Equipment and services available at the facility necessary to care for patients requiring emergency medical services and the severity of their injuries or condition.</u>		
<u>D. During the current 2-year evaluation period, has reported to Ventura County EMS Agency any change in status regarding its ability to provide care for emergency patients.</u>		
<u>E. Authorization by the Ventura County EMS Agency medical director to receive patients requiring emergency medical services, in order to provide for the best interests of patient care.</u>		
<u>COMMENTS</u>		

COUNTY OF VENTURA		EMERGENCY MEDICAL SERVICES
HEALTH CARE AGENCY		POLICIES AND PROCEDURES
Policy Title: Ventura County Stroke and STEMI Committees		Policy Number XXX
APPROVED: Administration: Steve L. Carroll, EMT-P		Date:
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date:
Origination Date: August 9, 2018		Effective Date: .
Date Revised:		
Date Last Reviewed:		
Review Date:		

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 EMERGENCY MEDICAL SERVICES		HEALTH CARE AGENCY POLICIES AND PROCEDURES	
Policy Title: Needle Thoracostomy		Policy Number: 715	
APPROVED: Administration: Steven L. Carroll, Paramedic EMT-P		Date: June 1, 2013	
APPROVED: Medical Director Daniel Shepherd Angelo Salvucci, M.D.		Date: June 1, 2013	
Origination Date: August 2010		Effective Date: June 1, 2013	
Date Revised: April 4, 2013			
Date Last Reviewed: April 11, 2013			
Review Date: March 31, 2015			

- I. Purpose: To define the indications, procedure and documentation for needle thoracostomy use by paramedics.
- II. Authority: Health and Safety Code, Sections 1797.220 and 1798. California Code of Regulations, Title 22, Sections 100145 and 100169.
- III. Policy: Paramedics may perform needle thoracostomy on patients with a suspected tension pneumothorax in accordance with this policy.
- IV. Procedure:
 - A. Indications
 1. Patients with **ALL** of the following:
 - a. Clinical suspicion of pneumothorax (e.g., trauma, dyspnea, chest pain),
 - b. Systolic Blood Pressure less than 90, and
 - c. Absent or significantly decreased breath sounds on the affected side.
 - B. Contraindications: None in this setting
 - C. Equipment
 1. Povidone-iodine prep swab
 2. 10 ml syringe
 3. ~~(Adults and pediatric patients > 40kg): 8.0-8.5 5.0-6.0 cm, 14 12-16-gauge~~ over-the-needle catheter
 3. Peds under 40KG(peds): 1.252-2.5 inch 164 gauge over-the-needle catheter
 4. Connection tubing
 5. Heimlich valve
 6. Tape
 - D. Placement
 1. Attach the syringe to the needle/catheter.
 2. Identify and prep the site with antiseptic solution.:

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Adults:(adults)

○ The lateral placement is the preferred method which is the fourth intercostal space in the anterior-axillary line (lateral to nipple).

○ If unable to access lateral placement due to patient size, position, or failed attempt, locate the second intercostal space in the mid-clavicular line. (This is the preferred site in pediatric patients. Locate the second intercostal space in the mid-clavicular line.

● If unable to place anteriorly, lateral placement is in the fourth intercostal space in the mid-axillary line.

● Prepare the site with antiseptic solution.

2-3. Insert patients). Insert the needle/catheter perpendicular to the skin over the rib and direct it just over the top of the rib into the intercostal space.

3-4. After inserting the needle under the skin, maintain negative pressure in the syringe.

4-5. Advance the needle/catheter through the parietal pleura until a "pop" is felt and/or air or blood enters the syringe, then advance **ONLY** the catheter (not the syringe/needle) until the catheter hub is against the skin.

CAUTION: Do not reinsert needle into cannula due to danger of shearing cannula.

5-6. Hold the catheter in place and remove and discard the syringe and needle.

6-7. Attach tubing and Heimlich valve.

7-8. Secure the catheter hub to the chest wall with dressings and tape.

8-9. Reevaluate the patient (VS, lung sounds).

E. Documentation

1. All needle thoracostomy attempts must be documented in the Ventura County Electronic Patient Care Reporting System (VCePCR).
2. Documentation will include location, size of equipment, number of attempts, success, complications, patient response and any applicable comments.

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COUNTY OF VENTURA EMERGENCY MEDICAL SERVICES		HEALTH CARE AGENCY POLICIES AND PROCEDURES	
Policy Title: Tourniquet Use		Policy Number: 731	
APPROVED: Administration: Steven L. Carroll, EMT-P		Date: December 1, 2015 2015	
APPROVED: Medical Director: Daniel Shepherd, MD Angelo Salvucci, M.D.		Date: December 1, 2015 December 1 June 14, 2018	
Origination Date: July 2010		Effective Date: December 1, 201 85	
Date Revised: July 10, 2018 August 13, 2015			
Date Last Reviewed: July 10, 2018 August 13, 2015			
Review Date: July 31, 2020 August, 2017			

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- I. Purpose: To define the indications, procedure and documentation for tourniquet use by EMTs and paramedics.
- II. Authority: Health and Safety Code, Sections 1797.220 and 1798.
- III. Policy: EMTs and Paramedics may utilize tourniquets on patients in accordance with this policy.
- IV. Procedure:
 - A. Indications
 - 1. Life threatening extremity hemorrhage that cannot be controlled by other means.
 - B. Contraindications
 - 1. Non-extremity hemorrhage.
 - 2. Proximal extremity location where tourniquet application is not practical.

C. Relative Contraindications

- 1. ~~1.~~ AV fistulas: Bleeding fistulas are best managed with firm direct pressure. Applying a tourniquet can ruin a fistula and should be a last resort. Base contact prior to applying a tourniquet is encouraged but not required.

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D. Tourniquet Placement:

- 1. Visually inspect injured extremity and avoid placement of tourniquet over joint, angulated or open fracture, stab or gunshot wound sites.
- 2. Assess and document circulation, motor and sensation distal to injury site.
- 3. Apply tourniquet proximal to wound (usually 2-4 inches).
- 4. Tighten tourniquet rapidly to least amount of pressure required to stop bleeding.
- 5. Cover wound with appropriate sterile dressing and/or bandage.
- 6. Do not cover tourniquet- the device must be visible.

7. Re-assess and document absence of bleeding distal to tourniquet.
8. Remove any improvised tourniquet that may have been previously applied.
9. Tourniquet placement time must be documented on the tourniquet device.
10. Ensure receiving facility staff is aware of tourniquet placement and time tourniquet was placed.

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D. Tourniquet Removal (Paramedic only), replacement, or repositioning

1.
BLS providers may reposition an improperly placed tourniquet or replace a malfunctioning device.
Only ALS personnel may formally remove a tourniquet to assess if it is still necessary.

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4.2. Indications

- a. ~~a.~~ Releasing the tourniquet should only be considered if applied for 60 minutes or longer. Improperly placed tourniquet
- b. Poorly functioning device
- c. Absence of bleeding distal to the tourniquet should be confirmed ~~after manipulation~~ after manipulation, adjustment, or removal.

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3.2. Procedure

- a. Obtain IV/IO access
- b. Maintain continuous ECG monitoring.
- c. If repositioning or replacing a tourniquet, place a second tourniquet proximal to the first device in the appropriate location.
- d. Hold firm direct pressure over wound for at least 5 minutes before releasing a tourniquet.
- e. Gently release the initial tourniquet and monitor for reoccurrence of bleeding.
- f. If appropriate, document the time the tourniquet was released.
- g. Bandage wound and re-assess and document circulation, motor and sensation distal to the wound site regularly.
- h. If bleeding resumes, requiring a tourniquet, re-application will be in accordance with application procedures outlined in Section IV of this policy.

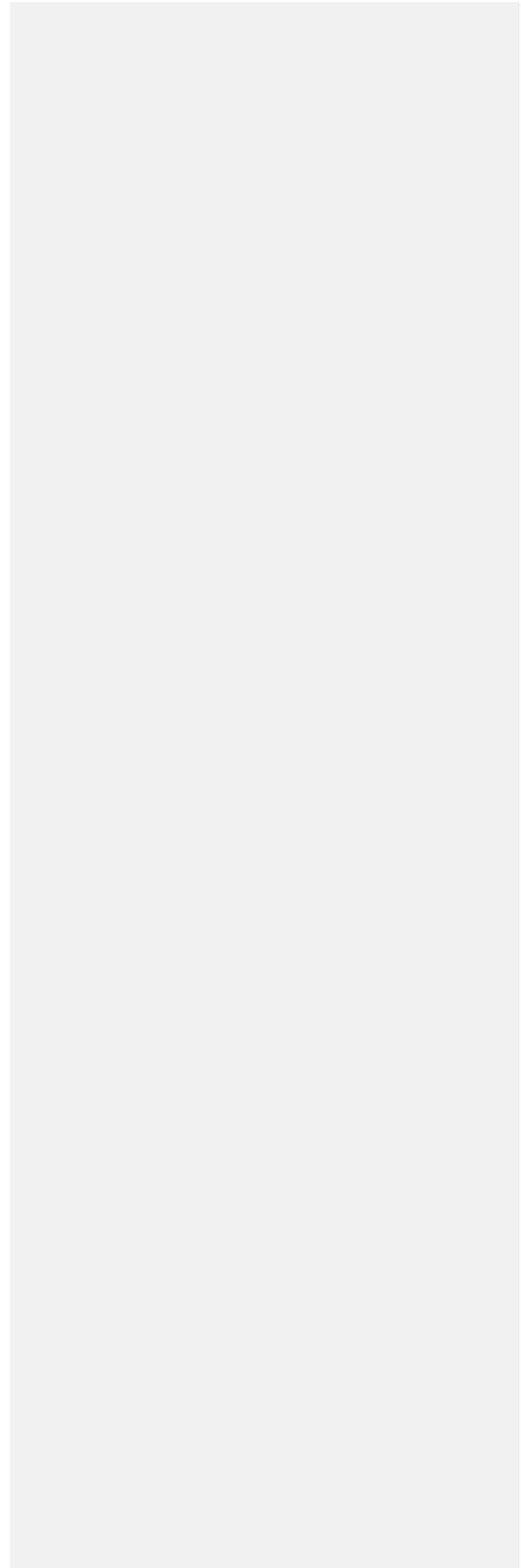
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E. Documentation

1. All tourniquet uses must be documented in the Ventura County Electronic Patient Care Reporting System.
2. Documentation will include location of tourniquet, time of application, and person at the receiving hospital to whom the tourniquet is reported.



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: June 1, 2018	
APPROVED: Medical Director Daniel Shepherd, MD		Date: June 1, 2018	
Origination Date:	May 24, 1987	Effective Date:	June 1, 2018
Date Revised:	April 12, 2018		
Last Reviewed:	April 12, 2018		
Review Date:	April 30, 2021		

- 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. [Mediation attempts should be documented in the comment section on the waiver request form, such as what vendors were contacted, etc.](#)



Ventura County EMS Agency Equipment/Medication Waiver Request

DRAFT

Date: Form completed by:

Agency:

Equipment/Medication (name, concentration, supplied dose, packaging):

Lot # and Expiration:

In response to an ongoing, or imminent shortage of the single and specific medication/equipment listed above, the provider agency requests the following *Action Plan* (choose one):

- A) One-time, 30-day waiver exempting the provider agency from minimum stocking standards listed in Policy 504 for the medication listed above requested to begin**
Explain specific issue and mediation attempt in comment section below:
- B) 90-day window for a preapproved, one-time, 30-day waiver exempting provider agency from minimum stocking standards listed in Policy 504 for the medication listed above to begin when on-hand stock of medication above falls below required minimum stocking levels.**
Explain specific issue and mediation attempt in comment below:
- C) Request for substitution of medication with alternative (concentration & amount)**
Explain specifics and mediation attempts in comment section below:

Pending approval of this request, the requesting provider agency certifies an understanding, and compliance with each of the following:

The provider agency will immediately report any adverse impacts on patient care resultant of this shortage to the EMS Agency.

If a need for continuing waiver is expected beyond 30 days the provider agency will submit a new request no later than five days before this waiver's expiration.

The provider agency will notify the EMS Agency within 24 hours when medication restock becomes available and this waiver will become null and void, unless otherwise specified by EMS Agency.

Action B only - The provider agency will notify the EMS agency within 24 hours when medication stock falls below minimum stocking levels and preapproved 30 day waiver is enacted.

The provider agency will provide any evidence required by EMS Agency of educational plan deemed necessary by EMS Agency to prepare field personnel to incorporate this shortage into patient care.

Submit to EMSA by email EMSAgency@ventura.org or fax to 805-981-5300

Comments:



Ventura County EMS Agency
Equipment/Medication
Waiver Request
DRAFT

EMS AGENCY USE ONLY

Requesting Agency

Date received:

Date Processed:

Equipment/Medication Shortage Mitigation and Response Strategies verified: Yes No

Waiver granted: Yes No

If yes, **Action Plan** granted: A B C

Waiver start date:

Expires:

Action plan B only - Preapproved period starts:

Expires:

Approved by

Medical Director:

EMS Administration:

Print:	
Sign:	Date:

Print:	
Sign:	Date:

Comments:

Policy Title: ALS Response Unit Staffing	Policy Number: 318
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: July 1, 2018
APPROVED: Medical Director Daniel Shepherd, MD	Date: July 1, 2018
Origination Date: June 1, 1997 Date Revised: June 14, 2018 Date Last Reviewed: June 14, 2018 Review Date: June 30, 2021	Effective Date: July 1, 2018

- I. PURPOSE: To establish medical control standards for ALS response unit paramedic staffing.
- II. AUTHORITY: Health and Safety Code, Sections 1797.214, 1797.220, 1798, and 1798.200
22 CCR Division 9, Chapter 4, Sections 100175, 100179
- III. DEFINITIONS:
 - A. ALS Response Unit: First Response ALS Unit, Paramedic Support Vehicle, or ALS Ambulance per VCEMS Policies 506 and 508.
 - B. Definition of an ALS Patient Contact: A patient contact where the paramedic successfully performs an ALS skill listed in VCEMS Policy 310, with the exception of glucose testing, cardiac monitoring and pulse oximetry.
- IV. POLICY:
 - A. All ALS Response Units must be staffed with a minimum of one Level II paramedic who meets the requirements in this policy.
 - B. Additional ALS Response Unit staff may be a Level I or II paramedic meeting the requirements in this policy and/or an EMT meeting requirements in VCEMS Policy 306. An ALS response unit may be staffed with a non-accredited Paramedic only when it is also staffed with an authorized Field Training Officer (FTO) or Paramedic Preceptor, unless the non-accredited Paramedic is functioning in a BLS capacity in accordance with VCEMS Policy 306.
 - C. ALS Patient Contact: A patient contact where the paramedic successfully performs an ALS skill listed in VCEMS Policy 310, with the exception of glucose testing, cardiac monitoring and pulse oximetry.
 - D. Field Training Officer (FTO): An agency designation for those personnel qualified to train others for the purposes of EMT ALS-Assist Authorization, Paramedic Accreditation, Level I or Level II Paramedic Authorization/Re-Authorization.
 - E. Paramedic Preceptor: A Paramedic, as identified in California Code of Regulations, qualified to train Paramedic Student Interns. A Paramedic Preceptor may also be a Field Training Officer, when designated by that individual's agency.

V. PROCEDURE:

A. Level I

1. A paramedic will have Level I status upon completion of the following:
 - a. Current Paramedic Licensure by the State of California
 - b. Current Accreditation in the County of Ventura per VCEMS Policy 315.
2. To maintain Level I status, the paramedic shall:
 - a. Maintain employment with an approved Ventura County ALS service provider.
 - b. Complete a minimum of 288 hours of practice as a paramedic or 30 patient contacts (minimum of 15 ALS) every six-month period (January 1 – June 30 and July 1 – December 31);
 - 1) With the approval of the EMS Medical Director, for those paramedics with a minimum of 1 year of field experience in Ventura County, are employed as a field paramedic in another county or work in an acute care setting (RN or LVN) on a full-time basis, complete a minimum of 144 hours of practice, or 20 patient contacts (minimum 10 ALS), in the previous ~~6-month~~6-month period in Ventura County.
 - c. Complete VCEMS continuing education requirements, as described in Section V.C.
3. If the paramedic fails to meet these requirements, s/he is no longer authorized as a Level I paramedic.
4. To be reauthorized as a Level I paramedic, the paramedic must complete a minimum of 48 hours as a second or third crewmember of direct field observation by an authorized Paramedic FTO, to include a minimum of 5 ALS contacts.

B. Level II

1. A paramedic will have Level II status upon completion of the following:
 - a. Employer approval.
 - b. All of the requirements of Level I.
 - c. A minimum of 240 hours of direct field observation by an authorized Ventura County Paramedic FTO.
 - 1) This will include a minimum of 30 patient contacts, (minimum 15 ALS contacts).
 - 2) If a paramedic has a minimum of 4000 hours of prehospital field experience performing initial ALS assessment and care, ~~Direct field observation~~Paramedic FTO with the approval of the Paramedic FTO and PCC may be reduced to 144 hours or 20 patient contacts (minimum 10 ALS).
 - d. Approval by the paramedic FTO who evaluated most of the contacts.

- e. Successful completion of competency assessments:
 - 1) Scenario based skills assessment conducted by the candidate's preceptor, Provider's clinical coordinator, PCC and PLP when possible.
 - 2) Written policy competency and arrhythmia recognition and treatment assessment administered by VCEMS. Minimum Passing score will be 80% on each assessment.
 - 3) Candidates who fail to attain 80% on either section V.B.e.2)-3) shall attend a remediation session with the Base Hospital PLP or designee or the provider's Medical Director prior to retaking either assessment. Written documentation of remediation will be forwarded to VCEMS.
 - f. Obtain favorable recommendations of the PCCs who have evaluated the paramedic during the upgrade process. The PCC's recommendations will be based upon a review of the completed performance evaluation standards, review of patient contacts and direct clinical observation.
 - 1) Delays in arranging or scheduling direct field observation shift(s) should not delay the Level II upgrade process. In the event an observation shift cannot be arranged with the PCC by the end of the 240 hour upgrade process, the observation requirement may be waived with VCEMS approval. Every attempt should be made to schedule this observation in advance, and conduct the shift prior to the completion of the 240 hour upgrade process.
 - g. Forward Appendix A, Appendix B and copies of the 30 patient contacts to VCEMS.
 - 1) Appendix A shall include all dates and times the upgrading paramedic has spent with the Paramedic FTO to total a minimum of 240 hours.
 - 2) Appendix B shall be completed each shift per the Method of Evaluation Key at the bottom of the form.
 - 3) Submit 30 patient contacts, 15 meeting criteria as defined in Section III, Definitions, ALS Patient Contact.
2. To maintain Level II status, the paramedic shall:
- a. Maintain employment with an approved Ventura County ALS service provider.
 - b. Function as a paramedic for a minimum of 576 hours or have a minimum of 60 patient contacts (minimum 30 ALS), over the previous six-month period (January 1 – June 30 and July 1 – December 31).
 - 1) For those paramedics with a minimum of 3 years field experience, no more than 144 hours of this requirement may be met by documentation of actual instruction at approved PALS, PEPP, ACLS, PHTLS, BTLs, EMT or Paramedic training programs.

- 2) With the approval of the EMS Medical Director, for those paramedics with a minimum of 3 years of field experience in Ventura County, are employed as a field paramedic in another county or work in an acute care setting (RN or LVN) on a full-time basis, complete a minimum of 288 hours of practice, or 30 patient contacts (minimum 15 ALS), in the previous 6 month period in Ventura County.
- 3) A paramedic whose primary duties are administering the ALS Program (90% of the time) for his/her agency and with approval of the EMS Medical Director may maintain his/her level II status by performing a minimum of 5 ALS calls per 6 months (January 1 – June 30 and July 1 – December 31).
- 4) If the paramedic fails to meet this requirement:
 - a) His/her paramedic status reverts to Level I.
 - b) If Level II authorization has lapsed for less than six months, reauthorization will require completion of a minimum of 96 hours of direct field observation by an authorized Ventura County Paramedic FTO, to include a minimum of 10 ALS patient contacts.
 - c) If Level II authorization has lapsed for less than one year and the paramedic has not worked as a paramedic for 6 months or more during the lapse interval OR if Level II authorization has lapsed for greater than one year, reauthorization will require completion of all of the requirements in Section V.B.1. These requirements may be reduced at the discretion of the VCEMS Medical Director.
 - d) If the paramedic has been employed as a paramedic outside of Ventura County or has worked in an acute care setting (RN or LVN) during the period of lapse of authorization, these requirements may be reduced at the discretion of the VCEMS Medical Director.
 - e) Complete VCEMS continuing education requirements, as described in Section V.C.

C. Continuing Education Requirements

Fifty percent (50%) of all CE hours shall be obtained through Ventura County approved courses and 50% of total CE hours must be instructor based.

1. Advanced Cardiac Life Support (ACLS) certification shall be obtained within three months and either Pediatric Advanced Life Support (PALS) certification or Pediatric Education for Prehospital Providers (PEPP) shall be obtained within six months and remain current.
2. Field Care Audits (Field care audit): Twelve (12) hours per two years, at least 6 of which shall be attended in Ventura County. Base Hospitals will offer Field care audit sessions.
3. Periodic training sessions or structured clinical experience (Lecture/ Seminar) as follows:
 - a. Attend one skills refresher session in the first year of the license period, one in the second year, and one every year thereafter.

- b. Education and/or testing on updates to local policies and procedures.
- c. Completion of Ventura County Multi-Casualty Incident training per VCEMS Policy 131.
- d. Successful completion of any additional VCEMS-prescribed training as required.

These may include, but not be limited to:

- 1) Education, and/or testing, in specific clinical conditions identified in the quality improvement program.
- 2) Education and/or testing for Local Optional Scope of Practice Skills.
- 3) The remaining hours may be earned by any combination of field care audit, Clinical hours, Self-Study/Video, Lecture, or Instruction at ALS/BLS level. Clinical hours will receive credit as 1-hour credit for each hour spent in the hospital and must include performance of Paramedic Scope of Practice procedures. The paramedic may be required by his/her employer to obtain Clinical Hours. The input of the Base Hospital Prehospital Care Coordinator and/or Paramedic Liaison Physician shall be considered in determining the need for Clinical Hours.
- 4) One airway lab refresher session per six (6) month period based on license cycle, to be held by a Base Hospital, ALS Provider Medical Director approved by the VCEMS Medical Director, or the VCEMS Medical Director.
- 5) Successfully complete a CPR skills evaluation using a recording/reporting manikin once per six (6) month period based on license cycle.

- 4. Courses shall be listed on the Ventura County Accreditation Continuing Education Log and submitted to VCEMS upon reaccreditation. Continuing education listed on the continuing education log is subject to audit.

- D. The VCEMS Medical Director may temporarily suspend or withdraw Level I or Level II authorization pending clinical remediation.
- E. Failure to comply with the standards of this policy will be considered to be operating outside of medical control.
- F. ALS Service Providers must report any change in Level I/II status to VCEMS within 5 days of taking action.

PARAMEDIC UPGRADE EMPLOYER RECOMMENDATION FORM

Employer: Please instruct the paramedic to complete the requirements in the order listed. Employer shall contact PCC to schedule appointment.

_____, paramedic has been evaluated and has met all criteria for upgrade to Level II status, as defined in Ventura County EMS Policy 318.

Level II Paramedic							
_____ All the requirement of level I met. _____ Completion of 240 hrs of direct field observation by an authorized Paramedic FTO _____ Approval by Paramedic FTO _____ Submit all appropriate documentation to VCEMS including							
	Date	Hours	FTO Print legibly		Date	Hours	FTO Print legibly
1				9			
2				10			
3				11			
4				12			
5				13			
6				14			
7				15			
8				16			
Total Hours Completed							

Please sign and date below for approval.

I have reviewed all supporting documentation and it is attached to this recommendation.

Paramedic FTO Signature	Print FTO name legibly	Date:
-------------------------	------------------------	-------

Employer Signature	Print Employer name legibly	Date
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Per section V.B.1.c.2): PCC signature required if paramedic qualifies for shortened upgrade process.

PCC Signature	Print PCC signature legibly	Date

Appendix B

Ventura County EMS Upgrade Procedure		240 hours or 10 shifts 30 patient contacts (minimum of 15 ALS)			
Shift	Policy	Procedure/Policy Title to Review	Date	Preceptor Signature	Method of Evaluation (see key)
1	310	Paramedic Scope of Practice			
	704	Base Hospital Contact			
	705	General Patient Guidelines			
		SVT			
		VT			
		Cardiac Arrest – Asystole/PEA			
		Cardiac Arrest – VF/VT			
		Symptomatic Bradycardia			
	726	Acute Coronary Syndrome			
	727	Transcutaneous Cardiac Pacing			
334	12 Lead ECG				
		Prehospital Personnel Mandatory Training Requirements			
		<i>Notify PCC of Level II upgrade and schedule PCC ride-along.</i>			
2	720	Limited Base Contact			
	705	Trauma Assessment/Treatment Guidelines			
		Altered Neurological Function			
		Overdose			
		Seizures			
		Suspected Stroke			
	614	Spinal Immobilization			
3	705	Behavioral Emergencies			
		Burns			
		Childbirth			
		Crush Injury			
		Heat Emergencies			
		Hypothermia			
		Hypovolemic Shock			
		Bites and Stings			
		Nerve Agent			
		Nausea/Vomiting			
	Pain Control				
	Sepsis Alert				
	451	Stroke System Triage			
4	705	Allergic/Adverse Reaction and Anaphylaxis			
		Neonatal Resuscitation			
		Shortness of Breath – Pulmonary Edema			
		Shortness of Breath – Wheezes/other			
	705	Trauma Assessment/Treatment Guidelines			
	1404	Guidelines for Inter-facility Transfer of Patients to a Trauma Center			
1405	Trauma Triage and Destination Criteria				
	1000	Documentation of Prehospital Care			
5	710	Airway Management			
	715	Needle Thoracostomy			
	716	Pre-existing Vascular Access Device			
	717	Intraosseous Infusion			
	729	air-Q			
	722	Transport of Pt. with IV Heparin and NTG			

6	600 601 603 606 613 306	Medical Control on Scene Medical Control at the Scene – EMS Personnel Against Medical Advice Determination of Death Do Not Resuscitate EMT-I: Req. to Staff an ALS Unit			
7	402 612 618	Patient Diversion/ED Closure Notification of Exposure to a Communicable Disease Unaccompanied Minor ECG Review Radio Communication			
8	131 607 1202 1203	Mega Codes MCI Hazardous Material Exposure-Prehospital Protocol Air Unit Dispatch for Emergency Medical Response. Criteria for Patient Emergency Transportation			
9		Multiple System Evaluation Review Head to Toe Assessments			
10		Review Policies and Procedures			
		VCEMS Policy and Arrhythmia Exams			

Paramedic Name: _____ License. # _____ Date _____

FTO Signature _____ Date _____

PCC Signature _____ Date _____

Employer Signature: _____ Date: _____

METHOD OF EVALUATION KEY	
E = EMEDS Review	DO = Direct Observation in the field or clinical setting
S = Simulation/Scenario	V = Verbalizes Understanding to Preceptor
D = Demonstration	NA = Performance Skill not applicable to this employee
T = Test/Self Learning Module	

Appendix C

NAME: _____

EMPLOYER: _____ LICENSE #: P _____

Ventura County Accreditation Requirements Continuing Education Log

This form should be used to track your continuing education requirements. This form must be turned in when it is time for your reaccreditation. When attending a continuing education course, remember to get a course completion, as EMS will audit 10% of all paramedics reaccrediting and if you are randomly selected you must provide a course completion for each course attended in order to receive credit for that course. Course completions must have the name of the course, number of hours, date, provider agency and provider number.

When you complete the Ventura County continuing education standards per Policy 318 you will automatically meet the State of California requirements for re-licensure.

Remember that the Skills Refresher and intubation requirements are to be completed yearly based on license cycle.

The Skills Refresher, Intubation refresher session and the EMS Update requirements are mandatory and they must be completed in the stated time frames or negative action will be taken against your paramedic training level.

Field Care Audit Hours (12 hours are required, 6 hours must be completed in Ventura County)				
	Date	Location	# Of Hours	Provider Number
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Lecture Hours

	Required Courses	# of Hours	Date	Location	Provider Number
1.	ACLS (4 hours)				
2.	PALS (4 hours)				

EMS Updates are held in **May** and **November** each year.
EMS Updates are completed as new or changed policies become effective. Enter **ACTUAL** Date of class attendance below:

	EMS Update	Target Dates	Date	Location	Provider Number
3.	EMS UPDATE #1 (1 hour)	Office use only			
	EMS UPDATE #2 (1 hour)	Office use only			
	EMS UPDATE #3 (1 hour)	Office use only			
	EMS UPDATE #4 (1 hour)	Office use only			
4.	Ventura County MCI COURSE (2 hours)	Office use only			

Skill Refreshers are held in **March** and **September** each year. The following requirements must be completed in each year of your license cycle (*for example*: If your re-licensure month is June 2020, you must complete year one requirement between June 2018 and June 2019 and year two requirement between June 2019 and June 2020).

	Paramedic Skills Lab	Target Dates	Enter ACTUAL Date of class attendance below:		
			Date	Location	Provider Number
5.	Skills Refresher year 1 (3 hours)	Office use only			
	Skills Refresher year 2 (3 hours)	Office use only			

6. Airway Lab refresher session (1 session every 6 months based on your license expiration date.)

	Airway Labs	Target Dates	Enter ACTUAL Date of class attendance below:		
			Date	Location	Provider Number
	#1 Airway Lab Session	Office use only			
	#2 Airway Lab Session	Office use only			
	#3 Airway Lab Session	Office use only			
	#4 Airway Lab Session	Office use only			

Additional Hours (12 hours)

(These hours can be earned with any combination of additional Field Care Audit, lecture, etc.)

	Date	# of Hours	Location	Provider Number
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

Neonatal Resuscitation			
BLS Procedures			
<p style="text-align: center;">Newly Born Infant</p> <p>Provide warmth, dry briskly and discard wet linen</p> <ul style="list-style-type: none"> Suction ONLY if secretions, including meconium, cause airway obstruction <p>Assess while drying infant</p> <ol style="list-style-type: none"> Full term? Crying or breathing? Good muscle tone? <p>If "YES" to all three</p> <ul style="list-style-type: none"> Place skin-to-skin with mother Cover both with dry linen Observe breathing, activity, color <p>If "NO" to any of three</p> <ul style="list-style-type: none"> Stimulate briefly (<15 seconds) <ul style="list-style-type: none"> Flick soles of infant's feet Briskly rub infant's back Provide warm/dry covering Continue to assess 	<p style="text-align: center;">Infant up to 48 hours old</p> <p>Provide warmth</p> <ul style="list-style-type: none"> Suction ONLY if secretions cause airway obstruction Stimulate briefly (<15 seconds) <ul style="list-style-type: none"> Flick soles of infant's feet Rub infant's back with towel <p>Provide warm/dry covering</p> <p>Continue to assess</p>		
<p>Assess Breathing</p> <ul style="list-style-type: none"> If crying or breathing, assess circulation If apneic or gasping <ul style="list-style-type: none"> Positive pressure ventilations (PPV) with BVM and ROOM AIR at 40-60 breaths per minute for 30 seconds <ul style="list-style-type: none"> Continue PPV, reassessing every 30 seconds, until infant is breathing adequately Reassess breathing, assess circulation <p>Assess Circulation</p> <ul style="list-style-type: none"> If HR between 60 and 100 bpm <ul style="list-style-type: none"> PPV with BVM and ROOM AIR at 40-60 breaths per minute for 30 seconds <ul style="list-style-type: none"> Continue PPV, reassessing every 30 seconds, until infant maintains HR >100 bpm If HR < 60 bpm <ul style="list-style-type: none"> CPR at 3:1 ratio for 30 seconds <ul style="list-style-type: none"> 90/min compressions 30/min ventilations Continue CPR, reassessing every 30 seconds, until HR > 60 bpm If no improvement after 90 seconds of ROOM AIR CPR, add supplemental O₂ until HR > 100 			
ALS Prior to Base Hospital Contact			
<p>Establish IO line only in presence of CPR</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <p>Asystole OR Persistent Bradycardia < 60 bpm</p> <ul style="list-style-type: none"> Epinephrine 0.1mg/mL <ul style="list-style-type: none"> IO – 0.01mg/kg (0.1mL/kg) q 3-5 min Normal Saline <ul style="list-style-type: none"> IO bolus – 10mL/kg </td> <td style="width: 50%; vertical-align: top;"> <p>PEA</p> <ul style="list-style-type: none"> Epinephrine 0.1mg/mL <ul style="list-style-type: none"> IO – 0.01mg/kg (0.1mL/kg) q 3-5 min Normal Saline <ul style="list-style-type: none"> IO bolus – 10mL/kg </td> </tr> </table>		<p>Asystole OR Persistent Bradycardia < 60 bpm</p> <ul style="list-style-type: none"> Epinephrine 0.1mg/mL <ul style="list-style-type: none"> IO – 0.01mg/kg (0.1mL/kg) q 3-5 min Normal Saline <ul style="list-style-type: none"> IO bolus – 10mL/kg 	<p>PEA</p> <ul style="list-style-type: none"> Epinephrine 0.1mg/mL <ul style="list-style-type: none"> IO – 0.01mg/kg (0.1mL/kg) q 3-5 min Normal Saline <ul style="list-style-type: none"> IO bolus – 10mL/kg
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Base Hospital Orders only			
<p>Consult with ED Physician for further treatment measures</p>			
<p>Additional Information:</p> <ul style="list-style-type: none"> Resuscitation efforts may be withheld for extremely preterm infants (< 21 weeks or < 9 inches long). Sensitivity to the desires of the parent(s) may be considered. If uncertain as to gestational age, begin resuscitation. A rising heart rate is the best indicator of adequate PPV 			

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

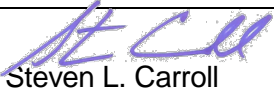

Date Revised: June 14, 2018
Last Reviewed: June 14, 2018

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

Date Revised: June 14, 2018
Last Reviewed: June 14, 2018



VCEMS Medical Director

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Interfacility Transfer of Patients		Policy Number 605	
APPROVED: Administration:	 Steven L. Carroll	Date: December 1, 2011	
APPROVED: Medical Director:	 Angelo Salvucci, M.D.	Date: December 1, 2011	
Origination Date:	July 26, 1991	Effective Date:	December 1, 2011
Date Revised:	April 13, 2006		
Date Last Reviewed:	August 11, 2011		
Next Review Date:	October 31, 2014		

- I. **PURPOSE:** To define levels of interfacility transfer and to assure that patients requiring interfacility transfer are accompanied by personnel capable and authorized to provide care.
- II. **AUTHORITY:** Health and Safety Code, Sections 1797.218, 1797.220, and 1798.
- III. **POLICY:** A patient shall be transferred according to his/her medical condition and accompanied by EMS personnel whose training meets the medical needs of the patient during interfacility transfer. The transferring physician shall be responsible for determining the medical need for transfer and for arranging the transfer. The patient shall not be transferred to another facility until the receiving hospital and physician consent to accept the patient. The transferring physician retains responsibility for the patient until care is assumed at the receiving hospital.

If a patient requires care during an interfacility transfer which is beyond the scope of practice of an EMT or paramedic or requires specialized equipment for which an EMT or paramedic is untrained or unauthorized to operate, and it is medically necessary to transfer the patient, a registered nurse or physician shall accompany the patient. If a registered nurse accompanies the patient, appropriate orders for care during the transfer shall be written by the transferring physician.
- IV. **TRANSFER RESPONSIBILITIES**
 - A. All Hospitals shall:
 1. Establish their own written transfer policy clearly defining administrative and professional responsibilities.
 2. Have written transfer agreements with hospitals with specialty services, and county hospitals.
 - B. Transferring Hospital
 1. Maintains responsibility for patient until patient care is assumed at receiving facility.

2. Assures that an appropriate vehicle, equipment and level of personnel is used in the transfer.

C. Transferring Physician

1. Maintains responsibility for patient until patient care is assumed at receiving facility.
2. Determines level of medical assistance to be provided for the patient during transfer.
3. Receives confirmation from the receiving physician and receiving hospital that appropriate diagnostic and/or treatment services are available to treat the patient's condition and that appropriate space, equipment and personnel are available prior to the transfer.

D. Receiving Physician

1. Makes suitable arrangements for the care of the patient at the receiving hospital.
2. Determines and confirms that appropriate diagnostic and/or treatment services are available to treat the patient's condition and that appropriate space, equipment and personnel are available prior to the transfer, in conjunction with the transferring physician.

E. Transportation Provider

1. The patient being transferred must be provided with appropriate medical care, including qualified personnel and appropriate equipment, throughout the transfer process. The personnel and equipment provided by the transporting agency shall comply with local EMS agency protocols.
2. Interfacility transport within the jurisdiction of VC EMS shall be performed by an ALS or BLS ambulance.
 - a. BLS transfers shall be done in accordance with EMT Scope of Practice per Policy 300
 - b. ALS transfers shall be done in accordance with Paramedic Scope of Practice per Policy 310

IV. PROCEDURE:

A. Non-Emergency Transfers

Non emergency transfers shall be transported in a manner which allows the provider to comply with response time requirements.

B. Emergency Transfers

Emergency transfers require documentation by the transferring hospital that the condition of the patient medically necessitates emergency transfer. Provider agency dispatchers shall verify that this need exists when transferring hospital personnel make the request for the transfer.

C. Transferring process

1. The transferring physician will determine the patient's resource requirements and request an inter-facility ALS, or BLS transfer unit using the following guidelines:

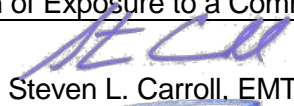

Patient Condition/Treatment	EMT	Paramedic	RN/RT/MD
a. Vital signs stable	x		
b. Oxygen by mask or cannula	x		
c. Peripheral IV glucose or isotonic balanced salt solutions running	x		
d. Continuous respiratory assistance needed (paramedic scope management)		x	
e. Peripheral IV medications running or anticipated (paramedic scope)		x	
f. Paramedic level interventions		x	
g. Central IV line in place		x	
h. Respiratory assistance needed (outside paramedic scope of practice)			x
i. IV Medications (outside paramedic scope of practice)			x
j. PA line in place			x
k. Arterial line in place			x
l. Temporary pacemaker in place			x
m. ICP line in place			x
n. IABP in place			x
o. Chest tube		x	x
p. IV Pump		x	
q. Standing Orders Written by Transferring Facility MD			x
r. Medical interventions planned or anticipated (outside paramedic scope of practice)			x

2. The transferring hospital advises the provider of the following:
 - a. Patient's name
 - b. Diagnosis/level of acuity
 - c. Destination
 - d. Transfer date and time
 - e. Unit/Department transferring the patient
 - f. Special equipment with patient

- g. Hospital personnel attending patient
- h. Patient medications
- 3. The transferring physician and nurse will complete documentation of the medical record. All test results, X-ray, and other patient data, as well as all pertinent transfer forms, will be copied and sent with the patient at the time of transfer. If data are not available at the time of transfer, such data will be telephoned to the transfer liaison at the receiving facility and then sent by FAX or mail as soon thereafter as possible.
- 4. Upon departure, the Transferring Facility will call the Receiving Facility and confirm arrangements for receiving the patient and provide an estimated time of arrival (ETA).
- 5. The Transferring Facility will provide:
 - a. A verbal report appropriate for patient condition
 - b. Review of written orders, including DNAR status.
 - c. A completed transfer form from Transferring Facility.

V. DOCUMENTATION

- A. Documentation of Care for Interfacility transfers will be done in accordance to Policy 1000.

4COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES	
Policy Title: Notification of Exposure to a Communicable Disease		Policy Number 612	
APPROVED: Administration:	 Steven L. Carroll, EMT-P	Date: December 1, 2014	
APPROVED: Medical Director:	 Angelo Salvucci, M.D.	Date: December 1, 2014	
Origination Date:	April 27, 1990	Effective Date:	December 1, 2014
Date Revised:	September 11, 2014		
Date Last Reviewed:	September 11, 2014		
Review Date:	September, 2017		

I. PURPOSE:

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

II. AUTHORITY:

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

III. DEFINITIONS:

- A. Aerosol Transmissible Exposure Incident – an event in which all of the following have occurred:
1. An employee who has been exposed to an individual who is a case or suspected case of a reportable ATD,
 2. The exposure occurred without the benefit of applicable exposure controls
 3. It reasonably appears from the circumstances of the exposure that transmission of disease is sufficiently likely to require medical evaluation
- B. Bloodborne Exposure Incident – a specific eye, mouth, other mucous membranes, non-intact skin, or parenteral (needle-stick) contact with blood or other potentially infectious materials that result from the performance of an employee’s duties
- C. Communicable Disease - an illness due to a specific infectious agent which arises through transmission of that agent from an infected person, animal or objects to a susceptible host, either directly or indirectly

- D. Contact Exposure – coming in touch with an object or surface that has been contaminated with a communicable disease
- E. Designated Officer (DO) – an official, or their designee, designated to evaluate and respond to possible infectious disease exposures of their employees
- F. Emergency Responder - paramedic, EMT, firefighter, peace officer, lifeguard and other public safety personnel
- G. Health Care Facility – any hospital which provides emergency medical care and which receives patients following care by emergency responders
- H. Infection Preventionist (IP) – a person, often an RN, who is assigned responsibility for surveillance and infection prevention, education and control activities
- I. OPIM – other potentially infectious material such as amniotic fluid, semen, vaginal secretions, CSF, synovial fluid, peritoneal fluid
- K. Reportable Disease – an infectious disease required to be reported to the Ventura County Communicable Disease Division pursuant to CCR, Title 17, Section 2500

IV. POLICY:

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

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

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

V. PROCEDURE:

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

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

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

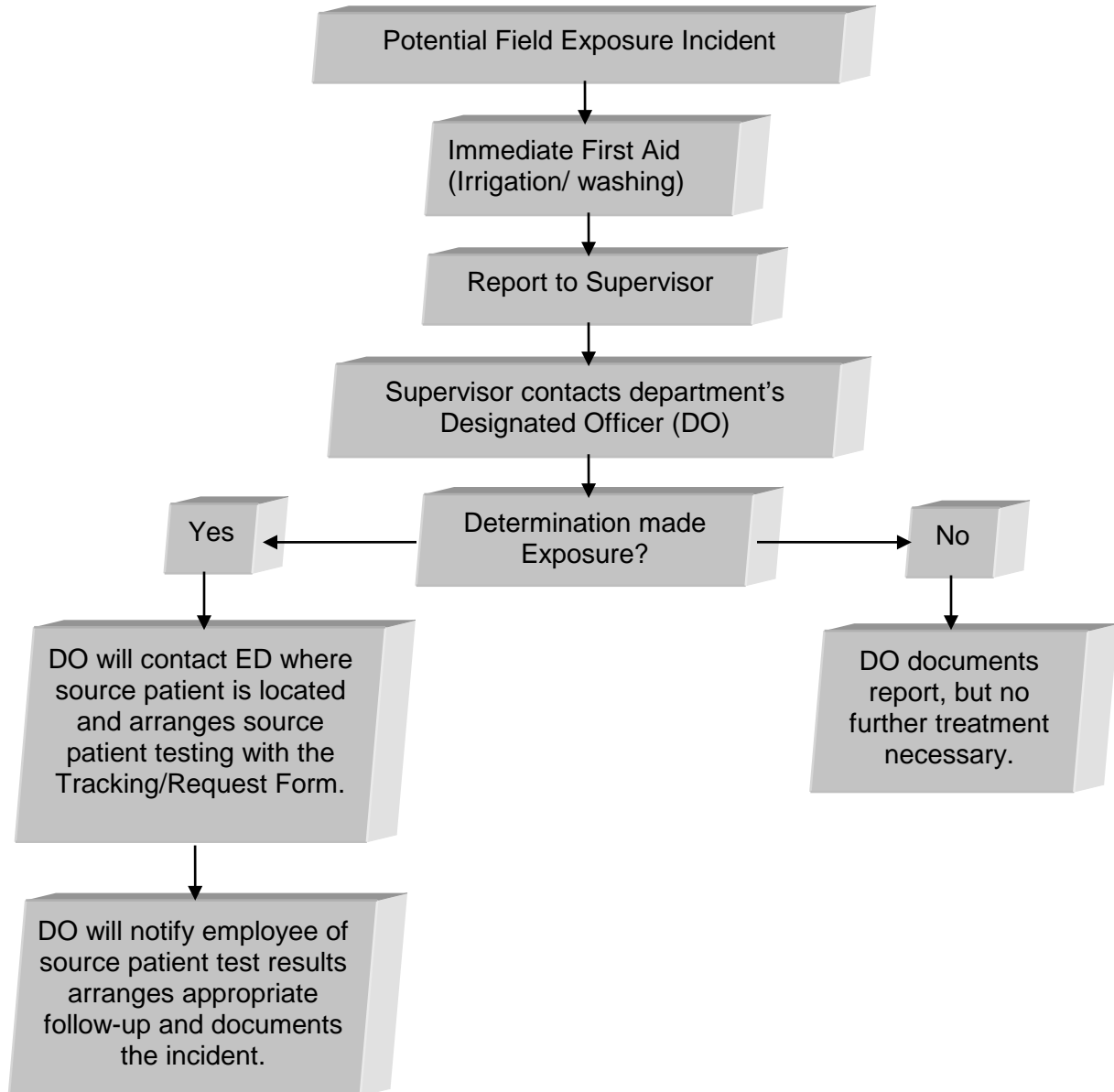
1. The Infection Control Preventionist or Emergency Department Personnel will notify Ventura County Public Health Officer or designee **AND** contact the DO of the involved department directly.
2. The Ventura County Public Health Officer will notify the Emergency Medical Services Agency (EMSA) Duty Officer.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

Pre Hospital Exposure Tracking/ Request Form

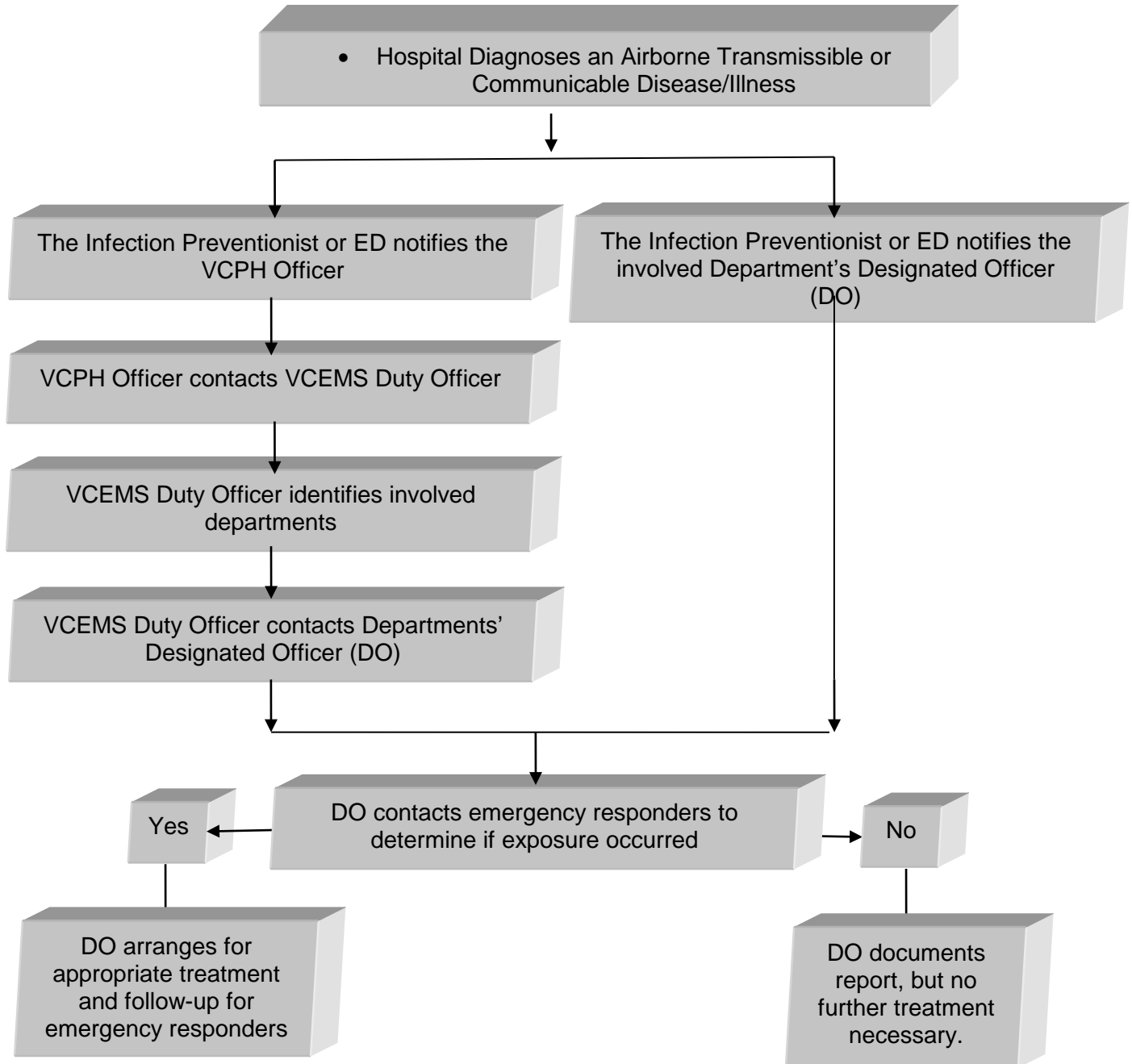
Hospital Receiving Request							
<input type="checkbox"/>	CMH	<input type="checkbox"/>	LRHMC	<input type="checkbox"/>	OVCH	<input type="checkbox"/>	SJPVH
<input type="checkbox"/>	SJPMC	<input type="checkbox"/>	SPH	<input type="checkbox"/>	SVH	<input type="checkbox"/>	VCMC
Name of Person Receiving Request							
Name:							
Requestor Information							
Date/Time of Request:			Fire Incident #:				
Name of Requestor:		Title:		Contact Number:			
Signature of Requestor:							
Agency Making Request							
AMR		GCA		FLM			
LMT		OXD					
SPA		SAR		VEN			
VFF		VNC		Other:			
Source Patient Information							
Source Patient:		DOB:		MR#			
Symptoms:							
Description of Bloodborne Exposure							
Description of Exposure:							
Hollow Needle Stick		Mucous Membrane Splash		Non-intact skin			
Description of Airborne Exposure							
Description of Exposure:							
Aerosol Transmissible		Disease		TB			
Recommended Source Patient Blood Work							
Hepatitis B Antigen		Hepatitis C Antibody		Rapid HIV			
RPR				Viral Load (if HIV +)			
Other:							
Diagnosis: Bloodborne Pathogen Exposure: V15.85							
Exposed Employee's Name:							
DOB:			Date of Injury/Exposure:				
Billing Information							
Workers Compensation Carrier:							
Name of Employer:							
Name:							
Address:							
Phone Number:							
FAX number:							
Release of Source Patient Results							
Release Results To:		Phone #:		FAX #:			
Date/Time Results Released:							

Appendix B

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



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



Aerosol Transmissible Diseases/Pathogens (Mandatory)

California Code of Regulation, Title 8, Section 5199

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

Diseases/Pathogens Requiring Airborne Infection Isolation

Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. Anthrax/*Bacillus anthracis*

Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)

Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out

Measles (rubeola)/Measles virus

Monkeypox/Monkeypox virus

Novel or unknown pathogens

Severe acute respiratory syndrome (SARS)

Smallpox (variola)/Variola virus

Tuberculosis (TB)/*Mycobacterium tuberculosis* -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected

Any other disease for which public health guidelines recommend airborne infection isolation

Diseases/Pathogens Requiring Droplet Precautions

Diphtheria pharyngeal

Epiglottitis, due to *Haemophilus influenzae* type b

Haemophilus influenzae Serotype b (Hib) disease/*Haemophilus influenzae* serotype b -- Infants and children

Influenza, human (typical seasonal variations)/influenza viruses

Meningitis

Haemophilus influenzae, type b known or suspected

Neisseria meningitidis (meningococcal) known or suspected

Meningococcal disease sepsis, pneumonia (see also meningitis)

Mumps (infectious parotitis)/Mumps virus

Mycoplasmal pneumonia

Parvovirus B19 infection (erythema infectiosum)

Pertussis (whooping cough)

Pharyngitis in infants and young children/Adenovirus, Orthomyxoviridae, Epstein-Barr virus, Herpes simplex virus,

Pneumonia

Adenovirus

- *Haemophilus influenzae* Serotype b, infants and children
- Meningococcal
- *Mycoplasma, primary atypical*
- *Streptococcus Group A*

Pneumonic plague/*Yersinia pestis*

Rubella virus infection (German measles)/Rubella virus

Severe acute respiratory syndrome (SARS)

Streptococcal disease (group A streptococcus)

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

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

Supraventricular Tachycardia	
ADULT	PEDIATRIC
BLS Procedures	
Administer oxygen as indicated	Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
Valsalva maneuver IV/ <u>IO</u> access <u>Stable</u> – Mild to moderate chest pain/SOB <u>Unstable</u> – ALOC, signs of shock or CHF <ul style="list-style-type: none"> Place on backboard and prepare for synchronized cardioversion 	Valsalva maneuver IV/ <u>IO</u> access <u>Stable</u> – Mild to moderate chest pain/SOB <u>Unstable</u> – ALOC, signs of shock or CHF <ul style="list-style-type: none"> Place on backboard and prepare for synchronized cardioversion
Communication Failure Protocol	
<u>Stable</u> <ul style="list-style-type: none"> Adenosine <ul style="list-style-type: none"> IV/<u>IO</u> – 6 mg rapid push immediately followed by 10-20 mL NS flush No conversion or rate control <ul style="list-style-type: none"> Adenosine <ul style="list-style-type: none"> IV/<u>IO</u> – 12 mg rapid push immediately followed by 10-20 mL NS flush May repeat x 1 if no conversion or rate control <u>Unstable</u> <ul style="list-style-type: none"> Midazolam <ul style="list-style-type: none"> IV/<u>IO</u> – 2 mg <ul style="list-style-type: none"> Should only be given if it does not result in delay of synchronized cardioversion For IV/<u>IO</u> use – Dilute 5 mg (1 mL) Midazolam with 4 mL NS for a final volume of 5 mL concentration of 1 mg/mL IO Access for unstable adults only. Synchronized Cardioversion <ul style="list-style-type: none"> Use the biphasic energy settings that have been approved by service provider medical director. 	<u>Stable</u> <ul style="list-style-type: none"> Adenosine <ul style="list-style-type: none"> IV/<u>IO</u> – 0.1 mg/kg (max dose 6 mg) rapid push immediately followed by 10-20 mL NS flush No conversion or rate control <ul style="list-style-type: none"> Adenosine <ul style="list-style-type: none"> IV/<u>IO</u> – 0.2 mg/kg (max dose 12 mg) rapid push immediately followed by 10-20 mL NS flush May repeat x 1 if no conversion or rate control <u>Unstable</u> <ul style="list-style-type: none"> Synchronized Cardioversion <ul style="list-style-type: none"> Use the biphasic energy settings that have been approved by service provider medical director.
Base Hospital Orders only	
Consult with ED Physician for further treatment measure	
Additional Information: <ul style="list-style-type: none"> Adenosine is contraindicated in pt with 2° or 3rd° AV Block, Sick Sinus Syndrome (except in pt with functioning pacemaker), or known hypersensitivity to adenosine. Unless the patient is in moderate or severe distress, consider IV access and transport only. Consider withholding adenosine administration if patient is stable until ED Physician evaluation. Prior to administering Adenosine in pediatric patients, evaluate for possible underlying causes of tachycardia (infection, dehydration, trauma, etc.) 	

Effective Date: December 1, -2018~~2~~
 Next Review Date: August 31, 2020~~September, 2016~~

Date Revised: August 9, 2018,
~~2012~~
 Last Reviewed: August 9, 2018~~September 11, 2014~~

- Document all ECG strips during adenosine administration and/or synchronized cardioversion.

Effective Date: December 1, -201~~8~~
Next Review Date: August 31,
2020~~September, 2016~~

Date Revised: August 9, 2018,
2012
Last Reviewed: August 9,
2018~~September 11, 2014~~

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Supraventricular_Tachycardia_OCT12.Docx


VCEMS Medical Director