County of Ventura **Notice of Changes to Policy Manual** **Emergency Medical Services**
Department of Public Health **Policies and Procedures**

To: ALL VENTURA COUNTY EMS POLICY MANUAL HOLDERS

DATE: December 6, 2022

Policy Status	Policy #	Title/New Title	Notes
Replace	111	Ambulance Company Licensing Procedure	• Requirement for Board of Supervisors approval was removed. Section III.B.7 (Page 9)
Replace	210	Abuse Report Guidelines	• Child and Adult abuse reporting were separated out, as they fall under different statute and regulations • Added Links to reporting forms and laws • Age for elder changed to 60 from 65
Replace	300	EMT Scope of Practice	• Added BiPAP
Replace	301	EMT Certification	• Minor language and formatting changes • Added language related to cognitive and psychomotor skills testing requirements for CPR
Replace	302	Emergency Medical Technician Renewal	• Provided additional detail related to California Code of Regulations Section 100080 that details required training for EMTs.
Replace	303	EMT Optional Skills	• Atropen added as an allowable medication for treatment of nerve agent exposure (Section IV.A.2 – Page 2) • Other minor formatting and language changes
Replace	304	EMT Challenge Exam	• Minor language and formatting changes • Added language related to cognitive and psychomotor skills testing requirements for CPR
Replace	440	Code STEMI: Transfer of Patients with STEMI for PCI	Reviewed by STEMI Committee – No Changes
Replace	450	Acute Stroke Center (ASC) Standards	Reviewed by Stroke Committee – No Changes
Replace	451	Stroke System Triage and Destination	Reviewed by Stroke Committee – No Changes
Replace	460	Guidelines for IFT of ED Acute Stroke Patients	Reviewed by Stroke Committee – • Changes to V.E.3 outlining requirements for RN or Paramedic during transports involving t-PA

Replace	500	Ventura County Emergency Medical Services Provider Agencies	• Removed Lifeline Medical Transport from the transport agency section and added All Town Ambulance (newly approved ground ambulance provider for BLS IFTs). • Removed Santa Paula Fire Department from First Responder Agencies due to their absorption into the Ventura County Fire Protection District.
Replace	501	Advanced Life Support Transport Provider Criteria	Reviewed by PSC – No Changes
Replace	502	Advanced Life Support Service Provider Approval Process	Reviewed by PSC – No Changes
Replace	504	BLS and ALS Equipment and Supplies	• CPAP and BiPap are now interchangeable, in terms of inventory (Page 2) • Added Peds BiPap requirements to Page 2 • Reduced minimum number of nerve agent auto-injectors from 9 to 3 (Page 2) • Added Needle Thoracostomy Anatomical Landmark Guide to Optional ALS Equipment (no minimum) on Page 6 • Minor formatting changes (font and table layout) throughout document.
Replace	506	Paramedic Support Vehicles	Reviewed by PSC – No Changes
Replace	508	First Responder Advanced Life Support Providers	• Handtevy Pediatric Provider Course added to Section IV.A.8 (on page 2).
Replace	600	Scene Control at a Medical Emergency	Reviewed by PSC – No Changes
Replace	604	Transport and Destination Guidelines	• Defined *medical* cardiac arrest in Section IV.E.2 on page 4. • Also added ELVO and TCASC to Section IV.E.4 on page 4

Replace	605	Interfacility Transfer of Patients	• Changed terminology for transfers as outlined in Sections IV.A.and IV.B on page 2 of policy. • In Section IV.C on page 3, clarifying language regarding specific types of transfers (Specialty Care, Non-Immediate, and Immediate Time Sensitive) was added. • Reference to documentation requirements for trauma transfers was added to Section VI.B on page 5.
Replace	612	Notification of Exposure to Communicable Disease	• LMT removed from list of agencies • SARS-CoV-2 Coronavirus Disease (COVID-19) added to list of reportable diseases
Replace	703	Medical Control at Scene – Private Physician/Physician on Scene	Reviewed by PSC – No Changes
	705	Treatment Protocols	• Removed training requirements on page 2 Section A • Added BiPAP #6 to Sec A page 2.
Replace	705.17	Nerve Agent Organophosphate	• IV/IO Atropine dosing added to ALS standing orders (Adult and Peds) When Mark I or DuoDote Antidote kit is not available
	705.21	SOB-Pulmonary Edema	• Added BiPAP
	705.22	SOB-Wheezes	• Added BiPAP and removed age requirement
Replace	705.23	Supraventricular Tachycardia	• Language to clarify that cardioversion standing order applies to unstable in rapid a-fib
Replace	711	Prehospital Capnography	• Added the language “In a patient with suspected sepsis, an ETCO2 < 25 mmHg further supports this provider impression” to page 2, #5.
Replace	717	Intraosseous Infusion	• Language surrounding preferred site was removed so that there is no preference between tibial or humeral head IO insertion. • Age reference for manual I/O has been removed • Policy language and formatting was updated to reflect a better policy flow.

Replace	720	Guidelines for LBC	• Language and formatting changes throughout policy • Updated Section III - Policy • Simplified and clarified patient criteria and corresponding treatment goals
Replace	723	Continuous Positive Airway Pressure	• Added BiPAP throughout policy • Changed definition for indications Sec IV,B • Removed Head injury under contraindication Sec IV, C, 1, g. • Changed “Relative Indications” to include definitions-Sec IV, C, 2 • Updated language under “Patient Treatment” and added definitions to other circumstances Sec IV, E

Replace	735	Push Dose Epinephrine	• Added two new indications to Section IV.B:
			  ○ Sepsis Alert
			  ○ Deteriorating patient condition with unknown shock etiology

Replace	737	Public Health Emergency Vaccine Administration	Reviewed – No Changes **Note: The California EMS Authority has withdrawn approval for EMT and Paramedic administration of COVID and Flu vaccine, effective 2/28/2023. This policy will expire at midnight on 3/1/2023 and be removed from the website.*
Replace	803	EMT AED Service Provider Program Standards	• Minor updates to reflect current practice and regulations. • Created annual reporting tool for providers to submit data
Replace	1000	Documentation of Prehospital Care	• Language added to Section IV – Policy defining when an ePCR is required. • Changes to language outlining documentation requirements (not necessarily a change to intent of section and/or policy – but rather a clarification of some awkward wording). • EMS system overload removed as an allowable reason for not uploading critical ePCRs within 30 minutes of arrival at destination. • Changes to abbreviations table

Replace	1100	EMT Training Program Approval	• New language outlining performance improvement plan requirement for training programs that fail to maintain a 3-year average cumulative pass rate of at least 80% within three attempts on the NREMT cognitive exam. • New language clarifying content and hands-on training that must be delivered to EMT students by the training program • Language added to better identify roles and responsibilities of the EMT training program • Reformatted policy for consistency and clarity
Replace	1102	EMR Training Program Approval	Reviewed – No Changes
Replace	1130	Continuing Education Provider Program Approval	Reviewed – No Changes
Replace	1132	CE Attendance Roster	Language added to policy that reflects tracking of attendance through new VCEMS learning management system (coming soon).
Replace	1133	CE for EMS Personnel	Added Paramedic to Section IV.D.10 Corrected minor error to section reference that existed in Section IV.E.1
Replace	1400	Trauma Care System General Provisions	Corrected minor formatting issues
Replace	1401	Trauma Center Designation	Changed language in Section III.A.1.d to the new ACS standard (2022).
Replace	1404	Guidelines for IFT of Patients to a Trauma Center	• Removed redundant language that had potential to create confusion. • Policy language and formatting was updated to reflect a better policy flow.
Replace	1405	Field Triage Decision Scheme	• Includes new/updated (2022) American College of Surgeons standards for field triage of a trauma patient.
Replace	1603	PSFA Nerve Agent Antidote Administration	• PSFA are only authorized to utilize auto-injectors containing atropine and pralidoxime chloride for the purposes of treating exposure to a nerve agent. • This eliminates the possibility of using devices containing only atropine. • Removed ‘Prehospital Personnel’ from Section III.B on Page 1

Replace	1604	PSFA O2 Administration and Airway Adjuncts	• Minor edit made to spelling error in title.
Replace	1606	PSFA Epinephrine Administration	• Minor spelling corrections to Section I.A and Section III.C (page 1)

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title AMBULANCE COMPANY LICENSING PROCEDURE		Policy Number 111
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Next Review Date:	June 1, 1997 November 10, 2022 November 10, 2022 November 30, 2025	Effective Date: January 3, 2023

I. Purpose: All ambulance companies conducting business within Ventura County shall be licensed to operate in the County of Ventura.

II. Authority: Ventura County EMS Agency (VCEMS) Policy 110, Ventura County Ordinance No. 4099.

III. Policy:

A. License Application:

Every applicant for an ambulance company license shall submit the application fee, if any, along with an ambulance license application packet, containing the following elements:

1. Letter of interest on company letterhead, labeled as “Attachment I”, stating at minimum:
   a. Company’s interest in providing services in Ventura County.
   b. Brief statement of your company’s service history and background, including the trade or other fictitious name, if any, under which the applicant does business and/or proposes to do business.
   c. The name, address, date of birth, height, weight, and color of eyes and hair of the applicant and of the owner of the ambulance(s).
2. The applicant and owner shall complete a California Bureau of Criminal Identification, Department of Justice background check via Live Scan Service. The applicant shall contact VCEMS for the fingerprinting procedure. A copy of the completed Live Scan form(s) shall accompany the application labeled as “Attachment II”.
3. Documentation of the training and experience of the applicant and managers involved in the transportation and care of patients, labeled as “Attachment III”. Evidence shall include applicant and manager resumes showing type and duration of transportation experience, including at least five (5) years of increasingly

responsible experience in the operation or management of a basic or advanced life support service. Each applicant and/or manager must complete, sign, and submit a written statement, (1) identifying all licenses and franchises held during the last ten (10) years, (2) disclosing whether the applicant or the principals of the applicant have ever been investigated by any governmental agency, the nature of the investigation, and the results of the investigation, including revocation or denial of licenses applicant previously held or applied for, and (3) describing the applicant and/or manager’s prior conviction of any misdemeanor or felony, and/or any pending criminal proceedings at the time of application.

4. The location and descriptions of the place or places from which ambulances are intended to operate, labeled as “Attachment IV”. Prior to approval of an ambulance license, applicant must establish at least one ambulance station within Ventura County, with the capability of supporting ambulance operations on a continuous 24-hour-per-day basis.
    a. All such locations will comply with all applicable zoning, building, and occupational health and safety regulations and shall be sufficient for all personnel in accordance with all local, state and federal regulations.
    b. Each ambulance station will be adequate to house the ambulance crew(s) required for the ambulance(s) based at that location. Each ambulance based at that location must be available as a disaster resource within one hour of VCEMS request.
    c. Ambulance stations are subject to announced or unannounced VCEMS inspection.

   Upon approval and issuance of an ambulance license, applicant will provide a minimum of one on-duty ambulance on a continuous 24-hour-per-day basis within the County of Ventura. Additionally, applicant must have a supervisor on duty 24 hours per day who will be available in Ventura County within one hour of a request from VCEMS.

5. Description of each ambulance proposed to be operated by the applicant, labeled as “Attachment V”. Provide a color photograph or drawing which clearly shows the color scheme and insignia for your ambulances and a description of the total number of vehicles operated by applicant and the number of ambulance licenses that applicant is requesting. For each ambulance listed for licensure, provide the unit number, license number, vehicle identification number (VIN), make, model

year, model type, mileage, projected vehicle life, and patient capacity of each vehicle. Attach copies of the current vehicle registration issued by the Department of Motor Vehicles (DMV), the California Highway Patrol (CHP) emergency vehicle license and the results of the most recent CHP inspection for each vehicle to be licensed. Prior to approval of an ambulance license, all ambulances proposed to operate in Ventura County will be inspected and shall meet the following:

a. Primary ambulances assigned to Ventura County must be less than six (6) years old and have less than 250,000 miles at time of initial licensure. Ambulances exceeding these maximums may be authorized for use in a reserve capacity following an annual inspection.
b. BLS transport unit equipment and supply requirements as established in VCEMS Policy 504.
c. Radio communication capabilities as provided in VCEMS Policy 905.
d. Radio identification number shall be clearly marked on all four sides of ambulances assigned to Ventura County.
e. All ambulances authorized to operate within Ventura County will be required to install and continuously operate automatic vehicle location (AVL) equipment compatible with the Ventura County Fire Department's regional communications system. Applicant shall contact VCEMS for AVL requirements and procurement procedure.

Any costs for procurement, installation and the continuous operation of the equipment/supplies, radio and AVL requirements are the sole responsibility of the ambulance provider. Only ambulances equipped as described above will be permitted to operate in Ventura County. Ambulances will be subject to announced and unannounced inspection by VCEMS.

6. A statement listing any facts which the applicant believes tend to prove that public convenience, safety and necessity require the granting of a license, labeled as "Attachment VI". Facts shall include written statements or other evidence of either inadequate response times or inadequate care from existing providers. To establish public convenience, safety, or necessity, the applicant shall demonstrate to the satisfaction of the VCEMS Administrator that it has complied with each of the following requirements:

a. The applicant has complied with all provisions of this policy.

b. The applicant is, under normal conditions, serving or likely to serve the public adequately.

c. The applicant has submitted a “business plan” or “statement of work” which demonstrates that the applicant will provide ambulance services which will enhance the current system and the level of services.

d. The applicant meets the minimum requirements to have an ambulance license.

7. A financial statement of assets, liabilities, and net worth for the past three (3) years prepared by a recognized accounting or bookkeeping firm, labeled as “Attachment VII”. If the applicant has had less than three (3) years experience in business, the financial statement will be required to cover the period of time the applicant has been in business and additional weight shall be given to documentation provided in response to Section III.A.3 above. The financial statements shall demonstrate that the applicant has adequate financial health, based on liquidity, profitability, and sustainability, to maintain ambulance service operations. All applicants must also submit current bank statements for the most recent three (3) months and data showing the estimated average cost of operating one trip, and the number of trips per day a vehicle must run to be profitable (the costs per trip should be itemized, you may use break-even formulas), and describe any unpaid judgments against the applicant, as well as the nature of transactions or acts giving rise to said judgments. All liabilities must be clearly defined and disclosed. If approved, applicant will submit annual financial statements to VCEMS within three (3) months of the end of the applicant’s fiscal year.

8. Applicant shall establish a VCEMS approved EMT AED Service Provider program which, at a minimum, meets all requirements of VCEMS Policies 802 and 803. Documentation of EMT AED Service Provider program and VCEMS approval shall be labeled as “Attachment VIII”.

9. Applicant shall provide verification of a VCEMS approved Continuous Quality Improvement Program (CQIP), labeled as “Attachment IX”. Applicant’s CQIP must meet the requirements of VCEMS Policy 120 and applicant must agree to fully participate in VCEMS CQI projects and committees.

10. Applicant shall provide copies of its medical dispatch policies and procedures, labeled as "Attachment X". Applicant must submit copies of dispatch logs for the thirty (30) day period immediately prior to the date of the application and a description of the qualifications for dispatchers. Applicant must also submit a letter of agreement to use the VCEMS approved "Dispatch Call Entry Form" for any Ventura County based ambulance requests.
11. Applicant shall provide a description of the company's accounts receivable management system, labeled as "Attachment XI". Documentation should include the location of the closest physical billing office to Ventura County and the training and experience of billing staff and billing management. If the location is not in Ventura County, applicant must provide staff specifically trained and available to address billing inquiries from Ventura County patients.
12. A list of insurance and liability coverage, including certificates of insurance or other evidence of coverage, labeled as "Attachment XII". The minimum insurance coverage types and limit requirements for ambulance companies include general liability insurance with limits of not less than $1 million each occurrence and $2 million aggregate; automobile liability insurance with limits of not less than $1 million each accident covering all vehicles used by the applicant; worker's compensation and employers' liability insurance, or an equivalent program of self-insurance coverage which complies with California Labor Code requirements; and professional liability insurance covering applicant's errors and omissions with limits of not less than $1 million per each claim and $2 million aggregate. Such insurance shall be provided by insurer(s) satisfactory to VCEMS and upon licensure approval, the general and auto liability insurance policies shall name the County of Ventura as an additional insured.
13. Applicant shall provide a written statement, labeled as "Attachment XIII", of intent to comply with the Multi-Casualty Incident Response plan as addressed in VCEMS Policy 131. During multi-casualty incidents (MCIs), the capability of the 911 ambulance providers to provide necessary prehospital emergency care and transportation may be insufficient for the number of casualties. Therefore, it is necessary that all non-911 ambulances operating in Ventura County be available to assist during an MCI. For this reason, each ambulance provider will make available, and place into service, all available licensed units upon VCEMS request. All ambulance providers, in the event of an MCI, will:

a. Provide immediate ambulance resource availability within Ventura County when requested by VCEMS.

b. Have an emergency response plan which includes a personnel call-back plan.

c. Have all management and field personnel trained for compliance with VCEMS Policy 131 within 6 months of licensure.

d. Provide, within reason, immediate response to any polls or surveys from VCEMS.

e. Provide, within reason, equipment, facilities, and personnel as requested by VCEMS.

f. When funding is available, the County of Ventura may assist the participating providers in seeking reimbursement for its costs from any disaster relief funding. The County of Ventura will have no financial responsibility for these costs or charges.

When requested by VCEMS, the licensed ambulance provider will participate in a Ventura County organized disaster exercise by assigning a minimum of one (1) fully staffed ambulance and one (1) supervisor. VCEMS will request participation from licensed providers with a minimum of thirty (30) days written notice. All costs associated with participation in the disaster exercise will be the sole responsibility of the licensed provider.

14. The applicant shall provide a written statement, labeled as “Attachment XIV”, of intent to comply with the requirements of the VCEMS Policies and Procedures Manual and the standards and policies set by the Medical Director of VCEMS.

15. Attach evidence of support for applicant and label as “Attachment XV”. Applicant must provide a minimum of three (3) written statements of support, on letterhead, from responsibly positioned, Ventura County-based, residents, institutions, or users of the service.

16. Submit the completed application packet and payment, if any, and five (5) copies of the entire application (including all attachments) to:

    EMS Administrator
    Ventura County EMS Agency
    2220 E. Gonzales Rd. #130
    Oxnard, CA 93036

The original and all copies of the application packet must be submitted in a 3-ring loose leaf binder, with labeled dividers for each attachment identified above. Do

not place documents or pages of the application in page protectors or covers. Two sided copies are encouraged, whenever possible. Applications determined to be incomplete will be returned to the applicant and will not be processed.

B. Procedure for Processing Application for Ambulance Company License:

1. VCEMS shall commence processing an application within fifteen (15) calendar days from the date the application is filed and determined to be complete. Application packets will initially be reviewed by VCEMS staff for compliance with the application requirements in Section III.A of this policy. Once all sections of the application have been reviewed for compliance, the VCEMS Administrator will determine if the application is complete or if the application is deficient in any area. If the application is determined to be deficient, the application will be denied and the applicant will be notified in writing. The applicant will have thirty (30) calendar days in which to respond. Failure to provide the requested information within thirty (30) days will result in the abandonment of the application and the complete application process, including fees, must be restarted in order to be considered for licensure. If the application is determined to be complete, the review process will continue as follows:

   a. VCEMS Administrator will notify all ambulance companies licensed by the County, members of the Prehospital Services Committee (PSC), and EMS Advisory Committee of the receipt of the application and the name and address of the applicant.

   b. VCEMS staff will thoroughly investigate the conditions and requirements listed in Section III.A (except for Sections III.A.7, III.A.11 and III.A.12) of the application packet to verify the information submitted as they relate to the applicant's ability to provide ambulance service in compliance with the standards of this policy.

2. Specific Ventura County departments will review sections of the application that are pertinent to their area of responsibility as follows:

   a. The Ventura County Auditor/Controller's Office shall be requested to review and comment on the financial statement and accounts receivable documents provided in response to Sections III.A.7 and III.A.11, as they relate to the applicant's ability to meet the financial obligations of the business.

b. The Ventura County Risk Management Division shall be requested to review the insurance and liability documents provided in response to Section III.A.12, as they relate to the minimum coverage requirements.

3. The VCEMS Administrator shall conclude evaluation of the application and prepare an administrative report that summarizes each of the application sections and verifies the applicant's compliance with all of the required elements of this policy.
4. VCEMS will present the administrative report and all information received regarding the application to the PSC within one hundred twenty (120) days of the date the application was determined to be complete. The committee shall regard the information as privileged and shall use discretion in its handling of the application materials. PSC members from current Ventura County licensed ambulance providers will be excused during the review process.
   a. PSC shall review the application and develop a written report of its findings to submit to the EMS Advisory Committee.
   b. The findings shall include:
      (1) Whether the applicant has substantially met all elements of the ambulance licensing procedure described in this policy.
      (2) Whether or not public convenience, safety and necessity requires the issuance of an ambulance license.
      (3) Whether the applicant's experience and past performance meets the standards in the VCEMS Policies and Procedures Manual.
      (4) Any other pertinent information.
5. The EMS Advisory Committee shall convene; within ninety (90) days from the date PSC completes its review, to evaluate the application packet, the VCEMS administrative report and the PSC report. The EMS Advisory Committee will develop a written report recommending approval or denial of the application and shall include:
   a. Whether the applicant has complied with all provisions of this policy.
   b. Whether the applicant is, under normal conditions, serving or likely to serve the public adequately.

c. Whether the applicant has submitted a “business plan” or “statement of work” which demonstrates that the applicant will provide ambulance services which will enhance the current system and the level of services.

d. Whether the applicant meets the minimum requirements to have an ambulance license.

e. Whether additional information is needed.

An approval recommendation by the EMS Advisory Committee is required before proceeding with the application process. Failure to receive an approval recommendation from the EMS Advisory Committee will result in an administrative denial of the application.

6. A denial recommendation from the EMS Advisory Committee may be appealed to the Ventura County Board of Supervisors by following the appeal provisions in Ventura County Ordinance No. 4099.
7. The VCEMS Administrator shall notify the Ventura County Auditor/Controller of approved applications and shall indicate the service area for which the license is valid.
8. Upon payment of the established license fee by the applicant, VCEMS shall issue the license.
9. The license shall be valid for two (2) years from the date of issue or until surrendered by the licensee, until sale of the company, or until revoked or suspended in accordance with the provisions of the VCEMS Policies and Procedures Manual.
10. The Director of the Health Care Agency or designee(s) shall deny, suspend or revoke an ambulance license in accordance with Sections 2424-1 and 2424-2 of Ventura County Ambulance Ordinance No. 4099.
11. Application for ambulance license renewal, and license renewal fee, if any, shall be received by VCEMS at least sixty (60) days prior to the expiration of the current ambulance license.
12. Ambulance providers that contract with the County to provide emergency ambulance service and which are required by contract to meet all the required conditions for license applicants, may be deemed by the VCEMS Administrator to meet the qualifications for a license and for ongoing license renewals. In such cases, the providers will not be required to comply with the application and re-application procedure described in Section III.A.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="3">Policy Title:
Child Abuse, Dependent Adult Abuse, or Elder Abuse Reporting</td><td>Policy Number
210</td></tr>
<tr><td>APPROVED:
Administration:</td><td colspan="2">Steven L. Carroll, Paramedic</td><td>Date: January 3, 2023</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td colspan="2">Daniel Shepherd M.D.</td><td>Date: January 3, 2023</td></tr>
<tr><td>Origination Date:
Date Revised:
Last Review:
Review Date:</td><td>June 14, 1984
November 10, 2022
November 10, 2022
November 30, 2024</td><td colspan="2">Effective Date: January 3, 2023</td></tr>
</table>

I. PURPOSE: To define child abuse or neglect, abuse of an elder or a dependent adult and outline the required reporting procedure for prehospital personnel in these cases.

II. AUTHORITY: Welfare and Institutions Code: ARTICLE 3 Mandatory and Nonmandatory Reports of Abuse [15630-15632]. Child Abuse and Neglect Reporting Act (CANRA): ARTICLE 2.5 Child Abuse and Neglect Reporting Act [11164-11174.3].

III. POLICY: EMS Providers are mandated reporters and will report all suspected cases of child abuse or neglect, and abuse of an elder or a dependent adult.

IV. DEFINITIONS:

A. "Abuse of an elder or a dependent adult" means physical abuse, neglect, abandonment, isolation, abduction, or other treatment with resulting physical harm or pain or mental suffering, the deprivation by a care custodian of goods or services that are necessary to avoid physical harm or mental suffering, or financial abuse.

B. "Child" means any person under the age of 18 years.

C. "Child abuse or neglect" means physical injury or death by other than accidental means upon a child by another person, sexual abuse, neglect, the willful harming or injuring of a child or the endangering of the person or health of a child, and unlawful corporal punishment or injury.

D. "Dependent adult" means a person, regardless of whether the person lives independently, between the ages of 18 and 59 years who resides in this state and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, persons who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age. Dependent adult also includes any person between the ages of 18 and 59 years who is admitted as an inpatient to a 24-hour health facility, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code.

E. "Elder" means any person residing in this state, 60 years of age or older.

F. “Mandated Reporter” includes an emergency medical technician I or II, paramedic, or other person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

G. "Reasonable suspicion" means that it is objectively reasonable for a person to entertain such a suspicion, based upon facts that could cause a reasonable person in a like position, drawing, when appropriate, on the person’s training and experience, to suspect child abuse or neglect, or abuse of an elder or a dependent adult.

V. PROCEDURE:

A. Suspected abuse of an elder or a dependent adult

1. Report online at ReporttoAPS.org or call 805-654-3200 within 48 hours of receiving information concerning the incident.
    a. Reporting online satisfies the State requirement for mandated reporters to call in and mail/fax a report.
    b. If online reporting cannot be done, reports may be emailed to HSA-APS-Referrals@ventura.org or faxed to 805-650-1521.
2. Failure to report suspected abuse of an elder or a dependent adult
    a. Failure to report, or impeding or inhibiting a report of, physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, is a misdemeanor, punishable by not more than six months in the county jail, by a fine of not more than one thousand dollars ($1,000), or by both that fine and imprisonment. A mandated reporter who willfully fails to report, or impedes or inhibits a report of, physical abuse, as defined in Section 15610.63, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, if that abuse results in death or great bodily injury, shall be punished by not more than one year in a county jail, by a fine of not more than five thousand dollars ($5,000), or by both that fine and imprisonment. If a mandated reporter intentionally conceals their failure to report an incident known by the mandated reporter to be abuse or severe neglect under this section, the failure to report is a continuing offense until a law enforcement agency specified in paragraph (1) of subdivision (b) of Section 15630 discovers the offense.

B. Suspected child abuse or neglect

1. Make an initial report by telephone immediately or as soon as practically possible to the 24-hour hotline 805-654-3200.
2. Submit a written report within 36 hours of receiving the information concerning the incident: (Form BCIA 8572) to HSA-CFS-SCAR@ventura.org.
3. Failure to report suspected child abuse or neglect
   a. A mandated reporter who fails to report an incident of known or reasonably suspected child abuse or neglect as required by this section is guilty of a misdemeanor punishable by up to six months confinement in a county jail or by a fine of one thousand dollars ($1,000) or by both that imprisonment and fine. If a mandated reporter intentionally conceals the mandated reporter's failure to report an incident known by the mandated reporter to be abuse or severe neglect under this section, the failure to report is a continuing offense until an agency specified in Section 11165.9 discovers the offense.

C. When two (2) or more persons, who are required to report, are present and jointly have knowledge of a suspected instance of child abuse or neglect, or abuse of an elder or a dependent adult, and when there is agreement among them, the telephone report may be made by a member of the team selected by mutual agreement and a single report may be made and signed by such selected member of the reporting team. Any member who has knowledge that the member designated to report has failed to do so, shall thereafter make such report.

D. The reporting duties are individual, and no supervisor or administrator may impede or inhibit such reporting duties and no person making such report shall be subject to any sanction for making such report. However, internal procedures to facilitate reporting and apprise supervisors and administrators of reports may be established provided that they are not inconsistent with the provisions of this article.

Reporting Suspected Abuse

Suspected abuse of an elder or dependent adult

Report online or call within 48 hours

Link to online report: ReporttoAPS.org	24-hour hotline: 805-654-3200

If unable to submit online report, submit through email or fax

Link to email: HSA-APS-Referrals@ventura.org	-OR-	FAX: 805-650-1521

Suspected child abuse or neglect

Initial report by telephone immediately or as soon as practically possible

24-hour hotline: 805-654-3200

Submit written report within 36 hours

Link to form: Form BCIA 8572	Email form to: HSA-CFS-SCAR@ventura.org

Policy Title: Emergency Medical Technician Scope of Practice		Policy Number 300
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date:	August 1988	Effective Date: January 3, 2023
Date Revised:	November 10, 2022	
Date Last Reviewed:	November 10, 2022	
Review Date:	November 30, 2025	

I. PURPOSE: To define the scope of practice of an Emergency Medical Technician (EMT) practicing in Ventura County.

II. AUTHORITY: Health and Safety Code, Section 1797.107, 1797.109, 1797.160, 1797.170, and California Code of Regulations, Title 22, Division 9, Section 100063, and 100064.

III. POLICY:

A. During training, while at the scene of an emergency and during transport of the sick or injured, or during interfacility transfer, a supervised EMT trainee or certified EMT is authorized to do any of the following:

1. Evaluate the ill and injured
2. Render basic life support, rescue and emergency medical care to patients.
3. Obtain diagnostic signs to include, but not be limited to the assessment of temperature, blood pressure, pulse and respiration rates, pulse oximetry, level of consciousness, and pupil status.
4. Perform cardiopulmonary resuscitation, including the use of mechanical adjuncts to basic cardiopulmonary resuscitation.
5. Administer oxygen
6. Use the following adjunctive airway and breathing aids:
   a. Oropharyngeal airway
   b. Nasopharyngeal airway
   c. Suction devices
   d. Basic oxygen delivery devices for supplemental oxygen therapy, including but not limited to, humidifiers, partial rebreathers, and venturi masks; and

e. Manual and mechanical ventilating devices designed for prehospital use, including continuous positive airway pressure (CPAP) and bilevel positive airway pressure (BiPAP).

7. Use various types of stretchers and spinal immobilization devices.
8. Provide initial prehospital emergency care of trauma, including, but not limited to:
   a. Bleeding control through the application of tourniquets;
   b. Use of hemostatic dressings from a list approved by the California EMS Authority
   c. Spinal motion restriction or immobilization;
   d. Seated spinal motion restriction or immobilization;
   e. Extremity splinting; and
   f. Traction splinting.
9. Administer oral glucose or sugar solutions.
10. Extricate entrapped persons.
11. Perform field triage.
12. Transport patients.
13. Apply mechanical patient restraint
14. Set up for ALS procedures, under the direction of a Paramedic.
15. Perform automated external defibrillation
16. Assist patients with the administration of physician-prescribed devices including, but not limited to, patient-operated medication pumps, sublingual nitroglycerin, and self-administered emergency medications, including epinephrine devices.

B. In addition to the activities outlined in the EMT Basic Scope of Practice, the VCEMS Medical Director may also establish policies and procedures to allow a certified EMT or a supervised EMT student who is part of the organized EMS System and in the prehospital setting and/or during interfacility transport to:

1. Monitor intravenous lines delivering glucose solutions or isotonic balanced salt solutions including Ringer's lactate for volume replacement. Monitor, maintain, and adjust if necessary, in order to maintain, a preset rate of flow and turn off the flow of intravenous fluid;
2. Transfer a patient, who is deemed appropriate for transfer by the transferring physician, and who has nasogastric (NG) tubes, gastrostomy tubes, heparin locks, Foley catheters, tracheostomy tubes and/or indwelling vascular access lines, excluding arterial lines;

3. Administer naloxone by intranasal and/or intramuscular routes for suspected narcotic overdose;
4. Administer epinephrine by auto-injector for suspected anaphylaxis and/or severe asthma;
5. Perform finger stick blood glucose testing, and;
6. Administer over the counter medications, when approved by the VCEMS medical director, including but not limited to:
   a. Aspirin

C. During a mutual aid response into another jurisdiction, an EMT may utilize the scope of practice for which s/he is trained and authorized according to the policies and procedures established by VCEMS within the jurisdiction where the EMT is employed as part of the organized EMS system.

I. PURPOSE: To identify the procedure for certification of Emergency Medical Technician.

II. AUTHORITY: California Code of Regulations (CCR) Section 100079 and 100081; California Health and Safety Code Sections 1797.50 and 1797.175.

III. POLICY:

A. General Eligibility

An individual who meets one of the following criteria shall be eligible for initial certification:

1. Pass the cognitive examination and psychomotor skills examination of the National Registry of Emergency Medical Technicians within two (2) years from the date of application, and have:
   a. A valid EMT course completion record or other documented proof of successful completion of any initial EMT course approved pursuant to Section 100066 of the CCR within two (2) years of the date of application, or
   b. Have documentation of successful completion of an approved out of state initial EMT training course that meets the requirements outlined in Section 100079 of the California Code of Regulations within two (2) years of the date of application, or
   c. A current and valid out-of-state EMT certificate, or.
2. Possess a current and valid National Registry EMT, Advanced EMT, or Paramedic registration certificate, or
3. Possess a current and valid out-of-state Advanced EMT or Paramedic certificate.
4. Possess a current and valid California Advanced EMT certification or a current and valid California Paramedic license.

B. In addition to meeting one of the criteria listen in Section III.A, to be eligible for initial certification, an individual shall:

1. Be eighteen (18) years of age or older,
2. Complete a background investigation via “Live Scan” through the California Department of Justice and Federal Bureau of Investigation for VCEMS as the requesting agency and a secondary notification for the State of California Emergency Medical Services Authority. Submit a copy of the “Request for Live Scan Services” form along with your application for certification as proof the service has been completed,
3. Complete the Ventura County EMS (VCEMS) Personnel Application. VCEMS must be notified within 30 days of any change in personal contact information.
4. Complete the Ventura County Eligibility Statement (a statement that the individual is not precluded from certification for reasons defined in Section 1798.200 of the Health and Safety Code),
5. Have successfully completed *both cognitive and skills testing* from a Professional Rescuer or Healthcare Provider level CPR course, which is consistent with the current American Heart Association Guidelines for CPR and Emergency Cardiovascular Care (ECC), within the previous two years,
7. Provide a current government issued form of identification,
8. Pay the established fee

C. The individual will be issued a wallet size card, pursuant to Section 100344, subdivisions (c) and (d) of Chapter 10 of the California Code of Regulations, after the above steps are completed and the applicant has passed the criminal background clearance.

1. The effective date of initial certification shall be the day the certificate is issued.
2. The certification expiration date for an initial EMT certificate shall be the last day of the month two (2) years from the effective date of the initial certification.
3. An EMT shall only be certified by one (1) certifying entity during a certification period.
4. It is the responsibility of the certified EMT to notify VCEMS within 7 days of any change in their eligibility status as outlined in Health and Safety Code, Division 2.5, Section 1798.200. (For items that this Section applies to, see EMS Personnel Application, Eligibility Statement.)

D. Reinstatement of an Expired California EMT Certificate:

1. The following requirements apply to individuals who wish to be eligible for reinstatement after their California EMT certificates have expired:

a. For a lapse of less than six months, the individual shall comply with the requirements by complying with VCEMS Policy 302, III.A 2-9a.

b. For a lapse of six months or more, but less than twelve months, the individual shall:

   1. Comply with the requirements of VCEMS Policy 302, III.A 2-9a, and
   2. Complete an additional twelve (12) hours of continuing education.

c. For a lapse of twelve months or more, but less than 24 months, the individual shall:

   1. Comply with the requirement in VCEMS Policy 302, III.A 2-9a, and
   2. Complete an additional twenty-four (24) hours of continuing education, and
   3. Pass the NREMT cognitive and psychomotor skills certification exams within two (2) years of the date of application for EMT reinstatement, unless the individual possesses a current and valid EMT, AEMT or paramedic National Registry Certificate or a current and valid AEMT certificate or paramedic license.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Emergency Medical Technician Renewal		Policy Number 302
APPROVED: EMS Administrator:	Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 1, 1984 October 13, 2022 October 13, 2022 October 31, 2025	Effective Date: January 3, 2023

I. PURPOSE: To identify the procedure for recertification of the Emergency Medical Technician.

II. AUTHORITY: Health and Safety Code, Sections 1797.220, 1798. California Code of Regulations (CCR), Sections 100080 and 100081.

III. POLICY: To maintain certification, an EMT shall participate in either continuing education courses or complete a refresher course approved by the Agency. Approved continuing education courses shall be accepted statewide.

A. To renew certification, an EMT shall:

1. Possess a current EMT Certification issued in California.
2. Meet one of the following continuing education requirements:
   a. Successfully complete a twenty-four (24) hours refresher course from an approved EMT training program within the 24 months prior to applying for renewal, or
   b. Obtain at least twenty-four (24) hours of continuing education (CE), within the 24 months prior to applying for renewal, from an approved CE provider program, as defined in VCEMS 1130 – Continuing Education Provider Program Approval.
3. Complete the Ventura County EMS (VCEMS) Personnel Application. VCEMS must be notified within 30 days of any change in personal contact information.
4. Complete the Ventura County Eligibility Statement (a statement that the individual is not precluded from certification for reasons defined in Section 1798.200 of the Health and Safety Code),
5. A new applicant to VCEMS, or an applicant whose certification has lapsed, must complete a background investigation via “Live Scan” through the California Department of Justice and Federal Bureau of Investigation for VCEMS as the

requesting agency and a secondary notification for the State of California Emergency Medical Services Authority. Submit the second copy of the "Request for Live Scan Services" form along with EMS application for certification as proof the service has been completed.

6. Have successfully completed ***both cognitive and skills testing*** from a Professional Rescuer or Healthcare Provider level CPR course, which is consistent with the current American Heart Association Guidelines for CPR and Emergency Cardiovascular Care (ECC), within the previous two years,
7. Provide a current government issued form of identification,
8. Pay the established fee.
9. Submit a completed skills competency verification form, EMSA-SCV (01/17). Skills competency shall be verified by direct observation of an actual or simulated patient contact. Skills competency shall be verified by an individual who is currently certified or licensed as an EMT, AEMT, Paramedic, Registered Nurse, Physician's Assistant, or Physician and who shall be designated by a VCEMS approved CE, EMT, Paramedic training program, or an approved VC EMS provider agency. Verification of skills competency shall be valid for a maximum of two (2) years for the purpose of applying for recertification.
   a. Starting July 1, 2019, an EMT renewing his or her certification for the first time shall submit documentation of successful completion of the training outlined in Section 100080(a)(B)(6)(A-C) of the California Code of Regulations by an approved EMT training program or approved CE provider program, which includes training in the administration of naloxone, epinephrine, and the use of finger stick blood glucose testing by a glucometer.

B. The individual will be issued a wallet size certificate card after renewal requirements are completed.

C. If the EMT renewal requirements are met within six (6) months prior to the expiration date, VCEMS shall make the effective date of recertification the date immediately following the expiration date of the current certificate. The certificate will expire two (2) years from the day prior to the effective date.

D. If the EMT renewal requirements are met greater than six (6) months prior to the expiration date, VCEMS shall make the effective date of renewal the date the certificate

was issued. The certification expiration date will be the last day of the month two (2) years from the effective date.

E. A California certified EMT who is a member of the Armed Forces of the United States and whose certification expires while deployed on active duty, or whose certification expires less than six (6) months from the date they return from active-duty deployment, with the Armed Forces of the United States shall have six (6) months from the date they return from active-duty deployment to complete the requirements outlined in Section III. A 2-9a of this policy. To qualify for this exception, the individual shall

1. Submit proof of their membership in the Armed Forces of the United States, and
2. Submit documentation of their deployment starting and ending dates.
3. Continuing education shall be in any of the topics contained in the current National Standard Curricula for training EMS personnel.
4. The continuing education documentation shall include verification from the individual's Commanding Officer attesting to the training attended.

F. Reinstatement of an Expired California EMT Certificate.

1. The following requirements apply to individuals who wish to be eligible for reinstatement after their California EMT Certificates have expired:
   a. For a lapse of less than six (6) months, the individual shall complete the requirements outlined in Section III.A 2-9a of this policy.
   b. For a lapse of six (6) months or more, but less than twelve (12) months, the individual shall:
      1. Complete the requirements outlined in Section III.A 2-9a of this policy,
      2. Complete an additional twelve (12) hours of continuing education.
   c. For a lapse of twelve (12) months or more, the individual shall:
      1. Complete the requirements outlined in Section III.A 2-9a of this policy,
      2. Complete an additional twenty-four (24) hours of continuing education, and
      3. Pass the NREMT cognitive and psychomotor skills certification exams within two (2) years of the date of application for EMT reinstatement, unless the individual possesses a current and valid EMT, AEMT or paramedic National Registry Certificate or a current and valid AEMT certificate or paramedic license.

I. PURPOSE: To define the process related to authorizing EMT optional skills and EMT trial studies

II. AUTHORITY: Health and Safety Code, Section 1797.107, 1797.109, 1797.160, 1797.170, and California Code of Regulations, Title 22, Division 9, Section 100064

III.

IV. POLICY:

A. In addition to the skills outlined in VCEMS Policy 300 – EMT Scope of Practice, the VCEMS Medical Director may establish policies and procedures for local accreditation of an EMT student or certified EMT to perform any or all of the following optional skills specified in this policy. Accreditation for EMTs to practice optional skills shall be limited to those whose EMT certification is active and are employed within the County of Ventura by an employer who is part of the organized EMS system.

1. Administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe for suspected anaphylaxis and/or severe asthma.

a. Training in the administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe for suspected anaphylaxis and/or severe asthma shall consist of no less than two (2) hours to result in the EMT being competent in the use and administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe and managing a patient of a suspected anaphylactic reaction and/or experiencing severe asthma symptoms. Included in the training hours listed above shall be the following topics and skills:

1) Names

2) Indications and contraindications

3) Complications
4) Side/adverse effects and interactions
5) Routes of administration
6) Dosage calculation
7) Mechanisms of drug actions
8) Medical asepsis
9) Disposal of contaminated items and sharps
10) Medical administration

b. At the completion of this training, the student shall complete a competency based written and skills examination for the use and/or administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe, which shall include:
1) Assessment of when to administer epinephrine,
2) Managing a patient before and after administering epinephrine,
3) Using universal precautions and body substance isolation procedures during medication administration,
4) Demonstrating aseptic technique during medication administration,
5) Demonstrating preparation and administration of epinephrine by prefilled syringe and/or drawing up the proper drug dose into a syringe, and
6) Proper disposal of contaminated items and sharps

2. Administration of the following medications through the use of an auto-injector for the purposes of treating exposure to a nerve agent
a. Atropine
b. Pralidoxime Chloride
c. In addition to a basic weapons of mass destruction training, the nerve agent antidotetraining shall consist of no less than two (2) hours of didactic and skills training to result in competency. Training in the profile of the medications contained in the DuoDote/Mark I auto-injector and atropine auto-injector shall include, but not limited to:
1) Indications and contraindications
2) Side/adverse effects
3) Routes of administration

4) Dosages
5) Mechanisms of drug action
6) Disposal of contaminated items and sharps
7) Medication administration

d. At the completion of this training, the student shall complete a competency based written and skills examination for the administration of the Duo-dote/Mark I and atropine auto-injector.
1) Assessment of when to administer the auto-injector,
2) Managing a patient before and after administering the auto-injector
3) Using the universal precautions and body substance isolation precautions during medication administration,
4) Demonstrating aseptic technique during medication administration,
5) Demonstrating the preparation and administration of medications by the intramuscular (IM) route, and
6) Proper disposal of contaminated items and sharps.

B. Competency training in procedures and skills for all EMT optional skills shall be completed at least every two (2) years.

C. VCEMS shall develop and maintain specific plans for each optional skill permitted. These plans will include:
1. A description of the need for use of the optional skill
2. A description of the geographic area within which the optional skills will be utilized
3. A description of the data collection methodology which shall also include an evaluation of the effectiveness of the optional skill
4. The policies and procedures to be instituted by the LEMSA regarding medical control and use of the optional skill

D. For an accredited EMT who fails to demonstrate competency in any of the optional skills outlined in this policy:
1. EMT accreditation shall be immediately suspended pending clinical remediation
2. Employer agency will submit a written plan of action to VCEMS to include: method of remediation, course curriculum, date(s) and location(s) of remediation training.

3. VCEMS will review and approve written plan of action prior to commencement of remediation training
4. Once complete, evidence of satisfactory training and minimum competency in the optional skills will be submitted to VCEMS prior to the reinstatement of the EMT accreditation.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: EMT Course Completion by Challenge Examination		Policy Number 304
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 1, 1984 November 10, 2022 November 10, 2022 November 30, 2025	Effective Date: January 3, 2023

I. PURPOSE: To identify the procedure for certification of the Emergency Medical Technician by challenge examination.

II. AUTHORITY: California Code of Regulations (CCR) Title 22, Division 9, Article 1, Sections 100066, 100078 – and Health and Safety Code Sections 1797.107, 1797.170, 1797.208 and 1797.210.

III. POLICY:

A. General Eligibility

An individual may obtain an EMT course completion record from an approved EMT training program by successfully passing by pre-established standards, developed and/or approved by the Ventura County EMS Agency in accordance with Section 100066 of the California Code of Regulations, a course challenge examination if s/he meets the following eligibility requirements:

1. Have successfully completed *both cognitive and skills testing* from a Professional Rescuer or Healthcare Provider level CPR course, which is consistent with the current American Heart Association Guidelines for CPR and Emergency Cardiovascular Care (ECC), within the previous two (2) years; AND,
2. Be a currently Licensed Physician, Registered Nurse, Physician Assistant, or Vocational Nurse; OR,
3. The individual provides documented evidence of having successfully completed an emergency medical service training program of the Armed Forces of the United States within the preceding two (2) years that meets

the U.S. DOT National EMS Education Standards (DOT HS 811 077A, January 2009). Upon review of documentation, the EMT certifying entity may also allow an individual to challenge if the individual was active in the last two (2) years in a prehospital emergency medical classification of the Armed Services of the United States, which does not have formal recertification requirements. These individuals may be required to take a refresher course or complete CE courses as a condition of certification.

B. Challenge Process

1. An approved EMT training program shall have a defined process for any EMT challenge request/application and shall offer the EMT challenge skills and written examination in conjunction with regularly scheduled testing times.
2. The course challenge examination shall consist of a competency based written and skills examination (National Registry) to test knowledge of the topics and skills per CCR 100078.
3. An eligible individual shall be permitted to take the EMT course challenge examination only one (1) time.
   a. An individual who fails to achieve a passing score on the EMT course challenge examination shall successfully complete an EMT course to receive an EMT course completion record.
   b. Upon successful completion of the written and skills challenge examination, the challenge applicant will be eligible to take the National Registry written examination.
4. Proof of successful completion of the National Registry written and skills examination will make the applicant eligible to apply for EMT certification in California, in accordance with VCEMS Policy 301 – EMT Certification.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: "Code STEMI": Transfer of Patients with STEMI for PCI		Policy Number 440
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: January 3, 2023
Origination Date: Date Revised: Last Reviewed: Review Date:	July 1, 2007 February 5, 2020 July 13, 2022 July 31, 2024	Effective Date: January 3, 2023

I. PURPOSE: To define the "Code STEMI" process by which patients with a STEMI are transferred to a STEMI Receiving Center (SRC) for emergency percutaneous coronary intervention (PCI).

II. AUTHORITY: Health and Safety Code, Sections 1797.220 and 1798. California Code of Regulations, Title 22, Sections 100147, 100169, 100270.124 and 100270.125

III. DEFINITIONS:

A. STEMI: ST Segment Elevation Myocardial Infarction.

B. STEMI Receiving Center (SRC): an acute care hospital with percutaneous coronary intervention (PCI) services that has been designated according to VC EMS Policy 430.

C. STEMI Referral Hospital (SRH): an acute care hospital in Ventura County that meets the requirements for a receiving hospital in VC EMS Policy 420 and has been designated according to VC EMS Policy 430.

D. PCI: Percutaneous Coronary Intervention.

IV. POLICY:

A. STEMI Referral Hospitals will:

1. Assemble and maintain a "STEMI Pack" in the emergency department to contain all of the following:

a. Checklist with phone numbers of Ventura County SRCs.

b. Preprinted template order sheet with recommended prior-to-transfer treatments. Treatment guidelines will be developed with input from the SRH and SRC cardiologists.

c. Patient Consent/Transfer Forms.

d. Treatment summary sheet.

e. Ventura County EMS Code STEMI data entry form.

2. Have policies, procedures, and a quality improvement system in place to minimize door-to-ECG and STEMI-Dx-to-transfer times.

3. Establish policies and procedures to make personnel available to accompany the patient during the transfer to the SRC. These policies will include patient criteria for requiring an RN to accompany patient.

B. Ambulance Dispatch Center will:

1. Respond to a “Code STEMI” transfer request by immediately dispatching the closest available ALS ambulance to the requesting SRH.

C. Ambulance Companies

1. Ambulance Companies will:
   a. Respond immediately upon request for “Code STEMI” transfer.
   b. Staff all ambulances with a minimum of one paramedic who has been trained in the use of intravenous heparin and nitroglycerin drips, and the pump being used, according to VC EMS Policy 722.
2. Transports performed according to this policy are not to be considered an interfacility transport as it pertains to ambulance contract compliance.

D. STEMI Receiving Centers will:

1. Maintain accurate status information on ReddiNet regarding the availability of a cardiac catheterization lab.
2. Publish a single phone number, that is answered 24/7, to receive notification of a STEMI transfer.
3. Immediately upon initial notification by a transferring physician at an SRH, accept in transfer all patients who have been diagnosed with a STEMI and who, in the judgment of the transferring physician, require urgent PCI.
4. Authorize the emergency physician on duty to confirm the acceptance in transfer of any patient with a STEMI.
5. Establish an internal communications plan that assures the immediate notification of all necessary individuals, including the cardiac catheterization services staff and on-call interventional cardiologist, of the transfer.
6. Adopt procedures to make an ICU/CCU bed available or to make alternate arrangements for post-PCI care.

V. PROCEDURE:

A. Upon diagnosis of STEMI, and after discussion with the patient, the SRH will:

1. Determine availability of the SRC by checking ReddiNet.
2. Immediately call the Ventura County Fire Communication Center at 805-384-1500 for an ambulance.
3. Identify their facility to the dispatcher and advise they have a Code STEMI transfer to [SRC].

4. After calling for ambulance, the SRH transferring physician will notify the SRC emergency physician of the transfer.
5. Perform all indicated diagnostic tests and treatments.
6. Complete transfer consent, treatment summary, and Code STEMI data forms.
7. Include copies of the ED face sheet and demographic information.
8. Arrange for one or more healthcare staff, as determined by the clinical status of the patient, to accompany the patient to the SRC.
    a. If, because of unusual and unanticipated circumstances, no healthcare staff is available for transfer, the SRH may contact the responding ambulance company to make a paramedic or EMT available.
    b. If neither the SRH or ambulance company has available personnel, a CCT transfer may be requested.
9. Contact SRC for nurse report at the time of, or immediately after, the ambulance departs.

B. Upon request for “Code STEMI” transfer, the dispatch center will dispatch the closest ALS ambulance and verbalize “MEDxxx Code STEMI from [SRH]”. The SRC will be denoted in the Incident Comments, which will display on the Mobile Data Computer (MDC). If a unit does not have an operational MDC, the SRH will advise the responding ambulance personnel of the SRC.

C. Upon notification, the ambulance will respond Code (lights and siren) and the ambulance personnel will notify their ambulance company supervisor of the “Code STEMI” transfer.

D. Ambulance units will remain attached to the incident and FCC will track their dispatch, en-route, on scene, en-route hospital, at hospital, and available times.

E. The patient shall be urgently transferred without delay. Every effort will be made to minimize on-scene time.
1. All forms should be completed prior to ambulance arrival.
2. Any diagnostic test results may be relayed to the SRC at a later time.
3. Intravenous drips may be discontinued or remain on the ED pump.
4. Ambulance personnel will place defibrillation pads on the patient.

F. Upon notification, the SRC will notify the interventional cardiologist and cardiac catheterization staff, who will respond immediately and prepare for the PCI procedure.

G. The SRH and SRC shall review all STEMI transfers within 24 hours for appropriate and timely care and to identify opportunities for improvement. Results will be reviewed and discussed at the Countywide EMS STEMI CQI Committee.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Acute Stroke Center (ASC) Standards		Policy Number 450
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: January 3, 2023
Origination Date: Date Revised: Last Review: Review Date:	October 11, 2012 June 24, 2020 June 22, 2022 June 30, 2024	Effective Date: January 3, 2023

I. PURPOSE: To define the criteria for designation as an Acute Stroke Center in Ventura County.

II. AUTHORITY: California Health and Safety Code, Sections 1797.114, 1797.220, 1798, 1798.2, 1798.101, and California Code of Regulations, Title 22, Section 100170.

III. DEFINITIONS:

Acute Stroke Center (ASC): Hospital designated as an Acute Stroke Center by the Ventura County EMS Agency that maintains certification as an ASRH, PSC, or CSC.

Acute Stroke Ready Hospital: (ASRH) Hospital certified by either The Joint Commission, Det Norske Veritas, or the Healthcare Facilities Accreditation Program as an Acute Stroke Ready Hospital.

Comprehensive Stroke Center: (CSC) Hospital certified by either The Joint Commission, Det Norske Veritas, or the Healthcare Facilities Accreditation Program as a Comprehensive Stroke Center.

Primary Stroke Center: (PSC) Hospital certified by either The Joint Commission, Det Norske Veritas, or the Healthcare Facilities Accreditation Program as a Primary Stroke Center.

Thrombectomy Capable Acute Stroke Center: (TCASC) Acute Stroke Center (ACS) that has the capability to perform neuroendovascular procedures for acute stroke including thrombectomy and intra-arterial thrombolysis.

IV. POLICY:

A. An Acute Stroke Center (ASC), approved and designated by Ventura County EMS (VC EMS) shall meet the following requirements:

1. All the requirements of a Receiving Hospital in VCEMS Policy 420.
2. Certification as an Acute Stroke Ready Hospital (ASRH), Primary Stroke Center (PSC), Thrombectomy Stroke Center, or a Comprehensive Stroke

Center (CSC) by either The Joint Commission, Det Norske Veritas, or the Healthcare Facilities Accreditation Program.

3. Participate in the Ventura County Stroke Registry.
   a. All data must be documented in the registry no later than 60 days after the end of the month of hospital admission.
4. Actively participate in the Ventura County EMS Stroke Quality Improvement Program.
5. Have policies and procedures that allow the automatic acceptance of any stroke patient from a hospital within Ventura County that is not designated as an ASC, upon notification by the transferring physician.

B. Designation Process:

1. Application:

   Eligible hospitals shall submit a written request for ASC designation to VC EMS no later than 30 days prior to the desired date of designation, documenting the compliance of the hospital with Ventura County ASC Standards.
2. Approval:
   a. Upon receiving a written request for ASC designation, VC EMS will arrange an on-site survey of the requesting hospital to assure compliance with stated requirements.
   b. ASC approval or denial shall be made in writing by VC EMS to the requesting hospital within two weeks after receipt of the request for approval and all required documentation and completion of the VC EMS site survey.
   c. Certification as an Acute Stroke Ready Hospital, Primary Stroke Center, Thrombectomy Stroke Center, or a Comprehensive Stroke Center by The Joint Commission, Det Norske Veritas, or the Healthcare Facilities Accreditation Program, shall occur no later than six months following designation as an ASC by VC EMS.
3. VCEMS may deny, suspend, or revoke the designation of an ASC for failure to comply with any applicable policies, procedures, or regulations. Requests for review or appeal of such decisions shall be brought to the Ventura County Board of Supervisors for appropriate action.
4. The VC EMS Medical Director may grant an exception to a portion of this policy upon substantiation of need by the ASC that compliance with the

regulation would not be in the best interests of the persons served within the affected area.

5. ASCs shall be reviewed on a biannual basis.
   a. ASCs shall receive notification of evaluation from the VCEMS.
   b. ASCs shall respond in writing regarding program compliance.
   c. On-site ASC visits for evaluative purposes may occur.
   d. ASCs shall notify VCEMS by telephone, followed by a letter or email within 48 hours, of changes in program compliance or performance.

C. Provisional Designation Process

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

1. Application:

   Eligible hospitals shall submit a written request for provisional ASC designation to VC EMS no later than 30 days prior to the desired date of provisional designation, documenting the compliance of the hospital with Ventura County ASC Standards.

2. Provisional Approval:
   a. Upon receiving a written request for provisional ASC designation, VC EMS will arrange an on-site survey of the requesting hospital to assure compliance with stated requirements.
   b. Provisional ASC approval or denial shall be made in writing by VC EMS to the requesting hospital within two weeks after receipt of the request for approval and all required documentation, as well as completion of the VC EMS site survey.
   c. Certification as an Acute Stroke Ready Hospital, Primary Stroke Center, Thrombectomy Stroke Center, or a Comprehensive Stroke Center by The Joint Commission, Det Norske Veritas, or the Healthcare Facilities Accreditation Program, shall occur no later than six months following provisional designation as an ASC by VC EMS.

3. VC EMS may deny, suspend, or revoke the designation of an ASC for failure to comply with any applicable policies, procedures, or regulations.

Requests for review or appeal of such decisions shall be brought to the Ventura County Board of Supervisors for appropriate action.

4. The VC EMS Medical Director may grant an exception to a portion of this policy upon substantiation of need by the provisional ASC that compliance with the regulation would not be in the best interests of the persons served within the affected area.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Stroke System Triage and Destination		Policy Number 451
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	October 11, 2012 June 24, 2020 June 22, 2022 June 30, 2024	Effective Date: January 3, 2023

I. PURPOSE: To outline the process of pre-hospital triage and transport of suspected acute stroke patients to facilities designated as an Acute Stroke Center (ASC) or a Thrombectomy Capable Acute Stroke Center (TCASC).

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

III. DEFINITIONS:

Acute Stroke Center (ASC): Hospital designated as an Acute Stroke Center, as defined in VCEMS Policy 450.

Comprehensive Stroke Center: (CSC) Hospital certified by either The Joint Commission, Det Norske Veritas, or the Healthcare Facilities Accreditation Program as a Comprehensive Stroke Center.

ELVO Alert: A pre-arrival notification by pre-hospital personnel to the base hospital that a patient is suffering a possible Emergent Large Vessel Occlusion (ELVO) ischemic stroke.

Emergent Large Vessel Occlusion (ELVO): An acute ischemic stroke caused by a large vessel occlusion.

Stroke Alert: A pre-arrival notification by pre-hospital personnel that a patient is suffering a possible acute stroke.

Thrombectomy Capable Acute Stroke Center: (TCASC) Acute Stroke Center (ASC) that has the capability to perform neuroendovascular procedures for acute stroke including thrombectomy and intra-arterial thrombolysis.

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

Ventura ELVO Score (VES): A tool designed for paramedics to screen for an ELVO in the prehospital setting.

IV. POLICY:

A. Stroke System Triage:
Patients meeting criteria in each of the following sections (1, 2, 3,) shall be triaged into the VC EMS stroke system.

1. Patient's TLKW is within 24 hours.

2. Blood Glucose is greater than sixty (60) OR patient continues to exhibit signs and symptoms of an acute stroke after pre-hospital treatment of abnormal blood glucose levels.

3. Identification of *ANY* abnormal finding of the Cincinnati Stroke Scale (CSS).
FACIAL DROOP
Normal: Both sides of face move equally
Abnormal: One side of face does not move normally
ARM DRIFT
Normal: Both arms move equally or not at all
Abnormal: One arm does not move, or one arm drifts down compared with the other side
SPEECH
Normal: Patient uses correct words with no slurring
Abnormal: Slurred or inappropriate words or mute

B. Perform the Ventura ELVO Score (VES) below:
Forced Eye Deviation: (1 point)
Force full deviation of BOTH eyes to one side or the other
Eyes will not pass midline

Aphasia: Patient is awake, but: (1 point). *ANY* of the following present is a positive (1 Point) for Aphasia)
Repetition: Unable to repeat a sentence ("Near the chair in the dining room.")
Naming: Unable to name an object (show a watch and a pen, ask patient to name the objects)
Mute: Ask the patient 2 Questions (What is your name? How old are you?)
Talking gibberish and/or not following commands

Neglect: (1 point)
Touch the Patient's right arm and ask if they can feel it
Touch the Patient's left arm and ask if they feel it
Now touch both of the Patient's arms simultaneously and ask the patient which side you touched
(If patient can feel both sides individually but only feels one side on simultaneous stimulation, this is neglect)
If Aphasic: Neglect can be evaluated by noticing that patient is not paying attention to you if you stand on one side, but pays attention to you if you stand on the other side.

Obtundation: (1 point)
Not staying awake in between conversation

C. ***Stroke Alert*** = TLKW is within 24 hrs, & includes any combination of CSS and VES other than CSS +3 & VES ≥ 1
   1. For a ***Stroke Alert***, Base Hospital Contact (BHC) will be established with regular catchment Base Hospital and a Stroke Alert will be activated.
   2. The Base Hospital will notify the appropriate ASC of the *Stroke Alert*

D. ***ELVO Alert*** = TLKW is within 24 hours, & CSS +3, VES ≥1
   1. For an ***ELVO Alert*,** the nearest TCASC is the base hospital for that patient. (East of Lewis Rd is LRH and west of Lewis Rd. is SJR). Prehospital personnel will make base contact with the appropriate TCASC and an ELVO alert will be activated. The appropriate specialist on-call will be notified by the MICN.
      a. The base hospital will determine the nearest ASC or TCASC using the following criteria:
         i. Patients condition
         ii. TCASC or ASC availability on ReddiNet
         iii. Transport time
         iv. Patient request

E. Destination Decision: patients meeting stroke system criteria shall be transported to the nearest ASC, except in the following cases:
   1. Stroke patients in cardiac arrest shall be transported to the nearest receiving hospital. Patients who have greater than thirty seconds of return of spontaneous circulation (ROSC) shall be transported to the nearest STEMI Receiving Center (SRC).

   2. The nearest ASC is incapable of accepting a stroke alert patient due to ED, CT or Internal Disaster diversion, transport to the next closest ASC.

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

   4. Patient meeting ELVO Alert criteria will be transported to the nearest TCASC if ***total*** transport time does not exceed 45 minutes.

F. Upon Arrival: You may be asked to take your patient directly to the CT scanner.
   a. Give report to the nurse, transfer the patient from your gurney onto the CT scanner platform, and then return to service.
   b. If there is any delay, such as CT scanner not readily available, or a nurse not immediately available, you will not be expected to wait. You will take the patient to a monitored bed in the ED and give report as usual.

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

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title:	Guidelines for Interfacility Transfer of Emergency Department Acute Stroke Patients	Policy Number 460
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: July 13, 2017 Date Revised: June 22, 2022 Last Reviewed: June 22, 2022 Review Date: June 30. 2024		Effective Date: January 3, 2023

I. PURPOSE: To define the interfacility transfer process by which emergency department patients with an acute stroke are transferred to: 1) an Acute Stroke Center (ASC) or 2) a Thrombectomy Capable Acute Stroke Center (TCASC).

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

III. DEFINITIONS:

Acute Stroke Center (ASC): Hospital designated as an Acute Stroke Center, as defined in VC EMS Policy 450.
Primary Stroke Center (PSC): Hospital certified by either The Joint Commission, Det Norske Veritas, or the Healthcare Facilities Accreditation Program as a Primary Stroke Center.
Thrombectomy Capable Acute Stroke Center (TCASC): ASC Hospital that has the capability to perform neuroendovascular procedures for acute stroke including mechanical thrombectomy and intra-arterial thrombolysis. (As defined in VC EMS Policy 452)
Comprehensive Stroke Center (CSC): Hospital certified by either The Joint Commission, Det Norske Veritas, or the Healthcare Facilities Accreditation Program as a Comprehensive Stroke Center.
Emergent large vessel occlusion (ELVO): An acute ischemic stroke caused by a large vessel occlusion.
Acute Stroke: A stroke as it pertains to this policy, a cerebral vascular accident (CVA) which needs immediate neurointervention, a neurosurgical procedure, specialty consultation, or a higher level of care.

IV. POLICY:

A. Hospitals will:

1. Assemble and maintain a “Stroke Transfer Pack” in the emergency department to contain all of the following:
   a. Phone numbers of all Ventura County ASCs and TCASCs.
   b. Phone numbers of the closest PSC or CSC outside the County.
   c. Preprinted template order sheet with recommended prior-to-transfer treatments. Treatment guidelines will be developed with input from the ED, Neurologists and the ASCs/TCASCs.
   d. Patient Consent/Transfer Forms.
   e. Treatment summary sheet.

2. Have policies, procedures, and a quality improvement system in place to minimize door in-to-door out, door-to-brain imaging interpretation, door to thrombolytic initiation and ischemic stroke diagnosis-to-transfer times.
3. Establish policies and procedures to make the appropriate personnel available to accompany the patient during the transfer to the ASC or TCASC. These policies will include patient criteria for requiring appropriate personnel to accompany patient when medications or procedures outside of the paramedic scope of practice are being used.

B. Ventura County Fire Communications Center (FCC) will:
1. Respond to a stroke transfer request by immediately dispatching the closest available ALS ambulance to the requesting hospital.

C. Ambulance Companies:
1. Will respond an ALS ambulance immediately upon request for a “stroke transfer”.
2. Transfers performed according to this policy are not considered an interfacility transport as it pertains to ambulance contract compliance.

D. ASC or TCASC will:
1. Maintain accurate status information on ReddiNet regarding the availability of neuroendovascular capability or status availability for ASC.
2. Publish a single phone number, that is answered 24/7, to receive notification of a stroke transfer.
3. Immediately upon initial notification by a transferring physician at the hospital, accept transfer of all patients who have been diagnosed with an acute stroke and who, in the judgment of the transferring physician, require either 1) an urgent endovascular procedure, or 2) a higher level of care.
4. Establish an internal communications plan that assures the immediate notification of all necessary individuals.
5. Adopt procedures to make an ICU/CCU bed available or to make alternate arrangements for inpatient care.

V. PROCEDURE:

A. Upon diagnosis of an ELVO, or an acute stroke needing a higher level of care; and after discussion with the patient or patient’s family/caregiver, the hospital will:
1. Determine availability by checking ReddiNet, and transfer patient to the closest ASC or TCASC. The destination will depend on the clinical context.
2. Immediately call the Ventura County Fire Communication Center at 805-384-1500 for a Stroke transfer.
3. Identify their facility to the dispatcher and advise they have a “stroke transfer”.

4. After calling for ambulance, the ED transferring physician will notify the ASC or TCASC emergency physician of the transfer.
5. Perform all indicated diagnostic tests and treatments.
6. Complete transfer consent, treatment summary, and stroke data forms.
7. Include copies of the ED face sheet and demographic information.
8. Have available if needed, one or more healthcare staff, as determined by the clinical status of the patient, to accompany the patient to the ASC or TCASC
    a. If, because of unusual and unanticipated circumstances, healthcare staff is unavailable for transfer, a Critical Care Transport (CCT) transfer may be requested by calling the CCT provider ambulance dispatch center. Please initiate the CCT transfer process ASAP to minimize delay.

B. Upon request for “stroke transfer”, the FCC will dispatch the closest ALS ambulance and verbalize “MEDxxx “stroke transfer” from [hospital]”. The destination hospital will be denoted in the Incident Comments, which will display on the Mobile Data Computer (MDC). If a unit does not have an operational MDC, the transferring hospital will advise the responding ambulance personnel of the destination hospital.

C. Upon notification, the ambulance will respond Code 3 (lights & sirens) to the transferring facility.

D. Ambulance units will remain attached to the incident and FCC will track their dispatch, en-route, on scene, en-route hospital, at hospital, and available times.

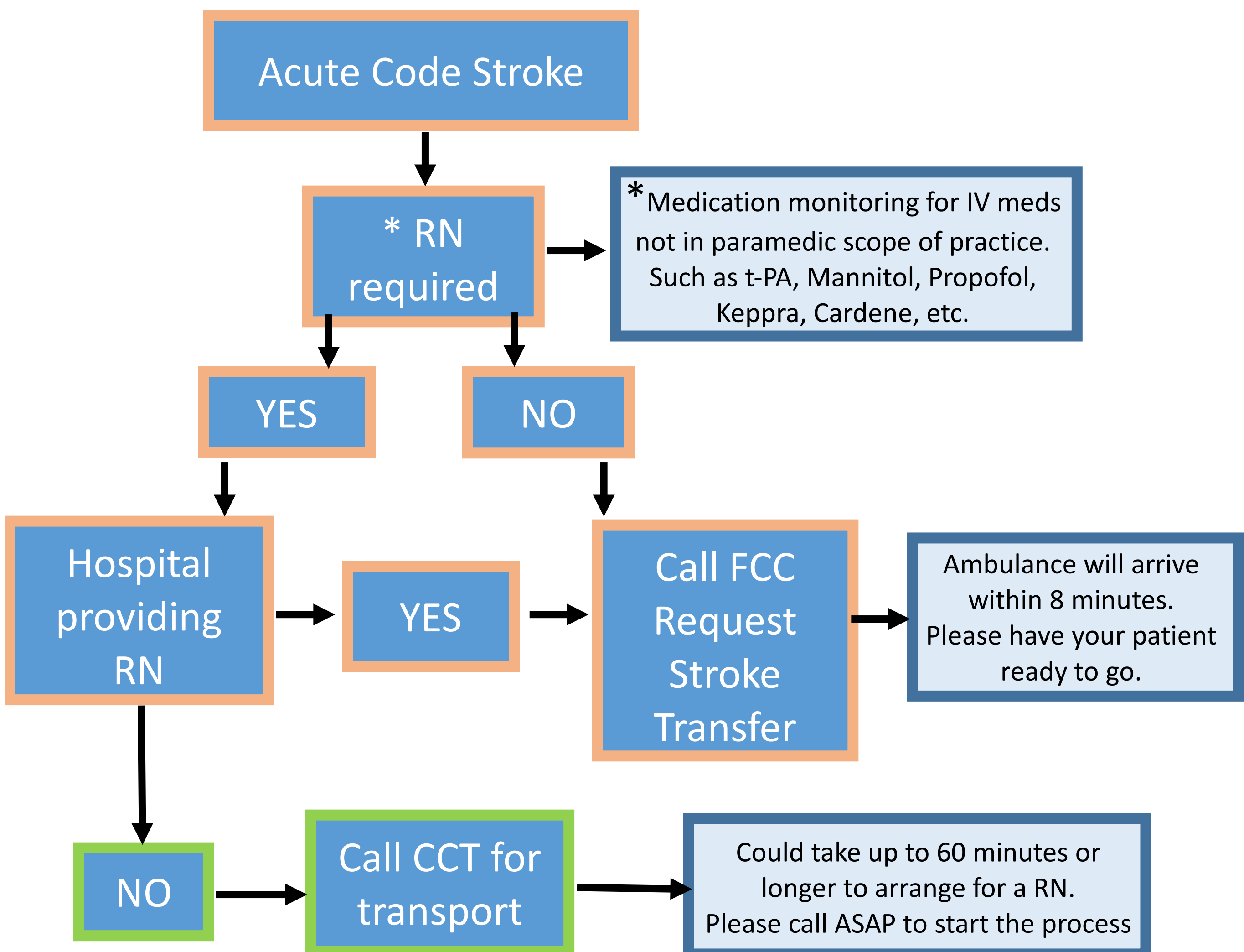
E. The patient shall be urgently transferred without delay. Every effort will be made to minimize on-scene time.
1. All forms should be completed prior to ambulance arrival.
2. Diagnostic test results may be relayed to the ASC or TCASC at a later time.
3. t-PA Administration:
    a. If t-PA will continue infusing during transfer, the patient must be accompanied by an RN or physician.
    b. If t-PA has been administered prior to transfer, the patient may be transported with a paramedic.
4. Nurse report will be given to the receiving hospital at the time of, or immediately after, ambulance departure.

F. Upon notification, the ASC or TCASC will notify appropriate staff to prepare for the patient.

G. The hospital and the ASC or TCASC shall review all stroke transfers within 24 hours for appropriate and timely care and to identify opportunities for improvement. Results will be reviewed and discussed at the Countywide EMS Stroke CQI Committee.

H. e-PCR documentation will be completed by ambulance personnel.

Emergency Department Only



<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="3">Policy Title:
Ventura County Emergency Medical Services Provider Agencies</td><td>Policy Number
500</td></tr>
<tr><td>APPROVED:
Administration:</td><td colspan="2">Steven L. Carroll, Paramedic</td><td>Date: January 3, 2023</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td colspan="2">Daniel Shepherd, M.D.</td><td>Date: January 3, 2023</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>July 1987
September 8. 2022
September 8, 2022
September 30, 2025</td><td colspan="2">Effective Date: January 3, 2023</td></tr>
</table>

Air Rescue

Ventura County Sheriff's Search and Rescue
375 Durley Avenue #A
Camarillo, CA 93010
805-388-4212

Law Enforcement

Cal State Channel Islands University Police Department
1 University Drive - Placer Hall
Camarillo, CA 93012
805-347-8444

First Responder Agencies

Channel Islands Harbor Patrol
3900 Pelican Way
Oxnard, CA 93035
805-382-3000

*Fillmore City Fire Department
250 Central
Fillmore, CA 93015
805-524-1500 X 226

Oxnard City Fire Department
360 W. Second St.
Oxnard, CA 93030
805-385-7722

Ventura County Federal Fire Dept.
Naval Air Station
Fire Division, Code 5140
Point Mugu, CA 93042-5000
805-989-7034

* Ventura City Fire Department
1425 Dowell Drive
Ventura, CA 93003
805-339-4319

* Ventura County Fire Protection District
165 Durley Drive
Camarillo, CA 93010
805-389-9702

Ventura Harbor Patrol
1603 Anchors Way
Ventura, CA 93003
805-642-8538

Transport Agencies

American Medical Response
616 Fitch Avenue
Moorpark, CA 93021
805-517-2000

Gold Coast Ambulance
P.O. Box 7065
200 Bernoulli Circle
Oxnard, CA 93030
805-485-1231

All Town Ambulance
7755 Haskell Ave.
Van Nuys, CA 91406
877-599-4282

* ALS First Responder

I. PURPOSE: To define the criteria for ALS transport providers.

II. POLICY: A Ventura County ALS Transport Provider shall meet the following criteria.

III. AUTHORITY:

Health and Safety Code, Section 1797.218. California Code of Regulations, Section 100168.

IV. PROCEDURE:

A. **ALS Transport Provider Requirements**

An Advanced Life Support Transport Provider, approved by Ventura County Emergency Medical Services (VC EMS), shall:

1. **ALS Unit Response Capability**

Provide medical services response on a continuous twenty-four (24) hours per day, basis 7 days a week. Any change in response capability of the ALS transport provider must be reported to VC EMS immediately or during the first day of office hours after the change in response capability. All requests for pre-hospital emergency care shall be met by ALS capable staff and vehicles.

Interfacility transfers are not considered emergency medical service unless the transfer is for an urgent life or limb threatening condition that cannot be medically cared for at the transferring facility. (Refer to Policy 605: Interfacility Transfers)

2. **ALS Unit Coverage and Staffing**

All requests for pre-hospital emergency medical care shall be responded to with the following:

a. An ambulance that meets the requirements of Policy 504 and

b. 2 paramedics or 1 paramedic and 1 EMT ALS Assist per VC EMS Policies 318 and 306. At least one paramedic must be employed by the contracted ambulance transport agency.

3. **ALS Patient Transport**

Provide transportation for ALS patients in an ALS unit.

4. **ALS Communications**

   Provide two-way communication capability between the paramedics and the Base Hospital. All radio equipment shall comply with VC EMS Policy 905.

5. **Satellite Phone**

   Each ALS Transport Provider shall have a minimum of one fully equipped and operational satellite phone. The device must be active with a satellite service provider and shall be readily deployable 24 hours a day for disaster communication purposes. The ALS Transport Provider will participate in occasional VC EMS sponsored satellite phone exercises. VC EMS will supply all providers with a current list of satellite phone contact numbers. Any changes to the satellite phone contact information shall immediately be forwarded to VC EMS.

6. **ALS Drugs, Equipment and Supplies**

   Provide and maintain ALS drugs, solutions, medical equipment and supplies as specified by VC EMS Policy 504.

   a. Ensure that security mechanisms and procedures are established for controlled substances and that mechanisms for investigation and mitigation of suspected tampering or diversion are established, in accordance with section 100168 of the California Code of Regulations

7. **Contract with VC EMS**

   Have a contract with VC EMS to participate in the ALS program and to comply with all applicable State legislation and regulations, and local ordinances and policies and procedures.

8. **Medical Direction**

   Assure that paramedics perform medical procedures only under specific orders of a physician or Ventura County authorized MICN except when operating under Prior to Base Hospital Contact and Communications Failure Policies.

9. **Personnel Records**

   Keep a personnel file for each paramedic and EMT, which includes but not limited to licensure/certification, accreditation, employment status, and performance.

10. **Certifications**

    Assure that each paramedic maintains current ACLS and either PALS, PEPP, or ENPC certification.

11. **Quality Assurance**

    Assist the VC EMS, Pre-hospital Services Committee, and EMS Medical Director in data collection and evaluation of the VC EMS system.

12. **Basic Life Support**

    Provide Basic Life Support services if ALS services are not indicated.

13. **ALS Rates**

    Charge ALS rates, as approved by the Board of Supervisors.

14. **Documentation**

    Submit documentation according to VC EMS Policy 1000.

B. **Advertising**

1. **ALS Transport Provider**

   No paramedic transport provider shall advertise itself as providing ALS services unless it does, in fact, routinely provide ALS services on a continuous twenty-four (24) hours per day and complies with the regulations of Ventura County Emergency Medical Services Agency.

2. **ALS Responding Unit**

   No responding unit shall advertise itself as providing ALS services unless it does, in fact, provide ALS services twenty-four (24) hours per day and meets the requirements of VC EMS.

C. **ALS Policy Development**

Medical policies and procedures for the VC EMS system shall be developed by the Pre-hospital Services Committee for recommendation to and approval by the EMS Medical Director.

D. **Contract Review**

VC EMS shall review its contract with each ALS transport provider on an annual basis.

E. **Denial, Suspension, or Revocation of Transport Provider Approval**

VC EMS may deny, suspend, or revoke the approval of an ALS transport provider for failure to comply with applicable policies, procedures, and regulation. Requests for review or appeal of such decisions shall be brought to the Pre-hospital Services Committee and the Board of Supervisors for appropriate action.

F. **ALS Transport Provider Review Process, New Designation**

Newly designated ALS providers shall undergo review for six (6) months according to VC EMS policies and procedures.

<table>
<tr><td>COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Advanced Life Support Service Provider Approval Process</td><td>Policy Number
502</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steven L. Carroll, Paramedic</td><td>Date: January 3, 2023</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td>Daniel Shepherd, M.D.</td><td>Date: January 3, 2023</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>May 1984
January 10, 2008
September 8, 2022
September 30, 2025</td><td>Effective Date: January 3, 2023</td></tr>
</table>

I. PURPOSE: To define criteria by which an agency may be designated as an Advanced Life Support (ALS) Service Provider (SP) in Ventura County.

II. POLICY: An agency wishing to become an ALS SP in Ventura County must meet Ventura County ALS SP Criteria and agree to comply with Ventura County regulations. An initial six-month review of all ALS activity will take place and subsequent program review will occur per Ventura County Emergency Medical Services (VC EMS) policies and procedures.

III. PROCEDURE:

A. **Request for ALS SP Program Approval**

The agency shall submit a written request for ALS SP approval to Ventura County Emergency Medical Services (VC EMS), documenting the compliance of the company/agency with the Ventura County EMS Policy 501 or 508.

B. **Program Approval or Disapproval:**

Program approval or disapproval shall be made in writing by VC EMS to the agency requesting ALS SP designation 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.

VC EMS shall establish the effective date of program approval upon the satisfactory documentation of compliance with all the program requirements. All contracts or memorandum of understanding must be approved by the County Board of Supervisors prior to implementation.

C. **Initial Program Evaluation**

Review of all ALS activity for the initial 6 months of operation as an Advanced Life Support Ambulance Provider shall be done in accordance with VC EMS policies and procedures.

D. **Program Review**

Program review will take place at least every two years according to policies and procedures established by VC EMS.

E. **ALS SP Program Changes**

An approved ALS Service Provider shall notify VC EMS by telephone, followed by letter within 48 hours of program or performance level changes.

F. **Withdrawal, Suspension or Revocation of Program Approval**

Non-compliance with any criterion associated with program approval, use of non-licensed or accredited personnel, or non-compliance with any other Ventura County regulation or policy applicable to an ALS SP may result in withdrawal, suspension, or revocation of program approval by VC EMS.

G. **Appeal of Withdrawal, Suspension or Revocation of Program Approval**

An ALS SP whose program approval has been withdrawn, suspended, or revoked may appeal that decision in accordance with the process outlined in the Ventura County Ordinance Code,

ADVANCED LIFE SUPPORT SERVICE PROVIDER APPROVAL PROCESS
CRITERIA COMPLIANCE STATEMENT

APPLICANT:	DATE:

The above named agency agrees to observe the following criteria as a condition of approval as an Advanced Life Support Provider in the Ventura County EMS system.

	YES	NO
1. Provide ALS service on a continuous 24-hour per day basis.		
2. Provide appropriate transportation for ALS patients.		
3. Provide for electronic communication between the EMT-Ps and the BH, complying with VC Communications Department requirements.		
4. Provide and maintain ALS drugs, solutions and supplies per VC EMS policies and procedures.		
5. Assure that all personnel meet certification/accreditation and or training standards in VCEMS policies.		
6. Cooperate with data collection, QA and CQI programs.		
7. Provide BLS service when ALS in not indicated.		
8. Charge for ALS services only when rendered.		
9. Submit patient care and other documentation per VC EMS policies and procedures.		
10. Comply with all VC EMS policies and procedures.		

If any statements are checked as “NO”, supply information stating the rationale for each “NO” answer. The information will be considered, but submission does not assure approval of the program.

Signature: ______________________________

Title: ______________________________

Date: ______________________________

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: January 3, 2023
APPROVED: Medical Director	Daniel Shepherd, MD	Date: January 3, 2023
Origination Date: Date Revised: Last Reviewed: Review Date:	May 24, 1987 November 10, 2022 November 10, 2022 November 30, 2023	Effective Date: January 3, 2023

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. DEFINITIONS:

BLS – Basic Life Support Unit

ALS – Advanced Life Support Unit

PSV – Paramedic Support Vehicle or Paramedic Supervisor Vehicle

CCT – Critical Care Transport Unit

BLS Command – Basic Life Support Staffed Command Vehicle

FR/ALS – First Responder Advanced Life Support Unit

Search and Rescue – Sheriff's SAR Helicopter Unit

V. PROCEDURE:

The following equipment and supplies shall be maintained on each response and/or transport unit in Ventura County.

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

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
A. ALL BLS AND ALS RESPONSE AND/OR TRANSPORT UNITS						
Bag valve units with appropriate masks Adult (1,000 mL) Child (500 mL) Infant (240 mL)	1 each	1 each	1 each	1 each	1 each	1 adult
Nasal cannula Adult	3	3	3	3	3	3
Nasopharyngeal airway 14 French 18 French 20 French 22 French 24 French 26 French 28 French 32 French 34 French 36 French	1 each	1 each	1 each	1 each	1 each	1 each
Continuous positive airway pressure (CPAP) device	1 Child 1 Small Adult 1 Adult	Optional	1 Child 1 Small Adult 1 Adult	1 Child 1 Small Adult 1 Adult	1 Child 1 Small Adult 1 Adult	1 Child 1 Small Adult 1 Adult
Nerve Agent Antidote Kit	Optional	Optional	9	9	9	Optional
Blood glucose determination devices	1	Optional	2	1	1	1
Occlusive Dressing	5	5	5	5	5	5
Oral glucose 15gm unit dose	1	1	1	1	1	1
Oropharyngeal Airways 40 mm (Size 00) 50 mm (Size 0) 60mm (Size 1) 70 mm (Size 2) 80 mm (Size 3) 90 mm (Size 4) 100 mm (Size 5) 110 mm (Size 6)	1 each size	1 each size	1 each size	1 each size	1 each size	1 each size
Oxygen with appropriate adjuncts (portability required)	15 L/min for 20 minutes (40 minutes for transport units)	15 L/min for 20 minutes	15 L/min for 20 minutes (40 minutes for transport units)	15 L/min for 20 mins.	15 L/min for 20 mins.	15 L/min for 20 mins.
Portable suction equipment	1	1	1	1	1	1
Nonrebreather oxygen masks Adult Child Infant	3 3 2	2 2 2	3 3 2	2 2 2	2 2 2	2 2 2
Bandage scissors	1	1	1	1	1	1

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
Bandages						
• 4"x4" sterile compresses or equivalent	12	12	12	12	12	5
• 2",3",4" or 6" roller bandages	6	2	6	2	6	4
• 10"x 30" or larger dressing	2	0	2	0	2	2
Blood pressure cuffs						
Thigh	1	1	1	1	1	1
Adult	1	1	1	1	1	1
Child	1	1	1	1	1	1
Infant	1	1	1	1	1	1
Emesis basin/bag	1	1	1	1	1	1
Flashlight	1	1	1	1	1	1
Traction splint or equivalent device	1	N/A	1	1	1	1
Pneumatic or rigid splints (capable of splinting all extremities)	4	N/A	4	4	4	4
Potable water or saline solution	4 liters	N/A	4 liters	4 liters	4 liters	4 liters
Cervical collar	2	N/A	2	2	2	2
Spinal immobilization backboard 60" minimum with at least 3 sets of straps	1	N/A	1	N/A	1	1
Sterile obstetrical kit	1	1	1	1	1	1
Tongue depressor	4	Optional	4	Optional	Optional	Optional
Cold packs	4	2	4	4	4	4
Tourniquet	2	2	2	2	2	2
1 mL,5 mL, and 10 mL syringes with IM needles	N/A	N/A	4	4	4	4
Automated External Defibrillator	1	1	N/A	N/A	N/A	N/A
Manual Defibrillator	N/A	N/A	1	1	1	1
Defibrillator pads	2 adult 2 peds	2 adult 2 peds	2 adult 2 peds	2 adult 2 peds	2 adult 2 peds	2 adult 2 peds.
Stethoscope	1	1	1	1	1	1
Cellular telephone	1	1	1	1	1	1
CO_2 monitor Infant (<0.5 mL sidestream or <1 mL mainstream adaptor) Pediatric / Adult (6.6 mL sidestream or < 5 mL mainstream adaptor)	Optional	Optional	2 of each	2 of each	2 of each	2 of each
CO_2 Monitor Adult size EtCO2 sampling nasal cannula Pediatric size EtCO2 sampling nasal cannula	Optional	Optional	1 of each	1 of each	1 of each	1 of each
Pediatric length and weight tape	1	1	1	1	1	1
Intranasal mucosal atomization device	Optional	Optional	2	2	2	2
SpO_2 Monitor (If not attached to cardiac monitor)	1	1	1	1	1	1
SpO2 Adhesive Sensor (Adult, Pediatric, Infant)	Optional	Optional	1 of each	1 of each	1 of each	1 of each
Thermometer	1	Optional	1	1	1	Optional
Personal Protective Equipment per State Guideline #216						
Rescue helmet	2	N/A	2	1	N/A	N/A
EMS jacket	2	N/A	2	1	N/A	N/A
Work goggles	2	N/A	2	1	N/A	N/A
Tyvek suit	2 L / 2 XXL	N/A	2 L / 2 XXL	1 L / 1 XXL	N/A	N/A

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
Tychem hooded suit	2 L / 2 XXL	N/A	2 L / 2 XXL	1 L / 1 XXL	N/A	N/A
Nitrile gloves	1 Med / 1 XL	N/A	1 Med / 1 XL	1 Med / 1 XL	N/A	N/A
Disposable footwear covers	1 Box	N/A	1 Box	1 Box	N/A	N/A
Leather work gloves	3 L Sets	N/A	3 L Sets	1 L Set	N/A	N/A
Field operations guide	1	N/A	1	1	N/A	N/A
OPTIONAL EQUIPMENT (No minimums apply)						
Chest seal						
Hemostatic gauze per EMSA guidelines						

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
B. TRANSPORT UNIT REQUIREMENTS						
Ambulance gurney	1	N/A	1	N/A	N/A	N/A
Collapsible stretcher or flat	1	N/A	1	N/A	N/A	2
KED or equivalent (One required for transport units)	1	N/A	1	N/A	N/A	N/A
Straps to secure the patient to the stretcher or ambulance cot, and means of securing the stretcher or ambulance cot in the vehicle.	1 set	N/A	1 Set	N/A	N/A	1 Set
Powered portable suction unit	1	N/A	1	N/A	N/A	N/A
Soft ankle and wrist restraints.	1 set of each	N/A	1 set of each	N/A	N/A	0
Sheets, pillow cases, blankets and towels for each stretcher or ambulance cot, and two pillows for each ambulance	1	N/A	1	N/A	N/A	0
Bedpan	1	N/A	1	N/A	N/A	N/A
Urinal	1	N/A	1	N/A	N/A	N/A

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimu m Amounts
C. ALS UNIT REQUIREMENTS						
Supraglottic Airway Devices: I-Gel with passive oxygenation port Sizes 1, 1.5, 2, 2.5, 3, 4, 5	N/A	N/A	2 of each	1 of each	1 of each	1 of each
I-Gel Airway Support Straps	N/A	N/A	2	2	2	2
Arm Boards 9” 18”	N/A	N/A	3 3	0 0	1 1	0 0
Colorimetric CO2 Detector Device	N/A	N/A	1	1	1	1
EKG Electrodes	N/A	N/A	10 sets	3 sets	3 sets	6 sets
Endotracheal tubes, sizes 6.0, 6.5, 7.0, 7.5, 8.0 with stylets	N/A	N/A	1 of each size	1 of each size	1 of each size	1 of each size
EZ-IO intraosseous infusion system	N/A	N/A	1 Each Size	1 Each Size	1 Each Size	1 Each Size
IV admin set - macrodrip	N/A	N/A	8	4	4	4
IV catheter, Sizes 14, 16, 18, 20, 22, 24	N/A	N/A	6 each 14, 16, 18, 20 3 each 22 3 each 24	2 each	2 each	2 each
Laryngoscope, replacement bulbs and batteries Curved blade #2, 3, 4 Straight blade #1, 2, 3	N/A	N/A	1 set 1 each 1 each	1 set 1 each 1 each	1 set 1 each 1 each	1 set 1 each 1 each
Magill forceps Adult Pediatric	N/A	N/A	1 1	1 1	1 1	1 1
Nebulizer	N/A	N/A	2	2	2	2
Nebulizer with in-line adapter	N/A	N/A	1	1	1	1
Needle Thoracostomy kit	N/A	N/A	2	2	2	2
Flexible intubation stylet	N/A	N/A	1	1	1	1
OPTIONAL ALS EQUIPMENT (No minimums apply)						
Cyanide Antidote Kit						

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
D. ALS MEDICATION, MINIMUM AMOUNT						
Adenosine, 6 mg	N/A	N/A	5	5	5	5
Albuterol 2.5mg/3ml	N/A	N/A	6	2	2	2
Aspirin, 81mg	N/A	N/A	4 ea 81 mg	4 ea 81 mg	4 ea 81 mg	4 ea 81 mg
Amiodarone, 50mg/ml 3ml	N/A	N/A	6	3	6	3
Atropine sulfate, 1 mg/10 ml	N/A	N/A	3	2	2	2
Diphenhydramine (Benadryl), 50 mg/ml	N/A	N/A	2	1	1	2
Calcium chloride, 1000 mg/10 ml	N/A	N/A	2	1	1	1
Dextrose						
• 5% 50ml, AND	N/A	N/A	2	1	2	1
• 10% 250 ml	N/A	N/A	2	2	2	2
Epinephrine						
• Epinephrine , 1mg/ml						
• 1 mL ampule / vial, OR	N/A	N/A	5	5	5	5
• Adult auto-injector (0.3 mg),	N/A	N/A	Optional	Optional	Optional	Optional
Peds auto-injector (0.15 mg)	N/A	N/A	Optional	Optional	Optional	Optional
• Epinephrine 0.1mg/ml (1 mg/10ml preparation)	N/A	N/A	6	3	6	4
Fentanyl, 50 mcg/mL	N/A	N/A	200 mcg	200 mcg	200 mcg	200 mcg
Glucagon, 1 mg/ml	N/A	N/A	2	1	2	1
Intravenous Fluids (in flexible containers) • Normal saline solution, 100 ml • Normal saline solution, 500 ml • Normal saline solution, 1000 ml	N/A	N/A	2 2 6	1 1 2	1 1 4	1 1 3
Lidocaine, 100 mg/5ml	N/A	N/A	2	2	2	2
Magnesium sulfate, 1 gm per 2 ml	N/A	N/A	4	4	4	4
Midazolam Hydrochloride (Versed)	N/A	N/A	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials	5 mg/ml 2 vials
Morphine sulfate, 10 mg/ml (Only required during a Fentanyl shortage)	N/A	N/A	2	2	2	2
Naloxone Hydrochloride (Narcan)						
• IN concentration - 4 mg in 0.1 mL (with atomizer)	N/A	N/A	Optional	Optional	Optional	Optional
• IM / IV concentration – 2 mg in 2 mL preload	N/A	N/A	5	5	5	5
Nitroglycerine preparations, 0.4 mg	N/A	N/A	1 bottle	1 bottle	1 bottle	1 bottle
Normal saline flush, 5 or 10 ml	N/A	N/A	5	5	5	5
Ondansetron (Zofran) • 4 mg IV single use vial • 4 mg oral	N/A N/A	N/A N/A	4 4	4 4	4 4	4 4
Sodium Bicarbonate 8.4%, 1 mEq/mL (50 mL)	N/A	N/A	4	2	2	2
Tranexamic Acid (TXA) 1 gm/10 mL	N/A	N/A	2	1	1	1

	BLS Unit Minimum Amount	BLS Command Minimum Amount	ALS Unit Minimum Amount	PSV/CCT Minimum Amount	FR/ALS Minimum Amount	Search and Rescue Minimum Amounts
E. BLS MEDICATION, MINIMUM AMOUNT						
Epinephrine						
• Epinephrine , 1mg/ml						
• 1 mL ampule / vial (with syringe and needle), OR	2	2	N/A	N/A	N/A	N/A
• Adult auto-injector (0.3 mg), AND	2	2	N/A	N/A	N/A	N/A
Peds auto-injector (0.15 mg)	2	2	N/A	N/A	N/A	N/A
Naloxone Hydrochloride (Narcan)						
• IN concentration - 4 mg in 0.1 mL (with atomizer) OR	2	2	N/A	N/A	N/A	N/A
• IM / IV concentration – 2 mg in 2 mL preload	2	2	N/A	N/A	N/A	N/A

Policy Title: Paramedic Support Vehicles		Policy Number 506
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Revised Date: Last Reviewed: Review Date:	October 1995 April 5, 2013 September 8, 2022 September 30, 2025	Effective Date: January 3, 2023

I. PURPOSE: To provide an additional Advanced Life Support (ALS) option to a County approved service provider by allowing a single paramedic to provide ALS services without a second paramedic or an EMT-ALS Assist in attendance.

II. POLICY: At those times when a Paramedic Support Vehicle (PSV) is either the closest ALS unit to an emergency, for a multi-patient incident, or when a BLS ambulance is being dispatched to a potential ALS call, the paramedic who is operating a PSV may respond and begin ALS care, and may continue to function as a paramedic during patient transport.

III. PROCEDURE:

A. **Dispatch of a PSV is recommended in the following circumstances:**

1. The PSV is the closest unit to a call.
2. A BLS ambulance is responding to a call that may require ALS services, and the PSV can make a response which will not delay in trauma, and will not delay inappropriately in other patient conditions, patient transportation to the nearest appropriate medical facility. All delays in transport shall be documented and reviewed by the PLP or PCC.
3. During Mass Casualty Incidents

B. **Personnel Requirements**

A PSV will be staffed by a paramedic who has been designated as a Level II paramedic in Ventura County.

C. **Equipment Requirements**

A PSV will carry supplies and equipment according to Policy 504.

D. **Documentation**

PSV care shall be documented per Policy 1000.

<table>
<tr><td colspan="2">R4COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="3">Policy Title:
First Responder Advanced Life Support Providers</td><td>Policy Number:
508</td></tr>
<tr><td>APPROVED:
Administration:</td><td colspan="2">Steven L. Carroll, Paramedic</td><td>Date: January 3, 2023</td></tr>
<tr><td>APPROVED:
Medical Director</td><td colspan="2">Daniel Shepherd, MD</td><td>Date: January 3, 2023</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>June 1, 1997
September 8, 2022
September 8, 2022
September 30, 2025</td><td colspan="2">Effective Date: January 3, 2023</td></tr>
</table>

I. Purpose: To define the criteria for First Responder Advanced Life Support (FRALS) providers.

II. Authority: Health and Safety Code, Sections 1797.206, 1797.220, and 1798. California Code of Regulations, Section 100168

III. Definition: First Responder Advanced Life Support (FRALS) means a non-transport ALS resource that is dispatched as part of the routine EMS response to a medical emergency.

IV. Policy:

A. **FRALS Provider Requirements:**

A FRALS provider approved by Ventura County EMS (VC EMS) shall:

1. Provide medical services response on a continuous twenty-four (24) hours per day basis 7 days a week. Any change in response capability of the provider must be reported to VC EMS immediately.
2. **ALS Unit Coverage and Staffing:**
   a. FRALS units shall meet the requirements of Policy 504 and
      1. Shall be staffed at a minimum with two (2) personnel, of which one shall be a paramedic who meets the applicable requirements of VC EMS Policy 318.
      2. Other personnel may be a paramedic who meets the requirements of VC EMS Policy 318 or an EMT-ALS Assist who meets the requirements of VC EMS Policy 306.
3. **ALS Communications**

   Provide two-way communication capability between the paramedics and the Base Hospital. All radio equipment shall comply with VC EMS Policy 905.

4. **Satellite Phone**

   Each FRALS provider shall have access to a satellite phone. The device must be active with a satellite service provider and shall be readily deployable 24 hours a day for disaster communication purposes. The FRALS provider will participate in occasional VC EMS sponsored satellite phone exercises. VC EMS will supply all providers with a current list of satellite phone contact numbers. Any changes to the satellite phone contact information shall immediately be forwarded to VC EMS.

5. **Written Agreement with VC EMS**

   Have a written agreement with VC EMS to participate in the ALS program and to comply with all applicable State legislation and regulations, and local ordinances and policies and procedures.

6. **Medical Direction**

   Assure that paramedics perform medical procedures only under specific orders of a physician or Ventura County authorized MICN except when operating under “Prior to Base Hospital Contact and per VCEMS Policy 705”.

7. **Personnel records**

   Keep a personnel file for each paramedic and EMT, which includes but not limited to licensure/certification, accreditation, employment status and performance.

8. **Certifications**

   ACLS certification and a Handtevy Pediatric Provider Course.

   Assure that each paramedic maintains current ACLS certification and current Handtevy Pediatric Provider Course.

9. **Quality Assurance**

   Assist the VC EMS, Pre-hospital Services Committee, and EMS Medical Director in data collection and evaluation of the VC EMS system.

10. **Equipment:**

    FRALS shall carry the following equipment:

    a. ALS Drugs, Equipment and Supplies

       Provide and maintain ALS drugs, solutions, medical equipment and supplies as specified by VC EMS Policy 504: BLS and ALS Unit Supplies and Equipment, FR/ALS column.

b. BLS Equipment as described in VC EMS Policy 504: BLS and ALS Unit Supplies and Equipment, FR/ALS column.

c. Manual or automatic defibrillator per VC EMS Policy 306.

11. **Security Mechanisms**

Ensure that security mechanisms and procedures are established for controlled substances and that mechanisms for investigation and mitigation of suspected tampering or diversion are established, in accordance with section 100168 of the California Code of Regulations

12. **Documentation**

Submit documentation according to VC EMS Policy 1000.

B. **ALS Policy Development**

Medical policies and procedures for the VC EMS system shall be developed by the Prehospital Services Committee for recommendation to and approval by the EMS Medical Director.

C. **Agreement Review**

VC EMS shall review its agreement with each FRALS provider on an annual basis.

D. **Denial, suspension, or Revocation of FRALS Provider Approval**

VC EMS may deny, suspend, or revoke the approval of an FRALS provider for failure to comply with applicable policies, procedures, and regulation. Requests for review or appeal of such decisions shall be brought to the Pre-hospital Services Committee and the Board of Supervisors for appropriate action.

E. **FRALS Provider Review Process, New Designation**

Newly designated FRALS providers shall undergo review for six (6) months according to VC EMS policies and procedures.

Policy Title: Scene Control at a Medical Emergency		Policy Number 600
APPROVED: Administration:	Steven L Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: January 3, 2023
Origination Date: Date Revised: Date Reviewed: Review Date:	January 1985 June 11, 2015 October 13, 2022 October 31, 2024	Effective Date: January 3, 2023

I. PURPOSE: To establish authority for scene control at a medical emergency.

II. AUTHORITY: California Health and Safety Code, Section 1797.6(c)

III. POLICY:

A. Authority for the management of the scene of an emergency shall be vested in the appropriate public safety agency having primary investigative authority.

B. The scene of an emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition, and priority shall be placed upon the interests of those persons exposed to the more serious and immediate risks to life and health.

C. Public safety officials shall consult emergency medical services personnel or other authoritative health care professionals at the scene in the determination of relevant risks.

Policy Title: Transport and Destination Guidelines		Policy Number 604
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 3, 1986 September 8, 2022 September 8, 2022 September 30, 2024	Effective Date: January 3, 2023

I. PURPOSE: To establish guidelines for determining appropriate patient destination, so that to the fullest extent possible, individual patients receive appropriate medical care while protecting the interests of the community at large by optimizing use and availability of emergency medical care resources.

II. AUTHORITY: Health and Safety Code, Section 1317, 1797.106(b), 1797.220, and 1798 California Code of Regulations, Title 13, Section 1105(c) and Title 22, Section 100147.

III. POLICY: In the absence of decisive factors to the contrary, patients shall be transported to the most accessible medical facility equipped, staffed, and prepared to receive emergency cases and administer emergency medical care appropriate to the needs of the patients.

IV. PROCEDURE:

A. Hospitals unable to accept patients due to an internal disaster shall be considered NOT "prepared to receive emergency cases".

B. In determining the most accessible facility, transport personnel shall take into consideration traffic obstruction, weather conditions or other factors which might affect transport time.

C. Most Accessible Facility

The most accessible facility shall ordinarily be the nearest hospital emergency department, except for:

1. Base Hospital Direction for ALS patients

a. Upon establishment of voice communication, the Base Hospital is responsible for patient management until the patient reaches a hospital and medical care is assumed by the receiving hospital. Paramedics will continue to follow their ALS Standing Orders

b. The Base Hospital may direct that the patient be transported to a more distant hospital which in the judgment of the BH physician or MICN is more appropriate to the medical needs of the patient.

c. Patients may be diverted in accordance with Policy 402.

2. Patients transported in BLS ambulances demonstrating conditions requiring urgent ALS care (e.g., unstable vital signs, chest pain, shortness of breath, airway obstruction, acute unconsciousness, OB patient with contractions), shall be transported to the nearest hospital emergency department prepared to receive emergency cases.

D. "Decisive Factors to the Contrary"

Decisive factors to the contrary for BLS or ALS patients include, but are not limited to, the following:

1. Prepaid Health Plans

a. EMS personnel shall not request information on insurance or delay transport or treatment while determining insurance status.

b. A member of a group practice prepayment health care service who volunteers such information and requests a specific facility may be transported according to that plan when the ambulance personnel or the Base Hospital determines that the condition of the member permits such transport. Therefore when the Base Hospital contact is made the Base Hospital must always be notified of the patient's request.

c. However, when the on duty supervisor determines that such transport would unreasonably remove the ambulance unit from the service area, the member may be transported to the nearest hospital capable of treating the member.

2. Patient Requests

a. When a person or his/her legally authorized representative requests emergency transportation to a hospital other than the most accessible emergency department, which may include out of the county, the request should be honored when ambulance personnel, BH physician or MICN determines that the condition of the patient permits such transport. Therefore when the Base

Hospital contact is made the Base Hospital must always be notified of the patient’s request.

b. When it is determined by the on duty supervisor that such transport would unreasonably remove the ambulance unit from the service area, the patient may be transported to the nearest hospital capable of treating him/her.

3. Private Physician's Requests

When a treating physician requests emergency transportation to a hospital other than the most accessible acute care hospital, which may include out of the county, the request should be honored unless it is determined by the on duty supervisor that such transport would unreasonably remove the ambulance from the service area. In such cases:

a. If the treating physician is immediately available, ambulance personnel shall confer with the physician regarding a mutually agreed upon destination.

b. If the treating physician is not immediately available, the patient should be transported to the nearest hospital capable of treating him/her.

c. If Base Hospital contact has been made due to the condition of the patient and the immediate unavailability of the treating physician, and the BH physician or MICN determines that the condition of the patient permits or does not permit such transport, BH directions shall be followed. If communication with the treating physician is possible, the BH should consult with the physician.

4. Physician on Scene per VC EMS Policy 703

When a bystander identifies him/herself as a physician and offers assistance on scene, VC EMS Policy 702 shall be followed.

5. Direct Admits

When a patient's physician has arranged direct admission to a hospital, the patient should be transported to that hospital regardless of Emergency Department diversion status unless the Base Hospital determines that the patient's condition requires that s/he be transported to a more appropriate facility.

E. “Medical facilities equipped, staffed and prepared to administer care appropriate to needs of the patients.”

1. Paramedics treating patients that meet trauma criteria Steps 1-3 in VCEMS Policy 1405 will make Base Hospital contact with a designated Trauma Center. The Trauma Center MICN or ED physician will direct the patient to either the Trauma Center or a non-trauma hospital.
2. Patients who meet STEMI criteria in VC EMS Policy 726 will be transported to a STEMI Receiving Center.
3. Patients who are treated for a ***medical*** cardiac arrest and achieve sustained return of spontaneous circulation (ROSC) will be transported to a STEMI Receiving Center.
4. Patients who meet Stroke or ELVO criteria in VC EMS Policy 451 will be transported to an Acute Stroke Center or a TCASC.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="3">Policy Title:
Interfacility Transfer of Patients</td><td>Policy Number
605</td></tr>
<tr><td>APPROVED:
Administration:</td><td colspan="2">Steven L. Carroll, Paramedic</td><td>Date: January 3, 2023</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td colspan="2">Daniel Shepherd, M.D.</td><td>Date: January 3, 2023</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Next Review Date:</td><td>July 26, 1991
October 13, 2022
October 13, 2022
October 31, 2024</td><td colspan="2">Effective Date: January 3, 2023</td></tr>
</table>

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-Immediate Transfers:

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

B. Immediate Time Sensitive Transfers:

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

C. **Specialty Care Transfers:**

1. Trauma Call Continuation, Emergent, or Urgent trauma transfers, refer to VCEMS Policy 1404.
2. For Stroke transfers, refer to VCEMS Policy 460.
3. For STEMI transfers, refer to VCEMS Policy 440.

D. ***Non-Immediate*** Interfacility Transfers:

Transferring process (For a patient who needs a non-immediate transfer who does not meet the Stroke, ELVO, Trauma or STEMI criteria). Example: Patient who is scheduled for a procedure or surgery at a later time. Patient who is a direct admit to the floor and is not having an emergent/urgent procedure. Call your provider and state you need a BLS, ALS or CCT "***non immediate interfacility transfer"*** using the chart below.

E. ***Immediate Time Sensitive*** Transfers:

Transferring process (For a patient who needs a ***time sensitive treatment or procedure*** and does not fall in the Specialty Care category above. Example: Patient with a GI bleed, complicated pregnancy, emergent/urgent surgery. Call FCC at 805-384-1500 and state you need an **"ambulance only"** for an **"immediate time sensitive transfer".**

1. The transferring physician will determine the patient's resource requirements and request an inter-facility ALS, or BLS, or CCT transfer unit using the following guidelines:
2. If hospital is sending their own RN, then an ALS request is acceptable.

	(BLS)	(ALS)	(CCT)
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	
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. COMMUNICATION

A. For patients with time sensitive conditions requiring transfer for emergency evaluation and/or treatment (i.e. STEMI, Stroke, Trauma, etc.) the ambulance personnel will contact the receiving facility advising of ETA and any change in patient condition. The intent is to provide the receiving facility with information for appropriate resources to be initiated.

VI. DOCUMENTATION

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

B. Hospital documentation for Trauma Transfers refer to VCEMS Policy 1404.

Policy Title: Notification of Exposure to a Communicable Disease		Policy Number 612
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	April 27, 1990 October 13, 2022 October 13, 2022 October 31, 2025	Effective Date: January 3, 2023

I. PURPOSE:

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

II. AUTHORITY:

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

III. DEFINITIONS:

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

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

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

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

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

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

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

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

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

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

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

IV. POLICY:

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

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

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

V. PROCEDURE:

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

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

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

B. Hospital Notification of a Communicable Disease or Illness

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

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

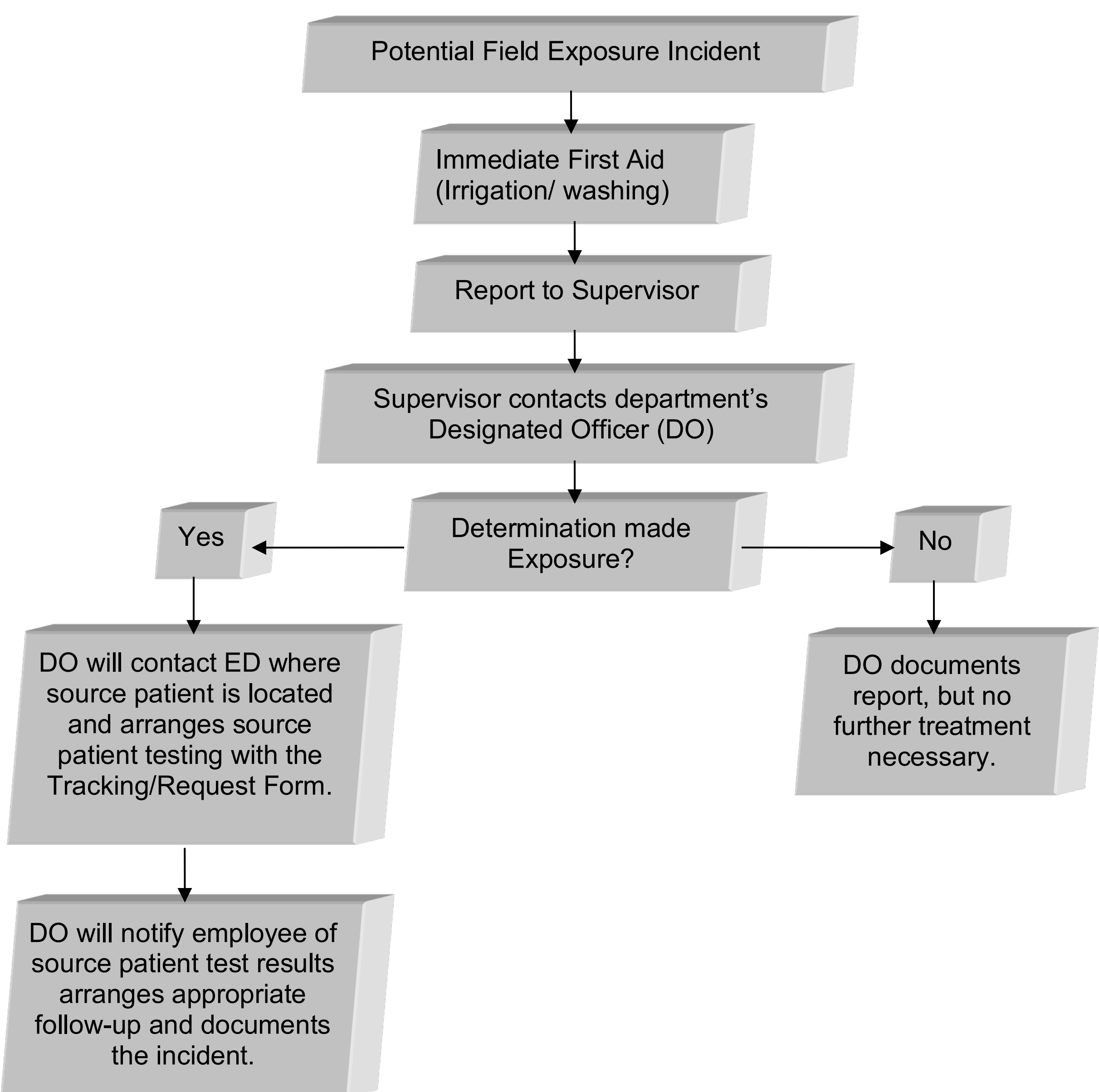
Appendix A

Pre Hospital Exposure Tracking/ Request Form

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

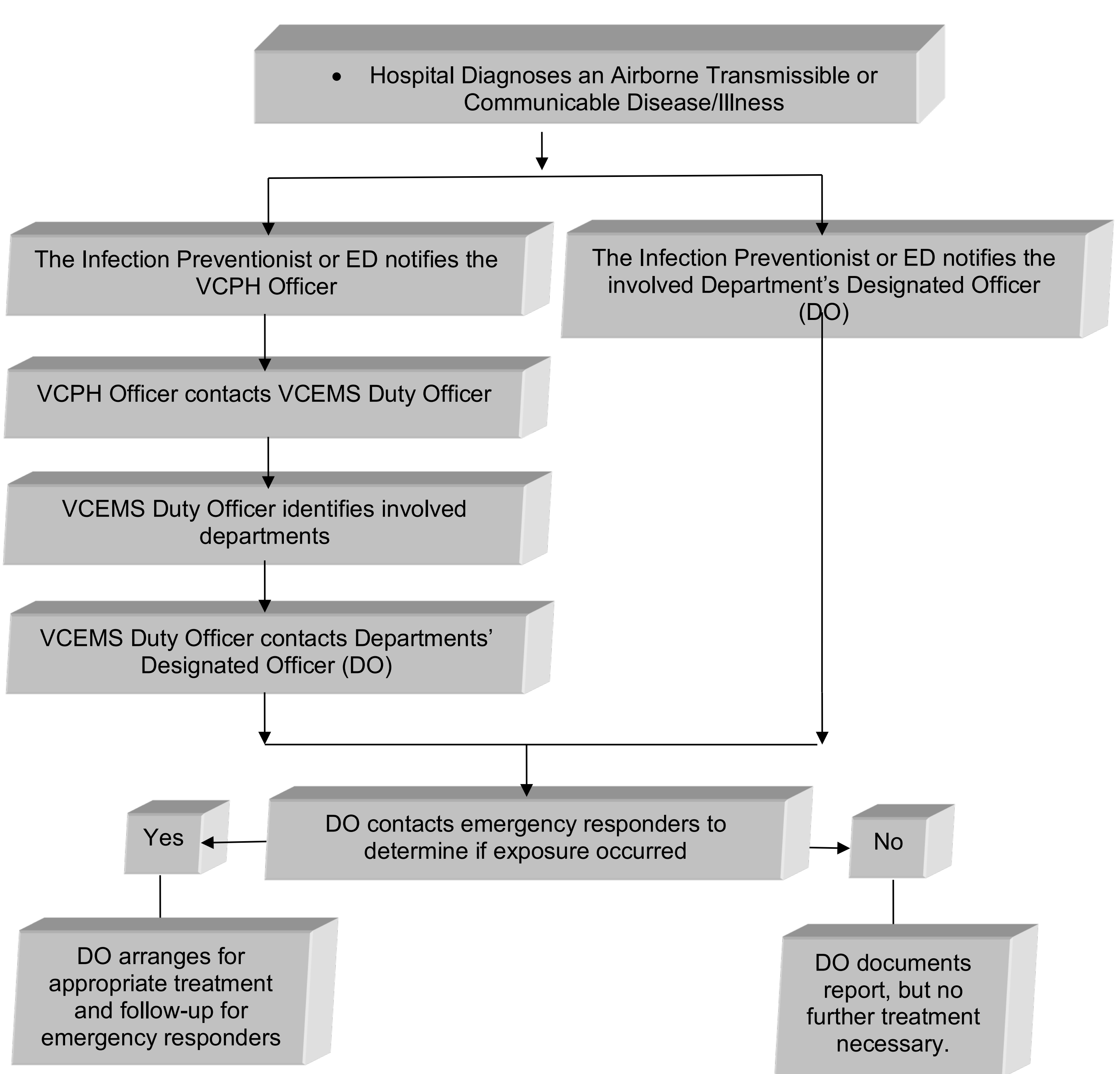
Appendix B

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



Appendix C

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



Appendix D

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

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

Diseases/Pathogens Requiring Airborne Infection Isolation
Aerosolizable spore-containing powder or other substance that is capable of causing serious human disease, e.g. Anthrax/*Bacillus anthracis*
Avian influenza/Avian influenza A viruses (strains capable of causing serious disease in humans)
Varicella disease (chickenpox, shingles)/Varicella zoster and Herpes zoster viruses, disseminated disease in any patient. Localized disease in immunocompromised patient until disseminated infection ruled out
Measles (rubeola)/Measles virus
Monkeypox/Monkeypox virus
Novel or unknown pathogens
Severe acute respiratory syndrome (SARS)
SARS-CoV-2 Coronavirus Disease (COVID-19)
Smallpox (variola)/Varioloa virus
Tuberculosis (TB)/*Mycobacterium tuberculosis* -- Extrapulmonary, draining lesion; Pulmonary or laryngeal disease, confirmed; Pulmonary or laryngeal disease, suspected
Any other disease for which public health guidelines recommend airborne infection isolation

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

Pneumonic plague/*Yersinia pestis*
Rubella virus infection (German measles)/Rubella virus
Severe acute respiratory syndrome (SARS)

Streptococcal disease (group A streptococcus)

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

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

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="3">Policy Title:
Medical Control At Scene, Private Physician/Physician on Scene</td><td>Policy Number:
703</td></tr>
<tr><td colspan="3">APPROVED:
Administration: Steven L. Carroll, Paramedic</td><td>Date: January 3, 2023</td></tr>
<tr><td colspan="3">APPROVED:
Medical Director: Daniel Shepherd, M.D.</td><td>Date: January 3, 2023</td></tr>
<tr><td>Origination Date:
Revised Date:
Date Last Reviewed:
Review Date:</td><td>January 1985
June 14, 2018
September 8, 2022
September 30, 2025</td><td colspan="2">Effective Date: January 3, 2023</td></tr>
</table>

I. Purpose: To establish guidelines for medical control of patient care at the scene of a medical emergency. To assist the paramedic who, arrives on the scene of a patient who is being attended by a California licensed physician.

II. Authority: Health and Safety Code, Division 2.5, Sections 1798 & 1798.6. California Code of Regulations, Title 22, Division 9, Section 100175.

III. Policy: paramedics shall use the following procedure to determine on-scene authority for patient care.

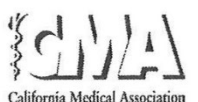
IV. Procedure:

A. When a bystander at the scene of a medical emergency identifies himself/herself as a physician, the paramedic shall:

1. Obtain proper identification from the individual (preferably California licensure as M.D., or D.O.) and document name on the PCR.

2. Present the CMA card "Note to Physician on Involvement with AEMTs and EMT-Ps (Paramedic)" to him/her to read and choose level of involvement.

STATE OF CALIFORNIA



California Medical Association

NOTE TO PHYSICIAN ON INVOLVEMENT WITH AEMTs AND EMT-Ps (PARAMEDIC)

A life support team AEMT or EMT-P (Paramedic) operates under standard policies and procedures developed by the local EMS agency and approved by their Medical Director under the Authority of Division 2.5 of the California Health and Safety Code. The drugs they carry and procedures they can do are restricted by law and local policy.

If you want to assist, this can only be done through one of the alternatives listed on the back of this card. These alternatives have been endorsed by CMA, State EMS Authority, CCLHO, and BMQA.

Assistance rendered in the endorsed fashion, without compensation, is covered by the protection of the "Good Samaritan Code" (see Business and Professions Code, Sections 2144, 2395-2398 and Health and Safety Code, Section 1799.104).

(over)

ENDORSED ALTERNATIVES FOR PHYSICIAN INVOLVMENT

After identifying yourself by name as a physician licensed in the state of California, and if requested, showing proof of identity, you may choose to do one of the following:

1. Offer your assistance with another pair of eyes, hands, or suggestions, but let the life support team remain under the base hospital control; or,

2. Request to talk to the base station physician and directly offer your medical advice and assistance; or,

3. Take total responsibility for the care given by the life support team and physically accompany the patient until the patient arrives at a hospital and responsibility is assumed by the receiving physician. In addition, you must sign for all instructions given in accordance with local policy and procedure. (Whenever possible, remain in contact with the base station physician.)

(REV. 1/12) 12 49638 **Provided by the Emergency Medical Services Authority**

OSP 12 126336

3. Contact the Base Hospital and advise them that there is a physician on scene.

4. Determine the level of involvement the physician wishes to have and inform the Base Hospital.

B. If the physician chooses not to assume patient care, the Base Hospital shall retain medical control and the paramedic's will utilize the physician as an "assistant" in patient care activities.

C. If the physician chooses to take medical control, the paramedic's will instruct the physician in radio operation procedures and have the physician at the scene communicate with the Base Hospital physician. The Base Hospital physician may do either of the following:

   1. Retain medical control, but consider and/or utilize suggestions offered by the physician at the scene.
   2. Request that the physician at the scene function in an observer capacity only.
   3. Delegate medical control to the physician at the scene.
   4. If the physician at the scene has been given medical control by the Base Hospital physician, the paramedic shall:
      a. Make ALS equipment and supplies available to the physician and offer assistance.
      b. Ensure that the physician accompany the patient in the ambulance to the hospital, and signs for all instructions and medical care given.
      c. Keep the Base Hospital advised.

D. The paramedic, while under the direction of a physician at the scene, shall perform only those procedures and administer only those drugs for which he/she is accredited for in Ventura County. Paramedics shall be held accountable and possibly liable for performing a procedure or treatment outside the paramedic scope of practice. If a physician at the scene wishes such a procedure or treatment performed, he/she may perform that procedure. The paramedic should attempt to have the on-site physician call the Base Hospital physician regarding the treatment.

E. The Base Hospital shall:

   1. Speak to the physician on scene, unless a delay would be detrimental to patient care, or the physician is the patient's personal physician, to determine qualification regarding emergency treatment and level of involvement chosen by the physician.
   2. Document the physician's intent to assume patient care responsibility.
   3. Relinquish patient care to the patient's personal physician, if he/she has arrived after Base Contact has been made and wishes to assume control.

4. In cases where a dispute arises regarding medical care, the ultimate decision as to patient care shall be made by the Base Hospital, except when the personal physician is present.

F. Private Physician on Scene

1. If the private physician is present and assumes responsibility for the patient care, the paramedic shall advise the Base Hospital that the patient is under the care of his/her private medical doctor (PMD) and inform the Base Hospital of the PMD's instructions.
2. The paramedic, while under the direction of a physician at the scene, shall perform only those procedures and administer only those drugs for which he/she is accredited for in Ventura County. Paramedics shall be held accountable and possibly liable for performing a procedure or treatment outside the paramedic scope of practice. If a physician at the scene wishes such a procedure or treatment performed, he/she may perform that procedure. The paramedic should attempt to have the on-site physician call the Base Hospital physician regarding the treatment.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Treatment Protocols		Policy Number 705
APPROVED: Medical Director: Daniel Shepherd, M.D.		Date: January 3, 2023
Origination Date: January 1988 Date Revised: See individual algorithms Date Last Revised: See individual algorithms Review Date: See individual algorithms	Effective Date: As indicated on individual algorithms	

I. PURPOSE: To provide uniform protocols for prehospital medical control in Ventura County.

II. AUTHORITY: Health and Safety Code 1797.220 and 1798; California Code of Regulations, Title 22, Division 9, Sections 100063, 100064, and100146.

A. DEFINITIONS:

1. Unless otherwise specified in an individual treatment protocol or policy, the following definitions shall apply:

a. Adult: Age 14 or greater (14th birthday and older)

b. Pediatric: Age less than 14 (up to 14th birthday)

B. Exceptions to the pediatric definition rule are in the following policies:

1. Policy 603: Refusal of EMS Services
2. Policy 606: Withholding or Termination of Resuscitation and Determination of Death
3. Policy 705.14: Hypovolemic Shock
4. Policy 710: Airway Management
5. Policy 717: Intraosseous Infusion
6. Policy 734: Tranexamic Acid Administration
7. Policy 1405: Trauma Triage and Destination Criteria

C. Cardiac Monitor/12 Lead EKG

1. When cardiac monitoring or a 12 Lead ECG is performed, copies of rhythms strips and 12 Lead ECGs shall be submitted to the ALS Provider(s), Base Hospital, and Receiving Hospital.

IV. POLICY: Treatment protocols shall be used as a basis for medical direction and control for prehospital use.

A. BLS personnel are authorized to administer the following medications and/or perform the following procedures for certain conditions as outlined below.

1. Epinephrine for anaphylaxis or severe respiratory distress because of asthma.
2. Naloxone for suspected opioid overdose
3. Nerve Agent Antidote Kit (Pralidoxime Chloride and Atropine Sulfate) for suspected nerve agent or organophosphate exposure
4. Determination of blood glucose level for altered neurological function and/or for suspected stroke
5. Continuous Positive Airway Pressure (CPAP) for severe respiratory distress or respiratory failure when absolute contraindications are not present
6. Bilevel Positive Airway Pressure (BiPAP) for severe respiratory distress or respiratory failure when absolute contraindications are not present

B. In the event BLS personnel administer naloxone, epinephrine, a nerve agent antidote kit, or applies CPAP or BiPAP, ALS personnel will assume care of the patient as soon as possible and continue care at an ALS level, in accordance with all applicable VCEMS policies and procedures.

C. Hypoglycemic patients with a history of diabetes, who are fully alert and oriented following determination of blood glucose level and a single administration of 15g of oral glucose may be transported at a BLS level of care.

V. PROCEDURE: See the following pages for specific conditions.

Contents

00 - General Patient Assessment

01 - Trauma Assessment/Treatment Guidelines

02 – Allergic Reaction and Anaphylaxis

03 - Altered Neurological Function

04 - Behavioral Emergencies

05 - Bites and Stings

06 - Burns

07 - Cardiac Arrest – Asystole/Pulseless Electrical Activity (PEA)

08 - Cardiac Arrest – VF/VT

09 - Chest Pain – Acute Coronary Syndrome

10 - Childbirth

11 - Crush Injury/Syndrome

12 - Heat Emergencies

13 – Cold Emergencies

14 – Hypovolemic Shock

15 - Nausea/Vomiting

16 - Neonatal Resuscitation

17 - Nerve Agent / Organophosphate Poisoning

18 - Overdose

19 - Pain Control

20 - Seizures

21 - Shortness of Breath – Pulmonary Edema

22 - Shortness of Breath – Wheezes/Other

23 - Supraventricular Tachycardia

24 - Symptomatic Bradycardia

25 - Ventricular Tachycardia – Not in Arrest

26 - Suspected Stroke

27 - Sepsis Alert

28 - Smoke Inhalation

29 - Traumatic Cardiac Arrest

Nerve Agent / Organophosphate Poisoning

The incident commander is in charge of the scene, and you are to follow his/her direction for entering and exiting the scene. Patients in the hot and warm zones MUST be decontaminated prior to entering the cold zone.

ADULT	PEDIATRIC

BLS Procedures

Patients that are exhibiting obvious signs of exposure (SLUDGEM) of organophosphate exposure and/or nerve agents

Maintain airway and position of comfort

Administer oxygen as indicated

- **Mark I or DuoDote Antidote Kit (If Available)**
  - Mild Exposure: IM x 1
    - May repeat in 10 minutes if symptoms persist
  - Severe Exposure: IM x 3 in rapid succession, rotating injection sites

ALS Standing Orders

Adult

Patient's that are exhibiting obvious signs of exposure (SLUDGEM) of Organophosphate exposure and/or Nerve Agents
If not already administered by BLS personnel:

- **Mark I or DuoDote Antidote Kit (If Available)**
  - Mild Exposure: IM x 1
    - May repeat in 10 minutes if symptoms persist
  - Severe Exposure: IM x 3 in rapid succession, rotating injection sites

When Mark I or DuoDote Antidote kit is not available:

- **Atropine**
  - Mild or Severe Exposure:
    - IV/IO – 2 mg
    - May repeat q 5 minutes for persistent symptoms

For seizures:

- Midazolam
  - IV/IO – 2 mg
    - Repeat 1 mg q 2 min as needed
    - Max 5 mg
  - IM – 0.1 mg/kg
    - Max 5 mg

Pediatric

Patient's that are exhibiting obvious signs of exposure (SLUDGEM) of Organophosphate exposure and/or Nerve Agents
If not already administered by BLS personnel:

- **Mark I or DuoDote Antidote Kit (If Available)**
  - Mild Exposure: IM x 1
    - May repeat in 10 minutes if symptoms persist
  - Severe Exposure: IM x 3 in rapid succession, rotating injection sites

When Mark I or DuoDote Antidote kit is not available:

- **Atropine**
  - Mild or Severe Exposure:
    - IV/IO – 0.05 mg/kg
    - May repeat every 5 minutes for persistent symptoms

For seizures:

- Midazolam
  - IV/IO – 0.1 mg/kg
    - Repeat q 2 min as needed
    - Max single dose 2 mg
    - Max total dose 5 mg
  - IM – 0.1 mg/kg
    - Max 5 mg

Base Hospital Orders Only

Consult with ED Physician for further treatment measures

- DuoDote contains 2.1 mg Atropine Sulfate and 600 mg Pralidoxime Chloride.
- **Diazepam** is available in the CHEMPACK and may be deployed in the event of a nerve agent exposure. Paramedics may administer diazepam using the following dosages for the treatment of seizures:
  - **Adult**: 5 mg IM/IV/IO q 10 min titrated to effect *(max 30 mg)*
  - **Pediatric**: 0.1 mg/kg IV/IM/IO (max initial dose 5 mg) over 2-3 min q 10 min titrated to effect *(max total dose 10 mg)*
- Mild Exposure symptoms:
  - Miosis, rhinorrhea, drooling, sweating, blurred vision, nausea, bradypnea or tachypnea, nervousness, fatigue, minor memory disturbances, irritability, unexplained tearing, wheezing, tachycardia, bradycardia, SOB, muscle weakness and fasciculations, GI effects.
- Severe Exposure:
  - Strange, confused behavior, severe difficulty breathing, twitching, unconsciousness, seizing, flaccid, apnea pinpoint pupils, involuntary defecation, urination

Shortness of Breath – Pulmonary Edema

BLS Procedures

Administer oxygen as indicated

Initiate CPAP/BiPAP for moderate to severe distress

ALS Standing Orders

Nitroglycerin

- SL or lingual spray – 0.4 mg q 1 min x 3
  - Repeat 0.4 mg q 2 min
  - No max dosage
  - Hold for SBP < 100 mmHg

If not already performed by BLS personnel, Initiate CPAP/BiPAP for moderate to severe distress

Perform 12-lead ECG (Per VCEMS Policy 726)

IV/IO access

If wheezes are present and suspect COPD/Asthma, consider:

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

If patient presents or becomes hypotensive

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

Base Hospital Orders only

Consult with ED Physician for further treatment measures

Additional Information:

- Refer to VCEMS Policy 735 for additional information on preparing push dose epinephrine solution.
- Nitroglycerin is contraindicated when phosphodiesterase inhibitor medications [Sildenafil (Viagra and Revatio), Vardenafil (Levitra), and Tadalafil (Cialis)] have been recently used (Viagra or Levitra within 24 hours; Cialis within 48 hours). These medications are most commonly used to treat erectile dysfunction or pulmonary hypertension. In this situation, NTG may only be given by ED Physician order.

Shortness of Breath – Wheezes/Other

BLS Procedures

Administer oxygen as indicated

Initiate CPAP/BiPAP for both moderate and severe distress

Assist patient with prescribed Metered Dose Inhaler if available

Severe Distress Only

- Epinephrine 1 mg/mL
  - If Under 30 kg
    - IM 0.15 mg
      - May repeat x1 in 5 minutes if patient still in distress
  - If 30 kg and Over
    - IM – 0.3 mg
      - May repeat x 1 in 5 minutes if patient still in distress

ALS Standing Orders

ADULT

Perform Needle Thoracostomy if indicated per VCEMS Policy 715

If not already performed by BLS personnel, consider CPAP/BiPAP for both moderate and severe distress

Moderate Distress

- **Albuterol**
  - Nebulizer – 5 mg/6 mL
  - MDI with spacer -4 puffs (360 mcg) is an acceptable alternative to nebulized Albuterol
  - Repeat Albuterol as needed

Severe distress

- **Epinephrine 1 mg/mL**, if not already administered by BLS personnel
  - IM - 0.3mg
    - May repeat q 5 minutes if patient still in distress and unable to obtain vascular access.
- **Albuterol**
  - Nebulizer – 5 mg/6 mL
    - Repeat as needed

Establish IV/IO access

Severe Distress, not improving with prior epinephrine administration

- **Epinephrine 10 mcg/mL**
  - 1 mL (10 mcg) q 2 minutes, slow IV/IO push
  - Titrate to overall improvement in work of breathing

PEDIATRIC

Perform Needle Thoracostomy if indicated per VCEMS Policy 715

If not already performed by BLS personnel, consider CPAP/BiPAP for both moderate and severe distress

Moderate Distress

- **Albuterol**
  - **Patients ≤ 30 kg**
    - Nebulizer – 2.5 mg/3 mL
    - MDI with spacer -2 puffs (180 mcg) is an acceptable alternative to nebulized Albuterol
  - **Patients > 30 kg**
    - Nebulizer – 5 mg/6 mL
    - MDI with spacer -4 puffs (360 mcg) is an acceptable alternative to nebulized Albuterol
  - Repeat Albuterol as needed

Severe Distress

- **Epinephrine 1 mg/mL,** if not already administered by BLS personnel
  - IM – 0.01 mg/kg up to 0.3mg
    - May repeat q 5 minutes, if patient remains in distress and unable to obtain vascular access.

Establish IV/IO access

Severe Distress, not improving with prior epinephrine administration

- **Epinephrine 10mcg/mL**
  - 0.1mL/kg (1mcg/kg) every 2 minutes, slow IV/IO push
  - Max single dose of 1mL or 10mcg
  - Titrate to overall improvement in work of breathing.

Suspected Croup- Mild

- **Normal Saline**
  - Nebulizer/Aerosolized Mask – 5 mL

Suspected croup - Severe (stridor or respiratory distress)

- **Nebulized 1 mg/mL Epinephrine**
  - **Patients less than 30 kg**
    - Nebulizer – 2.5 mg/2.5 mL
  - **Patients 30 kg and greater**
    - Nebulizer – 5 mg/5 mL

Base Hospital Orders Only

Consult with ED Physician for further treatment measures

Additional Information:.

- If hypotensive, consider alternative etiologies and refer to additional treatment protocols.
- High flow O_2 is indicated for severe respiratory distress, even with a history of COPD
- COPD patients have a higher susceptibility to spontaneous pneumothorax due to disease process
- If suspected Arterial Gas Embolus/Decompression Sickness secondary to SCUBA emergencies, transport patient in supine position on 15L/min O_2 via mask. Early BH contact is recommended to determine most appropriate transport destination.

Effective Date:	January 3, 2023	Date Revised:	November 10, 2022
Next Review Date:	November 30, 2024	Last Reviewed:	November 10, 2022

VCEMS Medical Director

Supraventricular Tachycardia

ADULT	PEDIATRIC
BLS Procedures	
Administer oxygen as indicated	
ALS Standing Orders	
Valsalva maneuver IV/IO access Stable - Mild to moderate chest pain/SOB **Adenosine** ○ IV/IO – 6 mg rapid push immediately followed by 10-20 mL NS flush No conversion or rate control **Adenosine** ○ IV/IO –12 mg rapid push immediately followed by 10-20 mL NS flush ○ May repeat x 1 if no conversion or rate control Unstable - ALOC, signs of shock or CHF **Synchronized Cardioversion** ○ **Zoll** 100, 120, 150, 200 Joules ○ **Lifepak** 100, 200, 300, 360 Joules ○ Consider sedation prior to cardioversion for special circumstances. Special Circumstances* **Fentanyl** ○ 1 mcg/kg IV/ IO / IN prior to electrical therapy.	Valsalva maneuver IV/IO access Stable - Mild to moderate chest pain/SOB **Adenosine** ○ IV/IO – 0.1 mg/kg (max 6 mg) rapid push immediately followed by 10-20 mL NS flush No conversion or rate control **Adenosine** ○ IV/IO – 0.2 mg/kg (max 12 mg) rapid push immediately followed by 10-20 mL NS flush ○ May repeat x 1 if no conversion or rate control Unstable - ALOC, signs of shock or CHF **Synchronized Cardioversion** ○ 0.5, 1, 2, 4, 6, 8 joules/kg ○ Consider sedation prior to cardioversion for special circumstances. Special Circumstances* **Fentanyl** ○ 1 mcg/kg IV/ IO / IN prior to electrical therapy.
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	

Additional Information:

- *Special circumstances for sedation prior to cardioversion include fully awake and alert, patients with unstable vital signs.
- Adenosine temporarily blocks AV nodal conduction with the goal of terminating AVNRT.
  - Administration should be reserved for cases with a high suspicion of electrical dysfunction and where heart rate is suspected to be the cause of symptoms. Generally, treatment should be reserved for heart rates greater than 150.
  - Consider patient potential underlying causes of tachycardia (sepsis, hypovolemia, heart failure) to aid in identifying cases where transport without Adenosine administration may be appropriate.
- Synchronized cardioversion is indicated for unstable patients with any tachycardic dysrhythmia including rapidly conducting atrial fibrillation and rapidly conducting atrial flutter.

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

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Prehospital Capnography		Policy Number 711
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	April 8, 2021 November 10, 2022 November 10, 2022 November 30, 2024	Effective Date: January 3, 2023

I. PURPOSE: To outline the use capnography in the assessment and treatment of EMS patients.

II. AUTHORITY: California Health and Safety Code, §1798, §1798.2; §1798.160 and §1798.170 and California Code of Regulations, Title 22, §100145 and §100146.

III. PRINCIPLES:

1. Ventilation is an active process, which is assessed with end-tidal CO_2 measurement. End-tidal CO_2 measurement is an indication of air movement in and out of the lungs. The “normal” value of exhaled CO_2 is 35-45 mmHg.

2. Oxygenation is a passive process, which occurs by diffusion of oxygen across the alveolar membrane into the blood. The amount of oxygen available in the bloodstream is assessed with pulse oximetry.

3. Capnography provides both a specific value for the end-tidal CO_2 measurement and a continuous waveform representing the amount of CO_2 in the exhaled air. A normal capnography waveform is square, with a slight upslope to the plateau phase during exhalation. (See figures below) The height of the waveform at its peak corresponds to the $ETCO_2$.

4. Capnography is necessary to monitor ventilation. For patients requiring positive pressure ventilation, capnography is most accurate with proper mask seal (two-hand mask hold for adults during bag-mask ventilation) or with an advanced airway.

5. Capnography can also be applied via a nasal cannula device to measure end-tidal CO_2 in the spontaneously breathing patient. It is useful to monitor for hypoventilation, in patients who are sedated either due to ingestion of substances or treatment with medication with sedative properties such as midazolam, opioids, or alcohol. In a patient with suspected sepsis, an ETCO2 < 25 mmHg further supports this provider impression.

6. Capnography is standard of care for confirmation of advanced airway placement. Unlike simple colorimetric devices, capnography is also useful to monitor the airway position over time, for ventilation management, and for early detection of return of spontaneous circulation (ROSC) in patients in cardiac arrest.

7. Capnography is the most reliable way to immediately confirm advanced airway placement. Capnography provides an instantaneous measurement of the amount of CO_2 in the exhaled air. The absence of a waveform, and/or values < 10 mmHg, suggest advanced airway misplacement. However, patients in cardiac arrest or profound shock may also have end-tidal CO_2 values <10 despite proper airway placement.

8. Capnography provides the most reliable way to continuously monitor advanced airway position. The waveform provides a continuous assessment of ventilation over time. A normal waveform which becomes suddenly absent suggests dislodgement of the airway and requires clinical confirmation.

9. The value of exhaled CO_2 is affected by ventilation (effectiveness of CO_2 elimination), perfusion (transportation of CO_2 in the body) and metabolism (production of CO_2 via cellular metabolism). In addition to the end-tidal CO_2 value, the ventilation rate as well as the size and shape of the capnograph must be used to interpret the results.

10. Decreased perfusion will reduce the blood flow to the tissues, decreasing offload of CO_2 from the lungs. Therefore, patients in shock and patients in cardiac arrest will generally have reduced end-tidal CO_2 values.

11. A sudden increase in perfusion will cause a sudden rise in end-tidal CO_2 values and is a reliable indicator of ROSC. It is common to have an elevated $ETCO_2$ reading after ROSC. Hyperventilation should not be done to in attempt to normalize the $ETCO_2$.

12. Ventilation can have varied effect on CO_2 measurement. Generally, hyperventilation will reduce end-tidal CO_2 by increasing offload from the lungs. Hypoventilation and disorders of ventilation that reduce CO_2 elimination (e.g., COPD), will cause CO_2 to build up in the body.

13. End-tidal CO_2 can be detected using a colorimetric device ($ETCO_2$ detector). These devices provide limited information about $ETCO_2$ as compared to capnography. Colorimetric devices do not provide continuous measurement of the value of CO_2 in the exhaled air and cannot be used in ongoing monitoring. Colorimetric devices should only be used for confirmation of endotracheal tube placement if capnography is unavailable due to equipment failure.

IV. POLICY:

1. Capnography monitoring is indicated and shall be used for patients meeting any of the following indications:
   a. Patients receiving positive pressure ventilation via CPAP/BiPAP or BVM.
   b. Patients at risk of developing respiratory failure, hypoventilation, or apnea.
   c. Patients in cardiac arrest.
   d. Advanced airway confirmation per policy 0710
   e. Paramedic judgement

2. Capnography may also be utilized when the paramedic determines it may aid the clinical assessment.
3. Providers will initiate capnography monitoring as soon as feasible and ensure that the capnography waveform is visible on screen throughout patient care or until no longer indicated.

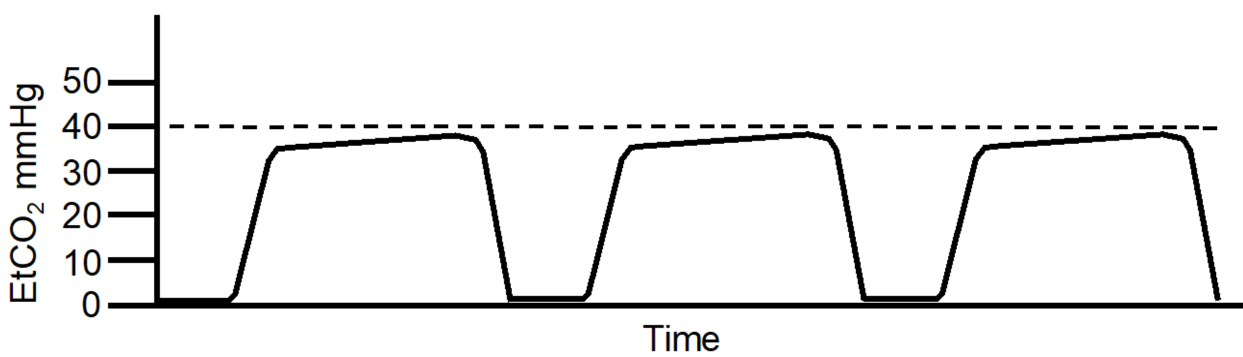
V. PROCEDURE:

1. Chose the appropriate CO2 measuring device;
   a. Nasal cannula device for spontaneously breathing patients with or without CPAP/BiPAP.
   b. Sidestream or mainstream inline measuring device for patients receiving BVM ventilations via BLS or ALS airway adjunct.

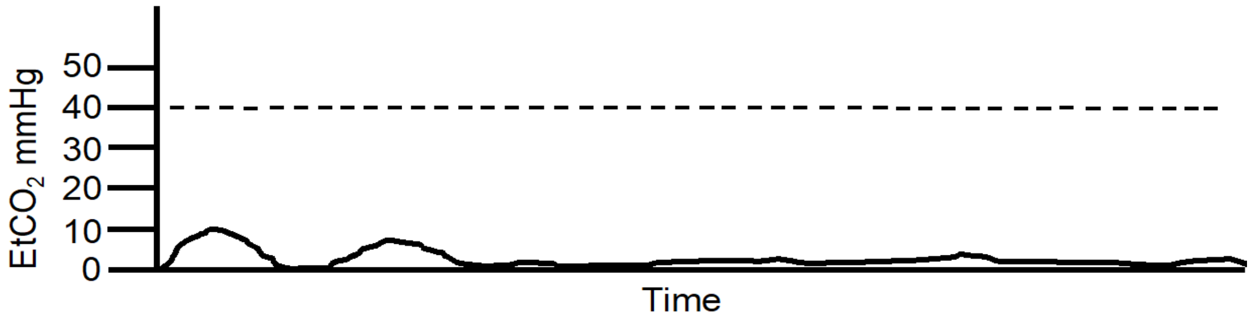
2. Attach measuring device to the monitor, wait for device to initialize, then attach to patient.
3. Assess that a capnography waveform is present with each breath prior to considering measurements to be accurate.
4. Assess EtCO2 value.
5. Assess for abnormalities in capnography waveform or EtCO2 value initially and for trends over time.
6. Endotracheal tube confirmation: per policy 710

VI. WAVEFORM INTERPRETATION

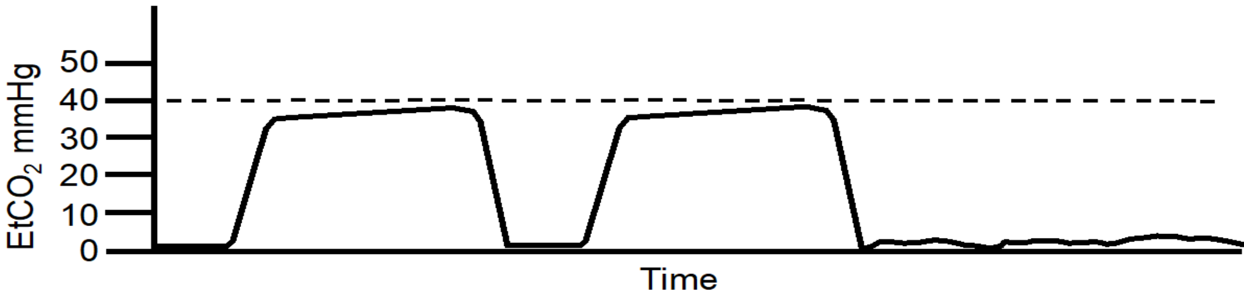
1. Normal shape of the capnograph is depicted below



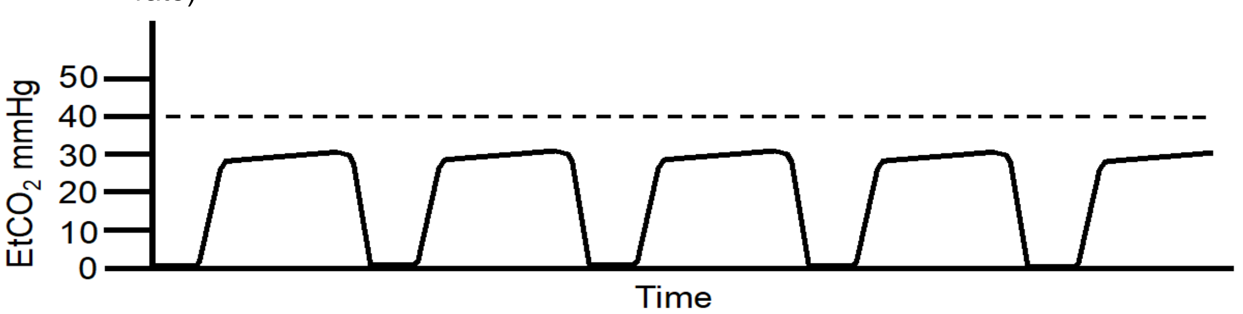
2. Esophageal Intubation (Low values and irregular waveform or flat line).



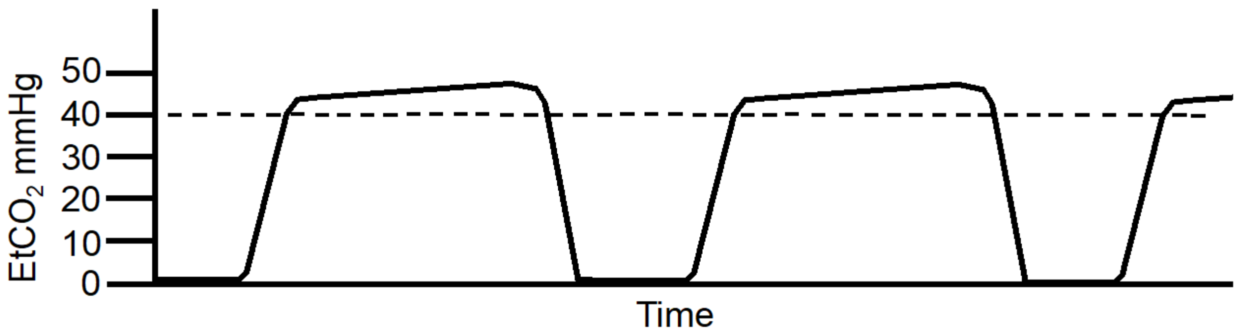
3. Obstructed or dislodged endotracheal tube (sudden loss of normal waveform followed by low irregular waveform or flat line).



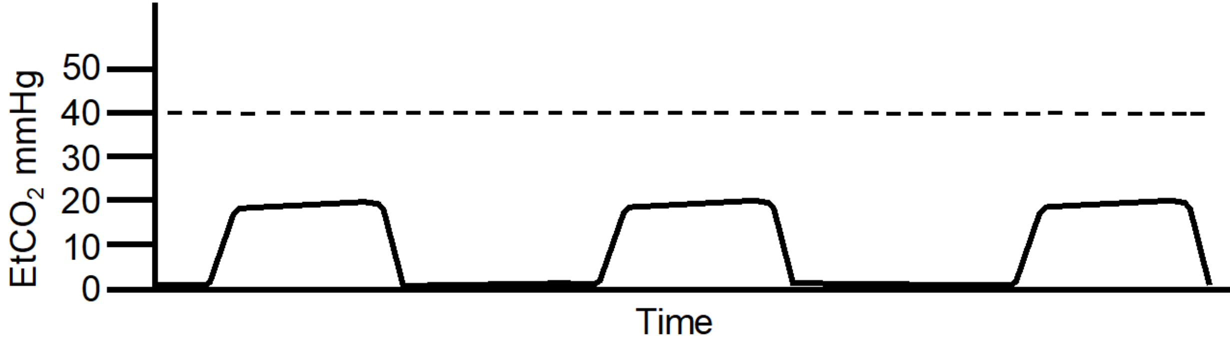
4. Hyperventilation (Normal waveform with reduced height, < 35 mmHg, and high ventilation rate)



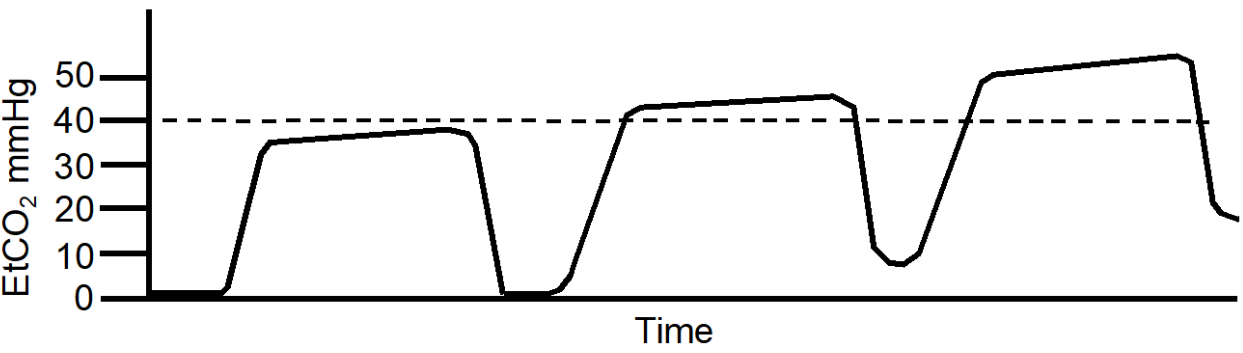
5. Hypoventilation/ Bradypnea (Normal waveform with increased height, > 45 mmHg)



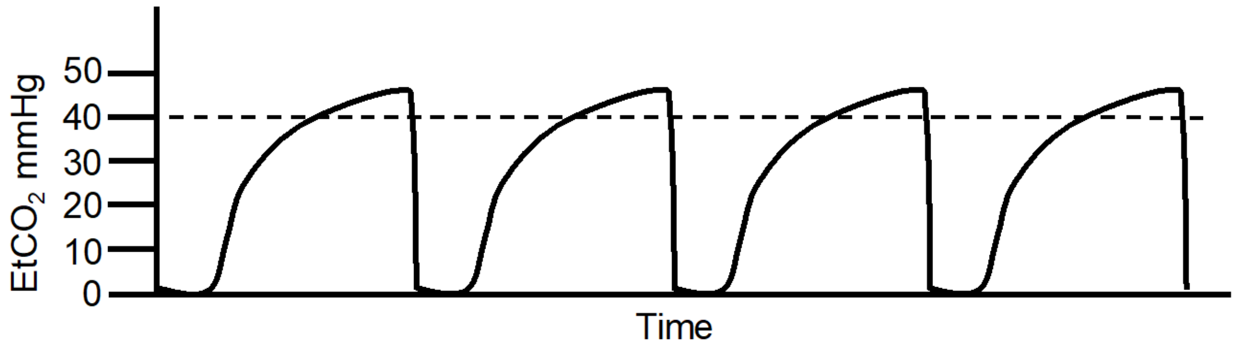
6. Hypoventilation/ Low tidal volumes (Normal waveform with reduced height, < 35 mmHg, and slow ventilation rate; A similar reduced height waveform can also be seen with shock - see progressive hypotension below).



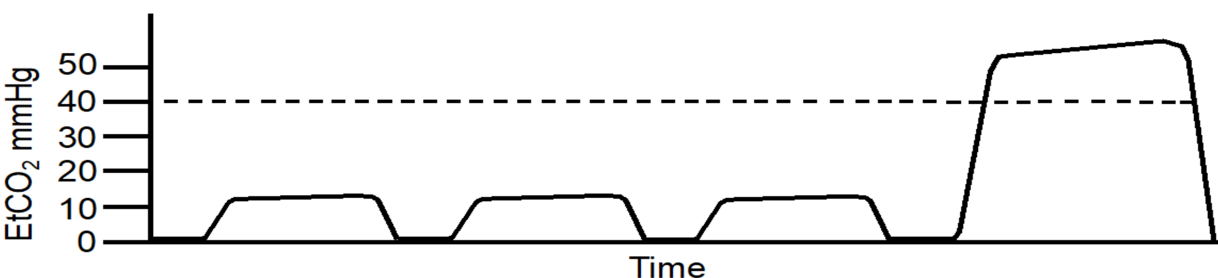
7. Air Trapping / Breath Stacking (Box wave forms that show increasing values with each successive breath)



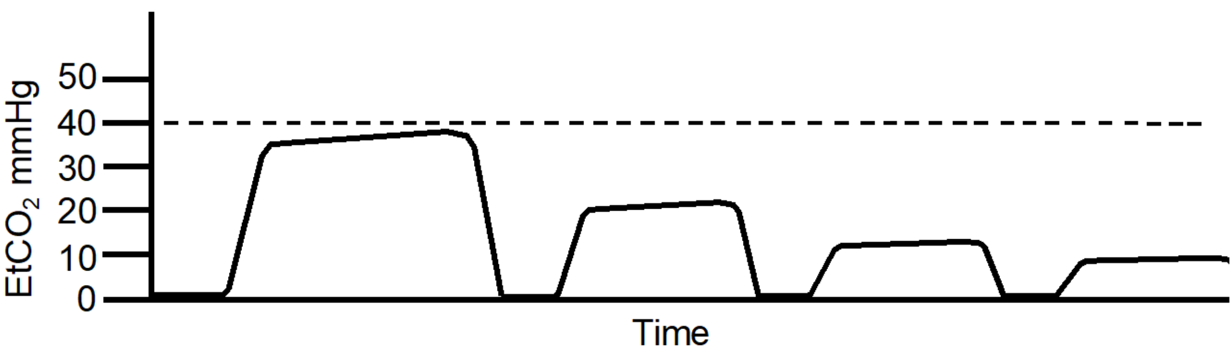
8. Bronchospasm (“Shark Fin Pattern”)



9. Return of Spontaneous Circulation (Sudden increase in values in a patient in cardiac arrest)



10. Progressive Hypotension or Re-arrest (Progressive decrease in values with each successive breath)



COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: INTRAOSSEOUS INFUSION		Policy Number: 717
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, MD	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	September 10, 1992 June 30, 2022 June 30, 2022 June 30, 2024	Effective Date: January 3, 2023

I. PURPOSE: To define the indications, procedure, and documentation for intraosseous insertion (IO) and infusion by paramedics.

II. AUTHORITY: Health and Safety Code, Sections 1797.178, 1797.214, 1797.220, 1798 and California Code of Regulations, Title 22, Sections 100145 and 100169.

III. POLICYIO access may be performed by paramedics who have successfully completed a training program approved by the EMS Medical Director

A. **Training**

The EMS service provider will ensure their paramedics successfully complete an approved training program and will notify EMS when that is completed.

B. **Indications**

Patient with an altered level of consciousness (ALOC) or in extremis AND there is an urgent need to administer intravenous fluids or medications AND venous access is not readily available.

C. **Contraindications**

1. Recent fracture (within 6 weeks) of selected bone.
2. Congenital deformities of selected bone.
3. Grossly contaminated skin, skin injury, or infection at the insertion site.
4. Excessive adipose tissue at the insertion site with the absence of anatomical landmarks.
5. IO in same bone within previous 48 hours.
6. History of significant orthopedic procedures at insertion site (ex. prosthetic limb or joint).

IV. PROCEDURE:

A. **Manual IO insertion:**

1. **Assemble the needed equipment**
   a. 16–18-gauge IO needle (1.5 inches long)
   b. Alcohol wipes
   c. Sterile gauze pads
   d. Two (2) 5 mL syringes and a primed IV line (with or without stopcock)
   e. Tape
   f. Splinting device
2. Prepare the site utilizing aseptic technique with alcohol wipe.
3. Fill one syringe with NS
4. **To insert the Manual IO needle at the proximal tibia:**
   a. Stabilize the site approximately 2 cm below the patella and 1 cm medial, on the anteromedial flat bony surface of the proximal tibia.
   b. Grasp the needle with obturator and insert through skin over the selected site at a 90° angle to the skin surface.
   c. Once the bone has been reached, continue to apply pressure rotating and gently pushing the needle forward.
   d. When the needle is felt to 'pop' into the bone marrow space, remove the obturator, attach the empty 5 mL syringe and attempt to aspirate bone marrow.
   e. For responsive patient infuse 2% cardiac lidocaine prior to fluid/medication administration for pain management:
      0.5 mg/kg (max 40 mg) slow IVP over 60 seconds.
   f. Attach the 5 mL syringe containing NS and attempt to flush the IO needle. If successful, remove the syringe, connect the IV tubing and secure the needle.
   g. Infuse NS and/or medications.
   h. Splint and secure the IO needle.
   i. Document distal pulses and skin color to extremity utilized for IO insertion before and after procedure. Monitor for complications.

B. **EZ-IO insertion**

1. **Assemble the needed equipment**
   a. Choose appropriate size IO needle
      1) 15 mm needle sets (pink): 3-39 kg
      2) 25 mm needle sets (blue): 3kg and over
      3) 45 mm needle sets (yellow): For ***humeral head*** or patients with excessive adipose tissue at insertion site
   b. Alcohol wipes
   c. Sterile gauze pads
   d. 10 mL syringe
   e. EZ Connect tubing
   f. Tape or approved manufacturer securing device
2. Prime EZ Connect tubing with 1 mL fluid
   a. If unresponsive use normal saline.
   b. If responsive prime with cardiac lidocaine as instructed below.
3. Prepare the site utilizing aseptic technique with alcohol wipes.

4. **To insert the EZ-IO needle at the proximal tibia:**
   a. Connect appropriate size needle set to the EZ-IO driver.
   b. Stabilize the insertion site on the anteromedial flat surface of the proximal tibia.
   c. **Pediatric:** 2 cm below the patella, 1 cm medial
   d. **Adult:** 2 cm medial to the tibial tuberosity
   e. Position the EZ-IO needle at 90° to the underlying bone and insert it into the skin. Continue to insert the needle until contacting the bone. Ensure at least one black band is visible above the skin.
   f. Once contact with the bone is made, activate the driver and advance the needle with light steady pressure until the bone has been penetrated.
   g. Once properly placed, attach primed EZ Connect tubing and attempt to aspirate bone marrow.
   h. For responsive patients, slow infusion of 2% cardiac lidocaine **over 60 seconds** prior to fluid/medication administration for pain management.

1) 3-39 kg: 0.5 mg/kg
2) ≥ 40 kg: 40 mg
3) Adjust for EZ-IO connector tubing

i. Flush with 10 mL NS to assess patency. If successful, begin to infuse fluid.

j. Splint the IO needle with tape or an approved manufacturer stabilization device.

k. Document time of insertion on included arm band and place on patient's wrist.

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

m. Manual insertion can be attempted in the event of driver failure.

5**. To insert the EZ-IO at the humeral head: (18 years or older)**

a. Connect the yellow (45mm) needle to the EZ-IO driver.

b. Locate and stabilize the site on the most prominent portion of the greater tubercle, 1-2cm above the surgical neck.

c. Point the needle set tip at a 45-degree angle to the anterior plane and posteromedial. Insert the needle into the skin until you contact bone. Ensure at least one black band (5mm) is visible above the skin.

d. Activate the driver and advance the needle with light, steady pressure until the bone has been penetrated.

e. Once properly placed, attach primed EZ Connect tubing and attempt to aspirate bone marrow.

f. For responsive patients, slow infusion of 2% cardiac lidocaine over 60 seconds prior to fluid/medication administration for pain management.

1) 3 – 39 kg: 0.5 mg/kg
2) ≥ 40 kg: 40 mg
3) Adjust for EZ-IO connector tubing

g. Flush with 10 ml NS to assess patency. If successful, begin to infuse fluid.

h. Splint the IO needle with tape or an approved manufacturer stabilization device. Maintain adduction of the arm and avoid extension of the shoulder.

i. Document time of insertion on included arm band and place on patient's wrist.

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

C. **IO Fluid Administration**

1. Active pushing of fluids may be more successful than gravity infusion. Use of pressure to assist with fluid administration is recommended, and usually necessary to achieve adequate flow.
2. Fluid administration on smaller patients should be given via syringe boluses to control/monitor amount infused. Close observation of the flow rate and total amount of fluid infused is required.
3. If infiltration occurs or the IO needle is accidentally removed, stop the infusion, leave the connector tubing attached.

D. **Documentation**

1. Document any attempt(s) at establishing a peripheral IV prior to attempting/placing an IO infusion in the Ventura County Electronic Patient Care Report (VCePCR) system.
2. The site and number of attempts, success, complications, and any applicable comments related to attempting an IO infusion shall be documented on the VCePCR. Any medications administered shall also be documented in the appropriate manner on the VCePCR.

Appendix B

Skills Assessment

Name____________________Agency____________Date_____________

- [ ] Demonstrates, proper body substance isolation
- [ ] States indication for EZ-IO use
- [ ] States contraindication for EZ-IO use
- [ ] Correctly locates target site
- [ ] Cleans site according to protocol
- [ ] Administers 2% cardiac lidocaine for patients responsive to pain
- [ ] Correctly assembles EZ-IO Driver and Needle Set
- [ ] Stabilizes the insertion site, inserts EZ-IO Needle Set, removes stylet and confirms placement
- [ ] Demonstrates safe stylet disposal
- [ ] Connects primed extension set and flushes the catheter
- [ ] Connects appropriate fluid with pressure infuser and adjusts flow as instructed
- [ ] Demonstrates appropriate securing of the EZ-IO
- [ ] States requirements for VC EMS documentation

Instructor Signature: ______________________________**Date**__________

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td>EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Guidelines for Limited Base Contact</td><td>Policy Number
720</td></tr>
<tr><td>APPROVED
Administrator:</td><td>Steven L. Carroll, Paramedic</td><td>Date: January 3, 2023</td></tr>
<tr><td>APPROVED
Medical Director:</td><td>Daniel Shepherd, MD</td><td>Date: January 3, 2023</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>June 15, 1998
November 10, 2022
November 10, 2022
November 30, 2024</td><td>Effective Date: January 3, 2023</td></tr>
</table>

I. PURPOSE: To define patient conditions for which Paramedics shall make limited base contact (LBC).

II. AUTHORITY: Health and Safety Code 1797.220.

III. POLICY: Paramedics shall make LBC for uncomplicated cases, utilizing the patient criteria listed below, which respond positively to initial treatment and require no ongoing treatment or further intervention or where symptoms have resolved. Patients who meet Stroke/ELVO, STEMI, or Trauma Triage Criteria are not eligible for LBC.

A. Patient criteria:

1. **Hypoglycemia:** Blood Glucose level less than 60 mg/dl.
2. **Narcotic Overdose**
3. **Chest Pain – Acute Coronary Syndrome:** No dysrhythmia, no shortness of breath.
4. **Shortness of Breath - Wheezes/Other**
5. **Seizure:** No drug ingestion, no dysrhythmia, not pregnant.
6. **Syncope or near-syncope:** Vital signs stable, no dysrhythmia.
7. **Pain:** Excluding head/neck/chest/abdominal and/or pelvic pain due to trauma.
8. **Nausea/Vomiting**
9. **BRUE**

B. Treatment may include BLS Procedures and/or ALS Standing Orders as listed below:

PATIENT CRITERIA	TREATMENT
1. Hypoglycemia	• treatment has resulted in blood glucose greater than 60 mg/dl
2. Narcotic Overdose	• naloxone
3. Chest Pain – Acute Coronary Syndrome	• aspirin • nitroglycerin
4. Shortness of Breath – Wheezes/Other	• albuterol nebulizer -OR- • MDI with spacer
5. Seizure	• midazolam
6. Syncope or near-syncope	• determine Blood Glucose Level
7. Pain	• fentanyl or morphine/ondansetron
8. Nausea/Vomiting	• ondansetron
9. BRUE	• determine Blood Glucose Level

C. Communication

1. The LBC contact call-in shall include the following information:
    a. ALS unit number
    b. "We have a LBC”
    c. Age/Gender
    d. Brief nature of call
    e. ETA and destination

D. Documentation

1. ALS Unit
    a. Complete a VCePCR with “ALS (Base Hospital Contact)” selected in the “Level of Service Provided.” .
2. MICN
    a. Complete log entry with "LBC" noted in the treatment section.
    b. Call will be documented on digital audio recording.

Policy Title: Continuous Positive Airway Pressure & Bilevel Positive Airway Pressure (CPAP/BiPAP)	Policy Number: 723
APPROVED: Administration: Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director Daniel Shepherd, MD	Date: January 3, 2023
Origination Date: December 2004 Date Revised: September 8, 2022 Last Reviewed: September 8, 2022 Review Date: September 8, 2024	Effective Date: January 3, 2023

I. PURPOSE: To define the indications, procedure and documentation for the use of Continuous Positive Airway Pressure and Bilevel Positive Airway Pressure (CPAP/BiPAP) by EMS Personnel

II. AUTHORITY: Health and Safety Code, Sections 1797.220 and 1798. California Code of Regulations, Title 22, Division 9, Section 100063.
POLICY: EMS Personnel may utilize CPAP/BiPAP on patients in accordance with Ventura County Policy 705.

III. PROCEDURE:

A. Training: Prior to using CPAP/BiPAP, EMS Personnel must successfully complete a training program approved by the VC EMS Medical Director, which includes operation of the device to be used.

B. Indications:

1. CPAP/BiPAP is indicated for all causes of severe respiratory distress or respiratory failure when absolute contraindications are not present

C. Contraindications:

1. Respiratory or cardiac arrest
2. Agonal respirations
3. Unconsciousness
4. Pneumothorax
5. Inability to maintain / protect airway patency

D. Relative Contraindications:

1. Vomiting
    a. CPAP may limit a patient's ability to protect their airway from aspiration in the event of vomiting. Consider Ondansetron administration and prepare suction for patients at risk of vomiting.
2. Altered level of consciousness
    a. Patients with altered level of consciousness may be less able to protect their own airway and may be at risk of a decreasing respiratory rate. Prepare to utilize suction, monitor capnography and responsiveness closely.
3. Systolic Blood Pressure < 90
    a. All forms of positive pressure ventilation, including CPAP and BiPAP, may exacerbate hypotension. Prepare to utilize Push-dose epinephrine per Policy 735 for patients who are hypotensive or at risk of hypotension.

D. PATIENT TREATMENT:

1. Place patient in an upright seated position to aid respiratory effort.
2. Apply nasal EtCO2 measurement device.
3. Monitor ECG, Vital signs, SpO2, and continuous waveform capnography.
4. Set up CPAP/BiPAP system
5. Explain procedure to patient.
6. Apply mask while reassuring patient.
7. Frequently reevaluate patient. Improvement is indicated by less labored breathing, increased SpO2, and relative normalization of the EtCO2 (normal range 35-45mmHg)
8. Should the patient’s condition worsen, assess lung sounds, capnography, and clinical circumstances. Closely consider, the following
    a. Pneumothorax – When present, a pneumothorax will worsen, and may evolve into a tension pneumothorax, as a result of positive pressure ventilation. When strong suspicion of pneumothorax is present discontinue CPAP/BiPAP and consider needle thoracostomy per policy 715
    b. Inadequate Respiratory Rate – CPAP/BiPAP is likely to be utilized for patients at risk for respiratory failure and/or respiratory arrest. Efficacy of breathing must be evaluated closely via direct observation and continuous waveform capnography. When inadequate respiratory rate, agonal respirations, or respiratory arrest are present, or impending, discontinue CPAP/BiPAP and support ventilations with BVM.

E. DOCUMENTATION

1. VCePCR, including attached medical device data, will be completed per VCEMS policy 1000.
2. Vital signs,SpO2, and EtCO2 must be documented every 5 minutes
3. Narrative documentation should include a description of the patient's response to CPAP/BiPAP treatment.

Policy Title: Push Dose Epinephrine		Policy Number 735
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	January 10, 2019 September 8, 2022 September 8, 2022 September 30, 2024	Effective Date: January 3, 2023

I. PURPOSE: To define the indications, contraindications, and procedure related to administration of push dose epinephrine

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 administer push dose epinephrine to adult and pediatric patients as defined by VCEMSA treatment protocols.

IV. Procedure:

A. Classification

1. Sympathomimetic agent (catecholamine)

B. Indications

1. Anaphylaxis with shock (ref: 705.02 – Allergic reaction / anaphylaxis)
2. Hypotension secondary to presumed cardiogenic shock (ref: 705.09 – Chest Pain – Acute Coronary Syndrome, 705.21 – SOB – Pulmonary Edema)
3. Hypotension secondary to Crush Injury (ref: 705.11 – Crush Injury)
4. Symptomatic bradycardia (ref: 705.24 – Symptomatic Bradycardia)
5. Sepsis Alert (ref: 705.27 – Suspect Shock)
6. Deteriorating patient condition with unknown shock etiology

C. Contraindications

1. None

D. Adverse Effects

Cardiovascular	**Neurological**	**Gastrointestinal**
Tachycardia	Anxiety	Nausea / Vomiting
Hypertension	Dizziness	
Chest Pain	Headache	
Palpitations	Tremors	
Arrhythmias		

E. Actions

Increases blood pressure and cardiac output via stimulation of alpha and beta adrenergic receptors.

F. Preparing the Concentration

1. Adults and Pediatrics
   - Using a “cardiac preload”: 1 mg/10mL (0.1 mg/mL or 100 mcg/mL)
     - Supplies Needed

       1 – 0.1 mg/mL epinephrine preload syringe

       1 – 100 mL bag of 0.9% normal saline

       1 – 1 mL syringe
     - Mixing Instructions
       - Push 10 mL of 0.1 mg/mL epinephrine from preload into 100mL bag of normal saline
       - Final concentration is essentially 10 mcg/mL (0.01 mg)
2. Points to Remember
   - Confirm your concentration prior to mixing
   - Maintain sterile technique
   - Label the bag with the drug name and final concentration
     - Example: “Epinephrine 10 mcg/mL”
   - DO NOT administer epinephrine and sodium bicarbonate in the same vascular access line and/or location unless that line has been flushed with at least 10mL of normal saline.

G. Dosing

1. Adults
   - 1mL (10mcg) every 2 minutes, slow IV/IO push
     - Titrate to SBP of greater than or equal to 90 mm/Hg
2. Pediatrics
   - 0.1 mL/kg (1 mcg/kg) every 2 minutes, slow IV/IO push
     - Max single dose of 1 mL or 10 mcg
     - Titrate to SBP of greater than or equal to 80 mm/Hg

H. Communication and Documentation

1. Communicate the use of push dose epinephrine to base hospital
   - Include final concentration delivered
   - Report total amount of push dose epinephrine administered, total elapsed time of administration, and patient response
2. Administration of epinephrine and any/all associated fields will be documented in the Ventura County electronic Patient Care Report (VCePCR)

I. Alternative Concentrations

1. In the event of a shortage that limits a provider agency from obtaining the necessary 100 mL bags of normal saline solution, please see below for acceptable alternatives:
   - Discard 1 mL from 10 mL saline flush syringe and draw 1 mL from epinephrine preload into flush syringe. This creates a solution of 10 mcg per 1 mL.
   - Draw 5 mL of from epinephrine preload into 50 mL bag of normal saline. This essentially creates a solution of 10 mcg per 1 mL.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Public Health Emergency Vaccine Administration		Policy Number 737
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	September 28, 2020 September 28, 2020 October 13, 2022	Effective Date: January 3, 2023

THIS POLICY WILL EXPIRE AT MINDIGHT ON 3/1/2023, FOLLOWING TERMINATION OF STATE PUBLIC HEALTH EMERGENCY

I. PURPOSE: To authorize paramedics to administer the intramuscular inactivated influenza and/or COVID-19 vaccine to adult patient populations (14 or older) when authorized by the Ventura County EMS Agency during the COVID-19 disaster declaration.

II. AUTHORITY: California Health and Safety Code, Sections 1797.220 and 1798. California Code of Regulations, Title 22, Sections 100145 and100169. State of California Emergency Proclamation for COVID-19

III. POLICY: Paramedics accredited by the Ventura County EMS Agency approved for this local optional scope of practice, and having had completed the VCEMSA approved training to administer intramuscular influenza and/or COVID-19 (when available) vaccines, may provide these vaccinations to persons as directed by VCEMSA Medical Director in conjunction with the County Public Health Department. These vaccination policies and procedures shall only be authorized and valid for paramedics accredited in accordance with VCEMS Policy 315 – Paramedic Accreditation to Practice that have been approved to utilize this local optional scope during the California COVID-19 emergency proclamation.

IV. PROCEDURE:

A. Vaccine Administration

1. Assess the need for the vaccine in question utilizing the current guidance on that vaccination, which will be provided by the Ventura County Public Health

Department. (also see CDC information regarding the seasonal flu vaccine https://www.cdc.gov/flu/prevent/keyfacts.htm)

2. Screen for contraindications and precautions of inactivated vaccine (listed below).
3. Collect and review Vaccine Consent/Record of Administration sheet.
    a. Confirm that the consent has been signed.
4. Vaccinate patients while they are seated or lying down and consider observing them for 15 minutes after receipt of the vaccine.
5. Paramedics must maintain aseptic technique when administering the influenza or COVID vaccines.
6. The screening questionnaire must be completed prior to administration of the influenza or COVID vaccine.
7. Equipment Required:
    a. Vaccine
    b. 23-25 g, 1-inch needle
        i. For larger patients, 1.5-inch needle length may be more appropriate.
        ii. See “Needle Gauge/Length and Injection Site Guidance” below for additional information.
        iii. COVID-19 vaccine may come as prefilled/ready to administer or require other injection supplies or sizes.

Needle Gauge/Length and Injection Site Guidance			
Gender, Age, Weight of Pt.	**Needle Gauge**	**Needle Length (inches)**	**Injection Site**
14 to 18 years	22-25	5/8* – 1 1 – 1 ½	Deltoid muscle of arm Anterolateral thigh muscle
Female or male less than 130 lbs	22–25	5⁄8*–1"	Deltoid muscle of arm
Female or male 130–152 lbs	22–25	1"	Deltoid muscle of arm
Female 153–200 lbs	22–25	1–1½"	Deltoid muscle of arm
Male 153–260 lbs	22–25	1–1½"	Deltoid muscle of arm
Female 200+ lbs	22–25	1½"	Deltoid muscle of arm
Male 260+ lbs	22–25	1½"	Deltoid muscle of arm

** A 5⁄8" needle may be used in patients weighing less than 130 lbs (<60 kg) for IM injection in the deltoid muscle with the skin is stretched tight, the subcutaneous tissue not bunched, and at a 90-degree angle to the skin, although specific differences may be required by various COVID-19 manufacturers.*

8. Hand hygiene and don gloves
9. Check expiration date of vaccine

10. Cleanse the area of the deltoid muscle with the alcohol prep.
    a. Deltoid landmarks: 2-3 finger widths down from the acromion process; bottom edge is imaginary line drawn from axilla.
11. Insert the needle at a 90-degree angle into the muscle.
    a. Pulling back on the plunger prior to injection is not necessary.
12. Inject the vaccine into the muscle.
13. Withdraw the needle, and using the alcohol prep, apply slight pressure to the injection site.
14. Do not recap or detach needle from syringe. All used syringes/needles should be placed in puncture-proof containers.
15. Monitor the patient for any symptoms of allergic reaction.
16. Document the following information:
    a. Date of vaccination
    b. Name of patient
    c. Injection site
    d. Vaccine lot number
    e. Vaccine manufacturer
17. Complete Appropriate Documentation:
    a. **Vaccine Consent/Record of Administration form:** ensure this is completed, retained and appropriately submitted after administration.
        i. Note that medical records/charts should be documented and retained in accordance with applicable state laws and regulations. If vaccine was not administered, record the reason(s) for non-receipt of the vaccine (e.g., medical contraindication, patient refusal). Discuss the need for vaccine with the patient (or, in the case of a minor, their parent or legal representative) at the next visit.
    b. **Vaccine Information Statement:** document the publication date and the date it was given to the patient.
    c. **Patient's medical record:** if accessible, record vaccine information (above) in the patient's medical record.
    d. **Personal immunization record card:** record the date of vaccination and name/location of administering clinic.

   e. **Immunization Information System (IIS), or "registry":** Report the vaccination to the appropriate state/local IIS, if available.
   f. **VAERS:** report all adverse events following the administration of a vaccine to the federal Vaccine Adverse Event Reporting System (VAERS).
      i. To submit a VAERS report online (preferred) or to download a writable PDF form, go to https://vaers.hhs.gov/reportevent.html. Further assistance is available at (800) 822-7967.

18. Give patient vaccine information sheet, using the appropriately translated sheet for non-English speaking client; these can be found at www.immunize.org/vis.
19. Advise patient when to return for subsequent vaccination, if appropriate.

B. Contraindications, Relative Contraindications, and Considerations for Vaccine Administration

1. Contraindications for Use of Vaccines
   a. Do not administer vaccines to a person who has an allergic reaction or a serious systemic or anaphylactic reaction to a prior dose of that vaccine or to any of its components. For a list of vaccine components, refer to guidance specific to this vaccine provided by the manufacturer and/or VCEMSA.
   b. The manufacturer's package insert contains a list of ingredients (www.immunize.org/fda) and these are also listed at www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf
   c. Contraindications for Live Attenuated Vaccines are not pertinent as these are not being administered under this local optional scope of practice
2. Relative Contraindications for Use of Vaccines
   a. Moderate or severe acute illness with or without fever
   b. History of Guillain-Barré syndrome within 6 weeks of a previous vaccination
   c. People with egg allergies can receive any licensed, recommended age-appropriate influenza vaccine (IIV, RIV4, or LAIV4) that is otherwise appropriate. People who have a history of severe egg allergy (those who have had any symptom other than hives after exposure to egg) should be vaccinated in a medical setting, supervised by a health care provider who is able to recognize and manage severe allergic reactions. Two completely egg-free

(ovalbumin-free) flu vaccine options are available: quadrivalent recombinant vaccine and quadrivalent cell-based vaccine.

3. Considerations for Vaccine Administration
    a. Treatment of medical emergencies related to the administration of vaccine will be in accordance with VCEMSA Policies and Procedures.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Emergency Medical Technician (EMT) Automatic External Defibrillation (AED) Service Provider Program Standards		Policy Number: 803
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Date Revised Date Last Reviewed: Review Date:	November 1988 April 12, 2018 September 8, 2022 September 30, 2025	Effective Date: January 3, 2023

I. PURPOSE: To establish criteria and procedure for approval and oversight of EMT AED Service Provider programs.

II. AUTHORITY: Health and Safety Code 1797.107, 1797.170, 1798 and California Code of Regulations, Title 22, 100063.1.

III. DEFINITION: An EMT AED service provider is an agency or organization that employs individuals as defined in Title 22, Division 9, Section 100060, and who obtain AEDs for the purpose of providing AED services to the general public.

IV. POLICY:

A. An AED Service Provider shall be approved by Ventura County Emergency Medical Services (VC EMS) prior to beginning service. In order to receive and maintain EMT AED Service Provider approval, an EMT AED Services Provider shall comply with the requirements of this policy.

B. An EMT AED Service Provider shall:

1. Provide orientation of AED authorized personnel to the AED
2. Ensure maintenance of AED equipment.
3. Ensure initial training and continued competency of AED authorized personnel
   a. Demonstration of skills competence at least every six months to the EMT Program Director or his/her designee as identified to the EMS office.
   b. Skills competency records shall be maintained for at least four years.
4. Ensure that EMT personnel complete first responder BLS Prehospital Care Record (PCR) or electronic PCR (ePCR) for all patient contacts.
5. Authorize personnel and maintain a current list of all EMT AED Service Provider authorized personnel and provide a list upon request by the VC EMS Agency. Authorized personnel means EMT personnel trained to operate an AED and authorized by an approved EMT AED Service Provider.
6. Train all EMTs who have not already been trained in use of AED. Training shall include the following:
   a. Perform emergency cardiac care in accordance with protocols developed

and/or approved by the EMS Agency Medical Director.

b. Recognize that a patient is in cardiac arrest and that CPR and immediate application of the automated external defibrillator is required.

c. Set up the automated defibrillator correctly.

d. Correctly apply the defibrillator pads.

e. Ensure that rescuers or bystanders are not in contact with the patient while the AED is analyzing or delivering a shock.

f. Deliver shocks for ventricular fibrillation in the shortest time possible following their arrival at the patient side, ideally within 90 seconds.

g. Recognize that a shock was delivered to the patient.

h. Provide supportive care to a patient who has been successfully defibrillated.

i. Immediately recognize and respond to patients when an arrest recurs either at the scene or during transport, in accordance with protocols.

j. Record the pertinent events of the emergency response on a PCR.

k. Maintain the AED and voice/ECG recorder or other documentation device in accordance with manufacturer's recommendations.

7. Develop and maintain a quality improvement program, approved by the VC EMS Medical Director that contains the following:

a. Assure timely and competent review of EMT managed cardiac arrest cases, accurate logging of required data, and timely, accurate and informative statistical summaries of system performance over time, as well as recommendations, as indicated, for modifications of system design, performance protocols, or training standards designed to improve patient outcome.

b. Collect, store and analyze, at a minimum, the following data related to EMT management of cardiac arrest patients:

(1) Patient Data:

a) Age,

b) Sex,

c) Whether arrest was witnessed or unwitnessed,

d) Distance of collapse from EMT responding unit, and

e) Initial cardiac rhythm.

(2) EMS System Data:

a) Estimated time from collapse to call for help,

b) Estimated time from collapse to initiation of CPR,

c) EMT responding unit response time, and

d) Scene to hospital transport time.

(3) EMT Performance:

a) Time from arrival to actual defibrillation,

b) Time between defibrillation attempts,

c) General adherence to established protocol.

(4) Patient Outcome:

a) Rhythm after each shock.

b) Return of pulse and/or spontaneous respirations in the field.

8. EMT AED documentation submission

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

b. If EMT AED Service Provider does not have ePCR capabilities, documentation submission shall be as follows:

(1) EMT documentation (incident printout and prehospital care record (PCR) shall be submitted to the receiving hospital as soon as possible (not more than two hours after patient arrival).

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

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

9. The EMT AED Service Provider shall
submit an annual written report to the EMS Agency to include as a minimum the following information.

a. The total number of cases in which the AED was activated. The number of those cases where return of spontaneous circulation (ROSC) was achieved.

b. The number of cases that presented in Ventricular Fibrillation (VF). The number of those cases where ROSC was achieved.

c. The number of cases that presented in witnessed VF. The number of those cases where ROSC was achieved.

d. The 90% fractile times from first notification to on-scene, to with patient and to first analysis, in case of secondary PSAP, time received.

e. The number of cases of cardiac arrest responded to where the AED was not activated and the 90% fractile time from first notification to on-scene for those cases, in case of secondary PSAP, time received.

IV. PROCEDURE:

A. Program Approval

1. Eligible programs shall submit a written request for EMT AED Service Provider approval to the EMS Agency and agree to comply with the provisions of this policy.

2. Application Receipt Process
Upon receipt of a complete application packet, the Agency will notify the applicant within fourteen business days that;

a. The request for approval has been received.

b. The request does or does not contain all required information.

c. What information, if any, is missing

5. Program Approval Time Frames

a. Program approval or disapproval shall be made in writing by the Agency to the requesting program, within sixty calendar days, after receipt of all required documentation.

b. The Agency shall establish an effective date for program approval in writing upon the satisfactory documentation of compliance with all program requirements.

c. Program approval shall be for four years following the effective date of the program and may be reviewed every four years subject to the procedure for program approval specified by the Agency.

6. Withdrawal of Program Approval

a. Noncompliance with any criterion required for program approval, use of any unqualified personnel, or noncompliance with any other applicable provision of Title 22 may result in suspension or revocation of program approval by the Agency.

b. An approved program shall have no more than sixty days to comply with corrections mandated by this policy.

B. Program Review and Reporting

1. All program materials are subject to periodic review by the Agency.

2. All programs are subject to periodic on-site evaluation by the Agency.

3. The Agency shall be advised of any change in Program staff.

4. Records shall be maintained by the EMT AED SERVICE PROVIDER for four years and shall contain the following:

   a. Roster of Authorized Personnel
   b. Documentation of skills competency

C. Application for Renewal

. The EMT AED SERVICE PROVIDER shall submit an application for renewal at least sixty calendar days before the expiration date of their Program approval in order to maintain continuous approval.

Ventura County Emergency Medical Services Agency

Emergency Medical Technician AED Service Provider

APPROVAL REQUEST

General Information

Program/Agency Name: ____

Address: ______________________________ City: __________Zip: __________

Phone: ______________ Fax: ______________ Email: _____________________

Date Submitted: __________________

Requirements
(All items below refer to Ventura County EMS Policy 803 and Title 22 Regulations)

1. Program Eligibility

Eligible Programs • Programs eligible for approval shall be limited to public or private organizations that meet the requirements identified in this policy. All private entities must possess a valid business license and proof of organizational registry (partnership, sole proprietorship, corporation, etc.)	**Name of Program**
Written request for EMT AED Service Provider Approval	□ Attached

2. Records and Quality Improvement

Agree to maintain all records for a minimum of four years.	Signature:______________________
Agree to participate in the VCEMS Quality Improvement Program and in research data accumulation.	Signature:______________________

VCEMS Office Use Only

All Requirements Submitted:		Date:
EMT AED SERVICE PROVIDER Application Approved:		Date:
Approval Letter Sent:		Date:
Re-Approval Due:		Date:
Signature of person approving EMT AED SERVICE PROVIDER		Date
Typed or printed name:		

Ventura County Emergency Medical Services Agency

Emergency Medical Technician AED Service Provider

ANNUAL REPORT

The Annual Report shall be submitted to EMSAgency@ventura.org, by January 31st. It shall be compiled from data obtained the prior calendar year, January 1st through December 31st.

Program/Agency Name: ____

Report submitted by (Name): ____

Phone: ___________________ Email: ____________________________________

Date Submitted: ____________________

Program Data

(All items below refer to Ventura County EMS Policy 803 and Title 22 Regulations)

The number of patients with sudden cardiac arrest receiving CPR prior to arrival of emergency medical care.	
The total number of patients on whom defibrillatory shocks were administered, witnessed (seen or heard) and not witnessed;	Witnessed: ___________ Unwitnessed: ___________
The number of these persons who suffered a witnessed cardiac arrest whose initial monitored rhythm was ventricular tachycardia or ventricular fibrillation	
The total number of cases in which the AED was activated.	
The number of those cases where return of spontaneous circulation (ROSC) was achieved	
The number of cases that presented in Ventricular Fibrillation (VF).	
The number of those cases where ROSC was achieved.	
The number of cases that presented in witnessed VF.	
The number of those cases where ROSC was achieved.	
The 90% fractile times from first notification to on-scene, to with patient and to first analysis, in case of secondary PSAP, time received.	
The number of cases of cardiac arrest responded to where the AED was not activated and the 90% fractile time from first notification to on-scene for those cases, in case of secondary PSAP, time received.	

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Documentation of Prehospital Care		Policy Number 1000
APPROVED: Administration:	Steven Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 15, 1998 October 13, 2022 October 13, 2022 October 31, 2025	Effective Date: January 3, 2023

I. PURPOSE: To define the use of standardized records to be used by Ventura County Emergency Medical Service (VCEMS) providers for documentation of pre-hospital care.

II. AUTHORITY: California Health and Safety Code, Sections 1797.225, and 1798; California Code of Regulations, Title 22, Division 9, Section 100147.

III. Definitions:

Incident: For the purposes of this policy, will be defined as any response involving any Ventura County pre-hospital personnel to any event in which there is an actual victim, or the potential for a victim

Patient Contact: Any encounter involving Ventura County pre-hospital personnel with any person consenting, either implied or informed, to assessment and/or treatment.

National EMS Information System (NEMSIS): The national data standard for emergency medical services as defined by the National Highway Traffic and Safety Administration (NHTSA) and the NEMSIS Technical Assistance Center (TAC)

California EMS Information System (CEMSIS): The California data standard for emergency medical services, as defined by the California EMS Authority (CalEMSA). This data standard includes the NEMSIS standards and state defined data elements.

VCEMS Data Standard: The local data standard, as defined by VCEMS. This data standard includes the NEMSIS and CEMSIS standards, in addition to locally defined data elements.

Ventura County Electronic Patient Care Report (VCePCR): The electronic software platform that allows for real time collection of prehospital patient care information at the time of service.

IV. POLICY: Patient care provided by first responders and transport personnel shall be documented using the appropriate method. The VCEMS VCePCR will be used to document the care provided by pre-hospital personnel for every incident in which there is a patient contact. Documentation shall be completed on any person with medical complaint, obvious injury or significant mechanism - regardless of consent.

V. PROCEDURE:

A. Provision of Access

VCEMS will provide access to the approved Ventura County Electronic Patient Care Report (VCePCR) system and software to EMS system stakeholders required to enter, edit, or analyze data.

B. Documentation

1. Specific requirements related to the documentation of patient care and coordination of that documentation between multiple agencies are outlined below:

   a. If a First Responder Advanced Life Support (FR ALS) Paramedic initiates care of the patient, the FR ALS Paramedic shall document all care provided to the patient on VCePCR.

   b. If/when care is turned over to another ALS agency, a VCePCR shall be completed by all pre-hospital provider agencies who delivered patient care and/or transport.

   c. All relevant fields pertaining to the EMS event will be appropriately documented on the VCePCR.

   d. Patient side documentation is encouraged and should be practiced whenever patient care would not be negatively affected.

   e. In the event of an incident with three or more victims, documentation will be accomplished as follows:

      1) MCI/Level I (3-14 victims): The care of each patient shall be documented using a VCePCR.

      2) MCI/Level II or III (15+ victims): Each patient transported to a hospital shall have their care documented on a Ventura County Multi-Casualty Patient Record.

         a) The transporting agency is responsible for completion of the multi-casualty patient record.

The record is designed to be completed by the transporting crew enroute to the receiving hospital.

b) The transporting agency retains the original of the multi-casualty patient record. A copy shall be left with the patient at the receiving hospital. The triage tag shall be attached to this copy and is included as official documentation in the patient's medical record.

c) The transporting agency shall distribute copies of the multi-casualty patient record to the base hospital and EMS Agency within twenty-four hours of demobilization of the incident.

C. Transfer of Care

1. Transfer of care between two field provider teams and between field provider and hospital will be documented on the VCePCR. The first arriving agency will post to the server and perform a coordinated electronic transfer of care whenever possible within the VCePCR system to the next incoming unit. The unit receiving the electronic transfer will download the correct corresponding report prior to completion of the VCePCR. This includes intra-agency units and inter-agency units.

   a. Any / all agencies involved in the transferring of electronic medical records shall ensure they are uploading and downloading the correct record for the correct patient.

2. A VCePCR shall be completed in accordance with training administered by VCEMS, or designee.

3. The time that patient care is transferred to hospital staff shall be documented by the primary provider handling patient care in all circumstances where a patient is transported to a hospital.

   a. Transfer of care to the receiving facility is complete when:

      1) The patient is moved off of the EMS gurney, and;

      2) Verbal patient report is given by transporting EMS personnel and acknowledged by Emergency Department

medical personnel and a signature of patient receipt is obtained in the VCePCR.

a) The signature time shall be the official transfer of care time and will be documented in eTimes.12 – Destination Patient Transfer of Care Date/Time Destination.

D. Cardiac Monitor

In the event the cardiac monitor is utilized as required by any of the VCEMS policy(ies), a complete ECG data transfer shall be recorded and attached to the corresponding VCePCR. ECG data shall be downloaded by each provider agency involved in that incident and attached to the corresponding VCePCR. An original 12 lead ECG shall be printed and submitted upon transfer of care to hospital staff for any patient where a 12 lead ECG was performed.

1. If a 12 lead ECG is performed by medical staff at a clinic or urgent care the original document shall be scanned or photographed and attached to the VCePCR, at the time of posting to the server, as part of the patient's prehospital medical record and the original or a copy of the 12-lead ECG shall be submitted to SRC staff upon transfer of care to hospital personnel.

E. Handtevy

In the event the patient is treated, within the pediatric definition of VCEMS Policies, a complete Handtevy data transfer will be recorded and attached to the corresponding VCePCR.

F. Submission to VCEMS

1. In the following circumstances, a complete VCePCR shall be completed and posted by any transporting unit, and by FR ALS personnel retaining care, within thirty (30) minutes of arrival at destination:
   a. Any patient that falls into Step 1 or Step 2 (1.1 – 2.8) of the Ventura County Field Triage Decision Scheme
   b. Any patient that is in cardiac arrest or had a cardiac arrest with ROSC.
   c. Any patient with a STEMI positive 12 lead ECG.

d. Any patient with a positive Cincinnati Stroke Screening (CSS +). This includes all prehospital Stroke Alerts and all prehospital ELVO alerts.

e. Any patient that is unable to effectively communicate information regarding present or past medical history.

2. For circumstances not listed above, in which the patient was transported to a hospital, the entire data set found within the VCePCR 'REPORT' tab shall be completed and electronically posted to the server by transporting agencies, and by FR ALS personnel retaining care, within thirty (30) minutes of arrival at destination. This includes all assessments, vital signs, procedures, and medications performed as part of the response.

3. All other reports not falling into the above criteria shall be completed and posted to the server as soon as possible and no later than by the end of the current shift.

4. In all circumstances in which a person is transported to a receiving hospital from the scene of an emergency, or as part of any emergent/urgent specialty care transfer (STEMI, Stroke, Trauma), the transporting personnel shall obtain and document the eOutcome.04 – Hospital Encounter Number.

G. For Refusal of EMS Services, Refer to Policy 603 for documentation requirements. Every patient contact resulting in refusal of any medical treatment and/or transport must be documented with the following information, the reason dispatched and/or chief complaint, assessment and vital signs, base hospital contact (when appropriate), patient advised to seek medical attention and completion of all applicable fields. Signatures will be captured by each agency at the time of patient contact/refusal. If, at any point, a signature is not obtained for any reason, a detailed explanation shall be documented in the narrative section of the VCePCR.

H. ALS Inter-facility Transfers (Acute Care Facility to Acute Care Facility) Documentation shall be completed on all ALS Inter-facility transfers only. Documentation will include, but not be limited to, baseline assessment, medications administered, reason for transfer, procedures done to the patient, vital signs and any changes from baseline assessment.

If the transferring facility sends staff to accompany the patient, the staff member(s) name(s) shall be documented on the VCePCR.

I. The completion of any VCePCR will not delay patient transport to hospital/receiving facility.

J. Patient Medical Record

The VCePCR and Ventura County Multi-Casualty Patient Record shall be considered a legal document and part of the patient's medical record.

K. The first responder agency, transport agency, and hospital are custodians of record. Printing should only be performed as needed, and an electronic copy of the VCePCR should be utilized and referred to whenever feasible. A print log and reason for printing shall be monitored regularly to help ensure security of protected health information within the system.

Attachment A

These abbreviations have been accumulated from the California approved EMT Curriculum and various other resource material. The abbreviations were collected by the Ventura County ALS CQI Team to assist EMS field, hospital and dispatch personnel in providing consistent medical documentation.

Term	Abbreviation
Above knee amputation	AKA
Antecubital	AC
Aspirin	ASA
Bi-Level Positive Airway Pressure	BiPAP
Bundle Branch Block	BBB
Central Nervous System	CNS
Circulation, Sensation, Motor	CSM
Continuous Positive Airway Pressure	CPAP
Diabetes Mellitus	DM
Deformity, Contusion, Abrasion, Penetration, Burn, Tenderness, Laceration, Swelling	DCAPBTLS
Drops	gtts
Endotracheal	ET
End-Tidal CO_2	$EtCO_2$
Every day*	qd*
Evening	pm
Foreign body	FB

Term	Abbreviation
Fracture	Fx
Gastrointestinal	GI
Genitourinary	GU
Glasgow Coma Score	GCS
Gun Shot Wound	GSW
Intravenous Push	IVP
Jugular venous distention	JVD
Metered Dose Inhaler	MDI
Morphine Sulphate*	MS*
Nausea/Vomiting	NV
Negative	neg
Nitroglycerin	NTG
No Acute Distress	NAD
No Known Drug Allergies	NKDA
Non Insulin Dependent Diabetes Mellitus	NIDDM
Over the Counter	OTC
Oxygen	O2
Oxygen Saturation	SpO_2
Pupils Equal Round and Reactive to Light	PERRL
Range of Motion	ROM

*THE JOINT COMMISSION and ISMP have indicated these abbreviations have a high likelihood of misinterpretation; thereby leading to medical errors, therefore, they are ***not*** to be used in ***handwritten*** documentation.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td>EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Emergency Medical Technician Training Program Approval</td><td>Policy Number
1100</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steven L. Carroll, Paramedic</td><td>Date: January 3, 2023</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td>Daniel Shepherd, M.D.</td><td>Date: January 3, 2023</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Reviewed:
Review Date:</td><td>February 2001
September 8, 2022
September 8, 2022
September 30, 2025</td><td>Effective Date: January 3, 2023</td></tr>
</table>

I. PURPOSE: To identify the procedure for approval of Emergency Medical Technician programs in Ventura County in accordance with the California Code of Regulations. The purpose of an EMT training program shall be to prepare individuals to render prehospital basic life support at the scene of an emergency, during transport of the sick and injured, or during interfacility transfer within an organized EMS system.

II. AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 2, Article 3

III. POLICY: EMT training may be offered only by approved training programs.

A. The approving authority for Emergency Medical Technician (EMT) training programs that will be managed or conducted by a qualified statewide public agency shall be the Director of the California EMS Authority. This shall apply to the California Highway Patrol, California Department of Forestry, etc.

B. The approving authority for Emergency Medical Technician training programs located within the County of Ventura shall be the Ventura County Emergency Medical Services Agency (VCEMS).

C. The purpose of an EMT training program shall be to prepare individuals to render prehospital basic life support at the scene of an emergency, during transport of the sick and injured, or during interfacility transfer within an organized EMS system.

D. EMT training may be offered only by approved training programs. Eligibility for program approval shall be limited to:

1. Accredited universities and colleges including junior and community colleges, school districts, and private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private Postsecondary and Vocational Education.

2. Medical training units of a branch of the Armed Forces of the United States including the Coast Guard of the United States.
3. Licensed general acute care hospitals which meet the following criteria:
   a. Hold a special permit to operate a Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Title 22, Division 5 of the California Code of Regulations; and
   b. Provide continuing education to other healthcare professionals.
4. Agencies of government, including public safety agencies.
5. Local EMS Agencies

IV. PROCEDURE for EMT Training Program Approval:

A. The Ventura County EMS Agency shall review and approve the following prior to approving an EMT training program:
1. A table of contents listing the required information detailed below, with corresponding page/section numbers
2. A written request for training program approval, signed by the training program director.
3. A statement verifying usage of the US Department of Transportation (DOT) National EMS Education Standards (DOT HS 811 077A, January 2009).
4. A statement verifying program meets or exceeds required course hours outlined in Section IV.C.1 of this policy and meets all content requirements outlined in section 100075 of the California Code of Regulations
5. Statement signed by training program director that all psychomotor skills outlined in Attachment A of this policy shall be taught, and that all students enrolled in course have been given multiple opportunities to practice required skills in person.
6. A statement verifying CPR training equivalent to the current American Heart Association's Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care at the Healthcare Provider level is a prerequisite for admission to an EMT basic course
7. Session guides and lesson plans for course(s) taught by program
8. Samples of cognitive (written) and psychomotor skills examinations used for periodic testing

9. Statement verifying that training program meets psychomotor skills testing requirements, and that all skills listed on the California EMS Authority's Skills Competency Verification Form (EMSA-SCV) are included in the testing.
10. Copies of checklists and/or verification documents used for final psychomotor skills competency exam.
11. A final cognitive (written) examination
12. Statement signed by training program director that a comprehensive performance improvement plan will be required when program performance falls below 3-year average of 80% on 1st pass rate for NREMT cognitive (written) examination.
13. The name and qualifications of the EMT training program director, program clinical coordinator, and principal instructor(s)
14. Provisions for clinical experienced, as defined in Section IV.D of this policy
15. Provisions for course completion by challenge, including a challenge examination (if different from the final examination)
16. Provisions for a twenty-four (24) hour refresher course including items 1-6 detailed above, required for recertification
    a. A statement verifying usage of the United States Department of Transportation's EMT-Basic Refresher National Standard Curriculum, DOT HS 808 624, September 1996. The U.S. Department of Transportation's EMT-Basic Refresher National Standard Curriculum can be accessed through the U.S. Department of Transportation's website, http://www.nhtsa.gov/people/injury/ems/pub/basicref.pdf.
17. Statement signed by training program director that an annual report shall be submitted within 45 days of year end. Report shall contain minimum content as outlined in Section IV.L.6 of this policy.
18. The location at which the courses are to be offered and their proposed dates and times for each class

B. The Ventura County EMS Agency shall provide, upon request by the California EMS Authority, any or all materials submitted by an EMT training program pursuant to the requirements of this policy for the purposes of assuring all applicable sections of the California Health and Safety Code and/or California Code of Regulations are being met.

C. Didactic and Psychomotor Skills Laboratory

1. An approved EMT training program shall assure that no more than ten (10) students are assigned to one (1) principal instructor/teaching assistant during psychomotor skills practice/laboratory sessions.

D. Clinical Experience for EMT

1. Each approved EMT training program shall have written agreement(s) with one or more general acute care hospital(s) and/or operational ambulance provider(s) or rescue vehicle provider(s) for the clinical portion of the EMT training course. The written agreement (s) shall specify the roles and responsibilities of the training program and the clinical provider(s) for supplying the supervised clinical experience for the EMT student(s).
   a. Supervision for the clinical experience shall be provided by an individual who meets the qualifications of a principal instructor or teaching assistant.
   b. No more than three (3) students will be assigned to one (1) qualified supervisor during the supervised clinical experience.

E. Teaching Staff

1. Each EMT training program shall provide for the functions of administrative direction, medical quality coordination, and actual program instruction. Nothing in this policy precludes the same individual from being responsible for more than one of the functions outlined below.
2. Program Director
   a. Each EMT training program shall have an approved program director who shall be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction. Examples of 40 hours of instruction in teaching methodology include, but are not limited to the following:
      1) Four (4) semester units of upper division credit in educational materials, methods, and curriculum development or equivalent; OR,
      2) California State Fire Marshall (CSFM) Instructor I and II; OR,
      3) National Fire Academy's (NFA) Fire Instructional Methodology Course; OR,
      4) National Association of EMS Educators (NAEMSE) Level I Instructor Course.
   b. Duties of the program director, in coordination with the program clinical coordinator, shall include but not be limited to the following:

1) Administering the training program
2) Approving course content
3) Approving all written examinations and the final skills examination
4) Coordinating all clinical and field activities related to the course
5) Approving the principal instructor(s) and teaching assistants
6) Signing all course completion records
7) Assuring that all aspects of the EMT training program are in compliance with this chapter and other related laws
8) Serving as the primary point of contact between the training program and the Ventura County EMS Agency

3. Clinical Coordinator
   a. Each training program shall have an approved program clinical coordinator who shall be either a Physician, Registered Nurse, Physician Assistant, or a Paramedic currently licensed in California, and who shall have two (2) years of academic or clinical experience in emergency medicine or prehospital care in the last five (5) years. Duties of the program clinical coordinator shall include, but not be limited to:
      1) Responsibility for the overall quality of medical content of the program
      2) Approval of the qualifications of the principal instructor(s) and teaching assistant(s)
4. Principal Instructor(s)
   a. Each training program shall have a principal instructor(s), who may also be the program clinical coordinator or program director, who shall be qualified by education and experience with at least forty (40) hours of documented teaching methodology instruction in areas related to methods, materials, and evaluation of instruction and shall meet the following qualifications:
      1) Be a Physician, Registered Nurse, Physician Assistant, or Paramedic currently licensed in California; or,
      2) Be an Advanced EMT or EMT who is currently certified in California.
      3) Have at least two (2) years of academic or clinical experience in the practice of emergency medicine or prehospital care in the last five (5) years.
      4) Be approved by the program director in coordination with the program clinical coordinator as qualified to teach the topics to which s/he is

assigned. All principal instructors from approved EMT training programs shall meet the minimum qualifications as specific above.

b. Examples of 40 hours of instruction in teaching methodology include, but are not limited to the following:
   1) Four (4) semester units of upper division credit in educational materials, methods, and curriculum development or equivalent; OR,
   2) California State Fire Marshall (CSFM) Instructor I and II; OR,
   3) National Fire Academy's (NFA) Fire Instructional Methodology Course; OR,
   4) National Association of EMS Educators (NAEMSE) Level I Instructor Course.

5. Teaching Assistant(s)
   a. Each training program may have teaching assistant(s) who shall be qualified by training and experience to assist with teaching of the course and shall be approved by the program director in coordination with the program clinical coordinator as qualified to assist in teaching the topics to which the assistant is to be assigned. A teaching assistant shall be supervised by a principal instructor, the program director and/or the program clinical coordinator.

F. Components of an Approved Program
   1. An approved EMT training program shall consist of the following:
      a. The EMT course, including clinical experience;
      b. Periodic and final written and psychomotor skills competency examinations to include all skills listed in section IV.H.3 of this policy;
      c. A challenge examination;
      d. A refresher course required for renewal or reinstatement.
   2. Ventura County EMS Agency may approve a training program that only offers refresher course(s).

G. EMT Training Program Required Course Hours
   1. The EMT course shall consist of not less than one hundred seventy (170) hours. These training hours shall be divided into:
      a. A minimum of one hundred forty-six (146) hours of didactic instruction and psychomotor skills laboratory; and
      b. A minimum of twenty-four (24) hours of supervised clinical experience. The clinical experience shall include a minimum of ten (10) documented patient

contacts wherein a patient assessment and other EMT skills are performed and evaluated.

1) High fidelity simulation, when available, may replace up to six (6) hours of supervised clinical experience and may replace up to three (3) documented patient contacts

c. The minimum hours shall not include the NREMT cognitive and/or the psychomotor skills examinations for EMT certification.

H. Required Course Content

1. The content of an EMT course shall meet all of the objectives contained in the U.S. current Department of Transportation (DOT) National EMS Education Standards;
2. In addition to National EMS Education Standards, EMT course shall meet all requirements outlined in California Code of Regulations, Title 22, Chapter 2, Section 100075.
3. Students shall be given multiple opportunities to practice all skills included in the National EMS education standards, as well as any additional skills outlined in Sections 100063 and 100075 of the California Code of Regulations. These specific skills requirements can be found at the following web addresses

   Section 100063
   https://govt.westlaw.com/calregs/Document/I0913119B5B6211EC9451000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

   Section 100075
   https://govt.westlaw.com/calregs/Document/I09A036675B6211EC9451000D3A7C4BC3?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

   a. Simulated or virtual experiences related to psychomotor skills practice will not be permitted, unless specifically granted under special provision or directives issued by the Ventura County EMS Agency and/or the California EMS Authority.

As part of the provision of four (4) hours of tactical casualty care, students shall participate in a hands-on drill or live exercise that allows the practical application of skills and concepts related to the content4. All applicants shall

complete Incident Command System (ICS) 100 and 700 training prior to completion of the course.

I. Required Testing

1. EMT training program shall include periodic and final competency-based examinations to test the knowledge and psychomotor skills specified in Section 100075 of the California Code of Regulations, and in the National EMS Education Standards.
2. Satisfactory performance in these written and skills examinations shall be demonstrated for successful completion of the course.
3. Satisfactory performance shall be determined by preestablished standards, developed by the training program director and clinical coordinator, and approved by the Ventura County EMS Agency at the time of program approval / re-approval.
4. The final psychomotor skills exam shall include, at a minimum, all skills listed on the current version of the California EMS Authority's Skills Competency Verification form, EMSA-SCV.

J. EMT Training Program Course Completion Record

1. An approved EMT training program shall issue a tamper resistant course completion record to each person who has successfully completed the EMT course, refresher course, or challenge examination.
2. The course completion record shall contain the following information:
   a. The name of the individual.
   b. The date of the course completion.
   c. Type of EMT course completed (i.e. EMT, refresher, or challenge), and the number of hours completed
   d. The signature of the training program director
   e. The name and location of the training program issuing the record
   f. Statement: "This EMT training program has been approved by the Ventura County EMS Agency"
   g. Statement in bold and capitalized print: "THIS IS NOT AN EMT CERTIFICATE"

h. Statement: This program includes required didactic and psychomotor skills training in Epinephrine, Glucometer, Naloxone, and four hours of Basic Tactical Casualty Care".

3. Within fifteen (15) days of course completion, each program shall submit the VCEMSA EMT Course Completion Roster that is attached to this policy. Students will not be processed for certification until the course completion roster is received by VCEMS.

K. EMT Training Program Course Completion Challenge Process

1. An approved EMT training program shall have a defined process for any EMT challenge request/application, and shall offer the EMT challenge psychomotor skills and cognitive examination in conjunction with regularly scheduled testing periods.
2. EMT course completion eligibility and challenge process shall be carried out in accordance with VCEMS Policy 304 – EMT Course Completion by Challenge Examination

L. EMT Training Program Review and Reporting

1. All program materials specified in this policy and in applicable Sections of the California Code of Regulations shall be subject to periodic review by the Ventura County EMS Agency.
2. All programs shall be subject to periodic on-site (announced and/or unannounced) evaluation by the Ventura County EMS Agency
3. EMT training program shall submit a schedule of psychomotor skills labs for each scheduled course (hybrid and/or traditional programs) that includes dates and list of psychomotor skills that are scheduled to be practiced on each date.
4. In the event that an approved EMT training program wishes to add a course to the schedule, notification shall be submitted in writing to the Ventura County EMS Agency no less than sixty (60) calendar days prior to the proposed start date.
5. The EMT training program shall notify the Ventura County EMS Agency in writing, in advance when possible, and in all cases within thirty (30) calendar days of any change in the following:

   a. Program director
   b. Clinical coordinator
   c. Principal instructor(s)
   d. Change of address, phone number or primary point of contact
   e. Change in course content or course hours of instruction
6. The EMT training program shall submit an annual report to the Ventura County EMS Agency within 45 days of year end. At minimum, this report shall be comprised of the following:
   a. Any changes to course content for the coming year. This does not replace the requirement outlined in Section IV.L.5 of this policy
   b. Changes to any teaching staff and/or program leadership. This does not replace the requirement outlined in Section IV.L.5 of this policy
   c. A listing of course dates and locations for the coming year.
   d. The number of students that successfully completed the program (broken down by term) versus number of students originally enrolled for the same period of time.

M. Quality Assurance and Improvement
   1. At the time of approval and subsequent application for program re-approval, each EMT training program shall submit a comprehensive quality assurance and improvement plan that, at a minimum, addresses the following:
      a. Methods of student remediation
      b. Methods of student evaluation in demonstrating competency in both cognitive concepts and practical application of psychomotor skills.
      c. A plan for continuous review and update of examinations and student materials
      d. Identifies the text and resource materials that will be utilized by the program
      e. Samples of student course evaluations
   2. Any program that fails to maintain a three-year average cumulative pass rate of at least 80% within three attempts on the NREMT cognitive examination shall submit a comprehensive improvement plan to the Ventura

County EMS Agency that outlines necessary steps to achieve the desired benchmark.

a. Data from the National Registry of EMTs will be pulled by the Ventura County EMS Agency on a quarterly basis and shared with EMT programs and with members of the Prehospital Services Committee

N. Withdrawal of EMT Training Program Approval

1. Failure to comply with the provisions of this policy may result in the denial, suspension, or revocation of EMT training program approval by the Ventura County EMS Agency

2. The requirements for training program noncompliance notification and actions are as follows:

   a. The Ventura County EMS Agency shall provide notification of noncompliance with the requirements of this policy and/or the regulations outlined in applicable sections of the California Code of Regulations. The notification shall be in writing and will be sent by certified mail to the EMT training program director.

   b. Within fifteen (15) working days from receipt of the noncompliance notification the approved EMT training program shall submit in writing, by certified mail, to the Ventura County EMS Agency on of the following:

      1) Evidence of compliance with the provisions of this policy and applicable sections of the California Code of Regulations

      2) A plan to comply with the provisions of this policy and applicable sections of the California Code of Regulations within sixty (60) calendar days from the day of receipt of the notification of noncompliance.

   c. Within fifteen (15) working days from receipt of the EMT training program's response, or within thirty (30) calendar days from the mailing date of the noncompliance notification if no response is received from the EMT training program, the Ventura County EMS Agency shall issue a decision letter by certified mail to the California EMS Authority and the EMT training program. The letter shall identify the Ventura County EMS Agency’s decision to take one or more of the following actions:

1) Accept the evidence of compliance provided.
2) Accept the plan for meeting compliance.
3) Place the program on probation.
4) Suspend or revoke the EMT training program approval.

d. The decision letter shall also include, but not be limited to, the following:
   1) The date of the Ventura County EMS Agency's decision;
   2) Specific provisions found noncompliant by the training program approving authority, if applicable;
   3) The probation or suspension effective and ending date, if applicable;
   4) The terms and conditions of the probation or suspension, if applicable; and
   5) The revocation effective date, if applicable.

e. If the EMT training program found noncompliant with the requirements of this policy, or with applicable sections of the California Code of Regulations does not comply with subsection b outlined above, the Ventura County EMS Agency may uphold the noncompliance finding and initiate a probation, suspension, or revocation action as described above.

f. The Ventura County EMS Agency shall establish the probation, suspension, or revocation effective dates no sooner than sixty (60) days after the date of the decision letter, as described above.

Ventura County Emergency Medical Services Agency
Emergency Medical Technician Training Program

Application Checklist

Sections 1-4 to be completed by training program

For additional information on requirements and approval process, please refer to VCEMS Policy 1100 – EMT Training Program Approval

<table>
<tr><td colspan="3">1. General Information</td></tr>
<tr><td colspan="3">Training Program Name:</td></tr>
<tr><td>Program Address</td><td>Program City</td><td>Program Zip</td></tr>
<tr><td>Program Phone Number</td><td>Program Fax Number</td><td>Program Email Address</td></tr>
<tr><td colspan="3">2. Training Program Affiliation</td></tr>
<tr><td colspan="2">a. Training program is affiliated with a:
☐ Accredited University or College
☐ Junior or Community College
☐ School District
☐ Private Post-Secondary School
(Submit Post-Secondary School Approval Document)
☐ Armed Forces Medical Unit
☐ Licensed Acute Care Hospital
(Submit special permit for Basic or Comprehensive Emergency Medical Services and proof of provision of Continuing Education to other Health Care Professionals)
☐ Agency of Government
☐ Public Safety Agency</td><td>Name of Affiliated Agency, Institution, or Business</td></tr>
<tr><td colspan="3">3. Program Administration and Staff</td></tr>
<tr><td colspan="2">a. Program Director
☐ Documentation of education and experience in methods, materials and evaluation of instruction by at least 40 hours in teaching methodology received (see policy section IV.A.2.g.1 for examples of qualifying education)</td><td>Name of Program Director</td></tr>
<tr><td colspan="2">b. Clinical Coordinator
☐ Copy of Current License Received
☐ Documentation of Academic and/or Clinical Experience (2 years in last 5 years) received</td><td>Name and Title of Clinical Coordinator (Physician, RN, PA, Paramedic)</td></tr>
<tr><td colspan="2">c. Principal Instructor(s)
☐ Copy of Current License(s) Received
☐ Documentation of education and experience in methods, materials and evaluation of instruction by at least 40 hours in teaching methodology received (see policy section III.A.2.g.3 for examples of qualifying education)
☐ Documentation of Academic and/or Clinical Experience (2 years in last 5 years) received
☐ Approval by the program director in coordination with the program clinical coordinator as qualified to teach the topics to which s/he is assigned.</td><td>Name(s) and Title(s) of Principal Instructor(s)
(Physician, RN, PA, Paramedic, Advanced EMT, EMT)</td></tr>
<tr><td colspan="2">d. Teaching Assistant(s)
☐ Copy of current license(s) received (if applicable)
☐ Qualified by training and experience to assists with teaching
☐ Approval by program director in coordination with the clinical coordinator</td><td>Names(s) and Title(s) of Teaching Assistant(s)</td></tr>
<tr><td colspan="3">4. Program Representative Completing Application</td></tr>
<tr><td colspan="3">Name of Program Representative Completing Application</td></tr>
<tr><td colspan="2">Signature</td><td>Date</td></tr>
<tr><td colspan="2">Phone Number</td><td>Email Address</td></tr>
</table>

VCEMS Office Use Only

1. Submission Checklist	
Required Item	**Date Received**
☐ Written request for program approval, signed by training program director.	
☐ Statement verifying use of the US DOT National EMS Education Standards (DOT HS 811 077A, January 2009) ☐ Statement verifying program meets or exceeds required course hours outlined in Section IV.C.1 of this policy and meets all content requirements outlined in section 100075 of the California Code of Regulations	
☐ Statement signed by training program director that all psychomotor skills outlined in CCR Sections 100063 and 100075 and any others listed in this policy shall be taught, and that all students enrolled in course have been given multiple opportunities to practice required skills in person.	
☐ Statement verifying implementation of current ECC / ILCOR guidelines	
☐ Session guides and/or lesson plans	
☐ Samples of psychomotor skills and cognitive (written) exams used for periodic testing	
☐ Statement verifying that training program meets psychomotor skills testing requirements, and that all skills listed on the California EMS Authority's Skills Competency Verification Form (EMSA-SCV) are included in the testing. ☐ Copies of checklists and/or verification documents used for final psychomotor skills competency exam.	
☐ Final cognitive (written) exam	
☐ Statement signed by training program director that a comprehensive performance improvement plan will be required when program fails to maintain a three-year average cumulative pass rate of at least 80% within three attempts on the NREMT cognitive examination	
☐ Detail of provisions for course completion by challenge, including a challenge examination (if different from final course examination).	
☐ Provisions for refresher course and/or continuing education	
☐ Statement signed by training program director that an annual report shall be submitted within 45 days of year end. Report shall contain minimum content as outlined in Section IV.L.6 of this policy.	
☐ Location and proposed dates at which the course(s) are to be offered	

2. Application Status	
Initial Application Received	Date
Additional Information Requested	Date
All Requirements Submitted	Date
Approval Letter Issued	Date
Approval Expiration	Date
EMS Agency Representative Information	
Name of EMS Agency Representative Reviewing Application	
Signature	Date
Phone Number	Email Address

Ventura County Emergency Medical Services Agency
Emergency Medical Responder Training Program

Application Checklist

Sections 1-4 to be completed by training program

For additional information on requirements and approval process, please refer to VCEMS Policy 1102 – EMR Training Program Approval

<table>
<tr><th colspan="3">1. General Information</th></tr>
<tr><td colspan="3">Training Program Name:</td></tr>
<tr><td>Program Address</td><td>Program City</td><td>Program Zip</td></tr>
<tr><td>Program Phone Number</td><td>Program Fax Number</td><td>Program Email Address</td></tr>
</table>

<table>
<tr><th colspan="2">2. Training Program Affiliation</th></tr>
<tr><td>a. Training program is affiliated with a:
☐ Accredited University or College
☐ Junior or Community College
☐ School District
☐ Private Post-Secondary School
(Submit Post-Secondary School Approval Document)
☐ Armed Forces Medical Unit
☐ Licensed Acute Care Hospital
(Submit special permit for Basic or Comprehensive Emergency Medical Services and proof of provision of Continuing Education to other Health Care Professionals)
☐ Agency of Government
☐ Public Safety Agency
☐ Local EMS Agency</td><td>Name of Affiliated Agency, Institution, or Business</td></tr>
<tr><th colspan="2">3. Program Administration and Staff</th></tr>
<tr><td>a. Program Director
☐ Documentation of education and experience in methods, materials and evaluation of instruction which shall be documented by at least forty (40) hours in adult teaching methodology or a k-12 teaching credential.</td><td>Name of Program Director</td></tr>
<tr><td>b. Principal Instructor(s)
☐ Copy of Current License(s) Received
☐ Documentation of education and experience in methods, materials and evaluation of instruction by at least 40 hours in teaching methodology received (see policy section III.A.2.g.3 for examples of qualifying education)
☐ Documentation of Academic and/or Clinical Experience (2 years in last 5 years) received
☐ Approval by the program director in coordination with the program clinical coordinator as qualified to teach the topics to which s/he is assigned.</td><td>Name(s) and Title(s) of Principal Instructor(s)
(MD, RN, PA, Paramedic, Advanced EMT, EMT)</td></tr>
</table>

Checklist Continued on Next Page

c. Teaching Assistant(s)	Names(s) and Title(s) of Teaching Assistant(s)
☐ Copy of current license(s) received (if applicable) ☐ Qualified by training and experience to assists with teaching ☐ Approval by program director in coordination with the clinical coordinator	

4. Program Representative Completing Application	
Name of Program Representative Completing Application	
Signature	Date
Phone Number	Email Address

VCEMS Office Use Only

1. Submission Checklist	
Required Item	**Date Received**
☐ Written request for program approval	
☐ A statement verifying usage of the US DOT National Highway Traffic Safety Administration (NHTSA) National EMS Education Standards: Emergency Medical Responder Instructional Guidelines, DOT HS 811 077B, January 2009	
☐ Statement verifying implementation of current ECC / ILCOR guidelines	
☐ Session guides and/or lesson plans	
☐ Samples of skills and written exams used for periodic testing	
☐ Final psychomotor skills competency exam	
☐ Final cognitive (written) exam	
☐ Location and proposed dates at which the course(s) are to be offered	

2. Application Status	
Initial Application Received	Date
Additional Information Requested	Date
All Requirements Submitted	Date
Approval Letter Issued	Date
Approval Expiration	Date

3. EMS Agency Representative Information	
Name of EMS Agency Representative Reviewing Application	
Signature	Date
Phone Number	Email Address

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Emergency Medical Responder (EMR) Training Program Approval	Policy Number 1102
APPROVED: Administration: Steve L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director: Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: April 13, 2017 Date Revised: May 11, 2017 Date Last Reviewed: September 8, 2022 Review Date: September 30, 2025	Effective Date: January 3, 2023

I. PURPOSE: As the Ventura County EMS Agency has primary responsibility for approving and monitoring the performance of EMR training programs located with the County of Ventura, this policy has been established to outline the process for approval of Emergency Medical Responder training programs to ensure their compliance with local policy, as well as national standards and guidelines.

II. AUTHORITY: California Health and Safety Code, Title 22, Division 2.5, Sections 1797.204, 1797.210, and 1797.212; California Code of Regulations, Title 22, Division 9, Chapter 1.5, Section 100026

III. POLICY: The approving authority for Emergency Medical Responder (EMR) training programs operating within the County of Ventura will be the Ventura County EMS Agency (VCEMSA). This does not apply to statewide public safety agencies such as California Highway Patrol, California State Parks, etc.

A. Programs eligible for program approval shall be limited to:

1. Accredited universities and colleges including junior and community colleges, school districts, or private post-secondary schools as approved by the State of California, Department of Consumer Affairs, Bureau of Private Postsecondary and Vocational Education
2. Medical training units of a branch of the Armed Forces of the United States including the Coast Guard.
3. Licensed general acute care hospitals which meet the following criteria:
   a. Hold a special permit to operate a Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Division 5; and
   b. Provide continuing education to other healthcare professionals.
4. Agencies of government
5. Public safety agencies

6. Local EMS Agencies

IV. PROCEDURE:

A. Program Approval

1. Eligible training programs shall submit a written request for EMR program approval to VCEMSA.
2. VCEMSA shall review and approve the following prior to approving an EMR training program.
   a. A statement verifying usage of the United States Department of Transportation's (US DOT) National Highway Traffic Safety Administration (NHTSA) National Emergency Medical Services Education Standards: Emergency Medical Responder Instructional Guidelines, DOT HS 811 077B, January 2009, which includes learning objectives, skills protocols, and treatment guidelines. (Available at http://www.ems.gov/pdf/811077b.pdf).
   b. A statement verifying CPR training equivalent to the current Emergency Cardiovascular Care guidelines.
   c. Samples of lesson plans including:
      1) At least two lecture or didactic sessions, and
      2) At least two practical (skills or psychomotor) sessions.
   d. Samples of periodic examinations or assessments including:
      1) At least two written examinations or quizzes.
      2) Statement of utilization of the National Registry EMR Skills Check-Off Sheets
   e. A final psychomotor skills competency examination
   f. A final cognitive (written) examination
   g. Educational Staff:

      Each EMR training program shall provide for the functions of administrative direction, medical quality coordination, and actual program instruction. Nothing in this section precludes the same individual from being responsible for more than one of the following functions if so qualified by the provisions of this section.

      1) Program Director:

         Each EMR training program shall have an approved program director who shall be qualified by education and experience in methods, materials and evaluation of instruction which shall be

documented by at least forty (40) hours in adult teaching methodology or a k-12 teaching credential. Duties of the Program Director shall include but not be limited to:

a) Administering the training program
b) Approving course content
c) Approving all written examinations and the final skills examination.
d) Approving the principal instructor(s) and teaching assistant(s).
e) Signing all course completion records.
f) Assuring that all aspects of the EMR training program are in compliance with applicable California Code of Regulations, local VCEMS policies and procedures and any other applicable regulations, guidelines, or laws.

2) Principal Instructor:

Each training program shall have principal instructor(s), who may also be the program director, who shall be qualified by education and experience with at least forty (40) hours of documented adult teaching methodology instruction or a k-12 teaching credential and shall meet the following qualifications:

a) Be a Physician, Registered Nurse, Physician Assistant or Paramedic licensed in California; or,
b) Be an EMT, Advanced EMT, who is currently certified in California.
c) Have at least two (2) years of academic or clinical experience in the practice of emergency medicine or prehospital care in the last five (5) years.
d) Be approved by the program director as qualified to teach the topics to which s/he is assigned.
e) All principal instructors from an approved EMR training programs shall meet the minimum qualifications outlined in this policy.

3) Teaching Assistants

Each training program may have teaching assistants who shall be qualified by training and experience to assist with teaching of the course and shall be approved by the program director as qualified to assist in teaching the topics to which the assistant is to be assigned. A teaching assistant shall be supervised by a principal instructor and the program director.

k. Course Location, Time, and Instructor Ratios
   1) Each EMR Training Program shall submit an annual listing of course dates and locations.
   2) In the event that an approved EMR Training Program wishes to add a course to the schedule, notification must be received in writing by VCEMSA no less than sixty days prior to the proposed start date.
   3) No greater than ten students shall be assigned to one instructor during the practical portion of course.

l. A table of contents listing the required information detailed in this policy with corresponding page numbers

m. Facilities and Equipment
   1) Facilities must comfortably accommodate all students, including those with disabilities.
   2) Restroom access must be available.
   3) Must permit psychomotor skills testing so that smaller break-out groups are isolated from one another.
   4) Training equipment and supply shall be modern and up to date as accepted by the industry and shall be maintained and/or replaced as necessary.

n. Quality Assurance and Improvement
   1) Each program shall submit a Quality Assurance and Improvement Plan that addresses the following:
      a) Methods of student remediation.
      b) A plan for continuous update of examinations and student materials.
      c) Identify the text and resource materials that will be utilized by the program.

d) Student course evaluations

o. Research Agreement Decree

1) Each approved training program shall provide a statement agreeing to participate in research data accumulation. This information shall be utilized to enhance the emergency medical services systems in Ventura County.

3. Program Approval Time Frames

a. Upon receipt of a complete application packet, VCEMS shall notify the training program submitting its request for training program approval within seven (7) working days of receiving the request that:

1) The request for approval has been received,

2) The request does or does not contain all required information, and

3) What information, if any, is missing from the request.

b. Program approval or disapproval shall be made in writing by VCEMS to the requesting training program, within a reasonable period of time, after receipt of all required documentation, not to exceed three (3) months.

c. VCEMS shall establish an effective date of program approval in writing upon the satisfactory documentation of compliance with all program requirements.

d. Program approval shall be for four (4) years following the effective date of program approval and may be renewed every four (4) years subject to the procedure for program approval specified by VCEMS in this policy.

4. Withdrawal of Program Approval

Noncompliance with any criterion required for EMR training program approval, use of any unqualified personnel, or noncompliance with any other applicable regulation, guidelines or laws may result in suspension or revocation of program approval by VCEMS. Notification of noncompliance and action to place on probation, suspend, or revoke shall be done as follows:

a. VCEMS shall notify the EMR training program director in writing, by registered mail, of the provisions of this policy with which the EMR training program is not in compliance.

b. Within fifteen (15) working days of receipt of the notification of noncompliance, the approved EMR training program shall submit in writing, by registered mail, to VCEMS one of the following:

1) Evidence of compliance with the provisions outlined in this policy, or

2) A plan for meeting compliance with the provisions outlined in this policy within sixty (60) calendar days from the day of receipt of the notification of noncompliance.

c. Within fifteen (15) working days of the receipt of the response from the approved EMR training program, or within thirty (30) calendar days from the mailing date of the noncompliance notification if no response is received from the approved EMR training program, VCEMS shall notify the approved EMR training program in writing, by registered mail, of the decision to accept the evidence of compliance, accept the plan for meeting compliance, place on probation, suspend or revoke the EMR training program approval.

d. If the EMR training program approving authority decides to suspend, revoke, or place an EMR training program on probation the notification specified in this policy shall include the beginning and ending dates of the probation or suspension and the terms and conditions for lifting the probation or suspension or the effective date of the revocation, which may not be less than sixty (60) days from the date of VCEMS' letter of decision to the EMR training program.

B. Program Review and Reporting

1. All program materials are subject to periodic review by VCEMSA.

2. All programs are subject to periodic on-site (scheduled or unscheduled) evaluation by VCEMSA.

3. VCEMSA shall be advised of any program changes in course content, hours of instruction, or instructional staff.

4. Approved programs shall issue a tamper resistant Course Completion Record to each student who successfully meets all requirements for certification. This Course Completion Record shall include:

a. The name of the individual

b. The date the course was completed

c. The name of the course completed "Emergency Medical Responder"

d. Number of hours of instruction completed.

e. The name and signature of the Program Director.

f. The name and location of the training program issuing the course completion.

g. The name of the approving authority (ie; Approved by the Ventura County EMS Agency)

h. The following statements in bold print:

1) "THIS IS NOT AN EMR CERTIFICATE"

2) This course completion record is valid to apply for certification up to a maximum of two years from the course completion date and shall be recognized statewide.

V. Each program shall submit the Agency provided Course Completion Roster no greater than fifteen (15) days following the completion of the program. This roster shall include the name and address of each person receiving a course completion record and the date of course completion.

I. PURPOSE: To identify the procedure for approval of Continuing Education Providers (CEP's) in Ventura County, both Advanced and Basic Life Support, in accordance with CCR, Title 22, Division 9, Chapter 11.

II. AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 11, Article 4.

III. POLICY:

A. The Approving Authority for Prehospital Continuing Education Providers (CEP's) shall be the Ventura County Emergency Medical Services Agency.

B. Programs eligible for approval shall be limited to public or private organizations that meet the requirements identified in this policy. All private entities must possess a valid business license and proof of organizational registry (partnership, sole proprietorship, corporation, etc).

IV. PROCEDURE:

A. Program Approval

1. Eligible programs shall submit a written request for CEP approval to the EMS Agency and agree to provide at least 12 hours of continuing education per year.

2. Applicant shall agree to participate in the VCEMS Quality Improvement Program and in research data accumulation.

3. Applicant shall agree to implement current American Heart Association ECC and CPR Guidelines.

4. Applicant shall submit resumes for the Program Director and the Clinical Director.

5. Educational Staff Requirements:

Nothing shall preclude one person from filling more than one position.

a. Program Director

1) Shall be qualified by education and experience in methods, materials and evaluation of instruction which shall be documented by at least forty hours in teaching methodology. The following are examples of courses that meet the required instruction in teaching methodology:
   a) California State Fire Marshal Fire Instructor 1-A, 1-B and 1-C, or;
   b) National Fire Academy "Fire Service Instructional Methodology" course or equivalent, or;
   c) Training programs that meet the US DOT/National Highway Traffic Safety Administration 2002 Guidelines for Educating EMS Instructors such as the National Association of EMS Educators Course.
   d) Individuals with equivalent experience may be provisionally approved for up to two years by the Agency pending completion of the above specified requirements.

b. Clinical Director
   1) Must be either a physician, registered nurse, physician assistant, or paramedic currently licensed in California and shall have two years of academic, administrative or clinical experience in emergency medicine or prehospital care in the last five years.

c. CE Provider Instructors
   1) Each CE provider instructor shall be approved by the program director and clinical director as qualified to teach the topics assigned, or have evidence of specialized training which may include, but is not limited to, a certificate of training or an advanced degree in a given subject area, or have at least one year of experience within the last two years in the specialized area in which they are teaching, or be knowledgeable, skillful and current in the subject matter of the course, class or activity.

6. Application Receipt Process

Upon receipt of a complete application packet, the Agency will notify the applicant within fourteen business days that;

a. The request for approval has been received.
b. The request does or does not contain all required information.

c. What information, if any, is missing

7. Program Approval Time Frames

a. Program approval or disapproval shall be made in writing by the Agency to the requesting program, within sixty calendar days, after receipt of all required documentation.

b. The Agency shall establish an effective date for program approval in writing upon the satisfactory documentation of compliance with all program requirements.

c. Program approval shall be for four years following the effective date of the program and may be reviewed every four years subject to the procedure for program approval specified by the Agency.

8. Withdrawal of Program Approval

a. Noncompliance with any criterion required for program approval, use of any unqualified personnel, or noncompliance with any other applicable provision of Title 22 may result in suspension or revocation of program approval by the Agency.

b. An approved program shall have no more than sixty days to comply with corrections mandated by this policy.

B. Program Review and Reporting

1. All program materials are subject to periodic review by the Agency.

2. All programs are subject to periodic on-site evaluation by the Agency.

3. The Agency shall be advised of any program changes in course content, hours of instruction, or instructional staff.

4. Records shall be maintained by the CEP for four years and shall contain the following:

a. Complete outlines for each course given, including brief overview, instructional objectives, outline, evaluations, and record of participant performance;

b. Record of time, place, and date each course is given and number of CE hours granted;

c. A curriculum vitae or resume for each instructor;

d. A roster of course participants (instructor based courses must have course participants sign roster)

5. Approved programs shall issue a tamper resistant Course Completion Certificate to each student who attends a continuing education course within 30 days of completion. This certificate shall include:
    a. Student full legal name.
    b. Certificate or license number
    b. The date the course was completed
    c. The name of the course completed
    d. The name and signature of the Instructor or Program Director.
    e. The name and address of the CE Provider.
    f. Course completion document must contain the following statement with the appropriate information filled in. “This course has been approved for (number) of hours of continuing education by an approved California EMS CE Provider and was (check one) instructor based or non-instructor based.” It also must have your C.E. provider number on it.
    g. The following statement in bold print:
    "This document must be maintained for no less than four years"
6. For the initial six months of CE program approval, the CE Provider shall submit a lecture approval form to the EMS Agency prior to offering a course. After the initial six month period, the CE Provider shall approve and maintain their own records subject to review by the EMS Agency.
7. A Continuing Education Roster shall be completed for every course offered by the CEP. This roster shall be maintained by the CEP and subject to review by the Agency.

    However, a copy of the Continuing Education roster for all required Ventura County CE programs (EMS Update, Skills testing, etc) shall be submitted to the Agency immediately after the completion of the program.
8. Each CEP shall provide an annual report to the Agency, within 45 days of year end, detailing the names of the courses, times, number of hours awarded, and participants. A form will be provided by the EMS Agency.

C. Application for Renewal

1. The CEP shall submit an application for renewal at least sixty calendar days before the expiration date of their CE provider approval in order to maintain continuous approval.
2. All CE provider requirements shall be met and maintained for renewal as specified in VCEMS Policy 1130 and CCR, Title 22, Division 9, Chapter 11.

Ventura County Emergency Medical Services Agency Continuing Education Provider

APPROVAL REQUEST

General Information

Program/Agency Name:____

Address:________________________________ City:__________Zip:__________

Phone:_______________ Fax:______________ Email:______________________

Date Submitted:___________________ Status Requested: ☐ BLS ☐ ALS

Requirements
(All items below refer to Ventura County EMS Policy 1130 and Title 22 Regulations)

1. Program Eligibility

Eligible Programs • Programs eligible for approval shall be limited to public or private organizations that meet the requirements identified in this policy. All private entities must possess a valid business license and proof of organizational registry (partnership, sole proprietorship, corporation, etc)	**Name of Program**
Written request for CEP Approval	☐ Attached
Submit resumes for Program Director and Clinical Coordinator	☐ Attached
If you will be offering CPR, state what organization will provide certification (AHA or ARC)	☐ AHA ☐ ARC
Our organization verifies that we have implemented the current American Heart Association ECC and CPR Guidelines.	Signature:____________________

2. Program Administration and Staff

Program Director • Shall be qualified by education and experience in methods, materials and evaluation of instruction which shall be documented by at least forty hours in teaching methodology as described in Policy 1130, Section IV.A.5.a.1). • Include current CV, resume, and copies of certifications/licensures.	Name of Program Director:

Clinical Director • Two years experience in emergency medicine or prehospital care in the past five years. • Currently licensed CA MD, RN, PA, or paramedic. • Include current CV, resume, and copies of certifications/licensures.	Name of Clinical Director:
CE Provider Instructor(s) • Each CE provider instructor shall be approved by the program director and clinical director as qualified to teach the topics assigned, or have evidence of specialized training which may include, but is not limited to, a certificate of training or an advanced degree in a given subject area, or have at least one year of experience within the last two years in the specialized area in which they are teaching, or be knowledgeable, skillful and current in the subject matter of the course, class or activity.	Name(s) of CE Provider Instructor(s):

3. CE Records and Quality Improvement

Agree to maintain all continuing education records for a minimum of four years.	Signature:________________________
Agree to participate in the VCEMS Quality Improvement Program and in research data accumulation.	Signature:________________________
Course Completion Certificate/Record • Provide a copy of the Course Completion Certificate/Record that will be issued upon completion of each session. Course completion shall state whether the course was instructor or nor instructor based.	□ Attached

VCEMS Office Use Only

All Requirements Submitted:		Date:
CEP Application Approved:		Date:
Approval Letter Sent:		Date:
Re-Approval Due:		Date:
Signature of person approving CEP		Date
Typed or printed name		

I. PURPOSE: To define the use of a continuing education attendance roster by continuing education provider programs approved by the Ventura County EMS Agency (VCEMS).

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

II. POLICY: A continuing education attendance roster shall be completed for all approved lectures or field care audits. In addition, the approved electronic CE roster issued by VCEMS will be utilized for continuing education that is required for prehospital personnel, including Mobile Intensive Care Nurses (MICNs).

III. PROCEDURE:

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

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

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

7. Continuing education provider number

B. Mandatory Education

1. The MICN, ’Paramedic or EMT name, employer, and certification number will be entered on the attendance roster by each MICN/ Paramedic or EMT. Each MICN, Paramedic or EMT shall sign his/her name.2.

The VCEMS approved electronic CE roster shall be utilized for all CE that is required for prehospital personnel to attend, as outlined in VCEMS Policy 334 – Mandatory Education Requirements.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Continuing Education for EMS Personnel		Policy Number 1133
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	January 11, 2018 October 13, 2022 October 13, 2022 October 31, 2025	Effective Date: January 3, 2023

I. PURPOSE: To identify acceptable continuing education topics for prehospital providers, in addition to outlining acceptable delivery formats and limitations related to continuing education.

II. AUTHORITY: California Health and Safety Code – Title 22, Division 2.5, Sections 1797 – 1979.207; California Code of Regulations – Title 22, Division 9, Chapter 11.

III. DEFINITIONS:

EMS Continuing Education Provider: EMS Continuing Education Provider means an individual or organization approved by the requirements of VCEMS Policy 1130 – Continuing Education Provider Approval to conduct continuing education courses, classes, activities or experiences and issue earned continuing education hours to EMS Personnel for the purposes of maintaining certification/licensure or re-establishing lapsed certification or licensure.

Continuing Education (CE): A course, class, activity, or experience designed to be educational in nature, with learning objectives and performance evaluations for the purpose of providing EMS personnel with reinforcement of basic EMS training as well as knowledge to enhance individual and system proficiency in the practice of pre-hospital emergency medical care.

Continuing Education Unit (CEU): Shall be any one of the following:

1. Every fifty minutes of approved classroom or skills laboratory activity.
2. Each hour of structured clinical or field experience when monitored by a preceptor assigned by an EMS training program, EMS service provider, or receiving/base hospital.
3. Each hour of media based / serial production CE as approved by VCEMS

IV. POLICY:

A. CE Provider Approving Authority

1. VCEMS shall be the agency responsible for approving EMS Continuing Education Providers whose headquarters are located within the County of Ventura, if not otherwise approved by an item listed below.
    a. Courses and/or CE providers approved by the Commission on Accreditation for Prehospital Continuing Education (formerly CECBEMS) or approved by EMS offices of other states are approved for use in California and need no further approval.
    b. Courses in physical, social or behavioral sciences (e.g., anatomy, physiology, sociology, psychology) offered by accredited colleges and universities are approved for CE and need no further approval.
        1) Ten (10) CEHs will be awarded for each academic quarter unit
        2) Fifteen (15) CEHs will be awarded for each academic semester unit
        3) Unofficial transcripts from the accredited college / university shall be the only method of verification when issuing CEH for these types of courses.
    c. The California EMS Authority shall be the agency responsible for approving CE providers for statewide public safety agencies and CE providers whose headquarters are located out-of-state if not otherwise approved according to one of the above items.

B. Continuing Education Topics
1. Continuing education for EMS personnel shall be in any of the topics contained in the respective National Standard Curricula for training EMS personnel, including advanced topics in subject matter outside the scope of practice of the certified or licensed EMS personnel but directly relevant to emergency medical care (e.g. surgical airway procedures).

C. Continuing Education Delivery Formats
1. Classroom - didactic and/or skills laboratory where direct interaction with instructor is possible.
2. Organized field care audits of base hospital communication and/or patient care records;
3. Courses offered by accredited universities and colleges, including junior and community colleges;
4. Structured clinical experience, with instructional objectives, to review or expand the clinical expertise of the individual.

5. Media based and/or serial productions (e.g. films, videos, audiotape programs, magazine articles offered for CE credit, home study, computer simulations or interactive computer modules).
6. Precepting EMS students or EMS personnel as a field preceptor or as a hospital clinical preceptor, as assigned by an approved EMS training program, an authorized EMS service provider, or as a receiving/base hospital that is approved as a continuing education provider, in accordance with VCEMS Policy 1130.
    a. CE for precepting can only be given for actual time precepting a student and must be issued by the EMS training program or EMS service provider that has an agreement or contract with the field preceptor or with the preceptor's employer.
    b. In order to issue CE for precepting EMS students or EMS personnel, an EMS service provider must be a CE provider approved in accordance with VCEMS Policy 1130.
7. Precepting EMS students or EMS personnel as a hospital clinical preceptor, as assigned by an EMS training program, an EMS service provider, or a receiving/base hospital that is approved as a CE provider program in accordance with VCEMS Policy 1130.
    a. In order to issue CE for precepting EMS students or EMS personnel, an EMS service provider, hospital or alternate base station must be a CE provider approved according to this Chapter.
    b. CE for precepting can only be given for actual time spent precepting a student or EMS personnel and must be issued by the EMS training program, EMS service provider, or receiving/base hospital that has an agreement or contract with the hospital clinical preceptor or with the preceptor's employer.

D. Limitations
1. CE courses shall not be approved for less than one hour of credit.
    a. For CE courses greater than one (1) CEH, credit may be granted in no less than half-hour increments.
2. No more than twelve (12) hours of continuing education, in any form, will be accepted within any twenty-four (24) hour period.

3. An individual may receive credit for taking the same CE course/class/activity no more than two times during a single certification or licensure cycle.
4. At least fifty percent of the required CE hours must be in a format that is instructor based, which means that instructor resources are readily available to the student to answer questions, provide feedback, provide clarification, and address concerns (e.g., on-line CE courses where an instructor is available to the student).
    a. This provision shall not include precepting or magazine articles for CE credit. VCEMS will determine whether a CE course, class or activity is instructor based.
5. During a certification or licensure cycle, an individual may receive credit, one time only, for service as a CE course/class/activity instructor.
    a. Credit received shall be the same as the number of CE hours applied to the course/class/activity.
6. During a certification or licensure cycle, an individual may receive credit, one time only, for service as an instructor for an approved EMT or paramedic training program
    a. The hours of service shall not exceed fifty percent of the total CE hours required in a single certification or licensure cycle.
7. When guided by the EMS service provider's quality improvement plan, an EMS service provider that is an approved CE provider may issue CE for skills competency demonstrations to address any deficiencies identified by the service provider.
    a. Skills competency demonstration shall be conducted in accordance with the respective National Standard Curriculum skills outline or in accordance with the policies and procedures of the VCEMS medical director.
8. If it is determined through a quality improvement plan that EMS personnel need remediation or refresher in an area of the individual's knowledge and/or skills, the VCEMS medical director or an EMS service provider may require the EMS personnel to take an approved CE course with learning objectives that addresses the remediation or refresher needed, as part of the individual's required hours of CE for maintaining certification or licensure.

9. Because paramedic license renewal applications are due to the California EMS Authority thirty days prior to the expiration date of a paramedic license, a continuing education course(s) taken in the last month of a paramedic's licensure cycle may be applied to the paramedic's subsequent licensure cycle, only if that CE course(s) was not already applied to the licensure cycle during which the CE course(s) was taken.
10. VCEMS shall not require additional continuing education hours for paramedic accreditation, beyond the state required minimum of forty-eight (48) hours.

E. Continuing Education Records

1. In order to receive credit, CE shall be completed during the current certification/licensure cycle, except as provided in Section IV.D.9 of this policy.
2. CE shall be valid for a maximum of two years prior to the date of a completed application for certificate/license renewal.
3. EMS personnel shall maintain for four years all CE certificates issued to them by any CE provider.
4. In order to verify the authenticity of continuing education certificates, or as part of a CE provider’s approval process, CE certificates may be audited by VCEMS.
5. Any/all continuing education records issued by a CE provider program shall meet the minimum requirements outlined in VCEMS Policy 1130.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Trauma Care System – General Provisions		Policy Number 1400
APPROVED: Administration:	Steven L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	July 1, 2010 July 8, 2020 June 30, 2022 June 30, 2024	Effective Date: January 3, 2023

I. PURPOSE: To provide standards and guidelines for the Ventura County Trauma Care System. To provide all injured patients the accessibility to an organized, multi-disciplinary and inclusive system of trauma care. To ensure that all injured patients are taken to the time-closest and most appropriate medical facility.

II. AUTHORITY: Health and Safety Code, §1797.160, §1797.161, and §1798, and California Code of Regulations, Title 22, §100255.

III. POLICY:

A. Multi-disciplinary Nature of Systematized Trauma Care

The Ventura County EMS Agency (VCEMS) recognizes the multi-disciplinary nature of a systemized approach to trauma care. VCEMS has adopted policies, guidelines and triage criteria that provide for the coordination of all resources and ensure the accessibility to the time-closest and most appropriate medical facility for all injured patients.

B. Public Information and Education

1. VCEMS is committed to the establishment of trauma system support and the promotion of injury prevention and safety education.
2. VCEMS facilitates speakers to address public groups, and serves as a resource for trauma information/education.
3. VCEMS assists community and professional groups in the development and dissemination of education to the public on such topics as injury prevention, safety education programs and access to the Trauma Care System.

4. Each designated facility must participate in the development of public awareness and education campaigns for their service area.

C. Marketing and Advertising

1. In accordance with the Health and Safety Code, Division 2.5, no healthcare provider shall use the term "trauma facility," "trauma hospital," "trauma center," "trauma care provider," "trauma care vehicle," or similar terminology in its signs or advertisements or in printed materials and information it furnishes to the general public unless its use has been authorized by VCEMS.
2. All marketing and promotional plans, with respect to trauma center designation shall be submitted to VCEMS for review and approval, prior to implementation. Such plans will be reviewed by VCEMS, with approval or denial issued within 10 days, based on the following guidelines:
    a. Shall provide accurate information
    b. Shall not include false claims
    c. Shall not be critical of other providers
    d. Shall not include financial inducements to any providers or third parties

D. Service Areas for Hospitals

Service areas for local trauma hospitals are determined by the VCEMS policy of transporting patients to the time-closest and appropriate facility.

E. EMS Dispatching

EMS dispatching for Ventura County is provided for and coordinated through the Ventura County Fire/EMS Communications Center. The closest ALS transporting unit to an incident is dispatched, as well as BLS, and in some cases ALS, first responders.

F. Training of EMS Personnel

1. Designated facilities will provide training to hospital staff on trauma system policies and procedures.
2. Base Hospitals conduct periodic classes to orient prehospital providers to the local EMS system. Representatives from a designated trauma center may present the orientation to the Ventura County trauma system.

G. Coordination and Mutual Aid between neighboring jurisdictions

1. VCEMS will establish and maintain reciprocity agreements with neighboring EMS jurisdictions that provide for the coordination of mutual aid within those jurisdictions.
2. VCEMS works cooperatively and executes agreements, as necessary, in order to ensure that patients are transported to the time-closest and appropriate facility.
3. VCEMS maintains contact with neighboring EMS agencies in order to monitor the status of trauma care systems in surrounding jurisdictions.

H. Interfacility Transfers
1. As an inclusive trauma system, all hospitals have a role in providing trauma care to injured patients.
2. Designated trauma centers are required to establish and maintain a transfer agreement with other trauma center(s) of higher designation for the transfer of patients that require a higher level of care.
3. Transferring facilities, in conjunction with the higher-level facility, shall be responsible for obtaining the appropriate level of transportation when transferring trauma patients.

I. Pediatric Trauma Care.

Integration of pediatric hospital (s), when applicable, into the overall trauma care system to ensure that all trauma patients receive appropriate trauma care in the most expeditious manner possible
1. Designated trauma centers are required to maintain a transfer agreement with a pediatric trauma center.
2. As with all specialties, pediatric consultation should be promptly available
3. The transferring facility, in conjunction with the higher-level facility, shall be responsible for obtaining the appropriate level of care during transport.

J. Coordinating and Integration of Trauma Care with Non-Medical Emergency Services
1. VCEMS ensures that all non-medical emergency service providers are apprised of trauma system activities, as it relates to their agency/organization.
2. Non-medical emergency service providers are included in the VCEMS committee memberships, as appropriate.

3. VCEMS disseminates information to non-medical emergency service agencies through written communication, as necessary.

K. Trauma Center Fees

VCEMS has developed a fee structure that covers the direct cost of the designation process and to effectively monitor and evaluate the trauma care system. Fees are based on the direct VCEMS cost of administering the trauma care system.

L. Medical Control and Accountability

1. Each designated trauma center shall:
   a. Provide base hospital medical control for field prehospital care providers.
   b. Provide base hospital service in accordance with California Code of Regulations, Title 22, as outlined in the VCEMS Base Hospital Agreements.
   c. Participate in the VCEMS data collection system as defined by VCEMS, CEMSIS-Trauma and the National Trauma Database.
   d. Participate in the VCEMS continuous quality improvement program.

I. PURPOSE: To establish a procedure for the designation of trauma centers in Ventura County

II. AUTHORITY: Health and Safety Code, §1797.160, §1797.161, and §1798, and California Code of Regulations, Title 22, §100255.

III. POLICY:

A. Trauma Center Designation

1. Ventura County Emergency Medical Services Agency will issue a request for proposal (RFP) for the designation of the trauma center(s). The RFP will include:

a. Introduction and background information about Ventura County's trauma system.

b. General information and instructions about trauma center designation including eligibility for application, primary service areas, fees and EMS's no guarantee policy of the minimum number of trauma patients

c. Level of designation desired

d. Reference to Title 22 and the American College of Surgeons "Resources for Optimal Care of the Injured Patient" (2022 Standards) as the criteria for designation. Applicants will be required to describe their current compliance with these criteria or to indicate plans to achieve compliance within 6 months of the nomination for designation.

e. List of the minimal requirements for designation that includes: hospital organization, medical staff support, the trauma program, the trauma medical director, the trauma resuscitation team, the trauma service, the trauma

program manager, the trauma registrar and interventional radiology services on site. (Please refer to the "Resources for Optimal Care of the Injured Patient" (2022 Standards) for full description of the above).

f. A list of trauma center conditions and requirements commensurate with the level of designation desired, which the applicant will be required to accept.

g. A contract between the applicant hospital and Ventura County Emergency Medical Services Agency to be completed when the hospital's application has been approved. Applicants will be required to indicate their acceptance of the contract or to submit alternative language for any clause which they are unwilling to accept.

h. A schedule of fees for trauma center applications and ongoing designation/contracts.

2. The RFP will be sent by registered, return-receipt-requested mail to those hospitals in Ventura County who submitted the required letter of interest. Any hospital wishing to respond to the RFP will be required to complete the RFP as outlined in the RFP and submit the application fee by a specified date and time. Thereafter, all communication regarding the process will be sent only to hospitals that have indicated their interest.
3. EMS will host a mandatory pre-proposal conference
4. Hospitals will have up to 60 days to submit an original and six copies of the proposal to ACS. Other submission requirements will be outlined in the RFP.
5. The independent review panel (IRP) will include experts as appropriate for the level of designation such as a trauma surgeon(s), emergency physician(s), trauma program manager(s), hospital administrator(s), EMS Agency administrator(s) and/or individuals with similar qualifications. The IRP shall be composed of individuals who work outside of the County of Ventura and have no affiliation or allegiance to any hospital within the County, and who are selected and approved by the Trauma Working Group.
6. The proposal review process will be contracted to American College of Surgeons which will include a site visit for the purpose of confirming the

information submitted as well as an evaluation of the hospital's capability and commitment to serve as a trauma center at the level of designation defined in the RFP. The IRP will evaluate proposals according to but not limited to:

a. Compliance with minimum standards
b. Quality and scope of service
c. Applicant's demonstrated commitment to the care of major trauma patients
d. Comprehensiveness
e. Cost effectiveness of the proposed service
f. Actuality of the demonstrated ability to provide Level II trauma services versus a stated plan to provide the service

7. The nominated designated hospital must agree to obtain verification by the American College of Surgeons as a trauma center at the level of designation desired within 3 years of designation at cost to the hospital.

B. Designation

1. Following the site visits, the IRP will report on its findings and decision on designation of trauma hospitals. This will include any recommended corrective action plan that would be required to meet trauma center requirements.
2. IRP recommendations will be forwarded to the Ventura County Board of Supervisors for final designation.
3. Reports of the IRP will be made available upon request.

C. Appeals

1. Notices of findings and copies of reports specific to each applicant will be sent to the appropriate applicant. Applicants will have 10 working days to appeal from the day of receipt of the preliminary recommendations of IRP. Grounds for appeals are limited to alleged failure to follow the RFP or proposal review process. Expert judgments or analyses of the survey team are not subject to appeal.
2. A three-member appeal panel whose members have expertise in proposal reviews, and have no allegiance or affiliation with any hospital within the County or to any member of the IRP, and who are selected and approved by the Trauma Working Group, will review the appeal and make a decision. All decisions are final and cannot be appealed further.

3. A fee of $5,000 will be required to request an appeal. These funds shall be used by the County to recover costs of resources used to reply to the appeal.

<table>
<tr><td colspan="2">COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td>EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Guidelines for Interfacility Transfer of Patients to a Trauma Center</td><td>Policy Number
1404</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steven L. Carroll, Paramedic</td><td>Date: January 3, 2023</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td>Daniel Shepherd, M.D.</td><td>Date: January 3, 2023</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>July 1, 2010
September 1, 2022
September 1, 2022
September 30, 2024</td><td>Effective Date: January 3, 2023</td></tr>
</table>

I. PURPOSE: To establish guidelines for the transfer of a trauma patient from a hospital in Ventura County to a Level II trauma center.

II. AUTHORITY: Health and Safety Code, §1797.160, §1797.161, and §1798, and California Code of Regulations, Title 22, §100255.

III. DEFINITIONS:

A. **Trauma Call Continuation:** A process by which a patient with potential life-or-limb threatening traumatic injuries who has been taken to the emergency department by ALS ambulance is transferred to a trauma center. The patient requires an immediate procedure at a trauma center, the **ALS ambulance is still on the premises**, and the treating physician **requests immediate transport** to a designated trauma center.

B. **EMERGENT** Transfer: A process by which a patient with potential life-or-limb threatening traumatic injuries is transferred to a trauma center. The patient requires an **immediate procedure** at a trauma center, and a delay in transfer will result in deterioration of the patient's condition, and the treating physician requests **immediate transport** to a trauma center.
(Ambulance will arrive within 10 minutes)

C. **URGENT** Transfer: A process by which a patient with time-critical traumatic injuries is transferred to a trauma center. The patient requires a **timely procedure** at a trauma center, and a lengthy delay will result in deterioration of the patient's condition, and the treating physician requests **prompt transport** to a trauma center. (Ambulance will arrive within 30 minutes)

IV **POLICY:** The following criteria will be used as a guideline for the transfer of a trauma patient to a trauma center.

A. For patients who are in the emergency department at a community hospital and have one or more of the following injuries, if the referring physician requests transfer to a trauma center, the trauma center will immediately accept the patient.

1. Carotid or vertebral arterial injury
2. Torn thoracic aorta or great vessel
3. Cardiac rupture
4. Bilateral pulmonary contusion with PaO2 to FiO2 ratio less than 200
5. Major abdominal vascular injury
6. Grade IV, V or VI liver injuries
7. Grade III, IV or V spleen injuries
8. Unstable pelvic fracture
9. Fracture or dislocation with neurovascular compromise
10. Penetrating injury or open fracture of the skull
11. Glasgow Coma Scale score <14 or lateralizing neurologic signs
12. Unstable spinal fracture or spinal cord deficit
13. >2 unilateral rib fractures or bilateral rib fractures with pulmonary contusion
14. Open long bone fracture
15. Significant torso injury with advanced co-morbid disease (such as coronary artery disease, chronic obstructive pulmonary disease, type 1 diabetes mellitus, or immunosuppression)
16. Amputations or partial amputations of any portion of the hand
17. Injury to the globe at risk for vision loss
18. Requiring Blood transfusion
19. ABC Score-anticipated Mass Transfusion Protocol (MTP) meets 2 or more criteria below:
    a) SBP < 90
    b) HR > 120
    c) + Fast exam
    d) Penetrating trauma to torso

B. **Ventura County Level II Trauma Centers:**

1. Agree to immediately accept from Ventura County community hospitals, patients with conditions included in the guidelines above.
2. Will publish a point-of-contact phone number for an individual authorized to accept the transfer of a patient with a condition included in the guidelines above, or to request consultation with a trauma surgeon.
3. Will establish a written interfacility transfer agreement with every hospital in Ventura County.
4. Immediately post on ReddiNet and notify EMS Administrator on-call when there is no capacity to accept trauma patients due to:
   a. Diversion for internal disaster
   b. CT scanner(s) non-operational
   c. Primary and back-up trauma surgeons in operating rooms with trauma patients

C. **Transferring Hospitals:**

1. Are not required to transfer patients with conditions included in the guidelines above to a trauma center when resources and capabilities for providing care exist at their facility.
2. Will enter into a written interfacility transfer agreement with every trauma center in Ventura County.

V. **PROCEDURES**

A. **Trauma Call Continuation**

1. ***Transferring hospital will:***
   a. Direct the ambulance personnel to prepare to continue the transport to the trauma center.
   b. Notify the designated trauma center ED of the immediate re-triage of a trauma patient and communicate the patient's apparent injuries or reason for the re-triage, after the call is continued and the patient is en route to the trauma center.
   c. Have policies, procedures, and a quality improvement system in place to track and review all Trauma Call Continuations.
2. ***Ambulance personnel will:***
   a. Notify FCC of their assignment to a Trauma Call Continuation. FCC will link the trauma transfer to the original 911 incident and continue tracking en-route hospital (departure from transferring hospital), at hospital (arrival at trauma center) and available times.

b. When the transferring physician determines the patient is ready, the same ALS personnel and ambulance that originally transported the patient to the transferring hospital will emergently transport the patient to the trauma center. The transporting paramedic will contact the trauma base hospital en route and provide updated patient information.

B. **EMERGENT** Transfers

1. **EMERGENT** transfers are indicated for patients with life-or-limb threatening injuries in need of emergency procedures at a trauma center. Criteria **MUST** include at least one of the following:
   a. Indications for an immediate neurosurgical procedure.
   b. Penetrating injury to head or torso.
   c. Penetrating or blunt injury with shock.
   d. Vascular injuries that cannot be stabilized and are at risk of hemorrhagic shock or loss of limb acutely (excluding fingers/toes).
   e. Pregnancy with indications for an immediate Cesarean section.
   f. Blood Product given

2. ***Trauma centers will:***
   a. Publish a single phone number (“hotline”), that is answered 24/7, for an individual authorized to accept the transfer of patients who have a condition as described in Section V.B.1 of this policy.
   b. Immediately upon initial notification by a transferring physician, accept in transfer all patients who have a condition as described in Section V.B.1 of this policy.

3. ***Transferring hospitals will:***
   a. Call the trauma hotline of the closest trauma center to notify of the transfer.
   b. Call FCC, advise they have an **EMERGENT** transfer, and request an ambulance. If the patient’s clinical condition warrants, the transferring hospital will call FCC *before* calling the trauma center’s hotline.
   c. Complete transfer consent and treatment summary.
   d. Prepare copies of the ED triage assessment form and demographic information form.

e. Limit ambulance on-scene time in the transferring hospital ED to ***ten minutes.***
   1. All forms should be completed prior to ambulance arrival.
   2. Any diagnostic test or radiologic study results may either be relayed to the trauma center at a later time, or if time permits, copied and sent with the patient to the trauma center.
   3. Intravenous drips may be discontinued ***or*** remain on the ED pump if medication is within the paramedic scope of practice.

f. Establish policies and procedures to make personnel available, when needed, to accompany the patient during the transfer to the trauma center.

g. Assemble and maintain an "Emergency Transfer Pack" in the emergency department to contain all of the following:
   1. Checklist with phone numbers of Ventura County trauma centers.
   2. Patient consent/transfer forms.
   3. Treatment summary sheet.
   4. Ventura County EMS "Emergency Trauma Patient Transfer QI Form." (See page 7)

h. Have policies, procedures, and a quality improvement system in place to track and review all Emergent transfers.

4. ***Ventura County Fire Communications Center*** **(FCC)** ***will:***

a. Respond to an **EMERGENT** transfer request by immediately dispatching the closest ALS ambulance and verbalize "MEDxxx EMERGENCY Trauma Transfer from [transferring hospital]". The trauma center will be denoted in the incident comments, which will display on the mobile data computer (MDC). If a unit does not have an operational MDC, the transferring hospital will advise the responding ambulance personnel of the destination trauma center.

b. FCC will track ambulance dispatch, en route, on scene, en route hospital, at hospital, and available times.

c. Will ***not*** be required to consider **EMERGENT** transports as an "interfacility transport" as it pertains to ambulance contract compliance. Transfers will be a follow-up to the original incident and will link the trauma transfer fire incident number to the original 911 fire incident number.

5. ***Ambulance companies will:***
    a. Upon notification, the ambulance will respond Code (lights and siren).
    b. Will ***not*** be required to consider **EMERGENT** transports as an “interfacility transport” as it pertains to ambulance contract compliance.

C. **URGENT** Transfers

1. **URGENT** transfers are indicated for patients with time-critical injuries in need of timely procedures at a trauma center.
2. ***Trauma centers will:***
    a. Publish a single phone number, that is answered 24/7, for a transferring hospital to request an urgent trauma transfer. Additionally, this line may be used to request additional consultation with a trauma surgeon if needed
3. ***Transferring hospitals will:***
    a. Call the trauma hotline for the closest trauma center to request an urgent trauma transfer. This call may be used to request additional consultation with the trauma surgeon if needed.
    b. Call the transport provider and advise they have an **URGENT** trauma transfer and request an ambulance.
    c. Complete transfer consent and treatment summary.
    d. Prepare copies of the ED triage assessment form.
    e. Limit ambulance on-scene time in the transferring hospital ED to ***twenty minutes.***
        1. All forms should be completed prior to ambulance arrival.
        2. Any diagnostic test or radiologic study results may either be relayed to the trauma center at a later time, or if time permits, copied and sent with the patient to the trauma center.
        3. Intravenous drips may be discontinued ***or*** remain on the ED pump if medication is within the paramedic scope of practice.
4. ***Ambulance companies will:***
    a. Upon request for an **URGENT** trauma transfer, the transport provider will dispatch an ambulance to arrive ***no later than thirty minutes*** after the request.

D. **Documentation:**

For all **Trauma Call Continuation**, **EMERGENT** or **URGENT** transfers, the transferring hospital will submit a completed Emergency Trauma Patient Transfer QI Form by using the link or QR Code found below, to the Ventura County EMS Agency within 72 hours. The transfer will be reviewed for appropriate and timely care and to identify opportunities for improvement. Results will be reviewed and discussed at the Countywide EMS Trauma Operational Review Committee.

Trauma Transfer QI Form

Use Link:

Emergent and Urgent trauma Transfer QI form

-OR-

Scan QR Code:

Ventura County Field Triage Decision Scheme

For patients with visible or suspected traumatic injuries

Measure vital signs and level of consciousness

STEP 1

1.1 Unable to follow commands (motor < 6)
1.2 Systolic Blood Pressure
- Age 0-9 years SBP < 70 mmHg + (2 x age years)
- Age 10-64 years SBP < 90 mmHg or HR > SBP
- Age 65 or older SPB SBP < 110 mmHg or HR > SBP

1.3 Respiratory
- RR < 10 or > 29 breaths/min
- Resp Distress or need for respiratory support
- Room-air pulse oximetry < 90%

Yes → **Contact base trauma center**
Transport to trauma center

Assess anatomy of injury

STEP 2

2.1 All penetrating injuries to head, neck, torso and extremities proximal to elbow and knee
2.2 Chest wall instability, deformity, or suspected flail chest
2.3 Suspected two or more proximal long-bone fractures (femur, humerus)
2.4 Crushed, degloved, mangled or pulseless extremity
2.5 Amputation proximal to wrist or ankle
2.6 Suspected pelvic fractures
2.7 Skull deformity, suspected skull fracture
2.8 Acute paralysis, extremity weakness, or sensory loss possibly due to spinal cord injury
2.9 Seat belt injury: significant bruising to neck, chest, or abdomen
2.10 Diffuse abdominal tenderness from blunt trauma
2.11 Active bleeding requiring a tourniquet or wound packing with continuous pressure

Yes → **Contact base trauma center / Transport to trauma center**

Assess mechanism of injury and evidence of high-energy impact

STEP 3

Falls
- **3.1.1** Adults: Fall from height > 10 feet (one story is equal to 10 feet)
- **3.1.2** Children < 14 years old: Fall from height > 10 feet or two times the height of the child

High-risk auto crash
- **3.2.1** Intrusion (Including roof) > 12" patient site ***or*** > 18" any occupant site
- **3.2.2** Ejection: partial or complete from automobile
- **3.2.3** Death in same passenger compartment

3.3 Auto vs. pedestrian/bicyclist thrown, run over, with significant impact or > 20 mph
3.4 Unenclosed vehicle crash > 20 mph ***or*** Rider separated from transport vehicle with significant impact (e.g. motorcycle, ATV, Horse, etc.)
3.5 Child (age 0-9) unrestrained or in unsecured child safety seat

Yes → **Contact base trauma center for destination decision**

Assess special patient or system considerations

STEP

4.1 Age > 65
4.2 Low level Falls in young children (age < 5 years) or older adults (age 65 or older) with significant head impact
4.3 Burns with trauma mechanism
4.4 Time sensitive extremity injury (open fracture, neurovascular compromise)
4.5 Pregnancy > 20 weeks with known or suspected abdominal trauma
4.6 Prehospital care provider or MICN judgment
4.7 Amputation or partial amputation of any part of the hand
4.8 Penetrating injury to the globe of the eye, at risk for vision loss
4.9 Anticoagulation use[1]

Yes → **Contact regular catchment base hospital**

Consider transport to trauma center or specific resource hospital

[1]See list

Transport to closest ED or by patient preference

Version 7 Revised 1/3/2023

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Nerve Agent Antidote Administration by Public Safety First Aid Personnel		Policy Number 1603
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	May 13, 2021 May 13, 2021 November 10, 2022 November 30, 2024	Effective Date: January 3, 2023

I. PURPOSE:

A. To outline criteria for approved Public Safety First Aid (PSFA) administration of nerve agent antidote for self/peer rescue in the event of confirmed or suspected exposure to a nerve agent / organophosphate pesticide.

B. To provide medical direction and nerve agent antidote administration parameters for approved PSFA optional skills provider agencies and personnel in the County of Ventura.

II. AUTHORITY: California Health and Safety Code, Division 2.5; California Code of Regulations, Title 22, Division 9, Chapter 1.5, Section 100019

III. POLICY:

A. PSFA personnel shall only be permitted to use the Nerve Agent Antidote Kit on self or other public safety personnel.

B. In Ventura County, the DuoDote® auto-injector and the Mark I auto injector (CHEMPACK only) are the only nerve agent antidote kits approved for use by PSFA. Atropine auto injectors are not permitted per regulations.

C. Training shall be completed in accordance with California Code of Regulations, Section 100019 and VCEMS Policy 1602 – PSFA Optional Skills and Training

D. PSFA agency training director shall be responsible for the following:

1. Ensuring the agency's supply of nerve agent antidote remains current and not expired at all times.
2. Ensuring proper and efficient deployment of nerve agent antidote kits for use within the agency.
3. Prompt replacement of any nerve agent antidote kit that is used in the course of care, or that is expired, damaged, or otherwise deemed unusable.

4. Ensuring all personnel that will be using the nerve agent antidote kit have received appropriate training
5. Maintain records of all documented use, restocking, damaged, expired or otherwise unusable nerve agent antidote kit(s).

IV. PROCEDURE:

A. Indications
1. Confirmed or suspected exposure to nerve agent or organophosphate
2. Obvious signs and symptoms of nerve agent / organophosphate exposure (*SLUDGEM* - Salivation, Lacrimation, Urinary incontinence, Defecation, Gastrointestinal distress, Emesis, Miosis)

B. Contraindications
1. No contraindications in the presence of poisoning by nerve agents / organophosphate insecticides.

C. Nerve Agent Antidote Kit Administration
1. If Treating Self:
   a. Avoid continued exposure by exiting from area of exposure; remove contaminated clothing; follow decontamination procedures when available.
   b. Following exposure and in the presence of symptoms, administer nerve agent antidote kit (DuoDote® or Mark I) into outer thigh. Auto injector may be administered through clothing.
   c. If symptoms persist, may repeat nerve agent antidote kit administration every 10 to 15 minutes up to two (2) additional times (for a total of three (3) administrations)
   d. Report administration of nerve agent antidote kit to prehospital personnel for additional assessment and follow-up care, as needed.
   e. Document administration of nerve agent antidote kit as indicated per PSFA agency policies and procedures.
2. If treating other public safety personnel:
   a. Maintain standard blood and body fluid precautions. Use appropriate personal protective equipment (gloves, face shield, gown), avoid cross contamination.
   b. Remove patient from area of continued exposure, remove contaminated clothing, and follow appropriate decontamination procedures.
   c. Assess patient’s respiratory, mental and pupillary status.

d. Open the airway using appropriate BLS techniques and perform rescue breathing, as indicated. Provide oxygen per VCEMS Policy 1604 – Oxygen Administration by Public Safety First Aid Personnel
e. Following exposure and in the presence of symptoms, administer nerve agent antidote kit (DuoDote® or Mark I) into outer thigh. Auto injector may be administered through clothing.
f. If symptoms persist, may repeat nerve agent antidote kit administration every 10 to 15 minutes up to two (2) additional times (for a total of three (3) administrations)
g. Report administration of nerve agent antidote kit to prehospital personnel for additional assessment and follow-up care, as needed.
h. Document administration of nerve agent antidote kit as indicated per PSFA agency policies and procedures.

<table>
<tr><td>COUNTY OF VENTURA
HEALTH CARE AGENCY</td><td colspan="2">EMERGENCY MEDICAL SERVICES
POLICIES AND PROCEDURES</td></tr>
<tr><td colspan="2">Policy Title:
Oxygen Administration and Basic Airway Adjunct Use by Public Safety First Aid Personnel</td><td>Policy Number
1604</td></tr>
<tr><td>APPROVED:
Administration:</td><td>Steve L. Carroll, Paramedic</td><td>Date: January 3, 2023</td></tr>
<tr><td>APPROVED:
Medical Director:</td><td>Daniel Shepherd, M.D.</td><td>Date: January 3, 2023</td></tr>
<tr><td>Origination Date:
Date Revised:
Date Last Reviewed:
Review Date:</td><td>May 13, 2021
May 13, 2021
November 10, 2022
November 30, 2024</td><td>Effective Date: January 3, 2023</td></tr>
</table>

I. PURPOSE:

A. To outline criteria for approved Public Safety First Aid (PSFA) administration of oxygen through a nasal cannula (NC), non-rebreather mask (NRB), or bag-valve mask (BVM), and for the use of basic airway adjuncts – specifically oropharyngeal airways (OPA) and nasopharyngeal airways (NPA).

B. To provide medical direction and oxygen administration and basic airway adjunct parameters for approved PSFA optional skills provider agencies and personnel in the County of Ventura.

II. AUTHORITY: California Health and Safety Code, Division 2.5; California Code of Regulations, Title 22, Division 9, Chapter 1.5, Section 100019

III. POLICY:

A. Training shall be completed in accordance with California Code of Regulations, Section 100019 and VCEMS Policy 1602 – PSFA Optional Skills and Training

B. PSFA agency training director shall be responsible for the following:

1. Ensuring the agency's supply of oxygen, oxygen delivery devices, and basic airway adjuncts remain current and not expired at all times
2. Ensuring proper and efficient deployment of oxygen and associated equipment for use within the agency
3. Prompt replacement of any equipment that is used during care, or that is expired, damaged, or otherwise deemed unusable
4. Ensuring all personnel that will be administering oxygen and/or utilizing any associated equipment have received appropriate training
5. Maintain records of all documented use, restocking, damaged, expired or otherwise unusable oxygen and/or associated equipment

IV. PROCEDURE:

A. Indications

1. Difficulty breathing or shortness of breath with signs and symptoms of poor oxygenation
2. Unresponsive and not breathing

B. Contraindications

1. No contraindications

C. Oxygen Administration

1. Difficulty Breathing or Shortness of Breath
    a. Ensure EMS has been activated through use of the 911 system
    b. Use appropriate personal protective equipment (PPE) and maintain body substance isolation precautions
    c. Assess patient’s level of responsiveness
    d. Ensure patient’s airway is patent and assess patient’s respiratory rate and effort
    e. Administer oxygen using nasal cannula or non-rebreather mask as indicated
    f. Report administration of oxygen to prehospital personnel for additional assessment and follow-up care, as needed
    g. Document administration of oxygen as indicated per PSFA agency policies and procedures
2. Unresponsive and Not Breathing
    a. Ensure EMS has been activated through use of the 911 system
    b. Use appropriate personal protective equipment (PPE) and maintain body substance isolation precautions
    c. Begin chest compressions
    d. Obtain an AED
    e. Ensure patient’s airway is patent utilize appropriate basic airway adjunct(s) such as an OPA or NPA as indicated
    f. Perform ventilations via BVM with oxygen as indicated
    g. Consider causes for current condition, such as opioid overdose anaphylaxis or exposure to nerve agent and treat those conditions per appropriate VCEMS PSFA policies
    h. Report administration of oxygen to prehospital personnel for additional assessment and follow-up care, as needed
    i. Document administration of oxygen as indicated per PSFA agency policies and procedures

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Epinephrine Administration by Public Safety First Aid Personnel		Policy Number 1606
APPROVED: Administration:	Steve L. Carroll, Paramedic	Date: January 3, 2023
APPROVED: Medical Director:	Daniel Shepherd, M.D.	Date: January 3, 2023
Origination Date: Date Revised: Date Last Reviewed: Review Date:	May 13, 2021 May 13, 2021 November 10, 2022 November 30, 2024	Effective Date: January 3, 2023

I. PURPOSE:

A. To outline criteria for approved Public Safety First Aid (PSFA) for the administration of epinephrine by auto injector for treatment of anaphylaxis.

B. To provide medical direction and epinephrine administration for approved PSFA optional skills provider agencies and personnel in the County of Ventura.

II. AUTHORITY: California Health and Safety Code, Division 2.5; California Code of Regulations, Title 22, Division 9, Chapter 1.5, Section 100019

III. POLICY:

A. PSFA personnel shall only be authorized to administer epinephrine via auto-injector for the treatment of anaphylaxis in patients aged 14 and older.

B. Training shall be completed in accordance with California Code of Regulations, Section 100019 and VCEMS Policy 1602 – PSFA Optional Skills and Training

C. PSFA agency training director shall be responsible for the following:

1. Ensuring the agency's supply of epinephrine auto injectors remain current and not expired at all times

2. Ensuring proper and efficient deployment of epinephrine auto injectors and associated equipment for use within the agency

3. Prompt replacement of any equipment/medication that is used during care, or that is expired, damaged, or otherwise deemed unusable

4. Ensuring all personnel that will be administering epinephrine and/or utilizing any associated equipment have received appropriate training

5. Maintain records of all documented use, restocking, damaged, expired or otherwise unusable epinephrine auto injectors and/or associated equipment

IV. PROCEDURE:

A. Indications

1. Exposure to a known or suspected allergen and any combination of two or more of the following signs and symptoms:
   a. Hives, itchy, swollen tongue/lips
   b. Respiratory compromise (wheezing, shortness of breath, stridor, hypoxia)
   c. Persistent GI distress (vomiting, diarrhea, abdominal pain)
   d. Hypotension (syncopal episode, decreased muscle tone, signs of shock, altered level of consciousness)

B. Contraindications

1. Patient is less than 14 years of age
2. No other contraindications for patients in the above situation

C. Epinephrine Administration

1. Ensure EMS has been activated through use of the 911 system
2. Use appropriate personal protective equipment (PPE) and maintain body substance isolation precautions
3. Provide supplemental oxygen and assist ventilations, if authorized, per VCEMS Policy 1604 – Oxygen Administration and Basic Airway Adjunct Use by PSFA Personnel
4. Administer Epinephrine via auto-injector into outer thigh (may be administered through clothing)
   a. If symptoms persist, may administer one (1) additional auto-injector dose in five (5) minutes for a total of two (2) doses
5. After Epinephrine administration, observe for improved breathing and level of consciousness. If breathing or level of consciousness do not improve, assist breathing with bag-valve-mask if available as authorized
6. Begin CPR if patient is not breathing
7. Report administration of epinephrine to prehospital personnel for additional assessment and follow-up care, as needed
8. Document administration of epinephrine as indicated per PSFA agency policies and procedures