| I. | Introductions |
| II. | Approve Agenda |
| III. | Minutes |
| IV. | Medical Issues |
|     | A. Choking in Cardiac Arrest |
|     | B. Cardioversion |
|     | C. Other |
| V. | New Business |
|     | A. 111 – Ambulance Company Licensing Procedure (Policy will be provided at meeting) |
|     | B. 334 – Prehospital Personnel Mandatory Training Requirements |
|     | C. 504 – ALS and BLS Unit Equipment and Supplies |
|     | D. 905 – Ambulance Provider Response Unit Required Frequencies |
|     | E. Other |
| VI. | Old Business |
|     | A. 131 – Multi-Casualty Incident Response |
|     | B. 722 – Interfacility transfer of patients with IV Heparin and Nitro |
|     | C. I.O. Success Rates |
|     | D. PRESTO Trial – Dr. Salvucci |
|     | E. Other |
| VII. | Informational/Discussion Topics |
|     | A. Other |
| VIII. | Policies for Review |
|     | A. 321 – MICN Authorization Criteria |
|     | B. 322 – MICN Reauthorization Criteria |
| IX. | Agency Reports |
|     | A. Fire Departments |
|     | B. Ambulance Providers |
|     | C. Base Hospitals |
|     | D. Receiving Hospitals |
|     | E. Law Enforcement |
|     | F. ALS Education Program |
|     | G. TAG |
|     | H. EMS Agency |
|     | I. Other |
| X. | Closing |
## Pre-hospital Services Committee Minutes

March 13, 2014
9:30 a.m.

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<th>Topic</th>
<th>Discussion</th>
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| II. Approve Agenda | | | Approved by Tom Gallegos  
Seconded by Betsy Patterson |
| III. Minutes | | | Approved by Tom Gallegos  
Seconded by Betsy Patterson |
| IV. Medical Issues | | | |
| A. DuoDote shortage and shelf life extension | Chris told the committee that our DuoDote will be expiring and there is a nationwide shortage of this. FDA said that we can extend for 1 year. | Angelo and the Committee agreed that the DuoDote should be extended for 1 year. | |
| B. Normal Saline Shortage | Karen stated that there is a shortage of Normal Saline throughout California. | Ambulance Companies are OK for up to 4 months. VCFPD is good for 6 months.  
Hospitals are looking at Saline Locks and 500 cc bags of NS. Ringers are also an option for some. | |
<p>| C. Humeral I.O Access | Mark K. asked that we approve the use of Humeral I.O Access in the field. There have been many situations where the Tibial access is not avail. | Angelo asked that anyone with data on this issue would forward it to him. He will also run reports on Tibial failures and we will discuss further at the next meeting. | |
| V. New Business | | | |
| A. Other | Robin S. is concerned that fire eng’s only carry 1 amp of Bicarb. Some patients require additional on Cardiac Arrests. Amb. carry 1 in bag and 2 in rig. During training, some fire personnel have reported that they only have 1 Bicarb. | Steve requested each department to look into this issue. | |
| VI Old Business | | | |
| A. 705.17 – Nerve Agent Poisoning - Draft | Chris discussed changes that were made. Committee members pointed out additional changes that should be | Chris will work on suggested changes, check Scope per Steve C. and bring back to next meeting. | |</p>
<table>
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<tr>
<th>VII. Information/Discussion Topics</th>
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<td>VIII. Policies for Review</td>
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A. 306 – Requirements to Staff an ALS Unit  
Committee pointed out format changes that are needed. Steve and Chris requested that Randy set up a meeting to review and make required AED changes.

B. 330 – EMT/Paramedic/MICN Decertification and Discipline  
Committee requested that “EMT-1” be changed to “EMT”

C. 613 – Do Not Resuscitate  
Table until May

D. 625 - POLST  
Table until May

E. 701 – Medical Control: Paramedic Liaison Physician  
Remove from Agenda. Previously reviewed.

F. 722 – Interfacility Transport of Patient with IV Heparin  
Angelo will check current dosages at each hospital and bring back to committee in May.

G. 802 – EMT – I Defibrillation (EMT- ID) Medical Director  
Bring back in May; Angelo wants additional time to review.

H. 803 – EMT AED Service Provider Program Standards  
Add CAM to page 2, #7. Have Randy review this policy in his sub-committee. Bring back in May.

I. 805 – EMT – ID Medical Cardiac Arrest.  
Randy will research how private AED providers are handled. Committee should review and make recommendation on whether to keep this policy or re-do it. Tabled until May.

J. 1400 – Trauma Care System  
Trauma Policy was changed by TORC. Policy for information only.

K. 1406 – Trauma Center Standards  
Policy for information only.

XI TAG Report
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<th>X. Agency Reports</th>
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| A. Fire departments | **VCFPD** – This is Norm’s last meeting before promotion. Chief Scott Zeller will be replacing him and attend future meetings. **Good Luck Norm and thanks for all your input and support.** Chief Gurrola and Chief LaPlant are retiring in the next few months.  
**VCFD** – Dede announced that Dave Endaya is VCFD’s new Fire Chief.  
**OFD** – Steph thanked GCA for their assistance with OFD’s MCI training.  
**FFD** – Fed. Fire – | |
| B. Transport Providers | **VCSO** – AMR/GCA – Hiring PM’s, have 7 new ambulances. The 911 fleet will soon be all brand new. | |
| C. Base Hospitals | **SVH** – LRRMC – New CEO. Skills lab with AMR. Cardiac Support Group still very helpful, Dr. Alves will talk on ICD’s. The survivors are great advocates for the Sidewalk CPR program.  
**SJRMC** – March 26th is Countywide MICN class. All Dignity Health hospitals are getting Cerner.  
**VCMC** – | |
| D. Receiving Hospitals | **CMH** – Rolling out new Stroke and Sepsis Program. Still under construction. Let them know if there are any parking or access issues.  
**PVH** -  
**OVCH** – Rolling out new Stroke and Sepsis Program. Thanks to Lifeline for their CAM presentation. | |
| E. ALS Education Programs | **Ventura College** – Students have completed hospital rounds. Thanks to all the agencies for taking them. Eleven will graduate. | |
| F. EMS Agency | **Angelo** – Thank you to everyone for putting down your encounter numbers on e-PCR’s. It has worked very well. Santa Barbara has seen Steve – We are still holding interviews for our front office. Please be patient with us. There will be a region wide sidewalk CPR event. Health-Trans are starting a Gurney Van Service. Let Steve know if there are any issues/problems. Katy and Steve met with CHP; they are concerned about traffic lanes being blocked for too long. Please remind your personnel to clear units as soon as possible.  
**Chris** – Working on OMB exercise. We will contact you about resource requests and appreciate your help in the past.  
**Julie** – Behavior Health follow-up meeting today after PSC. | |
<p>| G. Other | <strong>EMSAAC Conference May 28 and 29 at Lowes Coronado Resort</strong> | |
| Xi. Closing | <strong>Meeting adjourned at 1130.</strong> | |
|------------------------|----------|-----------|----------|------------|------------|------------|----------|------------|------------|------------|------------|------------|-------------|-------------|
| AMR                    | Stefansen| Adriane   |          |            |            |            | AS       |            |            |            |            |            |             |             |
| AMR                    | Panke    | Chad      | CP       |            |            |            | CP       |            |            |            |            |            |             |             |
| CMH - ER               | Canby    | Neil      | NC       |            |            |            | NC       |            |            |            |            |            |             |             |
| CMH/OVCH-ER            | Cobb     | Cheryl    | CC       |            |            |            | CC       |            |            |            |            |            |             |             |
| OVCH                   | Patterson| Betsy     | BP       |            |            |            | BP       |            |            |            |            |            |             |             |
| CSUCI PD               | Drehsen  | Charles   | CD       |            |            |            | CD       |            |            |            |            |            |             |             |
| CSUCI PD               | Rice     | Al        | AR       |            |            |            | AR       |            |            |            |            |            |             |             |
| FFD                    | Herrera  | Bill      | BH       |            |            |            |          |            |            |            |            |            |             |             |
| FFD                    | Scott    | Bob       | BS       |            |            |            |          |            |            |            |            |            |             |             |
| GCA                    | Norton   | Tony      | TN       |            |            |            | TN       |            |            |            |            |            |             |             |
| GCA                    | Shultz   | Jeff      | JS       |            |            |            | JS       |            |            |            |            |            |             |             |
| Lifeline               | Rosolek  | James     | JR       |            |            |            | JR       |            |            |            |            |            |             |             |
| Lifeline               | Winter   | Jeff      | JW       |            |            |            | JW       |            |            |            |            |            |             |             |
| LRRMC - ER             | Beatty   | Matt      | MB       |            |            |            | MB       |            |            |            |            |            |             |             |
| LRRMC - ER             | Licht    | Debbie    | DL       |            |            |            | DL       |            |            |            |            |            |             |             |
| OFD                    | Carroll  | Scott     | SC       |            |            |            | SC       |            |            |            |            |            |             |             |
| OFD                    | Huhn     | Stephanie | SH       |            |            |            | SH       |            |            |            |            |            |             |             |
| SJPVH                  | Hamilton | Shay      |          |            |            |            |          |            |            |            |            |            |             |             |
| SJPVH                  | Davies   | Jeff      |          |            |            |            |          |            |            |            |            |            |             |             |
| SJRMC                  | Russell  | Mark      | MR       |            |            |            | MR       |            |            |            |            |            |             |             |
| SJRMC                  | McShea   | Kathy     | KM       |            |            |            | KM       |            |            |            |            |            |             |             |
| SPFD                   | Dowd     | Andrew    | AD       |            |            |            | AD       |            |            |            |            |            |             |             |
| SVH - ER               | Tilles   | Ira       | IT       |            |            |            | IT       |            |            |            |            |            |             |             |
| SVH - ER               | Hoffman  | Jennie    | JH       |            |            |            | JH       |            |            |            |            |            |             |             |
| V/College              | O'Connor | Tom       | TO       |            |            |            | TO       |            |            |            |            |            |             |             |
| VCFD                   | Tapping  | Aaron     | AT       |            |            |            | AT       |            |            |            |            |            |             |             |
| VCFD                   | Utley    | Dede      | DU       |            |            |            | DU       |            |            |            |            |            |             |             |
| VNC                    | Zeller   | Scott     | NP       |            |            |            | NP       |            |            |            |            |            |             |             |
| VNC                    | Dullam   | Joe       | JD       |            |            |            | JD       |            |            |            |            |            |             |             |
| VNC - Dispatch         | Shedlosky| Robin     | RS       |            |            |            | RS       |            |            |            |            |            |             |             |
| VCMC - ER              | Chase    | David     | DC       |            |            |            | DC       |            |            |            |            |            |             |             |</p>
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**Eligible to Vote** Date Change/cancelled - not counted against member for attendance

**Non Voting Members**

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TEMPORARY PARKING PASS
Expires May 08, 2014

Health Care Services
2240 E. Gonzales Rd
Oxnard, CA 93036
For use in "Green Permit Parking" Areas only, EXCLUDES Patient parking areas

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

**2240 Gonzales Rd. location**
If you park in a designated "green permit parking" slot, fold this flyer in half and place pass face-up on the dash of your car, to avoid receiving a ticket.

**2100 Solar Drive**
An additional amount of "Green Permit Parking" spaces (only 30) are available in adjacent parking lot, those that back-up against venue parking area, (Enter this parking lot off of Gonzales[3rd driveway] or Solar Drive). **Place this flyer on your dash.** If all of those stalls are occupied, overflow parking is available at The Palms shopping area or side streets.

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

**Additional parking is available on side streets, Lombard, Solar and Wankel Way.**
### Ventricular Tachycardia Sustained – Not in Arrest

#### BLS Procedures

Administer oxygen as indicated

#### ALS Prior to Base Hospital Contact

**IV Access**

<table>
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<tr>
<th>Stable – Mild to moderate chest pain/SOB</th>
<th>Unstable – ALOC, signs of shock or CHF</th>
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<tr>
<td><strong>Amiodarone</strong></td>
<td><strong>Midazolam</strong></td>
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<td>o IVPB - 150 mg in 50mL D5W infused over 10 minutes.</td>
<td>o IV – 2 mg</td>
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- **Synchronized Cardioversion**
  - Use the biphasic energy settings that have been approved by service provider medical director
  - If patient needs sedation and there is a delay in obtaining sedation medication:
    - **Amiodarone**
      - IVPB - 150 mg in 50mL D5W infused over 10 minutes

**Unstable polymorphic (irregular) VT:**
- **Defibrillation**
  - Use the biphasic energy settings that have been approved by service provider medical director

If recurrent VT, perform synchronized cardioversion at last successful biphasic energy setting

#### Base Hospital Orders only

**Torsades de Pointes**
- **Magnesium Sulfate**
  - IVPB – 2 gm in 50 mL D5W infused over 5 min
  - May repeat x 1 if Torsades continues or recurs

- **Consult with ED Physician for further treatment measures**

**ED Physician Order Only:** After defibrillation, if patient converts to narrow complex rhythm greater than 50 bpm and not in 2nd or 3rd degree heart block, and amiodarone not already given, consider amiodarone - 150 mg IVPB in D5W infused over 10 minutes.

#### Additional Information:

- Early base hospital contact is recommended in unusual circumstances, e.g. Torsades de Pointes, Tricyclic OD and renal failure.
- Ventricular tachycardia (VT) is a rate > 150 bpm
# Supraventricular Tachycardia

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<tr>
<th>ADULT</th>
<th>PEDIATRIC</th>
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## BLS Procedures
- Administer oxygen as indicated

## ALS Prior to Base Hospital Contact

### Stable
- Mild to moderate chest pain/SOB
- Place on backboard and prepare for synchronized cardioversion

### Unstable
- ALOC, signs of shock or CHF
- Place on backboard and prepare for synchronized cardioversion

## Communication Failure Protocol

### Stable
- Adenosine
  - IV – 6 mg rapid push immediately followed by 10-20 mL NS flush
  - No conversion or rate control

### Unstable
- Midazolam
  - IV – 2 mg
    - Should only be given if it does not result in delay of synchronized cardioversion
    - For IV use – Dilute 5 mg (1 mL) Midazolam with 4 mL NS for a final volume of 5 mL concentration of 1 mg/mL
    - IO Access for unstable adults only.

### Synchronized Cardioversion
- Use the biphasic energy settings that have been approved by service provider medical director.

## Base Hospital Orders only
- Consult with ED Physician for further treatment measure

### Additional Information:
- Adenosine is contraindicated in pt with 2nd or 3rd AV Block, Sick Sinus Syndrome (except in pt with functioning pacemaker), or known hypersensitivity to adenosine.
- Unless the patient is in moderate or severe distress, consider IV access and transport only. Consider withholding adenosine administration if patient is stable until ED Physician evaluation.
- Prior to administering Adenosine in pediatric patients, evaluate for possible underlying causes of tachycardia (infection, dehydration, trauma, etc.)
- Document all ECG strips during adenosine administration and/or synchronized cardioversion.
**COUNTY OF VENTURA**

**HEALTH CARE AGENCY**

**EMERGENCY MEDICAL SERVICES**

**POLICIES AND PROCEDURES**

<table>
<thead>
<tr>
<th>Policy Title:</th>
<th>Pre-Hospital Personnel Mandatory Training Requirements</th>
<th>Policy Number:</th>
<th>334</th>
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<tbody>
<tr>
<td>APPROVED: Administration:</td>
<td>Steven L. Carroll, EMT-P</td>
<td>Date:</td>
<td>June 1, 2009</td>
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<tr>
<td>APPROVED: Medical Director</td>
<td>Angelo Salvucci, MD</td>
<td>Date:</td>
<td>June 1, 2009</td>
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<tr>
<td>Origination Date:</td>
<td>September 14, 2000</td>
<td>Date Revised:</td>
<td>December 11, 2008</td>
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<td>Effective Date:</td>
<td>June 1, 2009</td>
</tr>
<tr>
<td>Review Date:</td>
<td>December 31, 2012</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I. **PURPOSE:** To define the requirements for mandatory training sessions for EMT-1s, Paramedics, EMT-ALS Assist SAR EMT-1s, MICNs and Flight Nurses in Ventura County.

II. **AUTHORITY:** Title 22, California Code of Regulation, Division 9, Section 100175 and Chapter 6. Health and Safety Code Section 1797.214, 1797.220 and 1798.200.

III. **POLICY:** All pre-hospital personnel have requirements for on-going authorization or accreditation to provide pre-hospital care in Ventura County. These requirements are outlined in VCEMS Policy 318 for Paramedics, 306 and 803 for EMTs, 1201 for Flight Nurses and SAR EMT-1s and 322 for MICNs.

III. **PROCEDURE:**

A. **EMS Updates** – Applies to all personnel listed above except EMT-1’s.

Personnel shall attend mandatory education and/or testing on updates to local policies and procedures (EMS Update), which will be presented by the Base Hospitals in May and November each year (minimum of 12 opportunities to attend each session). Prehospital Services Committee members who attend 75% of the scheduled meetings over the previous 6 months may have this requirement waived.

B. **MCI Training** – Applies to all personnel listed above except MICN’s.

Personnel shall attend initial Basic or Advanced MCI training within 6 months of initially starting the certification or accreditation process and complete bi-annual refreshers as indicated in VC EMS Policy 131.

C. **Grief Training** – Applies to all personnel listed above except MICN’s.

All personnel shall be provided the self-study packet titled “Dealing with Grief: A Workbook for Prehospital Personnel.” After finishing the self-study packet, personnel shall complete the post-test and evaluation and mail them to VC EMS for a course completion and 2 hours CE credit. This requirement shall be completed within 6 months of initially starting the certification or accreditation process.
D. Emergency Response to Terrorism – Applies to all personnel listed above.
All personnel shall be provided the self-study packet titled “Emergency Response to
Terrorism.” After finishing the self-study packet, personnel shall complete the post-test
and mail it to VC EMS for a course completion and 3 hours CE credit. This requirement
shall be completed within 6 months of initially starting the certification or accreditation
process.

E. Paramedic Skills Refresher – Applies to Paramedics only
1. Paramedics shall attend one skills refresher session during the first year of
licensure and one skills refresher in the second year of licensure.
2. Skills Refreshers will be offered at least 4 times in March and 4 times in
September and will be offered over a 3 week period. Dates, times, and
locations for the Skills Refreshers will be published one year in advance. Late
arrivals will not be admitted into the Skills Refresher.

F. Nerve Agent Training – Applies to Paramedics only
All personnel shall be provided the self study PowerPoint presentation entitled “Ventura
County EMS Nerve Agents: Recognition and Treatment”. Providers shall forward a
copy of the attendance roster to VCEMS to verify completion of the training. New
employees shall complete training within 6 months of initially starting the accreditation
process.

G. Field Intubation Refresher Training– Applies to Paramedic and SAR Flight Nurses only
One intubation refresher session per six (6) month period based on license cycle as
described in Policy 318.

H. Advanced Cardiac Life Support (ACLS)- Applies to all personnel listed above except
EMT-1’s and SAR-EMT-1’s.
ACLS course completion certificate shall be obtained within three months of initially
starting the certification or accreditation process and remain current.

I. Pediatric Advanced Life Support (PALS) or Pediatric Education for Prehospital
Providers (PEPP)- Applies to Paramedics only.
PALS or PEPP course completion certificate shall be obtained within six months of
initially starting the accreditation process and remain current.

J. Failure to complete mandatory requirements:
1. Level II Paramedics who fail to complete any of these requirements will
immediately revert to a Level I Paramedic according to VCEMS Policy 318. The
Paramedic’s accreditation to practice in Ventura County will be suspended after
the State required 15 day notice until the following remediation criteria has been
met. All other required personnel who fail to complete these requirements will have their authorization immediately suspended.

2. Reinstatement of authorization or accreditation:
   a. Personnel who have not completed MCI Training, Grief Training or Emergency Response to Terrorism must complete the requirements and provide documentation of completion to VC EMS for determination on reinstatement.
   b. Personnel not attending EMS Update must complete the following remediation criteria.
      1) Personnel will attend a make-up session to be scheduled by VC EMS within 2 weeks of the last regularly scheduled EMS Update session.
      2) Personnel will submit a written statement to VC EMS explaining the circumstances why this requirement could not be met.
      3) Submit a $125.00 fine.
      4) A written post-test will be administered, and must be successfully completed by achieving a minimum passing score of 85%.
      5) If the VC EMS make up session is not attended, the employer may elect to assist the person in completing the requirement.
         a) The employer shall use the materials and test supplied by VC EMS.
         b) The employer will be responsible to forward the written statement and $125.00 fine to VC EMS.
         c) The employer will administer the written test and will forward it to VC EMS for scoring. Minimum passing score will be 85%.
         d) A make up session arranged by an employer will be approved by VC EMS before it is presented.
   c. Paramedics not attending Skills Refresher must complete the following remediation criteria.
      1) Paramedic will submit a written statement to VC EMS explaining the circumstances why this requirement could not be met.
      2) Submit a $125.00 fine.
      3) Paramedic will attend a remediation session on documentation and review of VC EMS Policy 318 to be administered by VC EMS.
4) ALS provider will confirm paramedic has read and reviewed VC EMS Policy and Procedure Sections 6 & 7.

5) ALS provider will be responsible to coordinate a Skills Refresher make-up session conducted by either an ALS Service Provider Medical Director, base hospital physician or their designee. Skills Refresher make-up will include all skills covered at the most recent Skills Refresher.

6) ALS provider will submit a written plan of action to VC EMS to include: course curriculum, date and location of Skills Refresher make-up, equipment to be used and names of instructors.

7) Completed reinstatement checklist, will be submitted to VC EMS for review and determination on reinstatement of paramedic accreditation.
## PARAMEDIC SKILLS REFRESHER REINSTATEMENT CHECKLIST

### Action | Date | Signature
--- | --- | ---
1. Read and reviewed EMS Policy and Procedure Sections 6 & 7 (signed by provider). |  |  
2. Orientation at EMS Office, Policy 318 review. |  |  
3. Documentation Station: Administered by EMS |  |  
4. Skills refresher verification: The skills must be signed off by a BH physician or Medical Director associated with your employer. |  |  
   a. |  |  
   b. |  |  
   c. |  |  
   d. |  |  
   e. |  |  
   f. |  |  
   g. |  |  

After the above is completed, please forward the checklist to the EMS Agency for review and determination on reinstatement of paramedic accreditation.
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 the requirements of this policy.

III. AUTHORITY: California Health and Safety Code Section 1797.178, 1797.204, 1797.218 and California Code of Regulations Section 10017

IV. PROCEDURE:
The following equipment and supplies shall be maintained on each Response and/or Transport Unit in Ventura County.
### Policy 504: ALS and BLS Unit Equipment and Supplies

**Page 2 of 5**

#### A. ALL BLS AND ALS RESPONSE AND/OR TRANSPORT UNITS

<table>
<thead>
<tr>
<th>Item</th>
<th>ALS / BLS Unit Minimum Amount</th>
<th>ASV/CCT Minimum Amount</th>
<th>FR/ALS Minimum Amount</th>
<th>Search and Rescue Minimum Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clear masks in the following sizes:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 adult</td>
</tr>
<tr>
<td>Child</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 infant</td>
</tr>
<tr>
<td><strong>Bag valve units</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 adult</td>
</tr>
<tr>
<td>Child</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 infant</td>
</tr>
<tr>
<td><strong>Nasal cannula</strong></td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Adult</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
</tr>
<tr>
<td><strong>Nasopharyngeal airway</strong></td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
</tr>
<tr>
<td>(adult and child or equivalent)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oropharyngeal Airways</strong></td>
<td>1 each size</td>
<td>1 each size</td>
<td>1 each size</td>
<td>1 each size</td>
</tr>
<tr>
<td>Adult</td>
<td>1 each size</td>
<td>1 each size</td>
<td>1 each size</td>
<td>1 each size</td>
</tr>
<tr>
<td>Child</td>
<td>1 each size</td>
<td>1 each size</td>
<td>1 each size</td>
<td>1 each size</td>
</tr>
<tr>
<td>Infant</td>
<td>1 each size</td>
<td>1 each size</td>
<td>1 each size</td>
<td>1 each size</td>
</tr>
<tr>
<td><strong>Oxygen with appropriate adjuncts (portability required)</strong></td>
<td>10 L/min for 20 minutes</td>
<td>10 L/min for 20 mins.</td>
<td>10 L/min for 20 mins.</td>
<td>10 L/min for 20 mins.</td>
</tr>
<tr>
<td><strong>Portable suction equipment</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Transparent oxygen masks</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult nonrebreather</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Child</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Infant</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Bandage scissors</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Bandages</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 4&quot;x4&quot; sterile compresses or equivalent</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>• 2&quot;, 3&quot;, 4&quot; or 6&quot; roller bandages</td>
<td>6</td>
<td>2</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>• 10&quot;x 30&quot; or larger dressing</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Blood pressure cuffs</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Adult</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Child</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Infant</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Emesis basin/bag</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Flashlight</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Half-ring traction splint or equivalent device</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Pneumatic or rigid splints (capable of splinting all extremities)</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Potable water or saline solution</strong></td>
<td>1 gallon</td>
<td>1 gallon</td>
<td>1 gallon</td>
<td>1 gallon</td>
</tr>
<tr>
<td><strong>Cervical spine immobilization device</strong></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td><strong>Spinal immobilization devices</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>KED or equivalent</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>50° minimum with straps</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Sterile obstetrical kit</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
## Policy 504: ALS and BLS Unit Equipment and Supplies

### Page 3 of 5

<table>
<thead>
<tr>
<th>Equipment</th>
<th>ALS / BLS Unit Minimum Amount</th>
<th>ASV/CCT Minimum Amount</th>
<th>FR/ALS Minimum Amount</th>
<th>Search and Rescue Minimum Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tongue depressor</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Cold packs</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

**OPTIONAL EQUIPMENT**

- Nerve agent antidote – (3 kits per person suggested)
- Tourniquet
- Impedance threshold device

### B. TRANSPORT UNIT REQUIREMENTS

- Ambulance cot and collapsible stretcher, or two stretchers, one of which is collapsible.
- Automated External Defibrillator (if not equipped with ALS monitor/defibrillator)
- Straps to secure the patient to the stretcher or ambulance cot, and means of securing the stretcher or ambulance cot in the vehicle.
- Ankle and wrist restraints. Soft ties are acceptable.
- Sheets, pillow cases, blankets and towels for each stretcher or ambulance cot, and two pillows for each ambulance.
- Bedpan
- Urinal

**Personal Protective Equipment per State Guideline #216**

- Rescue helmet
- EMS jacket
- Work goggles
- Tyvek suit
- Tychem hooded suit
- Nitrile gloves
- Disposable footwear covers
- Leather work gloves
- Field operations guide

<table>
<thead>
<tr>
<th>Equipment</th>
<th>ALS / BLS Unit Minimum Amount</th>
<th>ASV/CCT Minimum Amount</th>
<th>FR/ALS Minimum Amount</th>
<th>Search and Rescue Minimum Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rescue helmet</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>EMS jacket</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Work goggles</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tyvek suit</td>
<td>2 L / 2 XXL</td>
<td>1 L / 1 XXL</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tychem hooded suit</td>
<td>2 L / 2 XXL</td>
<td>1 L / 1 XXL</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nitrile gloves</td>
<td>1 Med / 1 XL</td>
<td>1 Med / 1 XL</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disposable footwear covers</td>
<td>1 Box</td>
<td>1 Box</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Leather work gloves</td>
<td>3 L Sets</td>
<td>1 L Set</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Field operations guide</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
### C. ALS TRANSPORT UNIT REQUIREMENTS

<table>
<thead>
<tr>
<th>Item</th>
<th>ALS / BLS Unit Minimum Amount</th>
<th>ASV/CCT Minimum Amount</th>
<th>FR/ALS Minimum Amount</th>
<th>Search and Rescue Minimum Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cellular telephone</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Two-way radio for alternative base hospital contact</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Alternate ALS airway device</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Arm Boards</td>
<td>9&quot;</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>18&quot;</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Blood glucose determination devices</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cardiac monitoring equipment</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>CO₂ monitor</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Continuous positive airway pressure (CPAP) device</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Defibrillator pads or gel</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>1 adult – No Peds.</td>
</tr>
<tr>
<td>Defibrillator w/adult and pediatric paddles/pads</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>EKG Electrodes</td>
<td>10 sets</td>
<td>3 sets</td>
<td>3 sets</td>
<td>6 sets</td>
</tr>
<tr>
<td>Endotracheal intubation tubes, sizes 5.5, 6.0, 6.5, 7.0, 7.5, 8.0, 8.5 with stylets</td>
<td>1 of each size</td>
<td>1 of each size</td>
<td>1 of each size</td>
<td>4, 5, 6, 6.5, 7, 7.5, 8</td>
</tr>
<tr>
<td>Intraosseous infusion needles</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Intravenous Fluids (in flexible containers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 5% Dextrose in water, 50 ml</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>• Normal saline solution, 500 ml</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>• Normal saline solution, 1000 ml</td>
<td>6</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>IV admin set - microdrip</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>IV admin set - macrodrip</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>IV catheter, Sizes 14, 16, 18, 20, 22, 24</td>
<td>6 each 14, 16, 18, 20</td>
<td>3 each 22</td>
<td>2 each</td>
<td>2 each</td>
</tr>
<tr>
<td>Laryngoscope, replacement bulbs and batteries</td>
<td>1 set</td>
<td>1 set</td>
<td>1 set</td>
<td>1 set</td>
</tr>
<tr>
<td>Curved blade #2, 3, 4</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
</tr>
<tr>
<td>Straight blade #1, 2, 3</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
<td>1 each</td>
</tr>
<tr>
<td>Magill forceps</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Child</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Nebulizer</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Nebulizer with in-line adapter</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Needle Thoracostomy kit</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Pediatric length and weight tape</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>SAO₂ monitor</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>OPTIONAL ALS EQUIPMENT (No minimums apply)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexible intubation style</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EZ-IO intraosseous infusion system</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## D. ALS MEDICATION, MINIMUM AMOUNT

<table>
<thead>
<tr>
<th>Medication</th>
<th>ALS/ BLS Unit Minimum Amount</th>
<th>ASV/CCT Minimum Amount</th>
<th>FR/ALS Minimum Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activated charcoal, adult and pediatric</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Adenosine, 6 mg</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Aspirin, 162 mg</td>
<td>2 ea. 162 mg or 4 ea 81 mg</td>
<td>2 ea. 162 mg or 4 ea 81 mg</td>
<td>2 ea. 162 mg or 4 ea 81 mg</td>
</tr>
<tr>
<td>Amiodarone, 50mg/ml 3ml</td>
<td>6</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Atropine sulfate, 1 mg/10 ml</td>
<td>2</td>
<td>2</td>
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</tr>
<tr>
<td>Diphenhydramine (Benadryl), 50 mg/ml</td>
<td>2</td>
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<td>1</td>
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<tr>
<td>Bronchodilators, nebulized beta-2 specific</td>
<td>6</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Calcium chloride, 1000 mg/10 ml</td>
<td>2</td>
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<td>1</td>
</tr>
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<td>Dextrose 50%, 25 GM/50</td>
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<td>Epinephrine 1:1,000, 1mg/ml</td>
<td>4</td>
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<tr>
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<td>Glucagon, 1 mg/ml</td>
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<td>Furosemide (Lasix), 20 mg/2ml</td>
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<td>Lidocaine, 100 mg/5ml</td>
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<td>2</td>
</tr>
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<td>2</td>
</tr>
<tr>
<td>Morphine sulfate, 10 mg/ml</td>
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</tr>
<tr>
<td>Naloxone Hydrochloride (Narcan), adult and pediatric doses</td>
<td>10 mg</td>
<td>4 mg</td>
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<td>Nitroglycerine preparations, 0.4 mg</td>
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<tr>
<td>Normal saline, 10 ml</td>
<td>2</td>
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<tr>
<td>Oral glucose 15gm unit dose</td>
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</tr>
<tr>
<td>Sodium bicarbonate, 50 mEq/ml</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Ondansetron 4 mg IV single use vial</td>
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<td>4</td>
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<tr>
<td>Ondansetron 4 mg oral</td>
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</tr>
<tr>
<td>Midazolam Hydrochloride (Versed)</td>
<td>5 mg/ml</td>
<td>5 mg/ml</td>
<td>5 mg/ml</td>
</tr>
<tr>
<td></td>
<td>2 vials</td>
<td>2 vials</td>
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I. PURPOSE: To define the communications frequencies required on VCEMS licensed ambulance provider response units.

II. AUTHORITY: Health and Safety Code, Division 2.5, Section 1797.204

III. POLICY: Ambulance provider response units shall be equipped as listed in this policy.

IV. PROCEDURE:

A. Ambulance provider response unit mobile radios shall be programmed with the first 64 channels of the current Ventura County Fire Protection District radio plan. To reduce confusion, assignments for channels 1-64 will be programmed exactly as listed in the radio plan on all vehicle mounted mobile radios. It is recommended that all portable radios also utilize the same program list; however, providers may adjust the portable lists to accommodate agency specific issues.

B. Channels 30, 31 and 32, in the Ventura County Fire Protection District radio plan, are available for the ambulance provider to program agency specific frequencies, if desired. Frequencies on channels 65 and above may be programmed at provider’s discretion.

C. Any VCEMS licensed ambulance provider units that respond to 911 calls shall have a minimum of one mobile radio and one portable radio compliant with this policy.

D. Ambulance providers will post a list of frequency channel assignments in each response unit.

E. A list of frequency channel assignments will be submitted to VCEMS by each ambulance provider.
I. PURPOSE: To develop a standardized protocol for Multi-Casualty Incident (MCI) response and training in Ventura County.

II. AUTHORITY: California Health and Safety Code, Section 1797.151, 1798, and 1798.220.

III. California Code of Regulations, Sections 100147 and 100169. APPLICATION: This policy defines the on-scene medical management, transportation of casualties, and documentation for a multi-casualty incident utilizing the principles of the Incident Command System as outlined in the MCI Plan.

IV. DEFINITIONS:

A. **MCI/Level I**—asuddenly occurring event that exceeds the capacity of the routine first response assignment. (Approx. 3-14 victims)

B. **MCI/Level II**—asuddenly occurring event that exceeds the capacity of the routine first response assignment. (Approx. 15-49 victims)

C. **MCI/Level III**—asuddenly occurring event that exceeds the capacity of the routine first response assignment. (Approx. 50+ victims)

V. TRAINING:

The following training will be required:

A. **Basic MCI Training** for fire companies, field EMS providers, and Mobile Intensive Care Nurses (MICNs).

   Focus: Hands-on functions as described in the Ventura County EMS (VCEMS) basic MCI curriculum
   1. Initial basic course: 4 hours
   2. Prerequisite for the course (for fire companies and EMS providers): Introduction to the Incident Command System (ICS 100), and ICS for Single Resource and Initial Action Incidents (ICS 200). There is no prerequisite for MICNs.
   3. Course will be valid for two years

B. **Advanced MCI Training** for battalion chiefs, EMS managers, field supervisors, and pre-hospital care coordinators

   Focus: Command and major function integration as described in the VCEMS advanced MCI curriculum.
   1. The advanced MCI course is divided into two modules. The morning session (module 1) is designed for new supervisory personnel and will cover specific principles of on-scene medical
Policy 131: Multi Casualty Incident Response
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management, transportation of casualties and documentation for multi-casualty incidents. The afternoon session (module 2) will consist of a curriculum review and advanced MCI tabletop scenarios. Participants attending their initial advanced MCI course are required to attend both module 1 and module 2.

2. Initial advanced MCI training will be offered annually in January.
3. Initial Advanced MCI Course: 8 hours
4. Prerequisite for the course: Introduction to the Incident Command System (ICS 100), ICS for Single Resource and Initial Action Incidents (ICS 200), and National Incident Management System, an Introduction (ICS 700)
5. Course will be valid for two years

C. Basic MCI Refresher Training
Focus: Overview of multi-casualty operations as described in the VCEMSMCIBasic Curriculum
1. Refresher Course: 2 hours
2. Course will be valid for two years

D. Advanced MCI Refresher Training (Module 2 of the Advanced MCI Course)
Focus: Overview of Command and Major Function Integration as described in the VCEMSAdvanced MCI Curriculum
1. Refresher Course: 4 hours
2. Advanced MCI refresher course will be offered twice annually, in January and July.
3. Course will be valid for two years

VI. ACTIVATION OF THE MULTI-CASUALTY INCIDENT RESPONSE PLAN:

A. Report of Incident
The report of a multi-casualty incident (MCI) will ordinarily be made to a Ventura County Public Safety Answering Point (PSAP) in the following manner:

- Citizen/witness report via 9-1-1 Public Service Answering Point (fire service will activate the MCI plan).
- Hospital personnel alerting VCEMS.
- Direct report from law enforcement, or an EMS provider with capability to contact a PSAP.

B. Prehospital Response

1. The first responder agency or other public safety official will determine that the number and extent of casualties exceed the capacity of the day-to-day EMS response and/or EMS system (depending on the level of the MCI) and will request their PSAP to contact the EMS Agency and activate the MCI Plan. The Incident Commander (IC) or appropriate public safety official will request activation and/or response of any

2. Supporting public safety/service agencies which may be needed, for example:
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- Transportation resources; such as additional ambulances or buses
- Ventura County Chapter American Red Cross
- Public Health/EMS Emergency Preparedness Office
- Disaster Caches

3.2. The IC will appoint a Patient Transportation Group Supervisor. The Patient Transportation Group Supervisor will retain or delegate the Medical Communications Coordinator (MEDCOMM) position to communicate all casualty transportation information to the base hospital or designated VCEMS representative. Periodically, a request will be made of involved hospitals to update their status in order to accommodate the number of casualties remaining to be evacuated from the scene. (The first responder will provide for the initial triage and treatment of casualties utilizing S.T.A.R.T. criteria.)

C. Ventura County Trauma System Considerations

1. For any level MCI in which a traumatic mechanism exists, the base hospital shall be the trauma center in whose trauma catchment area the incident occurred. The base hospital for any level MCI in which one or more patients present with traumatic injuries will be the trauma center for the area where the incident is located, based on the Ventura County trauma center service area map.

2. On an MCI/Level I, patients with traumatic injuries will be triaged utilizing the Ventura County Field Triage Decision Scheme, in addition to S.T.A.R.T. triage. On an MCI/Level I, the applicable VC trauma step shall be relayed to the base hospital by MEDCOMM for all patients with traumatic injuries, in addition to S.T.A.R.T. triage category, age, and gender.

3. Patients will be transported in accordance with VCEMS 131 Attachment C "MCI Trauma Patient Destination Decision Algorithm."

a. Refer to VCEMS 131 Attachment D "Initial Trauma Patient Care Capacity" for guidelines on initial capacity for hospitals within Ventura County.

D. Ventura County EMS Agency

Upon receiving MCI information and a request from scene public safety personnel to activate the MCI Plan, EMS may contact the Base Hospital that MEDCOMM has communicated with during the initial phases of the MCI, and request an update before relieving the Base Hospital of this duty. The EMS Agency may then enact the medical clearing house and perform the following:
Policy 131: Multi Casualty Incident Response

1. Alert all hospitals that an MCI has occurred and request that they prepare to receive casualties from the scene. This communication will include:
   • The type, size, and location of the incident.
   • The estimated number of casualties involved.
   • Advise area hospitals to be prepared to confirm their status and make preparations for the possible receipt of patients.

2. Update all hospitals periodically or when new or routine information is received. Hospitals in unaffected areas may or may not be requested to remain in a standby readiness mode.

3. Inform MEDCOM of each hospital’s availability.

4. Relay all requests/information regarding hospital resource needs or surpluses to the Regional Disaster Medical Health Coordinator (RDMHC) representative, when appropriate. Coordinate response of additional medical equipment and personnel.

5. Inform hospitals when remaining casualties have been cleared from the MCI scene.

6. Receive MCI information from PSAP and alert the appropriate VCEMS and Ventura County Health Care Agency (HCA) personnel.

7. Initiate the VCEMSE emergency response plan to an appropriate level appropriate to the information provided.

8. Activate the Health Care Agency – Department Operations Center, when appropriate.

9. Inform the Ventura County Sheriff’s Office of Emergency Services (OES) and/or the Operational Area EOC of EMS activity, when appropriate.

10. Alert the RDMHC representative, when appropriate.

11. Request out-of-county medical resources, when necessary, with EMS/HCA management approval. Coordinate requests with OES staff and RDMHC representative.

12. Assist in the coordination of transportation resources.

13. Assist in the coordination of health care facility evacuation.

14. Communicate with hospitals, skilled nursing facilities and appropriate EOCs when warranted.

15. Assist in coordination of incident evaluations and debriefings.

E. Hospital Response

1. Receive/acknowledge incident information and inform hospital administration.

2. Activate the hospital’s disaster/emergency response plan to an appropriate level based on the MCI’s location, type, and number of casualties.

3. Hospitals experiencing difficulty in obtaining needed resources to manage casualties should make needs known to the EMS Agency representative.
Policy 131: Multi Casualty Incident Response

F. Documentation

1. Level 1 MCI: The care of each patient will be documented using the Ventura County electronic patient care reporting system (VCePCR).

2. Level 2 and 3 MCI: Each patient transported to a hospital shall have their care documented on a multi-casualty patient record (Policy 131, Attachment A).
   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 en route 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 the incident.
   d. Patients not transported from a Level II or Level III MCI, may be documented using the multi-casualty non-transport record (Policy 131, Attachment B).

3. Ventura County EMS Approved MCI Worksheets
   a. Ventura County EMS Providers shall utilize the approved MCI worksheets described in the Basic and Advanced MCI courses and attached to this policy as follows:
      1. Form 131-C MCI Trauma Patient Destination Decision Algorithm (Policy 131, Attachment C)
      2. Form 131-D Initial Patient Care Capacity – MCI All Levels (Policy 131, Attachment D)
      3. Form 131-1 Level 1 MCI Worksheet (Policy 131, Attachment E)
      4. Form 131-2 Hospital Worksheet (Policy 131, Attachment F)
      5. Form 131-3 Out of County Hospital Worksheet (Policy 131, Attachment G)
      6. Form 131-4 Treatment Tarp Updates (Policy 131, Attachment H)
      7. Form 131-4A Immediate Treatment Area (Policy 131, Attachment I)
      8. Form 131-4B Delayed Treatment Area (Policy 131, Attachment J)
      9. Form 131-4C Minor Treatment Area (Policy 131, Attachment K)
     10. Form 131-4D Morgue Area (Policy 131, Attachment L)
4. Mobile Data Computer (MDC) Equipped Ambulances
   a. In an effort to enhance patient tracking, transport personnel operating ambulances equipped with MDC’s, when able, will document the triage tag number, patient name, and destination in the comment section of the dispatch ticket on the MDC.

VII. DE-MOBILIZATION OF THE MULTICASUALTY INCIDENT RESPONSE PLAN:

A. Prehospital de-mobilization
   1. The Incident Commander (IC) will notify EMS that the MCI has been cleared when all casualties have been removed from the MCI scene.
   2. VCEMS will notify all hospitals that the MCI scene has been cleared.
   3. VCEMS will advise hospitals that casualties may still be routed to various receiving facilities.
   4. Hospitals will supply EMS with data on casualties they have received via RedNet, telephone, fax, or RACES.
   5. VCEMS will maintain communication with all participants until all activity relevant to casualty scene disposition and hospital resource needs are appropriately addressed.
   6. VCEMS will advise all participants when VCEMS is being deactivated.

VIII. CRITIQUE OF THE MULTICASUALTY INCIDENT:

A. VCEMS Agency may conduct a post-incident analysis of the MCI at their discretion or at the request of agencies involved in the incident. All medically involved participants will be invited.

B. VCEMS Agency may publish a written report following the post-incident analysis. The report will include minutes from the post-incident analysis meeting, any summary data available, and written reports.
MULTICASUALTYMEDICAL RESPONSE PLAN

Steven L Carroll, Paramedic
Ventura County EMS Administrator

Angelo Salvucci, MD, FACEP
Ventura County EMS Medical Director

June 2013

County of Ventura Emergency Medical Services Agency
MULTICASUALTYMEDICALRESPONSEPLAN

SECTIONI INTRODUCTION

A. Purpose

The proper management of a large number of medical injuries following a natural or human-induced event is imperative if morbidity and mortality are to be minimized. The recognition of the type and number of injured, and a rapid dissemination of known information (communication) are necessary elements to begin an effective response to a medical disaster. A well-organized medical community, which has a viable communications system, an effective intelligence-gathering network, and scheduled exercises of its disaster response plan, will then be prepared to respond to the needs of the injured community.

The Ventura County Multi-Casualty Medical Response Plan is the result of ongoing cooperative efforts of many public/private agencies and individuals committed to the prevention of further suffering and loss of life following a large-scale medical incident.

The Ventura County Emergency Medical Services Agency (VCEMS) is responsible for leading efforts to define the structure and coordinate various components of the County’s Multi-Casualty Medical Response Plan. This plan is developed in concert with State, municipal, and other Ventura County agencies. It outlines the scope of responsibility for the County’s multi-casualty responders; however, it does not detail duties entrusted to a particular organization.

The County of Ventura Multi-Casualty Medical Response Plan is modeled after the State’s Emergency Medical Services Authority’s Disaster Medical Response Plan (September 2007), to promote standardization and continuity of response throughout the State of California. Acknowledgment is given hereinto the California EMS Authority’s commitment to this goal.

B. Goal

It is the goal of this plan to provide definition, structure, and coordination to the medical response elements within Ventura County to reduce multi-casualty related morbidity and mortality at anytime or location within the County.

C. Plan Organization

The County of Ventura Multi-Casualty Medical Response Plan is divided into five sections:

- Section I: Introduction
- Section II: Response Organizations
- Section III: Response Narrative
- Section IV: Planning Concepts
- Section V: Information Management
- Section VI: Resource Acquisition

In Section I, the plan, goal, organization, and authorities are referenced. Also included in this section is a brief discussion on the subject of medical disaster planning and the nature and implications of a medical disaster.

D. Planning for Medical Disasters
1. Levels of Medical Disaster

When a medical disaster occurs, it will be important to rapidly ascertain the actual (and projected) number of medical injuries. The number of victims injured will govern the community’s medical response. Responsibility lies with responders to accurately report incident information and casualty data. Directors of EMS resources must have reliable knowledge of area and county-wide medical capabilities. It is important for decision-makers to have an understanding of the EMS systems capabilities at any given time during a medical incident response and recovery phase. Together, incident information and resource knowledge can be combined to address the response to medical incidents.

In Ventura County, three levels of victim events have been defined. All involve more than one person injured; the separation of levels lies in the resources mobilized to respond to each situation. The listing in Section II begins to outline the responders and their activities.

The following describes the three levels of victim situations as recognized by VCEMS:

**MCI/Level I:** a suddenly occurring event that exceeds the capacity of the routine first response assignment (Approx. 3-14 victims).

**MCI/Level II:** a suddenly occurring event that exceeds the capacity of the routine first response assignment. (Approx. 15-49 victims)

**MCI/Level III:** a suddenly occurring event that exceeds the capacity of the routine first response assignment. (Approx. 50+ victims)

2. Addressing Medical Disasters

When planning the mitigation of a medical disaster, there are certain points which must be assumed prior to beginning the process. The MCI/LEVEL I is practiced regularly by local emergency agencies. An MCI/LEVEL II is less frequent and occurs several times a year. An MCI/LEVEL III occurs rarely and the following assumptions are primarily applicable to these situations:

The very nature of a medical disaster will injure and kill a large amount of people within a relatively short period of time. This will create a medical need, which will immediately overwhelm the day-to-day EMS response system. This situation may occur in one or more geographical locations of Ventura County, or may include the entire County.

The initial assessment of medical injuries may cause the disaster to be classified as a disaster scene at one level; however, further assessment may call for an upgrade of the size or classification. For example: an accident at a chemical plant, which initially injures 15 people, may be first classified as an MCI/LEVEL II. However, if a toxic material cloud injures 100 more, the incident may be re-classified.

To assess the medical disaster appropriately, two components must be available to responding officials: 1) intelligence regarding the complexity of the incident, the numbers, and types of injuries, and 2) communication to relay this information to others supporting agencies.

To respond to a medical disaster appropriately, two elements are necessary: 1) anticipation of needed medical resources, and 2) early request (activation) of those resources (in advance of when they are needed, if possible.)

The requested medical resources must be available at the designated area if life and limb are to be saved. These resources may be found inside Ventura County, or sought outside the County.
F. SECTION II  
RESPONSE ORGANIZATIONS

The following is a list of the organizations that may play a role in the medical response to an MCI. Included is a brief description of the scope of responsibility of each organization. This inventory reflects the primary charge(s), however, other duties/responsibilities may be undertaken which are not listed here.

1. Ventura County Health Care Agency (HCA)

   HCA is the parent organization of all of the County’s health services. In a widespread, declared medical crisis, policy and the general direction of medical services will come from the Agency’s Director and the County Health Officer. The divisions of the Health Care Agency are Public Health, Hospitals (Ventura County Medical Center and Santa Paula Hospital), Clinics/Ambulatory Care, Behavioral Health, and the Medical Examiner.

   Health Care Agency responsibilities during an MCI include:
   - Providing overall direction of medical and health care response to an MCI.
   - Requesting/offering of medical mutual aid from/to other counties through the Health Officer.
   - Communicating with State agencies (Department of Health Service, Emergency Medical Services Authority, California Emergency Management Agency (CalEMA)) in order to report on conditions and/or request needed services.
   - Calling for the activation of a Field Treatment Site (FTS).

2. Ventura County/Emergency Medical Services (VCEMS)

   VCEMS is a division of the Public Health department within the HCA. VCEMS coordinates and supports medical resources responding to an MCI; particularly those agencies and institutions offering emergency and acute medical care. EMS maintains working relationships with the State Emergency Medical Services Authority (EMS Authority), Ventura County transport and fire service providers, base and receiving hospitals, the Hospital Association of Southern California, and municipal emergency planning coordinators.

   VCEMS responsibilities during an MCI may include some or all of the following:
   - Coordinating destinations
   - Ascertaining hospital availability
   - Coordinating medical resources (in and out of county)
   - Communicating with the County Health Officer
   - Coordinating the dissemination of Public Health information
   - Responding to the scene, primary dispatch center, HCA Department Operations Center (DOC) or Emergency Operations Center (EOC)
   - Obtaining briefing from base hospital for transition
   - Establishing communication with OES (consider EOC activation)
   - Working within the Incident Command structure, as the medical/health branch of the Operations Section at the County’s EOC
   - Advising the County Health Officer as to the status of medical resources in Ventura County
   - Establishing liaison with the EMS Authority through the Regional Regional Disaster Medical/Health Coordinator (RDHMC)
   - Coordinating resource requests and availability between acute care hospitals, advanced life support
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rtproviders, bascilifesupporttransportproviders, skillednursingfacilities, and mentalhealthfacilities

- Maintain communications with receiving hospitals with Ventura County and throughout the region through the use of the Reddinet hospital communications system.
- Establishing direct communications with the Hospital Disaster Support Communications Radio Amateur Civil Emergency Services (RACES)
- Establishing contact with medical coordinators within city emergency operations centers via the Ventura County EOC to ascertain status and conditions at local Medical Aid Stations (MAS) and any other medical or related concerns
- Activate the Ventura County Medical Reserve Corps (MRC) as indicated and coordinate all MRC operations through VCEMS and HCA DOC.
- Requesting Disaster Medical Assistance Teams through the RDMHC to implement a Field Treatment Site (FTS) operation.
- Assisting in the request and coordination of deployment of Critical Incident Stress Management teams
- Gathering information and documentation from Medical Communications (MedComm)
- Initiating and coordinating an incident review
- Collecting data on casualties

3. Municipal Governments

Municipal governments have the responsibility and most likely the best capabilities for assessment of local community damage and injury. Public safety, Neighborhood Watch teams, Disaster Assistance Response Teams (D.A.R.T.), Community Emergency Response Teams (C.E.R.T.), and RACES operators are some of the data-gathering groups which may report on conditions to city/county EOCs. Maintaining effective communications between VCEMS and the EOC managers/coordinators at the city level through the use of a medical/health branch liaison is essential in verifying emergency medical care and available medical resources within the city or county jurisdictions. The city/county and VCEMS will coordinate efforts to facilitate medical aid stations and hospitals in the management of casualty care.

Responsibilities of municipal governments during an MCI include:

a. Ventura County Office of Emergency Services
   - Activating the EOC, coordinating large incidents
   - Coordinating notifications and non-medical mutual aid requests (regional, state, etc.)
   - Obtaining resources for on-scene personnel
   - Coordinating resource requests

b. Law Enforcement
   - Providing force protection
   - Providing Search and Rescue (SAR)
   - Providing Scene Control
   - Providing Traffic Control
   - Assisting with Incident Command System (ICS) establishment/Unified Command
   - Providing Body protection (mortuaries)
   - Conducting Investigations
   - Providing a Public Information Officer (PIO)
   - Conducting Damage Assessment
   - Managing Law Enforcement Air Operations
c. Coroner / Medical Examiner

- Responding to the scene
- Processing fatalities
- Providing body removal bags
- Investigating with law enforcement
- Designating Morgue Manager
- Conducting family notifications
- Requesting additional personnel or resources through the California Coroner / Medical Examiner Mutual Aid Plan (this includes Federal Disaster Mortuary Teams)

d. Fire Departments

The fire departments will engage in public safety activity. Fire suppression, rescue, medical aid and mitigation of hazardous conditions will occupy their resources along with intelligence gathering operations. Fire agencies will report to municipal and county EOCs as appropriate.

Fire agency responsibilities during an MCI include:

- Providing community assessment of damage and casualties
- Conducting mitigation of physical hazards
- Performing triage and treatment (including setting up, managing and staffing of treatment areas with First Responder ALS resources.
- Conducting scene assessment
- Determining resource needs
- Assisting with ICS establishment/Unified Command
- Conducting Hazard Control
- Providing Rescue
- Providing a Public Information Officer (PIO)
- Setting Incident Objectives
- Providing scene documentation
- Driving transport vehicles as needed
- Providing communications as needed (Notify EMS and Coroner)
- Providing Dispatch (automatic responses, coordinate with other fire dispatch, communicate with ICS)
- Managing fire and medical air operations
- Providing comfort measures

4. Media

Local television, radio, and newspapers responsibilities during an MCI include:

- Public awareness (traffic, safety issues, etc.)
- Working with PIOs
5. Transportation Agencies

The transportation agencies are those private air/ground ambulance operators licensed within Ventura County. During a time of medical crisis, this definition could be expanded to include private and public providers from outside the county, as well as other medical transportation providers such as wheelchair vans and buses (see Ventura County Transportation Authority below).

Responsibilities of Transportation Agencies during an MCI include:

a. Ground
   - Providing MEDCOMM
   - Setting up and staffing treatment areas
   - Providing medical supplies (initial and ongoing)
   - Conducting triage
   - Providing documentation (collect and forward information to VCEMS and base/receiving hospitals as needed)
   - Providing transport
   - Providing scene assessment
   - Determining resource needs
   - Providing scene documentation (collect documentation and forward to EMS)
   - Providing communications
   - Advising receiving hospital of number of patients they will receive

b. Air
   - Air Ambulance
     - Providing transport
     - Providing documentation
     - Conducting transfers
     - Providing additional aircraft as needed
   - Rescue Aircraft
     - Providing transport
     - Providing documentation
     - Conducting transfers
     - Providing additional aircraft as needed

6. Hospitals (Acute Care Health Facilities)

Hospitals are considered by many to be the frontline or main healthcare providers following a medical disaster. The base station hospitals will be responsible to coordinate patient destinations until relieved of that duty by VCEMS staff.

The primary responsibilities of a hospital in a medical crisis include:

Base Hospital
   - Communicating with MEDCOMM at the scene(s) of an MCI
   - Determining initial bed availability
   - Establishing destination decisions
   - Providing medical control
• Providing treatment
• Establishing patient tracking
• Activating in-house plan (as determined by hospital protocol)
• Coordinating with VCEMS
• Communicating casualty data to VCEMS
• Providing ongoing resource status and patient transport/destination information through the use of the ReddiNet system

Receiving Hospital
• Providing treatment
• Establishing patient tracking
• Activating in-house plan (as determined by hospital protocol)
• Coordinating with VCEMS
• Communicating casualty data to VCEMS
• Providing ongoing resource status and patient transport/destination information through the use of the ReddiNet system

7. American Red Cross-Ventura County Chapter

American Red Cross will assist in a variety of humanitarian ways to ease the negative consequences following a medical disaster.

American Red Cross identified duties during an MCI may include:

• Deployment of mental health teams for civilian critical incident stress management (Federal Mandated during air disasters).
• Establishing the disaster welfare inquiry service for the purpose of identifying and tracking medical disaster victims.
• Providing care and shelter for victims left homeless or displaced.
• Providing food/comfort services for emergency responders and victims.

8. California EMS Authority Region I Disaster Medical/Health Coordination (RDMHC) Area

RDMHC will act as a contact point for needed resources when an MCI exceeds the capability of the operational area (Ventura County) to manage the injuries.

The RDMHC is a network of regional counties, which are reformed together in an effort to access medical mutual aid following a large incident or widespread disaster. This region includes San Luis Obispo, Santa Barbara, Ventura, Los Angeles, and Orange Counties. Contact between the Region I RDMHC and Ventura County is the responsibility of the County’s Medical Health Operational Area Coordinator (MHOAC), or his designee.

Duties of the RDMHC following an MCI/LEVEL III may include:

• Assessing the disaster-affected county to ascertain needed resources.
• Accessing other counties within Region I to acquire resources for the requesting county.
• Contacting the State EMS Authority to request additional resources and coordinate those already obtained.

9. State of California Emergency Medical Services Authority
The Emergency Medical Services Authority ensures quality patient care by administering an effective, state-wide system of coordinated emergency medical care, injury prevention, and disaster medical response.

State EMS Authority identified duties during an MCImay include:

- Activate and/or liaison with the Region IRDMHC.
- Liaison between state and federal medical disaster relief.
- Maintaining communication with VCEMS relative to the status of the medical disaster and affected resources.

10. Hospital Association of Southern California (HASC)

The HASC consists of more than 200 hospitals (public, private, not-for-profit, for-profit, and specialty hospitals). The region covers six counties: Los Angeles, Orange, Santa Barbara, Ventura, Riverside, and San Bernardino.

HASC identified duties during an MCImay include:

Providing support and liaison to its member hospitals during a time of medical crisis.

11. Ventura County Transportation Authority

VCTA will respond to the request of public safety to assist with the evacuation of medical casualties from the scene. Buses, both large and small, may be used to transport casualties to and from hospitals, medical aid stations, or field treatment sites.

12. Salvation Army

Salvation Army is called upon to assist in the feeding and sheltering of emergency workers and those in need.

13. State and Federal Agencies that may be involved in an incident include:

- National Transportation and Safety Board
- Federal Aviation Administration
- State Office of Emergency Services
- State Emergency Medical Services Authority
- Regional Disaster Medical Health Coordinator / Specialist
- Federal Bureau of Investigation
- National Guard
- Military
- Alcohol, Tobacco, and Firearms
- Hazardous Materials Organizations
- California Department of Forestry
- Federal Emergency Management Administration
- State Parks
- National Disaster Medical System (NDMS – DMAT, DMORT, etc.).
- Coast Guard
SECTION III RESPONSE NARRATIVE

This section provides a narrative picture of the situations, which may typically unfold in the evolution of the three different types of medical disaster levels.

A. Multi Casualty Incident (MCI) LEVEL I

In the MCI/LEVEL I, first responders such as paramedics, fire service companies or BLS ambulance providers will be dispatched to the scene by the 9-1-1 system. Upon arrival, they will be presented with a situation which, by virtue of patient numbers, overwhelm the medical resources initially dispatched. The first responders will notify their agency’s dispatch of the need for additional resources. In order to organizationally address this incident, the Incident Command System will be utilized with an emphasis upon the Multi Casualty Branch of the Operations Section.

The paramedic base hospital will provide direction primarily by assigning those patients involved to a receiving hospital destination; and when necessary, by directing the medical control of those acutely injured victims.

Patient care information transmitted to the paramedic base hospital will be abbreviated and patients will be placed in “immediate”, “delayed” and “minor” categories in keeping with the Simple Triage and Rapid Treatment (S.T.A.R.T.) triage plan. Patients with traumatic injuries will also be triaged into the Ventura County trauma system and will be transported to a trauma center in accordance with VCEMS Policy 131 Attachment C - MCI trauma patient destination decision algorithm. Patient care is focused upon life stabilizing treatments and expeditious transport of victims to appropriate receiving hospitals.

Receiving hospitals receive those casualties as directed by the base hospital and provide emergency hospital care. They will be notified of the number of patients and classifications prior to their arrival and may be given an initial count of the patient’s injuries.

Review of the medical component of an MCI/LEVEL I is coordinated and managed by the base hospital. VCEMS will act primarily in a supportive role for this level incident, but may coordinate certain aspects of the incident as needed. VCEMS Agency may conduct a post-incident analysis of the MCI at their discretion or at the request of agencies involved in the incident. Should a post-incident analysis be conducted, all medically involved participants will be invited. VCEMS Agency will publish a written report following the post-incident analysis. The report will include minutes from the post-incident analysis meeting, any summary data available, and written reports.

B. Multi Casualty Incident (MCI) LEVEL II

The initial phase of an MCI/Level II is similar to that of the MCI/Level I; first responders are dispatched to the scene by the 9-1-1 system. However, upon arrival, rescuers are immediately presented with a scenario which provides a large number of patients in a situation that is difficult to treat definitively in the field. The stabilization and transportation of prioritized casualties to the appropriate receiving hospital is the most immediate objective. Management of the MCI/Level II is predicated on the assumption that there is an enough number of prehospital medical responders, adequate transportation resources, sufficient
additional prehospital medical and public safety resources are requested through the appropriate communication center. The Incident Command System is utilized in management of the casualty scene, in accordance with principles and practices outlined in the National Incident Management System (NIMS). Because of the greater number of injuries, more branches and positions of the IC will be activated. All scene responders, fire, law enforcement, ALS, BLS, first aid teams, and others will fall under the direction of the Incident Commander or Unified Command.

Initial responders will estimate the number of resources needed to triage and transport the casualties. Among the resources requested by the Incident Commander in the very early stages of the MCI/Level II will be the assistance of VCEMS. When VCEMS is activated, a representative will contact the base hospital MICN for an update and may reserve the communication time. VCEMS will also begin filling requests for additional appropriate resources for on-scene support. Hospitals may activate disaster plans and prepare to receive casualties. Victims will be transported from the scene as soon as on-scene personnel have classified patients according to the S.T.A.R.T. triage system and when transportation resources are available. Patients with traumatic injuries, who are triaged as immediate, will be prioritized to a trauma center whenever possible, in accordance with VCEMS Policy 131 Attachment C.

Considerations for transporting appropriate patients to a trauma center should be made. Because of the number of patients, trauma centers may become quickly inundated at which point patients should be transported to non-trauma hospitals.

If VCEMS is activated to support the on-scene personnel, a representative will respond to the scene, the Health Care Agency Department Operations Center (DOC) or Ventura County Fire Communications Center. The VCEMS representative will then contact the base hospital and MEDCOMM. If the incident requires more resources than the county can provide, those resources will be requested by the MHOAC (or designee) through the regional disaster medical health system.

The activation of the County’s EOC may or may not take place depending upon the complexity and needs of the incident. Activation of municipal EOC’s may take place, again, depending upon the complexity and needs of the incident. If affected cities do not activate their EOC’s, the incident may be considered a regional event.

The MCI/Level II will begin demobilization as determined by the Incident Commander. The IC will notify EMS when the scene has been cleared. VCEMS will advise all hospitals that the scene has been cleared of casualties, but there may still be patient needs to consider.

VCEMS may conduct a post-incident analysis of the MCI at their discretion or at the request of agencies involved in the incident. All medically involved participants will be invited. VCEMS Agency will publish a written report following the post-incident analysis. The report will include minutes from the post-incident analysis meeting, any summary data available, and written reports.

C. Multi Casualty Incident (MCI) Level III
The MCI/LEVEL III brings about a situation where one or more of the major components of the emergency medical system are overwhelmed beyond the resources found within Ventura County.

Indications of an MCI/Level III may be identified by many public safety agencies simultaneously. If telephone communications are intact, a flood of 9-1-1 calls will most likely be received. First responders will immediately go into an information-gathering mode in order to attempt to establish the magnitude of the situation. Individual public safety agencies, local municipalities, and other emergency medical responders will, in most instances, be the first to recognize the inability of local resources to manage the medical casualties. The County of Ventura Sheriff’s Office of Emergency Services will be notified and initiate the opening of the County EOC whendirected by the Ventura County Sheriff’s Officer of the Ventura County Board of Supervisors.

Similar to that of an MCI/Level II, initial responders will estimate the number of resources needed to triage and transport the casualties. Among the resources requested by the Incident Commander in the very early stages of the MCI/Level III will be the assistance of VCEMS. When VCEMS is activated, a representative will contact the base hospital MICN for an update and may elevate the event. VCEMS will also begin filling requests for additional appropriate resources for on-scene support. Hospitals may activate disaster plans and prepare to receive casualties. Victims will be triaged and classified according to the START triage system. Transport to the most appropriate location will be initiated. Patients with traumatic injuries, who are triaged as immediate, will be prioritized to a trauma center whenever possible, in accordance with VCEMS Policy 131 Attachment C. Because of the number of patients, trauma centers may become quickly inundated at which point patients should be transported to non-trauma hospitals.

Overwhelming numbers of victims may require non-traditional emergency medical resources such as cities and their local clinics, urgent care centers, MRC, D.A.R.T., C.E.R.T., or medical practices in order to provide initial emergency medical assistance. Spontaneous Aid Stations may be activated by volunteers, or the county and may be useful for treating walking wounded. The neighborhood medical first aid plan is built upon a two-way partnership between the city and pre-registered, pre-trained volunteers; all of whom cooperate under FCS. Medical Aid Stations (MAS) will be quick to appear, relatively speaking, considering that the staff of participants has been recruited from the local neighborhood. Considerations should be given to the proximity of MAS to public shelters. The MAS form of community EMS may be quite important if the cause of the medical disaster has a significant impact on transportation systems, communication networks, and other infrastructure. Further instruction on utilization will be given at the time of the event.

Hospitals will be completing assessments of their own capabilities. It is presumed that some hospitals may be able to receive patients, while others may already be overwhelmed with casualties or may have become victims themselves. VCEMS will conduct assessments of all hospitals (as well as other medical care resources) to determine each facility’s capabilities and needs following a major incident. RACES and VCEMS personnel at the County EOC or HCADOC will handle the process of hospital assessment.
With data gathered from hospitals, medical aid stations, EMS providers, skilled nursing facilities and other information sources, VCEMS will be able to proceed with a number of actions which include the following: 1) Advise the Health Officer to designate Field Treatment Sites (FTS). FTS's will be strategically located around the county, ideally near hospitals. 2) Provide the MHOAC and County Health Officer with a list of medical resources needed and suggest that mutual aid be requested through the Region IRDMH system. The MHOAC will direct medical resources to appropriate locations.

The Health Officer or his/her designee will establish FTS as needed. The FTS will be a reception site for patients who have been injured or are ill and unable to receive a hospital disposition. At the FTS, patients will receive a level of medical care commensurate to the level of staff and material resources available. The FTS will also function under the Incident Command System, thus promoting continuity throughout the Ventura County emergency medical care system. Patients sent to an FTS will be treated and held until a receiving hospital can be located. Location of a definitive medical receiving facility will be done through the cooperative efforts of the disposition personnel at the FTS and VCEMS. Telephone or amateur radio with the assistance of a County-designated communicator will handle communication between these two entities, if available.

If the requested activation of an FTS is for a magnitude, complexity and duration of the MCI/Level III medical disaster that exceeds all available medical resources within Ventura County, it may also be apparent to local officials that large amounts of out-of-county resources, such as military, may be necessary to assist with the movement of casualties to other medical facilities. VCEMS may make a request to the County Health Officer to seek the assistance of the State or Federal authorities in the establishment of a Regional Evacuation Point (REP) at a designated airport. The Disaster Medical Assistance Team (DMAT) or State/Federal/military-run Regional Evacuation Point (REP) will be the conduit for the relocation of out-of-county casualties needing definitive hospital care. It will be emphasized that at this point in the disaster, extremely large undertakings will only be considered if medical facilities in the Southern California area (within range of rotary wing aircraft) have reached maximum patient saturation levels.

The medical operations of the MCI/Level III, unlike those of the MCI/Level II, which may last a few hours or the MCI/Level I, may be sustained for days, weeks, or even months before all casualties are redispersed. The activation and deployment of personnel and material resources necessary to operate a MAS, FTS or REP will require a significant mobilization of equipment and personnel. It will take days to establish the entire medical care esonopatermatix, with some components operational before others.

Local officials at the municipal and county levels will direct the demobilization of the MCI/Level III. MAS in communication with their individual city EOCs may mutually determine when their services are no longer needed. This information will be passed on from the city EOC to the VCEMS. In turn, VCEMS, in contact with the participating hospitals, will request to be advised when hospitals have decided to "stand down" from their disaster or surge modes and have returned to operations as usual. The collective status of the city EOCs, the MAS, the acute care hospitals, and the general state of the public's health will determine when VCEMS medical disaster operations are terminated. The order to demobilize VCEMS medical disaster operations will be issued by the MHOAC or his/her designee.

VCEMS Agency may conduct a post-
incident analysis of the MCI at their discretion or at the request of agencies involved in the incident. All medically involved participants will be invited. VCEMS Agency shall publish a written report following the post-incident analysis. Thereport will include minutes from the post-incident analysis meeting, any summary data available and written reports.

SECTION V INFORMATION MANAGEMENT

VCEMS is dependent upon a multitude of resources for acquiring and processing information; it is called upon to collect credible information and share it with the medical community.

During an MCI/LEVEL I, information will be exchanged through the day-to-day base hospital communications method. Information and data collected and shared between the base hospital, receiving hospitals and the prehospital care providers. When appropriate, VCEMS will receive data in a post-incident review provided primarily by the base hospital. This information includes a scene description, casualty numbers and acuity which is gathered and reported by the responding fire service (or other public safety agency), will be relayed to hospitals, transport providers and VCEMS officials. Inter-jurisdictional frequencies normally used to coordinate public safety mutual aid will also be employed.

During an MCI/LEVEL II and above, VCEMS may assume communications at the scene, at the Fire Communications Center (FCC) or HCADOC (Departmental Operations Center), contact base hospital MICN, and will advise MEDCOM of hospital availability. Casualty receiving hospitals will receive data about expected patient arrivals and information about events related to the disaster (such as condition on scene) via ReddiNet, FCC or the HCADOC. It will be the casualty receiving hospital's responsibility to relay back via the designated radio frequency or phone, information regarding the actual casualties received. RACES amateur radio operators may provide primary or backup communications, when appropriate, to pass or confirm messages. They may also be used as an alternative means for relaying any data and information from the participating acute care facilities.

The nature of information gathered and transmitted during an MCI/LEVEL III will be different than that of the MCI/LEVEL I. Information will be slower to compile and disseminate because of the magnitude of the disaster and probable disruption of communications systems. It will be the larger MCI/LEVEL III, which will truly test the primary and backup communication paths. There is speculation as to the reliability of the everyday communications systems in an MCI/LEVEL III; if this is true, then emergency agencies will lose secondary communications pathways are in place. VCEMS plans to use the medical resource status center after an MCI/LEVEL III. VCEMS will take a proactive posture in assuring that all contacts, State and local, are kept informed with the most current intelligence concerning the disaster and the related medical response.

SECTION VI RESOURCE ACQUISITION

The MCI/LEVEL II scenario assumes a shortage of medical resources within Ventura County. VCEMS will log resource requests and resource availability of health care facilities and medical transportation. With the approval of the MHOAC or designee, VCEMS will direct available medical resources to areas of greatest need based on the best possible intelligence. VCEMS will make resource needs known to the County's EOC, and RDMHC.
GLOSSARY OF TERMS

ARC American Red Cross
The Federally chartered relief organization, which is charged to supply relief services to those with physical and emotional needs in time of war or disaster.

Base Hospital
A hospital that has been approved by the local EMS Agency to provide medical direction to prehospital emergency medical care personnel within its area of jurisdiction.

C.E.R.T. Community Emergency Response Team
An organization of trained volunteers who assist official emergency agencies.

D.A.R.T. Disaster Assistance Response Team
An organization of volunteer Disaster Service Workers serving a governmental agency for the protection of public health, safety and welfare; in accordance with the California Emergency Services Act.

Deceased (patient)
Fourth (last) priority in patient treatment according to the S.T.A.R.T. triage system.

Delayed (patient)
Second priority in patient treatment according to the S.T.A.R.T. triage system. These patients require aid, but injuries are less severe or pose no immediate threat to life.

EOC Emergency Operations Center-City/County
A secured location where disaster/emergency mitigation and recovery efforts may be directed and coordinated by those designated authorities.

EMS Emergency Medical Services
A local government (county) agency with the primary responsibility of coordinating the emergency response to disasters and facilitating the acquisition of additional resources to carry out the medical recovery mission.

EMSA Emergency Medical Services Authority-State of California
That agency within the State Health and Welfare Agency which is devoted to the coordination of policy and practice relative to emergency medical services throughout the State of California. This includes disaster mitigation and planning efforts.

FTS Field Treatment Site
A medical operation called for by the local health officer for the established purpose of collecting injured disaster victims who are in need of definitive medical care.

HCA Health Care Agency-County of Ventura
The local government (county) agency which is designated to develop, issue, and regulate policy in areas of public health and welfare.

HEICS Hospital Emergency Incident Command System
A generic medical response template developed by Ventura County EMS to provide healthcare facilities within the command-based, standardized emergency response plan.
HospitalInventory
Thenumberof"Immediate"and"Delayed"patientswhichahospitalhasidentifiedthatitmayca
reforatanygivetimeasaresultofanMCI.

Immediate(patient)
FirstlevelofpatientpriorityaccordingtotheS.T.A.R.T.triagesystem.Apatientwhorequires
rapidassessmentsandmedicalinterventioninordertoincreasechancesofsurvival.

MAS MedicalAidStation
Ane
ighborhooddisastermedicalresourcecenter;whichmaybeorganizedunderathree-
waypartnership:1)asponsoringcity,
2)hostmedicalsite,and3)communityvolunteers.

MCI MultiCasualtyIncident
Asuddenoccurringincident,whichinjuresmorethanoneindividual,andpresentsconditions
whichmayrequirefireandambulanceservicemutualaidresourcesandtheassistanceofVCEM
S.

Minor(patient)
ThirdpriorityofpatientintheS.T.A.R.T.triagesystem.Apatientrequiringonlysimple,rudiment
aryfirst-aid.Thesepatientsareconsideredambulatory.

MRC Medical Reserve Corps
A group of volunteers primarily comprised of medical personnel that is intended to
strengthen the medical and health infrastructure of the community they serve.

NDMS National Disaster Medical System
NDMS is a federally coordinated system that augments the Nation's medical
response capability. The overall purpose of the NDMS is to supplement an
integrated National medical response capability for assisting state and local
authorities in dealing with the medical impacts of major peacetime disasters.
Components of NDMS include Disaster Medical Assistance Teams (DMAT),
Disaster Mortuary Operational Response Teams (DMORT), International Medical
Surgical Response Teams (IMSURT), and National Veterinary Response Teams
(NVRT).

RACES RadioAmateurCivilEmergencyServices
RACESprovidesforamateurradioserviceforemergencymessagesandcommunicationspurposeonly
duringperiodsoflocal,regional,ornationalemergencies.MembersofRACESSorganizations
maketheirvolunteerservicesavailabletomunicipal,county,andsategovernmentson. Addition-
ally,RACESwillprovidenecessarycommunicationserviceswhereverthereisaneedforfirst-aid
propertypreservingassistance.

ReceivingHospital
A hospital that has been approved by the EMSAgency to receive patients requiring emergenc
ymedical services.

ReddiNet RapidEmergencyDigitalDataInformationNetwork
Web-basedcomputersystemtocoordinatehospitalandparamedicservicesintheeventofamaj
oremergency.Innon-
emergencysituations,ReddiNetprovideshospitalswithdailydiversionstatusupdatetodeter
mine whichhospitals can provide appropriate patient care.
S.T.A.R.T.  Simple Triage and Rapid Treatment
Aprahospital patient prioritizing system developed by Hoag Hospital and Newport Beach Fire Department for use during an MCI/LEVEL I, II, or III. The S.T.A.R.T. system is based on four levels of prioritization: Deceased, Minor, Delayed, or Immediate.

VCEMS  Ventura County Emergency Medical Services
That agency within the County of Ventura Health Care Agency, which is responsible for those duties assigned to the local government EMS.
I. PURPOSE:

To provide a mechanism for paramedics to be permitted to monitor infusions of nitroglycerin and heparin during interfacility transfers.

II. POLICY:

A. Paramedics: Only those Paramedics who have successfully completed a training program approved by the Ventura County EMS Medical Director on nitroglycerin and heparin infusions will be permitted to monitor them during interfacility transports.

B. ALS Ambulance Providers: Only those ALS Ambulance providers approved by the Ventura County EMS Medical Director will be permitted to provide the service of monitoring nitroglycerin and/or heparin infusions during interfacility transports.

C. Patients: Patients that are candidates for paramedic transport will have pre-existing intravenous heparin and/or nitroglycerin drips. Pre-hospital personnel will not initiate heparin and nitroglycerin drips.

III. PROCEDURE:

A. Medication Administration

1. The paramedic shall receive a report from the nurse caring for the patient and continue the existing medication drip rate.

2. If medication administration is interrupted by infiltration or disconnection, the paramedic may restart or reconnect the IV line.

3. All medication drips will be in the form of an IV piggyback monitored by a mechanical pump familiar to the Paramedic who has received training and is familiar with its use.

4. In cases of pump malfunction that cannot be corrected, the medication drip will be discontinued and the receiving hospital notified.
B. Nitroglycerin Drips:  Paramedics are allowed to transport patients on nitroglycerin drips within the following parameters:
   1. Infusion fluid will be D5W. Medication concentration will be either 25 mg/250ml or 50 mg/250ml.
   2. Drip rates will remain constant during transport. No regulation of the rate will be performed except to turn off the infusion completely.
   3. In cases of severe hypotension, the medication drip will be discontinued and the receiving hospital notified.
   4. Drip rates will not exceed 50 mcg/minute.
   5. Vital signs will be monitored and documented every 5 minutes.

C. Heparin Drips:  Paramedics are allowed to transport patients on heparin drips within the following parameters:
   1. Infusion fluid will be D5W or NS. Medication concentration will be 100 units/ml of IV fluid (25,000 units/250ml or 50,000 units/500 ml).
   2. Drip rates will remain constant during transport. No regulation of the rate will be performed except to turn off the infusion completely.
   3. In cases of severe uncontrolled bleeding, the medication drip will be discontinued and the base hospital notified.
   4. Drip rates will not exceed 1600 units/hour.
   5. Vital signs will be monitored and documented every 10 minutes.

D. QI:  All calls will be audited by the service provider and by the transferring and receiving hospitals. Audits will assess compliance with VCEMS Policy, including base hospital contact in emergency situations. Reports will be sent to the EMS agency as requested.
Intraosseous Infusion Success Rates
2/1/2012 - 5/4/2014

- 2012 (n=196): 182 Successful, 14 Unsuccessful, 1 Not Avail
- 2013 (n=228): 217 Successful, 11 Unsuccessful
- 2014 (n=106): 97 Successful, 9 Unsuccessful

Intraosseous Infusions - Incidence of Multiple Attempts
2/1/2012 - 5/4/2014

- 2012 (n=4): 3 2 Attempts, 1 3 Attempts
- 2013 (n=10): 9 2 Attempts, 1 3 Attempts
- 2014 (n=3): 3 2 Attempts, 0 3 Attempts
I. PURPOSE: To define the criteria by which a Registered Nurse (RN) can be authorized to function as a Mobile Intensive Care Nurse (MICN) in the Ventura County Emergency Medical Services (VCEMS) system.

II. AUTHORITY: Health and Safety Code 1797.56 and 1797.58.

III. POLICY: Authorization as a MICN requires professional experience and appropriate training, so that appropriate medical direction can be given to Emergency Medical Technician-Paramedic's (EMT-P) at the scene of an emergency.

IV. PROCEDURE: In order to be authorized as an MICN in Ventura County, the candidate shall:

A. Fulfill the requirements regarding professional experience and prehospital care exposure. (Section V.A and B.)

B. Successfully completes an approved MICN Developmental Course.

C. Ride with an EMT-P unit for a minimum of eight (8) maximum of (16) hours and observe at least one (1) emergency response requiring Base Hospital contact.

D. Be recommended for MICN authorization by his/her employer.

E. Successfully complete the authorization examination process.

F. Complete an MICN internship.

V. AUTHORIZATION REQUIREMENTS

A. Professional Experience:
   The candidate shall hold a valid California RN license and shall have a minimum of 1040 hours (equivalent to six months' full-time employment) critical care experience as an (RN). Critical care areas include, but are not limited to, Intensive Care Unit, Coronary Care Unit, and the Emergency Department.

B. Prehospital Care Exposure
The candidate shall be employed in a Ventura County Base Hospital. In addition, for a minimum of 520 hours (equivalent to three (3) months full time employment) within the previous six calendar months, the candidate shall have one or more of the following assignments.

1. Be assigned to clinical duties in an Emergency Department responsible for directing prehospital care. (It is strongly recommended that this requirement be in addition to and not concurrent with the candidate's six-(6) months' critical care experience. A Base Hospital may recommend an MICN candidate whose critical care and/or Emergency Department experience are concurrent based on policies and procedures developed by the Base Hospital), or

2. Have responsibility for management, coordination, or training for prehospital care personnel, or

3. Be employed as a staff member of VCEMS.

C. MICN Developmental Course

The candidate shall successfully complete an approved Mobile Intensive Care Nurses Development Course (See Appendix A).

D. Field Observation

Candidates shall ride with an approved Ventura County EMT-P unit for a minimum of eight (8) maximum of (16) hours and observe at least one emergency response requiring Base Hospital contact and performance of ALS skills by the EMT-Ps.

1. Candidates shall complete the field experience requirement prior to taking the authorization examination.

2. A completed Field Observation Form shall be submitted to the VC EMS as verification of completion of the field observation requirement (Appendix C).

E. Employer's Recommendation

1. The candidate shall have the recommendation of the Emergency Department Medical Director or Paramedic Liaison Physician (PLP), Paramedic Care Coordinator (PCC) and Emergency Department Nurse Supervisor.

2. Candidates employed by VCEMS shall have the approval of the Emergency Medical Services Medical Director.

3. All recommendations shall be submitted in writing to VCEMS prior to the authorization examination. (Appendix B.)

The recommendation shall include:

b. Verification that the candidate has been an employee of the hospital for a minimum of three (3) months (or has successfully completed the hospital's probationary period) and will, upon certification, will be assigned to the E.D. as set forth in Section B of the MICN Authorization Criteria.

c. Verification that each candidate has successfully completed an approved MICN Developmental Course.

d. Verification that each candidate has completed the Field Observation requirement as set forth in Section II.D of the MICN Authorization criteria.

F. Examination Process

1. Written Procedure: Candidates shall successfully complete a comprehensive written examination approved by VCEMS.
   a. The examination's overall minimum passing score shall be 80%.
   b. Employers shall be notified within two (2) weeks of the examination if their candidates passed or failed the examination.
   c. The examination shall be scheduled in conjunction with class completion dates.

2. Examination Failure
   a. A candidate who fails the initial MICN exam shall complete a repeat exam within 30 days. S/he may repeat the authorization exam one (1) time.
   b. A minimum score of 80% must be attained on repeat examination.
   c. If the repeat examination is not successfully completed, the candidate shall repeat the authorization application process, including the developmental course, prior to taking the subsequent examinations.

3. Failure to Appear
   a. If a scheduled candidate fails to appear for the scheduled examination, s/he shall be considered as having failed the examination.
   b. Within 24 hours of the scheduled examination, VCEMS shall notify the employer of any candidate failing to appear for testing.
c. Candidates who fail to appear for two scheduled authorization examinations shall not be eligible to take the authorization examination for one (1) calendar year from the last scheduled examination date and must repeat the entire authorization process.

G. Internship
Following notification of successful completion of the authorization examination, the candidate shall satisfactorily direct ten (10) base hospital runs under the supervision of a MICN, the PCC, and/or an Emergency Department physician.

1. The Communication Equipment Performance Evaluation Form shall be completed for each response handled by the candidate during the internship phase. (Appendix D)

2. Upon successful completion of at least ten (10) responses, the ten responses shall be evaluated by the Emergency Department Director or PLP, the Emergency Department Nursing Supervisor, and the PCC. All Communication Equipment Performance Evaluation Forms (Appendix D) and Verification of Internship Completion Form (Appendix E) shall be submitted to Ventura County EMS.

3. The internship requirement shall be completed within six (6) weeks of the successful completion of the authorization examination.

4. If an employer is unable to complete a candidate's internship process within six (6) weeks of the authorization examination, a BH representative shall submit a letter to Ventura County EMS explaining the situation and their intent. If the intent is to continue the authorization process for the individual, the projected date for internship completion shall be stated.

5. If an employer is unable to complete a candidate's internship process within one year of the authorization examination, a BH representative shall resubmit a letter of recommendation and the candidate shall repeat the authorization examination.

VI. AUTHORIZATION
Authorization shall be granted and an authorization card sent to the employer within fifteen (15) working days following receipt of the Communication Equipment Performance Evaluation and Verification of Internship Completion forms. Authorization is valid for a two (2) year period or during employment at a Ventura County Base Hospital. The nurse must be regularly assigned as an MICN per EMS Policy 322.
LETTER OF RECOMMENDATION
INITIAL AUTHORIZATION

_________________________ is recommended for Mobile Intensive Care Nurse Authorization in Ventura County.

We have reviewed the attached Mobile Intensive Care Nurse Application and verify that the applicant:

_______ Holds a valid California Registered Nurse License.
_______ Has at least 1040 hours of critical care experience.
_______ Has completed the Field Observation Requirement.

If authorized, will be employed in accordance with guidelines as set for the in Section V.B of the MICN Authorization Criteria

_______ Has been employed by ______________________ in the Emergency Department for at least 520 hours gaining prehospital care exposure.
_______ Has completed an approved Mobile Intensive Care Nurse Developmental Course.

______________________________________________
Emergency Department Medical Director/
Paramedic Liaison Physician

______________________________________________
Emergency Department Nursing Supervisor

______________________________________________
Prehospital Care Coordinator

Date: _______________________________
### MICN AUTHORIZATION APPLICATION

| County of Ventura  
| Emergency Medical Services Agency  
| 2220 E. Gonzales Road, Suite 130  
| Oxnard, CA 93036  
| 805-981-5301 |

**Application processing requires a minimum of 10 days once all materials are received.**  
*Authorization cards will be mailed. Complete application in ink.*

| Name: |  
| Street Address: |  
| City: | State: | Zip code: |

| Home phone: | Work Phone: |

| ( ) | ( ) |

| Base Hospital: |

| Current/Prior Authorization Number: | Expiration Date: |

**Initial Authorization:**
- Pass the Ventura County EMS MICN Exam with a score of 80% or higher.
- Provide a copy of a valid and current license as a registered nurse in California
- Provide a copy of a valid and current ACLS card (front and back of card)
- Field Observation Verification (VCEMS Policy 321, appendix C)
- Documentation of Critical Care Experience (VCEMS Policy 321, appendix A)
- Documentation of Ventura County Emergency Department Experience
- Letter of Recommendation
- Communication Equipment Performance Evaluation Form (VCEMS Policy 321, appendix D)

**Reauthorization**
- Provide a copy of a valid and current license as a registered nurse in California
- Provide a copy of a valid and current ACLS card (front and back of card)
- Verification of employment as an MICN at a designated base hospital
- Letter of Recommendation (VCEMS Policy 322, appendix A)
- Continuing Education Log (VCEMS Policy 322, appendix D)

| Applicant Signature: | Date |
| Prehospital Care Coordinator Signature: | Date |
FIELD OBSERVATION REPORT

MICN NAME: ___________________________________________ AUTH. NO.:___________

EMPLOYER: ___________________________ RIDE-ALONG DATE: ______________

TIME IN: ______________ TIME OUT: _______________ TOTAL HOURS: ______________

BASE CONTACT MADE WITH ALS PROCEDURES PERFORMED: YES: _____#_____ NO____

ALS PROVIDER: __________

SUMMARY OF FIELD OBSERVATION

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

____________________________________________________________________________

EMT-P Signature  EMT-P Signature

MICN Signature  PCC Signature

(Use other side for additional comments)
COMMUNICATION EQUIPMENT PERFORMANCE EVALUATION FORM

Candidate's Name: | MICN Exam Date: | Base Hospital:

MICN Evaluator: Please evaluate this MICN candidate for the following, to include but not be limited to: Proper operation of radio equipment; recommended radio protocols used; correct priorities set; additional info requested as needed; appropriate, complete, specific orders given; able to explain rationale for orders, notification of other agencies involved; and ability to perform alone or with assistance.

<table>
<thead>
<tr>
<th>Date</th>
<th>Incident # (and Pt # of Total as needed)</th>
<th>Chief Complaint</th>
<th>Treatment</th>
<th>Evaluator's Comments</th>
<th>Evaluator's Signature</th>
<th>PCC's Comments</th>
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VERIFICATION OF INTERNSHIP COMPLETION

______________________________, employed at _____________________, is/is not recommended for Authorization as a Mobile Intensive Care Nurse. S/He has achieved the following rating in the following categories:

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<tr>
<th>Category</th>
<th>Rating</th>
<th>Comments</th>
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<td>Understands and operates equipment properly</td>
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<td>Sets correct priorities</td>
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<td>Requests additional information as needed</td>
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<td>Orders are specific, complete and appropriate</td>
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<tr>
<td>Understands treatment rationale</td>
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NOTE:
In order to qualify for recommendation, a candidate must receive at least a rating of 3 in each category. Ratings are as follows:

1. Poor
2. Fair
3. Average
4. Good
5. Excellent

ATTACH COMMUNICATION EQUIPMENT PERFORMANCE EVALUATION FORM

Signatures: BH Medical Director/Paramedic Liaison Physician
Prehospital Care Coordinator
I. **PURPOSE:** To define the reauthorization procedures for Ventura County Mobile Intensive Care Nurse (MICNs).

II. **AUTHORITY:** Health and Safety Code Sections 1797.56 and 1797.58, 1797.213 and 1798.

II. **POLICY:**

Ventura County (MICNs) shall meet the requirements and apply for reauthorization every two years (Appendix A-C).

III. **PROCEDURE:**

A. Ventura County MICNs shall:

1. Complete a total of thirty-six hours of Continuing Education, 50% of which, in each category, shall have been obtained at Ventura County Base Hospitals. Document continuing education on Appendix D.

   a. Field Care Audits (Field care audit): Twelve hours per two years.

   b. Periodic training sessions or structured clinical experiences (Lecture/Seminar): Twelve hours per two years. Lecture/Seminar hours may be fulfilled by the following means:

      1) **EMS Updates** (Mandatory, up to two times per year, as offered).

      2) **ACLS recertification** - 4 hours credit

      3) **Self-Study/Video CE** - No more than 50% of the total lecture requirement shall be met by combination of self-study and/or video CE.

         a) Self study CE shall be documented by a certificate from the sponsor of the self study opportunity (e.g., EMS journals mail courses, etc.).
b) Video CE - Video CE shall be presented so that a physician or PCC is available to answer questions at the time of the presentation. A post test shall be successfully completed at the Base Hospital, signed by the MICN and PCC, and documentation of attendance maintained at the Base Hospital.

c) Ride along with an approved Ventura County EMT-P unit may be required at PCC discretion.

c. Miscellaneous Education: Twelve hours per two years.
   Miscellaneous education Includes:
   1) Ride-along on an ALS Unit for a maximum of 12 hours or at the discretion of the Prehospital Care Coordinator,
   2) ALS level teaching, maximum of 8 hours.
   3) Additional field care audit and/or lecture/ seminar, or
   4) Administrative assistance to PCC.

d. Verification of attendance must be retained by the MICN.
   1) The Base Hospital Attendance Roster shall be signed individually by each MICN and maintained by the Base Hospital.
   2) CE attendance verification for classes taken out of Ventura County shall be documented by completion of the EMT-P/MICN Continuing Education Record or a facsimile of a roll sheet signed by the sponsoring agency PCC with an additional original signature of the sponsoring agency PCC.
   3) Credit shall be given only for actual time in attendance at CE.
   4) Credit may be received for a class one time only in an authorization cycle.

2. To Maintain MICN Authorization
   a. Function as an MICN for an average of 32 hours per month over a six-month period or
   b. An MICN whose duties for his/her primary employer are administering a VC ALS Program may, with approval of the EMS Medical Director, maintain his/her MICN status by performing MICN clinical functions at a VC Base Hospital for 8 hours per month, averaged over a six month period.
3. Complete all reauthorization requirements (Appendix A-D) by the first day of the month that the Authorization card expires. In the event the MICN takes a leave of absence from their employer, he/she will have 60 days from the date of return to work to complete any outstanding CE prior to reauthorization, if an EMS Update was offered during leave of absence, it must be made up prior to radio assignment.


B. Upon successful completion of the above requirements, an MICN shall be authorized for a period of two years from the last day of the month in which all requirements were met.