Public Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Agenda	February 14, 2013 9:30 a.m.

I.	**Introductions**	
II.	**Approve Agenda**	
III.	**Minutes**	
IV.	**Medical Issues**	
	A.	Stroke System Update
	B.	CAM Update
	C.	King Airway/ITD Study
	D.	Lasix Discussion
	E.	Other
V.	**New Business**	
	A.	Policy 318: ALS Response Standards
	B.	Policy 705.14 Hypovolemic Shock
	C.	Policy 705.25 Vtach, Not in Arrest
	D.	Policy 705.26 Suspected Stroke
	E.	Other
VI	**Old Business**	
	A.	701: Medical Control: Base Hospital Medical Director
	B.	
	C.	Other
VII.	**Informational/Discussion Topics**	
	A.	Policy 1404: Guidelines for Interfacility Transfer of Patients to a Trauma Center
	B.	EMS Agency Office Security
	C.	Other
VIII.	**Policies for Review**	
	A.	Policy 124: Hospital Emergency Services Reduction Impact Assessment
	B.	Policy 1301: Public Access Defibrillation (PAD) Provider Standards
	C.	Policy 334: Prehospital Personnel Mandatory Training Requirements
	D.	Policy 342: Notification of Personnel Changes – Provider
	E.	Policy 501: Advanced Life Support Service Provider Criteria
	F.	Policy 506: Paramedic Support Vehicle
	G.	Policy 508: First Responder Advanced Life Support Units
	H.	Policy 607: Hazardous Material Exposure: Prehospital Protocol
	I.	Policy 615: Organ Donor Information Search
	J.	Policy 720: Guidelines For Limited Base Hospital Contact
	K.	Policy 724: Apparent Life Threatening Event (ALTE)
XI	**TAG Report**	
X.	**Agency Reports**	
	A.	ALS Providers
	B.	BLS Providers
	C.	Base Hospitals
	D.	Receiving Hospitals
	E.	ALS Education Programs
	F.	EMS Agency
	G.	Other
XI.	**Closing**	

TEMPORARY
PARKING PASS
Expires February 14, 2013

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

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

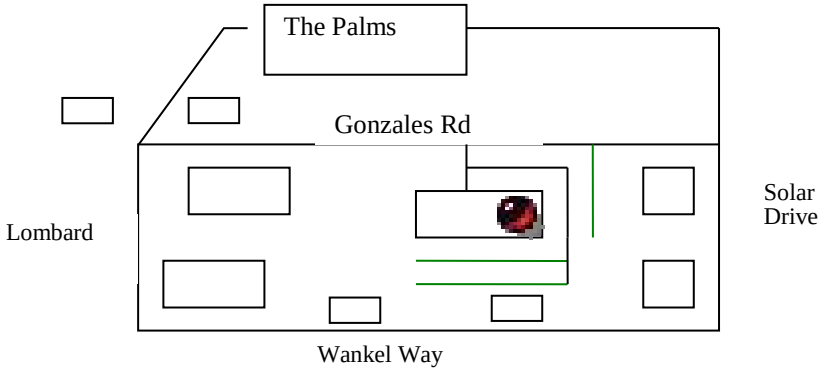
Parking Instructions: Parking at workshop venue is limited. Arrive early to allow for offsite parking if venue parking lot is full.

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

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

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

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



Prehospital Services Committee 2012

For Attendance, please initial your name for the current month

Agency	LastName	FirstName	1/12/2012	2/9/2012	03/08\12	4/12/2012	5/10/2012	6/14/2012	7/12/2012	8/9/2012	9/13/2012	10/11/2012	11/8/2012	12/13/2012	%
AMR	Stefansen	Adriane										AS			
AMR	Panke	Chad		CP		CP			CP	CP		CP			
CMH - ER	Canby	Neil		NC					NC						
CMH - ER	Cobb	Cheryl		CC		CC				CC		CC			
FFD	Herrera	Bill		BH								BH			
FFD	Scott	Bob		BS											
GCA	Norton	Tony		TN		TN			TN	TN		TN			
GCA	Stillwagon	Mike		MS		MS			MS						
Lifeline	Kuroda	Brian		BK		BK			BK	BK		BK			
Lifeline	Winter	Jeff		JW		JW			JW	JW		JW			
LRRMC - ER	Beatty	Matt				MB			MB			PD			
LRRMC - ER	Licht	Debbie		DL		DL			DL			DL			
OFD	Carroll	Scott		SC						NOE		SC			
OFD	Huhn	Stephanie		SPH		SPH			RT	SPH		SPH			
OVCH	Boynton	Stephanie		SB		SB				SB					
OVCH	Patterson	Betsy		BP		BP				BP					
SJPVH	Hernandez	Sandi		SH		SH			SH	SH		SH			
SJPVH	Davies	Jeff													
SJRMC	McShea	Kathy		KM		KM			KM	KM		KM			
SJRMC - SJPVH	Larsen	Todd		TL		TL			TL	TL		TL			
SPFD	Dowd	Andrew				AD			AD			AD			
SVH - ER	Tilles	Ira		IT		IT			IT	IT		IT			
SVH - ER	Hoffman	Jennie		JH		JH				JH		JH			
V/College	Mundell	Meredith		MM		MM			MM	MM		MM			
VCFD	Merman	Nancy		NM		NM			NM			NM			
VCFD	Tapking	Aaron		AT		AT			AT	AT		AT			
VNC	Plott	Norm		NP		NP			NP	NP		NP			
VNC	Black	Shannon		SB					SB			SB			
VNC	Shedlosky	Robin		RS		RS				RS		RS			
VCMC - ER	Chase	David		DC		DC			DC	DC		DC			
VCMC - ER	Utley	Dede		DU		DU			SS	DU		DU			
VCMC-SPH	Daucett	Michelle				MD			KB			KB			

Agency	LastName	FirstName	1/12/2012	2/9/2012	03/08\12	4/12/2012	5/10/2012	6/14/2012	7/12/2012	8/9/2012	9/13/2012	10/11/2012	11/8/2012	12/13/2012	%
VCMC-SPH	Beatty	Karen		KB		KB			DH	KB					
VCSO SAR	Hadland	Don		DH		DH				DH					
VCSO SAR	White	Don		DW		DW				DW					
VFF	Rhoden	Crystal		CR								CR			
VFF	Jones	Brad													
Eligible to Vote	**Date Change/cancelled - not counted against member for attendance**														
Non Voting Members															
EMS	Carroll	Steve		SC		SC			SC	SC		SC			
AMR	Drehsen	Charles		CD		CD			CD	CD		CD			
VCMC	Duncan	Thomas		TD					TD			TD			
EMS	Fisher	Barry								BF					
LMT	Frank	Steve		SF		SF				SF		SF			
EMS	Hadduck	Katy		KH		KH			KH	KH		KH			
EMS	Haney	Debora				DH				DH		DH			
EMS	Lara-Jenkins	Stephanie		SLJ		SLJ			SLJ	SLJ					
EMS	Rosa	Chris		CR		CR			CR	CR		CR			
EMS	Salvucci	Angelo				AS			AS	AS		AS			
SAR	Askew	Chris													
CSUDA	Parker	Pilar													
OFD	Donabedian	Chris													
VNC	Komins	Mark		MK		MK				ML		MK			
AMR	Glass	Gil		GG											
VNC	Gregson	Erica		EG		KD			EG			EG			
AMR	Taigman	Mike				MT			MT	MT					
VCMC-ED	Scott	Susan							SS						
VCMC	Berardi	Veronica							VB						
EMS	Grimes	Nikki							NG						

Public Health Administration Large Conference Room 2240 E. Gonzales, 2nd Floor Oxnard, CA 93036	Pre-hospital Services Committee Minutes	December 13, 2012 9:30 a.m.

Topic	Discussion	Action	Assigned
I. Introductions	Meeting called to order at VCMC introduced Le Ann Wilkie as the new PCC for VCMC. LeeAnn has been an MICN for the past 5 years and a nurse for 6 years. OCVH introduced Dan Pescue as the new Director of Nursing. EMS introduced Julie Frey who has been hired back with EMS and will be working with a multi disciplinary committee doing exercises and special projects.		
II. Approve Agenda	EMS added the topic of Gap Analysis under new business	Agenda approved with an addition (N. Merman/m. M. Mundell)	
III. Minutes		K. McShea previously forwarded corrections to last meeting minutes. sent in corrections to the minutes • Sandi Hernandez is over both ERs as Senior Director • PVH ER Director is Rebeka Medina • Sherry Sterling is under Sandi Hernandez It was M/S/C (B. Patterson/N. Merman) to approve the minutes with corrections.	
IV. Medical Issues			
A. Stroke System Update	The Program started on December 1. Dr. Salvucci asked the committee if there were any questions/problems. He stated that no data has been collected as yet. • Are patients being identified in the field? o SVH: There have been improvements in times.		

		○ Dr. Patterson is working with their administration to become an acute stroke center, • ER MD should be at bedside of these patients. History directly would be helpful. • Person who last saw patient normal give contact information as part of the standard transfer of care report. Electronic report is later but need before.		
B.	CAM Update	Currently gathering stats. We need to find out what data we are going to look at. • The field crews seem to like the process. • We are seeing a few more saves, but no dramatic jump. • Using new AEDs with built-in metronome. This is only complaint as the metronome is very loud. Working with company to adjust. • 19 cases since October 3. 3 of the 19 are confirmed saves. • CPR density, not looking at. • All positive feedback. No hospital complaints.		
C.	ITD Study	Expectation is to conclude the study. Presentation will be made to EMDAC and EMS commission in March. Final data will be completed by next meeting.		
D.	Policy 728: King Airway	Inflation volume discussed	Section 8, 2 of 4 deleted Use as rescue airway only. Policy statement will be distributed through a memo and then 710 will be brought back. Language will changed through Form deleted Page 2-3 use standard language for documentation system. Page 1.4 ETI should be ETT	Tabled
E.	Other		Consider removing Lasix from pre-hospital medications.	Agenda item next meeting.
V.	**New Business**			
A.	Policy 310:		It was M/S/C (M. Mundell/K. McShea) to	Approved

Paramedic Scope of Practice		approve the policy as submitted.	
B. Policy 614: Spinal Immobilization – for discussion	In looking at literature, we base our policies on the nexus criteria. Symptoms in the elderly are less obvious. Add in a little lower threshold for immobilizing individuals. • Section d, 2 of 2. penetrating torso or potential …. For highly likely spinal injuries • Do not c-spine penetrating trauma. • 705 says to sit them up. • We are telling crews two different things • Delete unless hard evidence. • Dr. Larson would like to see a blend of the Canadian and Nexus criteria for this policy.		Agenda
C. Policy 620: Oral Glucose – Propose deletion		Part of EMT Scope of Practice. It was M/S/C (M. Mundell/Larsen) to delete the policy.	Deleted
D. Other 1. Gap Analysis Update	Homeland security has given the County a grant to fix the gaps in our system. All after action recommendations are being instituted in some way. Each agency will be visited and the plan is to get all providers on the same page as far as disaster plans. Committee: Bill Boyd, Quin Finwick (law), Julie Frey (MH). Areas of improvement are: pandemic, earthquake, active shooter, nuclear, chemical attack.		
VI Old Business			
A. Policy 710: Airway Management	KH will notify providers for intubation documentation which do not contain of the documentation points,	Subcommittee will be formed.	Tabled. See notes from last meeting.
B. Sepsis Alert Update – Report from hospitals	VCMC: the process is going well. Only a few have slipped through. All hospitals are satisfied with the process. Please keep track and let EMS know if there are problems		
C. Other			
VII. Informational/Discussion Topics			

	A.	Policy 451: Stroke System Triage	Concept is to get all stroke patients to a stroke center. Policy designed to get patients immediate care. Patient could be transferred to another facility. Changes explained	
	B.	ePCR Upload Report to Informational/Discussion Topics	Issues with times discussed. • Upload time was final determination. Have since learned that if an additional report was uploaded, it constantly changes. • Working with Imagetrend to come up with a solution. • Need to correct issues before we can look at the data. Receiving reports from the hospitals that they are receiving the reports sooner. No big push for MDs to look for report but will push MDs to look when he sees the report. ALOC and ICU patients are main patients that reports are being reviewed.	ALOC and ICU patients: it is important to receive the reports. SV2 out of 8--9 are seeing half the time. LR Not used often, trying to get scribes to look up the report. Larsen, looking at the system a couple times a day.	
	C.	Other		ePCR issues/errors should be directed to Chris Rosa as they happen. Screen shot of error would be helpful.	
VIII.	**Policies for Review**				
	A.	Policy 100: Emergency Medical Service, Local Agency (9/13/84)		No changes	Review only
	B.	Policy 323: Mobile Intensive Care Nurse: Authorization Challenge			Approved
	C.	Policy 351:			Approved

	EMS Update Procedure			
D.	Policy 402: Diversion			Approved
E.	Policy 430: STEMI Center Receiving Standards			Approved
F.	Policy 502: Service provider approval process			Approved
G.	Policy 506: ASV			Tabled for title change.
H.	Policy 615: Organ Donor Information Search			Approved
I.	Policy 619: Safely Surrendered Babies		Look at designation Look at updating the packets	Tabled for review
J.	Policy 701: Medical Control: Base Hospital Medical Director		Approved Title change – PLP vs BHMD	Tabled for title change
K.	Policy 705.16: Neonatal Resuscitation		Approved	
L.	Policy 710: Airway Management			
M.	Policy 715: Needle Thoracostomy		Documentation match with ePCR language	Agenda
XI	**TAG Report**	**No report**		

		PSC recognized Meredith Mundell for all her years of service to the EMS System. This is Meredith's last "official" meeting.		
X.	**Agency Reports**			
	A. ALS Providers	VNC announced that there have been 27 CPR saves for 2012. This is the best CPR save year. Completed ePCR module concentrating on procedure and posting. Communication is an issue. Started more active QI process to ensure completion There has been an increase in other fire agencies to asking how we do it in VC. Credit to all who are involved in the process. DeAnza Middle school, teacher, staff did chest compression and use of AED. SAR – staffing changes, Shane Matthews has left. Changes in CQI internally and until the position is filled the hat is being shared. Dr. Marynium reviews all calls and shared by 3 staff at this time		
	B. BLS Providers	VFF – no report OFD – academy currently going on with 13. Announcement for new chief expected any day. It will be someone from out of town		
	C. Base Hospitals	SVH – no report LR – active shooter with VNC last Friday Ped Emer class in January which will be offered to all p and nurses. Zoll monitor with impedence. ER docs not intubate people until after impedence monitor on floor. Ask Debbie for recap Ucsd data has trippled Vcmc – tomorrow grossman burn lecture, encourage staff to go. Last FCA. Publickly thanked everyone who worked on 15 minutes. Thanked all participants. Prescription meds, Trauma transfers – emergent, fit policy but then used regulare IFT for dispatch. Medics need to make BH contact to activate team. AGENDA item SHV – no report. Drug diversion database, Larsen can accept data and no need for notarizationl.		

D. Receiving Hospitals	CMH – construction continues Daucet p0 bi report OF p0 no report PVH 0 new manager, Rebeka Medina		
E. ALS Education Programs	Students hanging in . Hospital time is starting.		
F. EMS Agency	EMS Jeopardy – good attendance. Ty lr for Recruiting for CQI nurse but joint position with EPO. PH nurses interested point to Steve. Radio project is done. Everyint should be installed at hospitals. Some additional traiong for what you do in a disaster Reddinet hope to go to the board ½ wek of January. Shoreline ambulance application, denied, they have 30 days to appeal decision. If appeal goes to BOS. Recovery project. Significant part with homeland security for trainhing. People with disabilities – working on Emergency plans to deal with that population Affordable care act – EMSAAC dealing with the effects that it will have on EMS providers. More insured with lower rates. Chance for significant impact. Statewide effort looking at ambulance wait times. We have a small problem not as large as ours. Transfer of care time in ePCR is being done most times. Important that field crew document . This time needs to be under 15 mintues. Data for VC will be out shortly.		
G. Other			
XI. Closing	**Adjourned 11:20**		

Respectfully submitted
Debbie Haney

Ventura County EMS Agency
Cardiac Arrest Outcome Data

3/08 – 11/08 18 months before study	Presumed Cardiac		BVM	ETT	KA	Combi-Tube	Failed advanced airway, BVM only
N	242		67	128	7	12	28
VT/VF Unknown Shockable	66	27%	18	39	3	1	5
Asystole	119	49%	25	65	4	8	17
PEA	56	23%	23	24	0	3	6
Unknown Unshockable	1	0.4 %	1	0	0	0	0
ROSC	76	31%	30	35	2	1	8
D/C Alive	26	11%	17	8	1	0	0
CPC 1 or 2	25	10%	16	8	1	0	0
CPC 3 or 4	1	0.4%	1	0	0	0	0

12/08 – 8/09 9 months before study	Presumed Cardiac		BVM	ETT	KA	Failed advanced airway, BVM only
N	279		65	132	58	24
VT/VF Unknown Shockable	83	30%	20	36	25	2
Asystole	123	42%	28	60	19	16
PEA	72	26%	17	35	14	6
Unknown Unshockable	1	0.4%	0	1	0	0
ROSC	117	42%	36	53	21	7
D/C Alive	40	14%	20	13	4	3
CPC 1 or 2	35	13%	18	13	2	2
CPC 3 or 4	5	2%	2	0	2	1

9/09 – 5/10 Study, months 1 – 9 (Segment 1)	Presumed Cardiac		BVM	ETT	KA	Failed advanced airway, BVM only
N	291		36	31	219	5
VT/VF Unknown Shockable	72	25%	8	5	59	0
Asystole	152	52%	16	17	117	2
PEA	64	22%	10	9	45	0
Unknown Unshockable	5	2%	4	0	1	0
ROSC	110	38%	17	6	86	1
D/C Alive	32	11%	9	1	22	0
CPC 1 or 2	20	7%	9	0	11	0
CPC 3 or 4	12	4%	0	1	11	0
6/10 – 2/11	Presumed		BVM	ETT	KA	Failed

Ventura County EMS Agency
Cardiac Arrest Outcome Data

Study, months 10-18 (Segment 2)	Cardiac					advanced airway, BVM only
N	279		113	123	41	2
VT/VF Unknown Shockable	58	21%	32	21	4	1
Asystole	148	53%	52	72	24	0
PEA	70	25%	26	30	13	1
Unknown Unshockable	3	1%	3	0	0	0
ROSC	104	37%	54	40	9	1
D/C Alive	30	11%	26	3	1	0
CPC 1 or 2	26	9%	26	2	1	0
CPC 3 or 4	4	1%	3	1	0	0

3/11 – 11/11 Study, months 19-27 (Segment 3)	Presumed Cardiac		BVM	ETT	KA	Failed advanced airway, BVM only
N	285		116	132	22	15
VT/VF Unknown Shockable	68	24%	31	28	5	4
Asystole	144	50%	51	75	10	8
PEA	72	25%	33	29	7	3
Unknown Unshockable	1	0.4%	1	0	0	0
ROSC	114	40%	51	53	6	4
D/C Alive	36	13%	23	12	1	0
CPC 1 or 2	32	11%	21	9	1	0
CPC 3 or 4	5	2%	2	3	0	0

12/11 – 8/12 Study, months 28-36 (Segment 4)	Presumed Cardiac		BVM	ETT	KA	Failed advanced airway, BVM only
N	301		130	117	17	37
VT/VF Unknown Shockable	90	30%	39	29	7	15
Asystole	148	49%	62	63	6	17
PEA	59	20%	28	25	4	5
Unknown Unshockable	1	0.3%	1	0	0	0
ROSC	122	41%	63	42	3	14
D/C Alive	41	14%	30	8	1	2
CPC 1 or 2	36	12%	26	7	1	2
CPC 3 or 4	5	2%	4	1	0	0

Ventura County EMS Agency
Cardiac Arrest Outcome Data
Witnessed, All Rhythms vs. Witnessed, VF/VT/Unk Shockable

	3/08 – 11/08 18 months before study		12/08 – 8/09 9 months before study		9/09 – 5/10 Study, months 1 – 9 (Segment 1)		6/10 – 2/11 Study, months 10-18 (Segment 2)		3/11 – 11/11 Study, months 19-27 (Segment 3)		12/11 – 8/12 Study, months 28-36 (Segment 4)	
Presumed Cardiac	242		279		291		279		285		301	
Bystander Witnessed, All Rhythms	93		123		117		110		116		127	
ROSC	45	48%	71	58%	62	53%	61	55%	61	53%	67	53%
D/C Alive	16	17%	28	23%	22	19%	22	20%	21	18%	24	19%
CPC 1 or 2	16	17%	25	20%	14	12%	19	17%	20	17%	20	16%
CPC 3 or 4	0	0%	3	2%	8	7%	3	3%	1	0.9%	4	6%

	3/08 – 11/08 18 months before study		12/08 – 8/09 9 months before study		9/09 – 5/10 Study, months 1 – 9 (Segment 1)		6/10 – 2/11 Study, months 10-18 (Segment 2)		3/11 – 11/11 Study, months 19-27 (Segment 3)		12/11 – 8/12 Study, months 28-36 (Segment 4)	
Presumed Cardiac	242		279		291		279		285		301	
Bystander Witnessed	93		123		117		110		116		127	
VT/VF/ Unk Shockable	43		58		55		36		45		60	
ROSC	22	51%	37	64%	32	58%	27	75%	31	69%	36	60%
D/C Alive	11	26%	23	40%	17	31%	16	44%	15	38%	20	33%
CPC 1 or 2	11	26%	22	38%	11	20%	15	42%	15	33%	19	32%
CPC 3 or 4	0	0%	1	2%	6	11%	1	3%	0	0%	1	2%

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: ALS Response Unit Staffing		Policy Number: 318
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: December 1, 2010
APPROVED: Medical Director	Angelo Salvucci, MD	Date: December 1, 2010
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 1, 1997 October 14, 2010 October 14, 2010 October 31, 2014	Effective Date: December 1, 2010

I. PURPOSE: To establish medical control standards for ALS response unit paramedic staffing.

II. AUTHORITY: Health and Safety Code, Sections 1797.214, 1797.220, 1798, and 1798.200
22 CCR Division 9, Chapter 4, Sections 100175, 100179

III. DEFINITIONS:

A. ALS Response Unit: First Response ALS Unit, Ambulance Support Vehicle, or ALS Ambulance per VCEMS Policies 506 and 508.

B. Definition of an ALS Patient Contact: A patient contact where the paramedic successfully performs an ALS skill listed in VCEMS Policy 310, with the exception of glucose testing, cardiac monitoring and pulse oximetry.

IV. POLICY:

A. All ALS Response Units must be staffed with a minimum of one Level II paramedic who meets the requirements in this policy.

B. Additional ALS Response Unit staff may be a Level I or II paramedic meeting the requirements in this policy and/or an EMT-1 meeting requirements in VCEMS Policy 306.

C. An ALS Response Unit may be staffed with a paramedic who is not authorized as a Level I or II only if is also staffed by an authorized Ventura County Paramedic Preceptor.

V. PROCEDURE:

A. Level I

1. A paramedic will have Level I status upon completion of the following:
    a. Current Paramedic Licensure by the State of California
    b. Current Accreditation in the County of Ventura per VCEMS Policy 315.
2. To maintain Level I status, the paramedic shall:

a. Maintain employment with an approved Ventura County ALS service provider.
b. Complete a minimum of 288 hours of practice as a paramedic or 30 patient contacts (minimum of 15 ALS) every six month period (January 1 – June 30 and July 1 – December 31);
c. Complete VCEMS continuing education requirements, as described in Section V.C.

3. If the paramedic fails to meet these requirements, s/he is no longer authorized as a Level I paramedic.
4. To be reauthorized as a Level I paramedic, the paramedic must complete a minimum of 48 hours as a second or third crewmember of direct field observation by an authorized Ventura County Paramedic Preceptor, to include a minimum of 5 ALS contacts.

B. Level II

1. A paramedic will have Level II status upon completion of the following:
   a. Employer approval.
   b. All of the requirements of Level I.
   c. A minimum of 288 hours of direct field observation by an authorized Ventura County Paramedic Preceptor.
      1) This will include a minimum of 30 patient contacts, (minimum 15 ALS contacts).
      2) If a paramedic has a minimum of 4000 hours of prehospital field experience performing initial ALS assessment and care, Ventura County Preceptor observation with the approval of the Paramedic Preceptor and PCC may be reduced to 144 hours or 20 patient contacts (minimum 10 ALS).
   d. Approval by the paramedic preceptor who evaluated the majority of contacts.
   e. Successful completion of competency assessments:
      1) Scenario based skills assessment conducted by the candidate's preceptor, provider's clinical coordinator, PCC and PLP when possible.
      2) Written policy competency assessment administered by VCEMS. Passing score will be 80%.
      3) Arrhythmia recognition and treatment assessment administered by VCEMS. Passing score will be 80%.

4) Candidates who fail to attain 80% on either section V.B.e.2)-3) shall attend a remediation session with the Base Hospital PLP or designee or the provider's Medical Director prior to retaking either assessment. Written documentation of remediation will be forwarded to VCEMS.

f. Obtain favorable recommendations of the PCCs who have evaluated the paramedic during the upgrade process. The PCC's recommendations will be based upon a review of the completed performance evaluation standards, review of patient contacts and direct clinical observation. Appeals may be made to the VCEMS Medical Director.

g. Forward Appendix A, Appendix B and copies of the 30 patient contacts to VCEMS.

1) Appendix A shall include all dates and times the upgrading paramedic has spent with the preceptor to total a minimum of 288 hours.

2) Appendix B shall be completed each shift per the Method of Evaluation Key at the bottom of the form.

3) Submit 30 patient contacts, 15 meeting criteria as defined in Section III, Definitions, ALS Patient Contact.

2. To maintain Level II status, the paramedic shall:

a. Maintain employment with an approved Ventura County ALS service provider.

b. Function as a paramedic for a minimum of 576 hours, or have a minimum of 60 patient contacts (minimum 30 ALS), over the previous six-month period (January 1 – June 30 and July 1 – December 31).

1) For those paramedics with a minimum of 3 years field experience, no more than 144 hours of this requirement may be met by documentation of actual instruction at approved PALS, PEPP, ACLS, PHTLS, BTLS, EMT-1 or Paramedic training programs.

2) With the approval of the EMS Medical Director, for those paramedics with a minimum of 3 years of field experience in Ventura County, are employed as a field paramedic in another county or work in an acute care setting (RN or LVN) on a full time basis, complete a minimum of 288 hours of practice, or 30

patient contacts (minimum 15 ALS), in the previous 6 month period in Ventura County.

3) A paramedic whose primary duties are administering the ALS Program (90% of the time) for his/her agency and with approval of the EMS Medical Director may maintain his/her level II status by performing a minimum of 5 ALS calls per 6 months (January 1 – June 30 and July 1 – December 31).

4) If the paramedic fails to meet this requirement:

a) His/her paramedic status reverts to Level I.

b) If Level II authorization has lapsed for less than six months, reauthorization will require completion of a minimum of 96 hours of direct field observation by an authorized Ventura County Paramedic Preceptor, to include a minimum of 10 ALS patient contacts.

c) If Level II authorization has lapsed for less than one year and the paramedic has not worked as a paramedic for 6 months or more during the lapse interval OR if Level II authorization has lapsed for greater than one year, reauthorization will require completion of all of the requirements in Section V.B.1. These requirements may be reduced at the discretion of the VCEMS Medical Director.

d) If the paramedic has been employed as a paramedic outside of Ventura County or has worked in an acute care setting (RN or LVN) during the period of lapse of authorization, these requirements may be reduced at the discretion of the VCEMS Medical Director.

e) Complete VCEMS continuing education requirements, as described in Section V.C.

C. Continuing Education Requirements

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

1. Advanced Cardiac Life Support (ACLS) certification shall be obtained within three months and either Pediatric Advanced Life Support (PALS) certification or Pediatric Education for Prehospital Providers (PEPP) shall be obtained within six months, and remain current.

2. Field Care Audits (Field care audit): Twelve (12) hours per two years, at least 6 of which shall be attended in Ventura County. Base Hospitals will offer Field care audit sessions.
3. Periodic training sessions or structured clinical experience (Lecture/ Seminar) as follows:
    a. Attend one skills refresher session in the first year of the license period, one in the second year, and one every year thereafter.
    b. Education and/or testing on updates to local policies and procedures.
    c. Completion of Ventura County Multi-Casualty Incident training per VCEMS Policy 131.
    d. Successful completion of any additional VCEMS-prescribed training as required. These may include, but not be limited to:
        1) Education, and/or testing, in specific clinical conditions identified in the quality improvement program.
        2) Education and/or testing for Local Optional Scope of Practice Skills.
        3) The remaining hours may be earned by any combination of field care audit, Clinical hours, Self-Study/Video, Lecture, or Instruction at ALS/BLS level. Clinical hours will receive credit as 1-hour credit for each hour spent in the hospital and must include performance of Paramedic Scope of Practice procedures. The paramedic may be required by his/her employer to obtain Clinical Hours. The input of the Base Hospital Prehospital Care Coordinator and/or Paramedic Liaison Physician shall be considered in determining the need for Clinical Hours.
        4) One endotracheal intubation refresher session per six (6) month period based on license cycle, to be held by a Base Hospital, ALS Provider Medical Director approved by the VCEMS Medical Director, or the VCEMS Medical Director.
        5) Successfully complete a CPR skills evaluation using a recording/reporting manikin once per six (6) month period based on license cycle.

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

D. The VCEMS Medical Director may temporarily suspend or withdraw Level I or Level II authorization pending clinical remediation.

E. Failure to comply with the standards of this policy will be considered to be operating outside of medical control.

F. ALS Service Providers must report any change in Level I/II status to VCEMS within 5 days of taking action.

Appendix A

PARAMEDIC UPGRADE EMPLOYER RECOMMENDATION FORM

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

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

Level II Paramedic

_____ All the requirement of level I met.
_____ Completion of 288 hrs of direct field observation by an authorized VC Paramedic Preceptor
_____ Approval by Paramedic preceptor
_____–Submit all appropriate documentation to VCEMS including

	Date	**Hours**	**Preceptor** Print legibly		**Date**	**Hours**	**Preceptor** Print legibly
1				9			
2				10			
3				11			
4				12			
5				13			
6				14			
7				15			
8				16			
Total Hours Completed							

Please sign and date below for approval.

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

Paramedic Preceptor Signature	Print preceptor name legibly	Date:
Employer Signature	Print Employer name legibly	Date

Per section V.B.1.c.2): PCC signature required if paramedic qualifies for shortened upgrade process.

PCC Signature	Print PCC signature legibly	Date

Appendix B

Ventura County EMS Upgrade Procedure			**288 hours or 12 shifts 30 patient contacts (minimum of 15 ALS)**		
Shift	**Policy**	**Procedure/Policy Title to Review**	**Date**	**Preceptor Signature**	**Method of Evaluation (see key)**
1	310	Paramedic Scope of Practice			
	704	Base Hospital Contact			
	705*	General Patient Guidelines			
		SVT			
		VT			
		Cardiac Arrest – Asystole/PEA			
		Cardiac Arrest – VF/VT			
		Symptomatic Bradycardia			
		Acute Coronary Syndrome			
	726	Transcutaneous Cardiac Pacing			
	727	12 Lead ECG			
	334	Prehospital Personnel Mandatory Training Requirements			
	~~1005~~	~~Communication Failure~~			
2	720	Limited Base Contact			
	705	Trauma Assessment/Treatment Guidelines			
		Altered Neurological Function			
		Overdose			
		Seizures			
		Suspected Stroke			
	614	Spinal Immobilization			
3	705*	Behavioral Emergencies			
		Burns			
		Childbirth			
		Crush Injury			
		Heat Emergencies			
		Hypothermia			
		Hypovolemic Shock			
		Bites and Stings			
		Nerve Agent			
		Nausea/Vomiting			
		Pain Control			
		Sepsis Alert			
	451	Stroke System Triage			
4	705*	Allergic/Adverse Reaction and Anaphylaxis			
		Neonatal Resuscitation			
		Shortness of Breath – Pulmonary Edema			
		Shortness of Breath – Wheezes/other			
	705	Trauma Assessment/Treatment Guidelines			
	1404	Guidelines for Inter-facility Transfer of Patients to a Trauma Center			
	1405	Trauma Triage and Destination Criteria			
	1000	Documentation of Prehospital Care			
5	710	Airway Management			
	~~713~~	~~Intralingual Injection~~			
	715	Needle Thoracostomy			
	716	Pre-existing Vascular Access Device			
	717	Intraosseous Infusion			
	728	King Airway			
	722	Transport of Pt. with IV Heparin and NTG			

6	600 601 603 606 613 306	Medical Control on Scene Medical Control at the Scene – EMS Personnel Against Medical Advice Determination of Death Do Not Resuscitate EMT-I: Req. to Staff an ALS Unit			
****		Notify PCC of progress and set dates for tests and ride-a-long.			
7	402 612 618	Patient Diversion/ED Closure Notification of Exposure to a Communicable Disease Unaccompanied Minor ECG Review Radio Communication			
8	 131 607 1202 1203	Mega Codes MCI Hazardous Material Exposure-Prehospital Protocol Air Unit Dispatch for Emergency Medical Response. Criteria for Patient Emergency Transportation			
9		Multiple System Evaluation Review Head to Toe Assessments			
10		Practice Tests			
11		Review Policies and Procedures			
12		Review Policies and Procedures			
	*	Review Drugs, rates and routes that are present in that policy			
	**	PCC ride-a-long			
	**	PCC, Clinical Coordinator, Preceptor and Base Hospital Medical Director interview and scenario			
		Written Test			

Paramedic Name: _____ **License. #**_____**Date**_____

Preceptor Signature_____ **Date**_____

PCC Signature_____ **Date**_____

Employer Signature: _____ **Date:** _____

METHOD OF EVALUATION KEY

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

Appendix C

NAME: _____

EMPLOYER: _____LICENSE #: P_____

Ventura County Accreditation Requirements
Continuing Education Log

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

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

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

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

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

Lecture Hours					
Required Courses		**Date**	**Location**	**# Of Hours**	**Provider Number**
1.	**ACLS** (4 hours)				
2.	**PALS** (4 hours)				
EMS Updates are held in May and November each year. EMS Updates are completed as new or changed policies become effective.					
3.	**EMS UPDATE #1** (1 hour)				
	EMS UPDATE #2 (1 hour)				
	EMS UPDATE #3 (1 hour)				
	EMS UPDATE #4 (1 hour)				
4.	**Ventura County MCI COURSE** (2 hours)				
Any hours that are in addition to the noted amounts in the above categories, should be noted in the additional hours section of this log.					
Skill Refreshers are held in March and September each year. The following requirements must be completed in each year of your license cycle (for example: If your re-licensure month is June 2006, you must complete year one requirement between June 2004 and June 2005 and year two requirement between June 2005 and June 2006).					
5.	**Skills Refresher year 1** (3 hours)				
	Skills Refresher year 2 (3 hours)				
6.	**Endotracheal intubations refresher session (1 session every 6 months based on your license expiration date.)**				
	#1				
	#2				
	#3				
	#4				
Additional Hours (12 hours) These hours can be earned with any combination of additional field care audit, lecture, etc.)					
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					

Hypovolemic Shock

ADULT	PEDIATRIC
BLS Procedures	
Place patient in supine position Administer oxygen as indicated	Place patient in supine position Administer oxygen as indicated
ALS Prior to Base Hospital Contact	
IV access **Normal Saline** • IV bolus – 1 Liter o Caution with cardiac and/or renal history o Evaluate lung sounds. If signs of CHF, decrease IV to TKO o If vital signs return to within normal limits, decrease IV to TKO <u>Traumatic Injury</u> • Do not delay transport for first IV attempt • Attempt second IV while enroute to ED • Refer to Policy 705.01- Trauma Treatment Guidelines, for fluid therapy in abdominal and pelvic trauma.	IV/IO access **Normal Saline** • IV/IO bolus – 20 mL/kg o Caution with cardiac and/or renal history o Evaluate lung sounds. If signs of CHF, decrease IV to TKO o If vital signs return to within normal limits, decrease IV to TKO <u>Traumatic Injury</u> • Do not delay transport for first IV attempt • Attempt second IV while enroute to ED
Communication Failure Protocol	
If shock persists: • *Repeat* **Normal Saline** o IV bolus – 1 Liter	If shock persists: • *Repeat* **Normal Saline** o IV/IO bolus – 20 mL/kg
Base Hospital Orders only	
Consult with ED Physician for further treatment measures	Consult with ED Physician for further treatment measures

Ventricular Tachycardia Sustained – Not in Arrest

BLS Procedures

Administer oxygen as indicated

ALS Prior to Base Hospital Contact

IV Access

Stable – Mild to moderate chest pain/SOB
- **Amiodarone**
  - IVPB **-** 150 mg over 10 minutes

Unstable – ALOC, signs of shock or CHF
- **Midazolam**
  - IV – 2 mg
    - Should only be given if it does not result in delay of synchronized cardioversion
    - For IV use – Dilute 5 mg (1mL) Midazolam with 4 mL NS for a final volume of 5 mL concentration of 1 mg/mL
- **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 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 D_5W 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 IV 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

Suspected Stroke

ADULT

BLS Procedures

Cincinnati Stroke Scale (CSS)
Administer oxygen as indicated

- Administer oxygen if SAO2 < 94% or unknown

If low blood sugar suspected, refer to VC EMS Policy 705.03 – Altered Neurologic Function

ALS Prior to Base Hospital Contact

IV/IO access

Cardiac monitor – document initial and ongoing rhythm strips

Determine Blood Glucose level, treat according to VC EMS policy 705.03 – Altered Neurologic Function

If patient meets Stroke Alert Criteria, as defined in VC EMS Policy 451, expedite transport to nearest Acute Stroke Center (ASC)

Base Hospital Orders only

Consult with ED Physician for further treatment measure

Aditional Information

- **Cincinnati Stroke Scale (CSS).**
  Facial Droop
  Normal: Both sides of face move equally
  Abnormal: One side of face does not move normally
  Arm Drift
  Normal: Both arms move equally or not at all
  Abnormal: One arm does not move, or one arm drifts down compared with the other side
  Speech
  Normal: Patient uses correct words with no slurring
  Abnormal: Slurred or inappropriate words or mute
- Patients meeting Stroke Alert Criteria, as defined in VC EMS Policy 451, shall be transported to the nearest Acute Stroke Center (ASC).
- Stroke patients in cardiac arrest with sustained ROSC (>30 seconds) shall be transported to the nearest STEMI Receiving Center (SRC).
- For seizure activity, refer to VC EMS Policy 705.20 Seizure.
- Minimize scene time and transport Code 3 if symptoms present for 4.5 hours or less.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Medical Control: Paramedic Liaison Physician~~Base Hospital Medical Director~~	Policy Number 701
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: 06/01/2008
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: 06/01/2008
Origination Date: August 1, 1988 Date Revised: January 10, 2008 Date Last Reviewed: November 12, 2009 Review Date: January 31, 2013	Effective Date: June 1, 2008

I. PURPOSE: To define the role and responsibility of the Paramedic Liaison Physician (PLP)~~Base Hospital Medical Director~~ with respect to EMS medical control.

II. AUTHORITY: Health and Safety Code Sections 1707.90, 1798, 1798.2, 1798.102, and 1798.104. California Code of Regulations, Title 22, Sections 100147 and 100162

III. POLICY: The Base Hospital shall implement the policies and procedures of VC-EMS for medical direction of prehospital advanced life support personnel. The PLP~~Base Hospital Medical Director~~ shall administer the medical activities of licensed and accredited prehospital care personnel and ensure their compliance with the policies, procedures and protocols of VC-EMS. This includes:

A. Medical direction and supervision of field care by:

1. Ensuring the provision of medical direction and supervision of field care for Base Hospital physicians, MICNs, PCCs, and Paramedics.
2. Ensuring that field medical care adheres to current established medical guidelines, and that ALS activities adhere to current policies, procedures and protocols of VC EMS.

B. Education by ensuring the development and institution of prehospital education programs for all EMS prehospital care personnel (MDs, MICNs, Paramedics).

C. Audit and evaluation by:

1. Providing audit and evaluation of Base Hospital Physicians, MICNs, PCCs, and ALS field personnel. This audit and evaluation shall include, but not be limited to:
   a. Clinical skills and supervisory activities pertaining to providing medical direction to ALS field personnel.

b. Compliance with current policies, procedures and protocols of the local EMS agency.

c. Base Hospital voice communication skills.

d. Monthly review of all ALS documentation when the patient is not transported.

D. Investigations according to VC EMS Policy 150.

E. Recordkeeping by ensuring that proper accountability and records are maintained regarding:

1. The activities of all Base Hospital physicians, MICNs and Paramedics.
2. The education, audit, and evaluation of base hospital personnel
3. Communications by base hospital personnel

F. Communication equipment operation by ensuring that the base hospital ALS field personnel communication/ telemetry equipment is staffed and operated at all times by personnel who are properly trained and authorized in its use according to the policies, procedures and protocols of VC EMS.

G. Base Hospital liaison by ensuring:

1. Base Hospital physician and PCC representation at Prehospital Services Committee and other appropriate committee meetings
2. Ongoing liaison with EMS provider agencies and the local medical community.
3. On-going liaison with the local EMS agency.

H. Ensuring compliance with Base Hospital Designation Agreement.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Guidelines for Interfacility Transfer of Patients to a Trauma Center	Policy Number 1404
APPROVED: Administration: Steven L. Carroll, EMT-P	Date: October 4, 2012
APPROVED: Medical Director: Angelo Salvucci, M.D.	Date: October 4, 2012
Origination Date: July 1, 2010 Date Revised: October 4, 2012 Date Last Reviewed: October 4, 2012 Review Date: October, 2014	Effective Date: October 4, 2012

I. PURPOSE: To establish guidelines for the transfer of a trauma patient from a hospital in Ventura County to a Level II trauma center.

II. AUTHORITY: Health and Safety Code, §1797.160, §1797.161, and §1798, and California Code of Regulations, Title 22, §100255.

III. DEFINITIONS:

A. **EMERGENT** Transfer: A process by which a patient with potential life-or-limb threatening traumatic injuries is transferred to a trauma center. The patient requires an immediate procedure at a trauma center, and a delay in transfer will result in deterioration of the patient's condition, and the treating physician requests immediate transport to a trauma center.

1. Trauma Call Continuation: A process by which a patient with potential life-or-limb threatening traumatic injuries who has been taken to the emergency department by ALS ambulance is transferred to a trauma center. The patient requires an immediate procedure at a trauma center, the ALS ambulance is still on the premises, and the treating physician requests immediate transport to a designated trauma center.

B. **URGENT** Transfer: A process by which a patient with time-critical traumatic injuries is transferred to a trauma center. The patient requires a timely procedure at a trauma center, and a lengthy delay will result in deterioration of the patient's condition, and the treating physician requests prompt transport to a trauma center.

IV POLICY: The following criteria will be used as a guideline for the transfer of a trauma patient to a trauma center.

A. For patients who are in the emergency department at a community hospital and have one or more of the following injuries, if the referring physician requests transfer to a trauma center, the trauma center will immediately accept the patient

1. Carotid or vertebral arterial injury
2. Torn thoracic aorta or great vessel
3. Cardiac rupture
4. Bilateral pulmonary contusion with PaO2 to FiO2 ratio less than 200
5. Major abdominal vascular injury
6. Grade IV, V or VI liver injuries
7. Grade III, IV or V spleen injuries
8. Unstable pelvic fracture
9. Fracture or dislocation with neurovascular compromise
10. Penetrating injury or open fracture of the skull
11. Glasgow Coma Scale score <14 or lateralizing neurologic signs
12. Unstable spinal fracture or spinal cord deficit
13. >2 unilateral rib fractures or bilateral rib fractures with pulmonary contusion
14. Open long bone fracture
15. Significant torso injury with advanced co-morbid disease (such as coronary artery disease, chronic obstructive pulmonary disease, type 1 diabetes mellitus, or immunosuppression)

B. Ventura County Level II Trauma Centers:

1. Agree to immediately accept from Ventura County community hospitals, patients with conditions included in the guidelines above.
2. Will publish a point-of-contact phone number for an individual authorized to accept the transfer of a patient with a condition included in the guidelines above, or to request consultation with a trauma surgeon.
3. Will establish a written interfacility transfer agreement with every hospital in Ventura County.

C. Community Hospitals:

1. Are not required to transfer patients with conditions included in the guidelines above to a trauma center when resources and capabilities for providing care exist at their facility.
2. Will enter into a written interfacility transfer agreement with every trauma center in Ventura County.

D. **EMERGENT** Transfers

1. **EMERGENT** transfers are indicated for patients with life-or-limb threatening injuries in need of emergency procedures at a trauma center. Criteria **MUST** include at least one of the following:
   a. Indications for an immediate neurosurgical procedure.
   b. Penetrating gunshot wounds to head or torso.
   c. Penetrating or blunt injury with shock.
   d. Vascular injuries that cannot be stabilized and are at risk of hemorrhagic shock or loss of limb acutely (excluding fingers/toes).
   e. Pregnancy with indications for an immediate Cesarean section.
2. For **EMERGENT** transfers, trauma centers will:
   a. Publish a single phone number ("hotline"), that is answered 24/7, for an individual authorized to accept the transfer of patients who have a condition as described in Section D.1 of this policy.
   b. Immediately upon initial notification by a transferring physician, accept in transfer all patients who have a condition as described in Section D.1 of this policy.
   c. Immediately post on ReddiNet when there is no capacity to accept trauma patients.
3. For **EMERGENT** transfers, community hospitals will:
   a Assemble and maintain a "Emergency Transfer Pack" in the emergency department to contain all of the following:
      1. Checklist with phone numbers of Ventura County trauma centers.
      2. Patient consent/transfer forms.
      3. Treatment summary sheet.
      4. Ventura County EMS "Emergency Trauma Patient Transfer QI Form."
   b. Have policies, procedures, and a quality improvement system in place to track and review all **EMERGENT** transfers and Trauma Call Continuations.
   c. Maintain an ambulance arrival to emergency department (ED) departure time of no longer than ten minutes.

d. Establish policies and procedures to make personnel available, when needed, to accompany the patient during the transfer to the trauma center.

4. For **EMERGENT** transfers, Ventura County Fire Communications Center (FCC) will:
   a. Respond to an **EMERGENT** transfer request by immediately dispatching the closest available ALS ambulance to the requesting hospital.
   b. Consider Trauma Call Continuation transfers to be a follow-up to the original incident, and will link the trauma transfer fire incident number to the original 911 fire incident number.
5. For **EMERGENT** transfers, ambulance companies will:
   a. Respond immediately upon request.
   b. For "Trauma Call Continuation" requests, immediately transport the patient to a trauma center with the same ALS personnel and vehicle that originally transported the patient to the community hospital.
   c. Not be required to consider **EMERGENT** transports as an "interfacility transport" as it pertains to ambulance contract compliance.

E. **URGENT** Transfers
1. **URGENT** transfers are indicated for patients with time-critical injuries in need of timely procedures at a trauma center.
2. For **URGENT** transfers, trauma centers will:
   a. Publish a single phone number, that is answered 24/7, for a community hospital physician to consult with a trauma surgeon.
3. For **URGENT** transfers, community hospitals will:
   a. Maintain an ambulance arrival to emergency department (ED) departure time of no longer than twenty minutes.
4. For **URGENT** transfers, ambulance companies will:
   a. Arrive at the requesting ED no later than thirty minutes from the time the request was received.

V. PROCEDURE:

A. **EMERGENT** Transfers
1. After discussion with the patient, the transferring hospital will:

a. Call the trauma hotline of the closest trauma center to notify of the transfer.

b. Call FCC, advise they have an **EMERGENT** transfer, and request an ambulance. If the patient's clinical condition warrants, the transferring hospital will call FCC *before* calling the trauma center's hotline.

c. Complete transfer consent and treatment summary.

d. Prepare copies of the ED triage assessment form and demographic information form.

2. Upon request for an **EMERGENT** transfer, the dispatch center will dispatch the closest ALS ambulance and verbalize "MEDxxx E MERGENCY Trauma Transfer from [transferring hospital]". The trauma center will be denoted in the incident comments, which will display on the mobile data computer (MDC). If a unit does not have an operational MDC, the transferring hospital will advise the responding ambulance personnel of the destination trauma center.

3. Upon notification, the ambulance will respond Code (lights and siren).

4. FCC will track ambulance dispatch, enroute, on scene, en-route hospital, at hospital, and available times.

5. The patient shall be emergently transferred without delay. Every effort will be made to limit ambulance on-scene time in the transferring hospital ED to ten minutes.

a. All forms should be completed prior to ambulance arrival.

b. Any diagnostic test or radiologic study results may either be relayed to the trauma center at a later time, or if time permits, copied and sent with the patient to the trauma center.

c. Intravenous drips may be discontinued or remain on the ED pump.

d. The transporting paramedic will contact the trauma base hospital enroute and provide updated patient information.

B. Trauma Call Continuation

1. Upon determination of a Trauma Call Continuation, and after discussion with the patient, the community hospital will:

a. Direct the ambulance personnel to prepare to continue the transport to the trauma center.

b. Notify the designated trauma center ED of the immediate re-triage of a trauma patient, and communicate the patient's apparent injuries or reason for the re-triage, after the call is continued and the patient is enroute to the trauma center.

2. Upon notification of Trauma Call Continuation, the ambulance personnel will notify FCC of their assignment to a Trauma Call Continuation. FCC will link the trauma transfer to the original 911 incident and continue tracking en-route hospital (departure from community hospital), at hospital (arrival at trauma center) and available times.

3. When the transferring physician determines the patient is ready and directs ambulance personnel to continue the transport, the ambulance will emergently transport the patient to the trauma center. The transporting paramedic will contact the trauma base hospital enroute and provide updated patient information.

C. **URGENT** Transfers

1. After discussion with the patient, the transferring hospital will:
   a. Call the trauma hotline for the closest trauma center to consult with the trauma surgeon.
   b. Call the transport provider to request an ambulance.
   c. Complete transfer consent and treatment summary.
   d. Prepare copies of the ED triage assessment form.
   e. Limit ambulance on-scene time in the transferring hospital ED to twenty minutes.

2. Upon request for an Urgent transfer, the transport provider will dispatch an ambulance to arrive no later than thirty minutes after the request.

D. For all **EMERGENT** and **URGENT** transfers, the transferring hospital will submit a completed Emergency Trauma Patient Transfer QI Form to the Ventura County EMS Agency within 72 hours. The transfer will be reviewed for appropriate and timely care and to identify opportunities for improvement. Results will be reviewed and discussed at the Countywide EMS Trauma Operational Review Committee.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Hospital Emergency Services Reduction Impact Assessment		Policy Number 124
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: 06/01/2008
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 1999 May 13, 2004 November 12, 2009 April, 2013	Effective Date: December 1, 2004

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

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

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

A. The notification of change proposal must include:

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

B. Evaluation Process

1. Upon receiving notification of a planned reduction or elimination of emergency medical services by a hospital or the California Department of Health Services, the Department, all local hospitals, fire departments, and ambulance providers, and all local planning and or zoning authorities will be notified.
2. Within thirty-five (35) days of notification, the EMS Agency, in consultation with emergency service providers and planning/zoning authorities, will complete and distribute a draft EMS Impact Evaluation utilizing the Impact Evaluation Instrument (Attachment A) and set a public hearing date. At a

minimum, the Impact Evaluation report shall include:

a. Assessment of community access to emergency medical care.
b. Effect on emergency services provided by other entities.
c. Impact on the local EMS system.
d. System strategies for accommodating the reduction or loss of emergency services.
e. Potential options, if known.
f. Public and emergency services provider comments.
g. Suggested/recommended actions.

3. Within fifty (50) days of notification, the EMS Agency will release the draft impact evaluation report to prehospital and hospital emergency services personnel, with a 10 working day comment period; and conduct at least one (1) public hearing, and incorporate the results of those hearings in the final Impact Evaluation. These public hearings may be incorporated with other public meetings held by the Public Health Department, Board of Supervisors and/or other government agencies, commissions, or committees.
4. Within sixty (60) days of receiving notice, the EMS Agency will prepare the final Impact Evaluation, and submit those findings to the California Department of Health Services, State EMS Authority, Board of Supervisors, all city councils, fire departments, ambulance services, hospitals, planning/zoning authorities, local EMS participants and other interested parties.
5. The hospital will serve notice of the public hearing to the community through standard and reasonable efforts (i.e. local newspapers and notices at hospitals) within the affected county.
6. The Department of Health Services will make the final determination as to the nature of emergency services to be provided by the hospital seeking reduction or closure.
7. The hospital proposing a reduction or closure of service(s) will be charged a $750.00 fee by Ventura County Emergency Medical Services for the impact evaluation.

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

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

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

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

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Lay Rescuer Automated External Defibrillation (AED) Provider Standards		Policy Number 1301
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: March 11, 2010
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: March 11, 2010
Origination Date: Date Revised: Date Last Reviewed: Review Date:	September 14, 2000 March 11, 2010 March 11, 2010 March 31, 2012	Effective Date: March 11, 2010

I. PURPOSE

A. To provide for system wide lay rescuer automated external defibrillation standards, review and oversight by Ventura County Emergency Medical Services.

B. To provide structure to programs implementing automated external defibrillators for use by lay persons treating victims of cardiac arrest.

C. To provide for integration of public access defibrillation programs in the established emergency medical services system.

D. To provide a mechanism for AED Quality Improvement throughout the Ventura County EMS System.

II. AUTHORITY

A. California Health and Safety Code Sections 1797.5, 1797.107, 1797.190 and 1797.196.

B. California Code of Regulations Title 22, Division 9, Chapter 1.8 Sections 100031 through 100042, as revised January 8, 2009.

III. SERVICES PROVIDED AND APPLICABILITY

AED programs shall be operated consistent with VCEMS policy and California State statutes and regulations.

IV. DEFINITIONS

A. “AED Service Provider” means any agency, business, organization or individual who purchases an AED for use in a medical emergency involving an unconscious person who is not breathing. This definition does not apply to individuals who have been prescribed an AED by a physician for use on a specifically identified individual.

B. “Automated External Defibrillator” or “AED” means an external defibrillator that after user activation is capable of cardiac rhythm analysis and will charge and deliver a shock, either automatically or by user interaction, after electronically detecting and assessing ventricular fibrillation or rapid ventricular tachycardia.

C. "Lay Rescuer" means any person, not otherwise licensed or certified to use the automated external defibrillator, who has met the training standards of this policy.

D. "Medical Director" means a physician and surgeon currently licensed in California, who provides medical oversight to the AED Service Provider as set forth in California Code of Regulations, Title 22, Section 100040..

E. "Cardiopulmonary resuscitation" or "CPR" means a basic emergency procedure for life support, consisting of artificial respiration, manual external cardiac massage, and maneuvers for relief of foreign body airway obstruction.

F. "Internal Emergency Response Plan" means a written Internal Emergency Response Plan of action which utilizes responders within a facility to activate the "9-1-1" emergency system, and which provides for the access, coordination, and management of immediate medical care to seriously ill or injured individuals.

V. GENERAL TRAINING PROVISIONS: APPLICATION AND SCOPE

A. Any training program, AED Service Provider or vendor may authorize a Lay Rescuer to apply and operate and AED on an unconscious person who is not breathing only if that Lay Rescuer has successfully completed a CPR and AED course according to the standards prescribed in this policy.

B. The training standards prescribed by this policy shall apply to employees of the AED Service Provider and not to licensed, certified or other prehospital emergency medical care personnel as defined by Section 1797.189 of the Health and Safety Code.

VI. MEDICAL DIRECTOR REQUIREMENTS

Any AED Service provider shall have a physician Medical Director who:

A. Meets the qualifications of a Medical Director per California Code of Regulations, Title 22, Section 100036.

B. Shall ensure that AED Service Provider's Lay Rescuer CPR and AED training meets the requirements of this policy.

C. Shall review each incident where emergency care of treatment on a person in cardiac arrest is rendered and to ensure that the Internal Emergency Response Plan, along with the CPR and AED standards that the Lay Rescuer was trained to, were followed.

D. Is involved in developing an Internal Emergency Response Plan and to ensure compliance for training, notification, and maintenance as set forth in this policy.

E. The Medical Director shall maintain a list of authorized individuals that s/he has trained.

F. The Medical Director (or his/her designee) shall maintain a record of authorized individuals that are currently participating in the AED program under that physician's control. The record shall include the authorized individuals:

1. Name
2. Address
3. Telephone Number
4. Copy of CPR certificate
5. Date of initial training
6. Dates of retraining

G. VCEMS may audit or review this information upon request.

H. The Medical Director shall review each incident of application and the recordings of such.

I. The Medical Director (or his/her designee) shall submit a "Report of CPR or AED Use" form (attachment A) to Ventura County EMS within 96 hours of a cardiac arrest incident at an AED site. Send this completed form to:

AED Program
Ventura County EMS
2220 E. Gonzales Road, Suite 130
Oxnard, CA 93036-0619

VII. AED VENDOR REQUIREMENTS:

Any AED vendor who sells an AED to an AED Service Provider shall notify the AED Service Provider, at the time of purchase, both orally and in writing of the AED Service Provider's responsibility to comply with this policy.

A. Notify the local EMS Agency of the existence, location, and type of AED at the time it is acquired.

B. Provide to the acquirer of the AED all information governing the use, installation, operation, training, and maintenance of the AED.

VIII. AED TRAINING PROGRAM REQUIREMENTS: REQUIRED TOPICS AND SKILLS

The Lay Rescuer shall maintain current CPR and AED training, as prescribed in this policy.

CPR and AED training shall comply with the American Heart Association or American Red Cross CPR and AED Guidelines. The training shall include the following topics and skills:A. Basic CPR skills;

B. Proper use, maintenance and periodic inspection of the AED;

C. The importance of;

1. Early activation of an Internal Emergency Response Plan
2. Early CPR
3. Early defibrillation

4. Early advanced life support, and

D. Overview of the local EMS system, including 9-1-1 access, and interaction with EMS personnel; E. Assessment of an unconscious patient, to include evaluation of airway and breathing, to determine appropriateness of applying and activating an AED.

F. Information relating to defibrillator safety precautions to enable the individual to administer shock without jeopardizing the safety of the patient or the Lay Rescuer or other nearby persons to include, but not limited to;

1. Age and weight restrictions for use of the AED,
2. Presence of water of liquid on or around the victim,
3. Presence of transdermal medications, and
4. Implantable pacemakers or automatic implantable cardioverter-defibrillators;

G. Recognition that an electrical shock has been delivered to the patient and that the defibrillator is no longer charged.

H. Rapid, accurate assessment of the patient's post-shock status to determine if further activation of the AED is necessary; and,

I. The responsibility for continuation of care, such as continued CPR and repeated shocks, as indicated, until the arrival of more medically qualified personnel.

J. The training standards prescribed by this section shall not apply to licensed, certified or other prehospital emergency medical care personnel as defined by Section 1797.189 of the California Health and Safety Code.

IX. TESTING

CPR and AED training for Lay Rescuers shall include a competency demonstration of skills on a manikin, directly observed by an instructor which tests the specified conditions prescribed in California Code of Regulations, Title 22, Section 100038.

X. AED SERVICE PROVIDER OPERATIONAL REQUIREMENTS

A. An AED Service Provider shall ensure their internal AED programs include all of the following:

1. Development of a written Internal Emergency Response Plan which describes the procedures to be followed in the event of an emergency that may involve the use of an AED and complies with this policy. The written Internal Emergency Response Plan shall include but not be limited to, immediate notification of 9-1-1 and trained office personnel at the start of AED procedures.
2. Maintain AEDs in working order and maintain current protocols on the AEDs.
3. That all applicable VCEMS policies and procedures be followed.

4. That Lay Rescuers complete a training course in CPR and AED use and maintain current CPR and AED training that complies with requirements of this policy at a minimum of every two years and are familiar with the Internal Emergency Response Plan.
5. For every AED acquired up to five units, no less than one Lay Rescuer per AED unit shall complete a training course in CPR and AED use that complies with the requirements of this policy. After the first five AED units are acquired, one Lay Rescuer shall be trained for each additional five AED units required. AED Service Providers shall have Lay Rescuers who should be on site to respond to an emergency that may involve the use of an AED unit during normal operating hours.
6. That the defibrillator is maintained and regularly tested according to the operation and maintenance guidelines set forth by the manufacturer, and according to any applicable rules and regulations set forth by the governmental authority under the Federal Food and Drug Administration and any other applicable state and federal authority.
7. Every AED shall be checked for readiness after each use and at least once every 30 days if the AED has not been used in the preceding 30 days. Records of these periodic checks shall be maintained.
8. That a mechanism exists to ensure that any person, either a Lay Rescuer as part of the AED Service Provider, or member of the general public who renders emergency care of treatment on a person in cardiac arrest by using the service provider's AED activates the emergency medical services system as soon as possible, and reports any use of the AED to the Medical Director and the local EMS Agency.
9. That there is involvement of a currently licensed California physician and surgeon that meets the requirements of California Code of Regulations, Title 22, Section 100040.
10. That a mechanism exists that will assure continued competency of the CPR and AED trained individuals in the AED Service Provider's employ to include periodic training and skills proficiency demonstrations.

XI. INTERNAL EMERGENCY RESPONSE PLAN

A. AED programs are required to establish and utilize an AED medical control program meeting the requirements of Title 22, Division 9, Chapter 1.8, Section 1000.35

B. The Medical Director of Ventura County EMS is responsible for authorizing AED programs, and assuring those programs comply with the medical control requirements of Title 22, Division 9, Chapter 1.8, Section 100035.

Attachment A

Ventura County EMS Agency
REPORT OF CPR OR AED USE

AED Program (location name)	
AED Provider (defibrillator user)	
Place of Occurrence (address and specific site)	
Date Incident Occurred	
Time of Incident	
Patient's Name (if able to determine)	
Patient's Age (Estimate if unable to determine)	
Patient's Sex (Male or Female)	
Time (Indicate best known or approximated time):	
• Witnessed arrest to CPR	
• Witnessed arrest to 9-1-1 Called	
• Witnessed arrest to first shock	
• Patient contact to first shock	
• 9-1-1 to arrival on scene	
• 9-1-1 to first shock	
• Total number of defibrillation shocks	

Was the cause of the arrest determined?	Yes	No
Was the cause of the arrest cardiac?	Yes	No
Was the arrest witnessed?	Yes	No
Was bystander CPR implemented?	Yes	No
Was there any return of spontaneous circulation?	Yes	No

Please attach any additional information that you think would be helpful.

This form must be completed and sent to Ventura County EMS within 96 hours of a cardiac arrest incident at an AED site. Send this completed form to:

Ventura County EMS - AED Program
2220 E. Gonzales Road, Suite 130
Oxnard, CA 93036-0619
FAX: 805-981-5300

Office Use Only

• Date Received by EMS Agency	
• Patient prehospital outcome	
• Patient discharged from hospital?	

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Pre-Hospital Personnel Mandatory Training Requirements		Policy Number: 334
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: June 1, 2009
APPROVED: Medical Director	Angelo Salvucci, MD	Date: June 1, 2009
Origination Date: Date Revised: Date Last Reviewed: Review Date:	September 14, 2000 December 11, 2008 December 11, 2008 December 31, 2012	Effective Date: June 1, 2009

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

Paramedic Name: _____ **CA License No.:** _____

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.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Notification Of Personnel Changes-Provider		Policy Number 342
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: 12/01/07
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: 12/01/07
Origination Date: Date Revised: Last Review: Review Date:	May 15, 1987 September 13, 2007 June 11, 2009 September 30, 2012	Effective Date: December 1, 2007

I. PURPOSE

To define a procedure to assure that the Ventura County Emergency Services Agency is notified of hiring or termination of employment of an EMT-IA or paramedic and MICN.

II. AUTHORITY:

Health and Safety Code, Chapter 1, Article 1.

III. POLICY

Each provider of prehospital EMS services shall notify, Emergency Medical Services Administrative Office, in writing or by e-mail, of hiring or termination of employment of an EMT-I, paramedic or MICN.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Advanced Life Support Transport Provider Criteria		Policy Number 501
APPROVED Administration:	Steve L. Carroll, EMT-P	Date: June 1, 2010
APPROVED Medical Director:	Angelo Salvucci, M.D.	Date: June 1, 2010
Origination Date: Date Revised: Last Reviewed: Review Date:	April 1984 September 8, 2005 November 12, 2009 April 30, 2013	Effective Date: December 1, 2005

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

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

III. AUTHORITY:

Health and Safety Code, Section 1797.218.

IV. PROCEDURE:

A. ALS Transport Provider Requirements

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

1. ALS Unit Response Capability

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

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

2. ALS Unit Coverage and Staffing

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

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

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

3. ALS Patient Transport

Provide transportation for ALS patients in an ALS unit.

4. ALS Communications

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

   Alternatively staffed ALS units shall have mobile, hands free communication units to allow the paramedic to establish and maintain Base Hospital contact on scene or en route while continuing patient care.

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

5. ALS Drugs, Equipment and Supplies

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

6. Contract with VC EMS

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

7. Medical Direction

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

8. Personnel Records

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

9. ACLS and PALS/PEPP Course

   Assure that each paramedic maintains current ACLS and PALS/PEPP courses.

10. Quality Assurance

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

11. Basic Life Support

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

12. ALS Rates

    Charge ALS rates, as approved by the Board of Supervisors, only when ALS services are performed.

13. Documentation

    Submit documentation according to VC EMS Policy 1000.

B. Advertising

1. ALS Transport Provider

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

2. ALS Responding Unit

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

C. ALS Policy Development

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

D. Contract Review

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

E. Denial, Suspension or Revocation of Transport Provider Approval

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

F. ALS Transport Provider Review Process, New Designation

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

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Advanced Life Support (ALS) Support Vehicles		Policy Number 506
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: 06/01/2008
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: 06/01/2008
Origination Date: Revised Date: Last Reviewed: Review Date:	October 1995 November 8, 2007 August 13, 2009 November 30, 2012	Effective Date: June 1, 2008

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

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

III. PROCEDURE:

A. Dispatch of an ALS Support Vehicle is recommended in the following circumstances:

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

B. Personnel Requirements

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

C. Equipment Requirements

An ASV will carry supplies and equipment according to Policy 504.

D. Documentation

ASV care shall be documented per Policy 1000.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: First Responder Advanced Life Support Providers		Policy Number: 508
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: 06/01/2010
APPROVED: Medical Director	Angelo Salvucci, MD	Date: 06/01/2010
Origination Date: Date Revised: Date Last Reviewed: Review Date:	June 1, 1997 October 13, 2005 November 12, 2009 April, 2013	Effective Date: December 1, 2005

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

II. Authority: Health and Safety Code, Sections 1797.206, 1797.220, and 1798.

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

IV. Policy:

A. FRALS Provider Requirements:

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

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

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

Alternatively staffed ALS units shall have mobile, hands free communication units to allow the paramedic to establish and maintain Base Hospital contact on scene or en route while continuing patient care.

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

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

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

   Keep a personnel file for each paramedic and EMT-I, which includes but not limited to licensure/certification, accreditation, employment status and performance.
7. ACLS and PALS/PEPP Course

   Assure that each paramedic maintains current ACLS and PALS/PEPP course.
8. Quality Assurance

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

   FRALS shall carry the following equipment:

   a. ALS Drugs, Equipment and Supplies

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

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

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

10. Documentation

Submit documentation according to VC EMS Policy 1000.

B. ALS Policy Development

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

C. Agreement Review

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

D. Denial, suspension or Revocation of FRALS Provider Approval

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

E. FRALS Provider Review Process, New Designation

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

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Hazardous Material Exposure: Prehospital Protocol	Policy Number: 607
APPROVED: Administration: Steven L. Caroll, EMT-P	Date: 06/01/2010
APPROVED: Medical Director Angelo Salvucci, MD	Date: 06/01/2010
Origination Date: February 12, 1987 Date Revised: March 11, 2010 Date Last Reviewed: March 11, 2010 Review Date: March, 2013	Effective Date: June 1, 2010

I. PURPOSE: This policy establishes guidelines for the response of pre-hospital care providers to incidents involving hazardous materials.

II. AUTHORITY: Health and Safety Code, Division 2.5, Sections 1797.220 & 1798. California Code of Regulations, Title 22, Division 9, Section 100175.

III. POLICY: The Ventura County Regional Response Team (VCRRT), under direction of the Incident Commander, assumes responsibility for control of the hazardous materials incident.

The responding Emergency Medical Services personnel assume responsibility for patient care and transportation after release and/or decontamination by VCRRT. The EMS personnel and/or treatment team shall coordinate treatment/transport efforts with VCRRT so as not to jeopardize scene integrity, causing unnecessary spread of contamination to ambulance, equipment, EMS personnel and hospital personnel or citizens.

IV. PROCEDURE:

A. INITIAL NOTIFICATION

1. The responding EMS unit shall be notified by the Fire Department as soon as possible on all hazardous material incidents in order to facilitate their entry into the scene. Necessary information should include:

   a. Radio channel/frequency for the incident

   b. Estimated number of victims or potential victims

   c. Urgency of the incident

   d. Approach to the incident

e. Location of the staging area
f. Identification (radio designation) of the Incident Commander
g. Hazardous substance involved
h. Request for specialized equipment needed

2. While enroute, the EMS unit shall make radio contact with the Incident Commander or FCC and verify location, approach and staging information prior to their arrival on-scene.
3. Upon arrival at the scene, the ambulance unit shall notify the base hospital or receiving hospital affected as to the number of patients, description of hazard, and any other pertinent information relative to hospital needs. (Note: the IC or VCRRT should provide this information upon request).

B. ARRIVAL ON-SCENE

1. If the scene has not been secured and a staging area has not been established, the ambulance unit should make radio contact with the Incident Commander or FCC for staging instructions.
2. In the absence of an Incident Commander and/or a staging area, EMS personnel should stay upwind and avoid entering the contaminated area.
3. If the scene has been secured, the first-in ambulance unit should enter the staging area and report to the Incident Commander for direction.

C. VICTIM DECONTAMINATION

1. Victims contaminated by a hazardous substance or radiation shall be appropriately decontaminated by VCRRT, despite the urgency of their medical condition, prior to being moved to the triage area for transporation.
2. VCRRT shall determine the disposition of all contaminated clothing ad personal articles.
3. The transfer of the victim from the contaminated zone to the safe zone must be accomplished by trained personnel in an appropriate level of protective clothing and carefully coordinated so as not to permit the spread of contamination.
4. Contaminated clothing and personal articles shall be properly prepared for disposal by the VCRRT.

5. Every effort shall be made to preserve, protect and return personal articles.

D. TRANSPORTATION

1. Any equipment, including transportation units, found to have been exposed and contaminated by a hazardous substance shall be taken out of service pending decontamination and a second ambulance unit responded to transport patients to the hospital when available.
2. At no time shall ambulance personnel transport contaminated patients. If during transport a victim off-gasses a strong odor or vomits what is believed to be toxic emesis, personnel/victim shall vacate ambulance and request assistance from fire.
3. Prior to transportation of patients to the hospital, the ambulance unit shall notify the hospital of the following:
   a. number of victims
   b. confirmation that patients being transported have been field decontaminated
   b. extent each patient was contaminated
   c. materials causing contamination
   d. extent of injuries
   e. patient assessment
   f. ETA
   g. any other pertinent information

E. ARRIVAL AT EMERGENCY ROOM

1. Upon arrival at the hospital, emergency room personnel shall meet the patient at the ambulance in order to determine if further decontamination is needed prior to delivery of patient(s) into the emergency room.
2. All hospitals should develop a plan for receiving patients who have been decontaminated and those patients who may need additional decontamination and a contingency plan for mass decontamination.
3. If additional decontamination resources are needed, the VCRRT decontamination equipment and personnel may be requested through dispatch.

F. EMERGENCY PERSONNEL DECONTAMINATION

1. All treatment team members coming in contact with contaminated patients or contaminated materials shall take immediate measures to insure proper decontamination. Secondary decontamination is recommended which includes taking a shower and changing clothes.
2. Clothing, bedding, instruments, body fluids, etc. may be considered extremely hazardous and must be handled with care, contained and disposed of properly.
3. Follow-up monitoring of all personnel shall be conducted as deemed necessary by the Medical Director.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Organ Donor Information Search		Policy Number 615
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: 06/01/2008
APPROVED: Medical Director:	Angelo Salvucci, M.D.	Date: 06/01/2008
Origination Date: Date Revised: Date Last Reviewed: Review Date:	October 1, 1993 March 11, 2004 November 12, 2009 January, 2013	Effective Date: June 1, 2004

I. PURPOSE: To establish guidelines for Emergency Medical Services (EMS) field personnel to meet requirements that they search for organ donor information on adult patients for whom death appears to be imminent.

II. AUTHORITY: Health and Safety Code Section 7152.5(b)

III. POLICY: EMS field personnel shall make a brief reasonable search to determine the presence or absence of an organ donor card on adult patients for whom death appears to be imminent. This brief search shall not interfere with patient care, and must be done in the presence of a witness, preferably a public safety officer, unless extenuating circumstances make having a witness clearly infeasible.

IV. DEFINITIONS:

A. "Reasonable Search": A brief attempt by EMS field personnel to locate documentation that may identify a patient as a potential organ donor, or one who has refused to make an anatomical gift. This search shall be limited to a wallet, purse or other personal belongings on or near the individual likely to contain a driver's license or other identification card with this information. A REASONABLE SEARCH SHALL NOT TAKE PRECEDENCE OVER PATIENT CARE/TREATMENT.

B. "Imminent Death": A condition wherein illness or injuries are of such severity that in the opinion of EMS field personnel, death is likely to occur before the patient arrives at a hospital. For purposes of this policy, this definition does not include any conscious patient regardless of the severity of illness or injury.

C. "Receiving Hospital": The hospital to which the patient is being transported.

IV. PROCEDURE:

A. When EMS field personnel encounter an unconscious adult patient for whom it appears that death is imminent (that is, death prior to arrival at a hospital), they shall attempt a "reasonable search" as defined in Section III. A. This search must be done in the presence of a witness, preferably a public safety officer, unless extenuating circumstances make having a witness clearly infeasible. If a family member or patient representative is the only witness available, EMS field personnel should clearly and carefully explain the intent of the brief search. The identity of the witness to the brief search will be documented on the approved Ventura County Documentation System.

B. Treatment and transport of the patient remains the highest priority for EMS field personnel. This search shall not interfere with patient care or transport.

C. EMS field personnel shall notify the receiving hospital if organ donor information is discovered. Advanced Life Support (ALS) units shall notify the base hospital in addition to the receiving hospital.

D. Any organ donor document that is discovered should be transported to the receiving hospital with the patient unless it is requested by the investigating law enforcement officer. If the investigating law enforcement officer retains the organ donor card, the presence of the card will be documented on the approved Ventura County documentation system. In the event that the patient is not transported, any document will remain with the patient.

E. Field personnel should briefly note the results of the search, notification of hospital, and witness name(s) on the approved Ventura County Documentation System.

F. No search is to be made by EMS field personnel after patient death occurs.

G. If a member of the patient's immediate family or other patient representative objects to the search for an organ donor document at the scene, no search shall be made, and their response to a question about the patient's organ donor wishes may be considered to satisfy the requirement of this policy. This information shall be documented on the approved Ventura County Documentation System.

COUNTY OF VENTURA HEALTH CARE AGENCY	EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Guidelines for Limited Base Contact	Policy Number 720
APPROVED Administrator: Steven L. Carroll, EMT-P	Date: Jun 1, 2011
APPROVED Medical Director: Angelo Salvucci, MD	Date:June 1, 2011
Origination Date: June 15, 1998 Date Revised: February 10, 2011 Date Last Reviewed: February 10, 2011 Review Date: February, 2013	Effective Date: June 1, 2011

I. PURPOSE: To define patient conditions for which Paramedics shall establish LIMITED BH contact.

II. AUTHORITY: Health and Safety Code 1797.220.

III. POLICY: Paramedics shall make Limited BH contact for uncomplicated cases, which respond positively to initial treatment and require no further intervention or where symptoms have resolved.

A. Patient criteria:

1. Hypoglycemia
2. Narcotic Overdose.
3. Chest pain – Acute Coronary Syndrome no arrhythmia, or associated shortness of breath.
4. Shortness of Breath - Wheezes/Other
5. Altered Neurological Function - Chemstick > 60 6. Seizure: No drug ingestion, no dysrhythmias, Chemstick > 60 (no longer seizing, not status epilepticus, not pregnant).
7. Syncope or near-syncope (stable vs. no dysrhythmia, Chemstick > 60.)
8. Pain
9. Nausea and vomiting

B. Treatment to include:

1. Hypoglycemia: Prior to Contact procedure up to Dextrose
2. Narcotic Overdose: Prior to Contact procedure up to Naloxone
3. Chest Pain: Prior to Contact procedure up to three sublingual nitroglycerin or nitroglycerin spray (administered by paramedic) and Aspirin 324 mg po.
4. Shortness of Breath – Wheezes/Other: Prior to Contact procedure up to one nebulized breathing treatment only (administered by paramedic).
5. Altered Neurological Function: Prior to Contact procedure up to administration of Dextrose.
6. Seizure: Prior to contact procedure up to administration of Dextrose and/or Versed.
7. Syncope or near-syncope: Prior to Contact procedure up to IV Chemstick check.

8. Pain: Prior to Contact procedure, including administration of Morphine.
9. Nausea/Vomiting: Prior to Contact procedure, up to and including administration of Ondansetron.

C. Communication
   1. The limited BH contact call-in shall include the following information:
      a. ALS unit number
      b. "We have a Limited Base Contact (LBC)"
      c. Age/Sex
      d. Brief nature of call
      e. ETA and destination

D. Documentation
   1. ALS Unit
      a. Complete the Approved Ventura County Documentation System with "LBC" noted in the "Base Hospital Contact" box.
   2. MICN
      a. Complete log entry with "LBC" noted in the treatment section.
      b. EMT-P/BH Communication form is NOT required.
      c. Call will be documented on tape.

COUNTY OF VENTURA HEALTH CARE AGENCY		EMERGENCY MEDICAL SERVICES POLICIES AND PROCEDURES
Policy Title: Apparent Life-Threatening Event (ALTE)		Policy Number: 724
APPROVED: Administration:	Steven L. Carroll, EMT-P	Date: 06/01/2008
APPROVED: Medical Director	Angelo Salvucci, MD	Date: 06/01/2008
Origination Date: Date Revised: Date Last Reviewed: Review Date:	March, 2005 November 12, 2009 April, 2013	Effective Date: June 1, 2005

I. PURPOSE: To define and provide guidelines for the identification and management of pediatric patients with an Apparent Life-Threatening Event (ALTE).

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

III. POLICY: All EMS personnel should be knowledgeable with ALTE and follow the guidelines listed below.

IV. PROCEDURE:

A. Recognition:

1. Chief Complaint.
   a. ALTEs (or "near miss SIDS" as previously termed) usually occur in infants under 12 months old, however; any child less than 2 years of age who exhibits any of the symptoms listed below should be considered an ALTE.
   b. An Apparent Life-Threatening Event (ALTE) is any episode that is frightening to the observer (may even think infant or child has died) and usually involves any combination of the following symptoms:
      1) **Marked change or loss in muscle tone**
      2) **Color change** (cyanosis, pallor, erythrism, plethora)
      3) Apnea (central or obstructive)
      4) Loss of consciousness
      5) Choking or gagging
2. History:
   a. Hx of any of the following:
      1) Apnea
      2) Loss of consciousness
      3) Color change
      4) Loss in muscle tone

5) Episode of choking or gagging

b. Determine the severity, nature and duration of the episode.
   1) Was child awake or sleeping at time of episode?
   2) What resuscitative measures were taken?

c. Obtain a complete medical history to include:
   1) Known chronic diseases?
   2) Evidence of seizure activity?
   3) Current or recent infections?
   4) Recent trauma?
   5) Medication history?
   6) Known gastro esophageal reflux or feeding difficulties?
   7) Unusual sleeping or feeding patterns?

3. Treatment:
   a. **Assume the history given is accurate**.
   b. Perform a comprehensive physical assessment that includes general appearance, skin color, extent of interaction with the environment, and evidence of current or past trauma. **Note: Exam May Be Normal**
   c. Treat any identifiable causes as indicated.
   d. Transport. **Note: If parent/guardian refuses medical care/and or transport, a consult with Base Hospital is required prior to completing a Refusal of Care form**.

4. Precautions and Comments
   a. In most cases, the infant/child will have a normal physical exam when assessed by prehospital personnel. The parent/caregiver's perception that "something is or was wrong" must be taken seriously.
   b. Approximately 40-50% of ALTE cases can be attributed to an identifiable cause(s) such as child abuse, SIDS, swallowing dysfunction, gastro esophageal reflux, infection, bronchiolitis, seizures, CNS anomalies, cardiac disease, chronic respiratory disease, upper airway obstruction, metabolic disorders, or anemia. The remaining causes have no known etiology.
   c. Keep in mind, especially if the parent/guardian declines transportation, that child abuse is one cause of ALTE.